



## Preface

This document is a work in progress and part of a much larger collaboration of many more people than is reflected on the cover. For over 25 years Chestnut Health Systems has been at the forefront of developing better substance abuse treatment. Chestnut was among the first treatment providers to experiment with combining treatment for alcoholics and drug users, social detoxification, diversion of criminal offenders, and case management for adolescents in treatment. Over 10 years ago the organization created its Lighthouse Institute in response to the need for research, training and publications that were more relevant to the needs of line treatment staff. Chestnut staff have a long history of using standardized assessment and training that have helped it to repeatedly achieve “commodation status” (top 10%) in reviews by the Joint Commission for the Accreditation of Healthcare Organizations.

The current development of the GAIN is part of a multi-prong response to major changes in substance abuse treatment over the last five years. This includes new diagnostic criteria (DSM-IV, APA, 1994), new accreditation standards (JCAHO, 1995), new patient placement criteria (PPC, ASAM, 1996), integration into managed behavioral health care and an increasing emphasis on outcome monitoring. Together, these changes mean that at the very time the staff are being asked to assess and document at an increasing level, they are given less resources and time to do so (and treat clients). Dissatisfied with available instruments and the nature of others under development, Chestnut has launched three overlapping initiatives. First, it developed an organizational structure for sharing management, quality assurance, computer, training and research resources. Second, Chestnut has been working on developing more appropriate tools (like this), outcome monitoring data to guide decision making, and a series of studies on how to develop more effective and cost-effective approaches to treatment.

The GAIN also benefits from the ideas and contributions of many people. The idea for these instruments came from an early colleague, Jerome Jaffe. During the first year of the Office of Treatment Improvement (Now the Center for Substance Abuse Treatment), Jaffe noted the duplication and waste in the overlap between the information collected by administrators, clinicians and researchers and argued that we should develop an integrated instrument or system for doing this. Starting with the Client Assessment Profile (CAP) being developed for NIDA’s Methadone Quality Assurance Treatment System, the initial Individual Assessment Profile (IAP) was developed by Schlenger and colleagues (1989) for the National Treatment Improvement Evaluation Study (NTIES). That version, however, was never used. It was revised well over two dozen times and resulted in the development of several different instrument streams used in different demonstration projects (as well as an evaluation-only version used in NTIES).

The Global Appraisal of Individual Needs was one of the offsprings of the IAP, and was initially developed as part of a collaboration between researchers, administrators and clinicians at the Research Triangle Institute and two methadone clinics (PBA the Second Step in Pittsburgh and Pathways/Sisters of Charity in Buffalo) under a NIDA-funded Training and Employment Program (TEP) study (Dennis, Fairbank, et al., 1995). To better meet the needs of the clinics, many of the lifetime epidemiological questions were simplified or dropped. In addition, the following questions were added: simple behavioral counts like those in the Addiction Severity Index; questions on what the client “wanted” in order to help with treatment planning; multiple-symptom based screeners according to recommendations from NIDA’s diagnostic sourcebook (Rounsaville, Tims, Horton, & Sowder, 1993) and to meet the interest of clinical staff in other areas they regularly needed to address (e.g., physical and mental distress, violence, environment, problem solving, victimization). Finally, question formats were simplified to reduce respondent burden, and information was added for immediate hand scoring by clinicians. A revised version of this instrument was then adopted for use as part of the New Orleans Target Cities Project, and

several key scales and treatment-need questions were used in the Target Chicago project - both CSAT demonstrations.

Under a grant from the Interventions Foundations, the author revised the GAIN again for the Drug Outcome Monitoring Study (DOMS) to develop norms and case mix adjustments to compare clients in adults and adolescent levels of care. This work was then further expanded for the Adolescent Aftercare Protocol experiment under a grant from the National Institute on Alcohol Abuse and Alcoholism (R01 AA10368) and the Cannabis Youth Treatment study under a cooperative agreement with the Center for Substance Abuse Treatment (TI 11320). The secondary goal of this work was to match DSM-IV for diagnosis, PPC-2 for placement, follow JCAHO for integrating assessment into treatment planning and be integrated into the outcome monitoring to facilitate evaluation and meet documentation requirements. Our continuing goal is to develop a flexible, cost-efficient method of integrated research and clinical assessment and to develop computer applications that help clinicians and researchers with diagnosis, interpretation, placement, treatment planning, outcome monitoring and documentation. Needless to say this has been a challenging and intellectually rewarding process.

Numerous people have made contributions to this work and are acknowledged at [www.chestnut.org/li/gain](http://www.chestnut.org/li/gain) . But I need to single out a thank you Jerry Jaffe for getting me started on this question; Paul Ingram, Marlene Burk, John Guyett, Ken Bossert, Jim Becnel, Scott Ray, Mark Godley, and Chris Scott for letting me work with them on earlier versions; Doug Anglin, Ward Condelli, Tom McLellan, Dwayne Simpson, and Peter Delany for encouraging me; Kathy Rourke who helped developed earlier versions of the material here on standardized interviewing; Jim Fraser for being the one who dared to make the initial commitment when everyone pondered the balance of what was needed with the complexities of accomplishing it; Russ Hagen and Peter Bokos for backing it in the DOMS project; Joan Unsicker, Rod Funk and Jim Ma for not giving up after so many versions; Loree Adams and the staff of both Chestnut and Interventions for contributing so much when the returns were so far down- stream for them; Bill White and Ed Senay for providing countless insights and recommendations that influenced the instrument in more ways than they probably realize. The list could easily go on to include hundreds of counselors and thousands of clients who have helped shape this effort. While I cannot list them all here, I do also want to thank Mike Bohlig, Arthur Bonito, Barry Brown, Mike Boyle, Juesta Caddell, Betty Cavanaugh, Wilson Compton, George Deleon, Sam DiMenza, John Fairbank, Mike French, John Guyett, Paul Ingram, Georgia Karuntzos, Rick Lennox, Bruce MacDonald, Lou Mattia, Valley Rachal, Joyce Roland, Murray Strauss, Holly Waldron, Randy Webber, Wendee Wechsberg, Gail Woods, Jim Wrich and Gary Zarkin.

Finally I would also like to thank the PIs of the AAP study (Mark and Susan Godley) other members of the Executive Committee of the CYT study (Tom Babor, Guy Diamond, Jean Donaldson, Susan Godley, Jim Herrell, and Frank Tims) and Randy Muck for providing the opportunity to further this work.

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# 1. Introduction, Questions and Organization

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Introduction. These instructions are for administering the December 1999 versions of the Global Appraisal of Individual Needs (GAIN). Further instructions for scoring and interpretation are covered in chapters 4-6. The assessment can be self-administered or administered by a clerk, interviewer, or research assistant under the supervision of a person qualified to interpret the results and/or deal with any problems that arise (such as someone becoming emotional or suicidal).

Organization of Documents. The remainder of this document is organized into the following sections: Section 2 reviews information on doing standardized assessments that should be used if you “orally” administer the GAIN and/or if you have no prior training in standardized testing; Section 3 covers basic administration of the assessment, and ratings. In addition, there should be “study specific” attachments related to site, staff, and participant IDs.

Organization of the GAIN and related Instruments. While there are several versions of the GAIN, they are all interrelated in that they share the same general instructions, question numbers, scoring, interpretation, and clinical decision trees. The main two are:

- C **The GAIN-Initial (GAIN-I)** is a full bio-psycho-social that integrates scoring and treatment planning information into the assessment. It includes information for state reporting requirements (e.g., DARTS, DASA, 1996; CDS, OAS, 1995), the Diagnostic and Statistical Manual IV (DSM-IV; APA, 1994) minimum criteria for alcohol and drug abuse and dependence, and the American Society of Addiction Medicine (ASAM, 1996) Patient Placement Criteria-2 (PPC-2) and Joint Commission on the Accreditation of Health Care Organizations (JCAHO, 1995) assessment and treatment planning criteria.
- C **The GAIN - Monitoring for 90 days (GAIN-M90)** is a quarterly follow-up for monitoring how participants respond to treatment and/or do after they have been discharged. It is largely a subset of the GAIN-I and has the same question numbers (which explains why many numbers are skipped).

The GAIN is often supplemented with the respective versions of two sister instruments:

- C **The Collateral Assessment Form for Intake (CAF-I) and CAF-for Follow-up (CAF-F)** which are given to parents, guardians, spouses or other collaterals to help validate participant self reports and check for any areas of denial. The CAF has the same cover page and administration conventions as the GAIN and, where applicable, questions have the same question numbers.
- C **The Supplemental Assessment Form for Intake (SAF-I) and SAF-for Follow-up (SAF-F)** which are used to add additional scales or questions to the GAIN. The SAFs have similar front pages and administration conventions, but are limited to questions that do not overlap with the GAIN.

The content of the GAIN (and main section of the CAF) is divided into eight areas: background and treatment arrangements, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational. In full version, the questions check for major problem areas and the recency of any problems. If a given problem occurred in the past year, additional symptom-based questions (e.g., criteria for alcohol dependence) are asked for the past year to clarify the problem. If it occurred in the past 90 days, detailed behavioral counts are collected (e.g., days of alcohol use, days of drinking 5+ drinks per day, etc.). The GAIN also asks detailed questions about lifetime and current (past 90 days) service

utilization, as well as, changes in the participant's cognitive state (e.g. self efficacy to resist alcohol use, resistance to treatment, motivation to be in treatment, and what services the participant currently wants from treatment). It can be administered orally or initially done as a self-administered assessment by a participant (but which then needs to be reviewed). The GAIN-Monitoring (GAIN-M90) version includes only the questions on current (past 90-day) functioning and service utilization, and is primarily for outcome monitoring post-discharge or long-term treatment participants. The CAF only includes the 90-day questions and a handful of the symptom questions.

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## 2. Conducting Standardized Needs Assessments

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The goal of conducting a standardized needs assessment is to ask the questions (including any probes or follow-up questions) in a uniform and consistent manner. When this is done, we can compare the needs of different participants or groups of participants, or chart the need and behavior of participants over time so that we can determine how to proceed. The principles that help us achieve this will be referred to as General Conventions. These conventions apply to the use of many different types of instruments designed to be administered to a similarly wide range of people in several different ways. For the sake of clarity, the instrument, inventory, or assessment being used will be referred to as the assessment. The person administering the assessment (e.g., clerk, intake worker, counselor, interviewer, research assistant) will be referred to as the administrator. The person answering the questions (e.g., the participant, patient, or person who has since left treatment) will be referred to as the participant. Exhibit 2-1 shows 11 key rules that need to be followed in administering virtually any standardized assessment. Using material adapted from Dennis, Rourke, and colleagues (1995), each of these rules is discussed in the following sections, along with examples showing why they are so important.

### **Exhibit 2-1. Eleven Common Rules for Doing Standardize Assessment**

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1. Ask the questions exactly as printed
  2. Ask the questions in the exact order as printed.
  3. Ask every question specified.
  4. Read the complete question.
  5. Repeat questions that are misunderstood.
  6. Read the question slowly.
  7. Do not suggest answers to the respondent.
  8. Use introductory or transitional statements
  9. Use neutral probes
  10. Listen to responses
  11. Use common sense
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Ask the Questions Using the Exact Words Printed in the Assessment. Each participant must be asked exactly the same question so that the answers indicating their behavior, opinion, attitude, or experience are responses to the same stimulus. When an administrator changes the wording in a question--even slightly--answers may change accordingly. The following example illustrates how changes in wording can produce changes in answers.

<b>Example</b>		
VERSION	QUESTION	ANSWER
Assessment Version	About how many hours do you work in an average week?	20-30 hours
Altered Version 1	How many hours a week do you work?	It depends on what's available. Sometimes 40 or so, other times not at all.
Altered Version 2	How often do you work?	Not often.

A carefully worded and carefully asked question will elicit a fairly precise response. Any deviation from the exact wording of a question, whether deliberate or not, can easily change the response. In the example above, the assessment version of the question asks the participant to perform the following task: consider the number of hours you spend working over a period of time and then give me your best estimate of how many hours you work in what might be considered an average or typical week.

Altered version 1 (above) changes the participant's task; the new task is for the participant to provide a number of hours that he or she works in a week--any week. Altered version 2 does not ask the participant to estimate units within time, and the answer received provides no useful data. In this version, the participant's task is reduced to providing an imprecise measure of working without regard to time period.

Just as altering the wording of the question may affect a participant's answer, reordering words or phrases within the question may also affect the answer. In questions where response categories are part of the question, any change in the order of the response categories may distort results. Likewise, omitting or adding response categories may produce bias. Even when a participant interrupts a question in order to answer, ask him or her to permit you to read all of the response choices before giving a final answer.

You must constantly guard against unintentional changes in wording. You must also, of course, resist the temptation to improve the wording when a question seems difficult to read or understand. Every word in a question is purposely chosen. Therefore, questions must be read exactly as printed wherever possible. It is important to observe this rule so that each participant hears the questions in the same way. If something is problematic, bring it up for review with your clinical supervisor and team. Something should be changed only if everyone agrees.

Ask the Questions in the Exact Order in Which They Appear in the Assessment. The meaning of a question may change or be unclear if it is asked out of sequence, and you may miss some questions entirely if you do not follow the prescribed order. In the GAIN, for instance, questions are often

sequenced to define a problem before asking a general question. Failure to follow the prescribed order will change the participant's understanding of the question. A clear example of this can be seen in the help ratings. At the end of each section in the GAIN-I, participants are asked about specific types of help they might want and then the overall importance of getting this help. Asking them to rate their need first would change the meaning from specific assistance needs to a general sense of need in each area.

Ask Every Question Specified in the Assessment. It is not unusual for a participant to provide information in the answer to one question that seems to answer another question that occurs later in the assessment. In such a case, the administrator may be tempted to skip the later question. These situations should be handled in the following manner. When the administrator receives information that seems to answer an upcoming question, the information should be recorded under the question where it is received. Later, when the related question occurs, the administrator should acknowledge to the participant that he or she remembers what was said earlier. For example, the administrator might say: "We've already talked about this topic a bit, but let me ask..." or "You've told me something about this, but this next question asks..." Then, the question should be asked exactly as it is worded in the assessment. Assuming that the answer to an upcoming question has already been provided is a dangerous practice. The answer received in the context of one question may not be the same answer that will be received when the specific question is asked exactly and directly. Consider the following example.

<b>Example</b>	
<i>Question 1:</i>	Now think about the time you and your husband were planning to get married. Did you and your husband put off your marriage for any length of time for financial reasons?
<i>Response:</i>	Yes. We had to wait about 8 months until my husband could find a job.
<i>Comment:</i>	The participant has provided a response that includes a precise amount of time that she and her husband put off their marriage while he sought employment.
<i>Question 2:</i>	After you and your husband decided to get married, how long was it before you actually did get married?
<i>Response:</i>	Well, we waited the 8 months while my husband looked for a job and then we had to wait another 4 or 5 months until we could save some money. In all, we waited over a year.

In this example, the response to Question 1 is only a partial answer to Question 2, as shown by the additional information provided in the response to Question 2. An assumption that the participant waited 8 months to marry after she and her husband decided to get married is, in this case, totally incorrect.

In summary, every question specified must be asked, even if the administrator feels that he or she already has the answer to a question, based on previous responses. Acknowledge information already

obtained, but permit the participant to answer every question directly. Note that in the quick administration option we have identified a subset with a valid sequence that will still allow interpretation.

Read the Complete Question. A participant may interrupt you and answer before he or she has heard the complete question. When this happens, read the question again, making sure the participant hears it through to the end. Do not assume a premature response applies to the question as written.

Repeat Questions That are Misinterpreted or Misunderstood by the Participant. To do this, you must be familiar with the intent and frame of reference of each question and listen carefully to determine whether or not the response is appropriate before recording.

Read the Questions Slowly. You, as the administrator, are familiar with each question before you conduct your first interview. The participant, however, is hearing every question for the first time and needs to consider individual words and phrases as well as the complete question in order to provide the information requested. Studies have shown that the reading pace established by the administrator is one of the critical elements of the interview. A pace of about two words per second is considered optimal. This allows the administrator time to enunciate every word carefully and gives the participant time to listen and formulate a careful response.

When administrators read questions slowly and carefully, they are demonstrating desirable behavior that should be copied by the participant. If the administrator seems to race throughout the interview, the participant will probably help by providing short, terse responses. One clear indication of asking questions too rapidly is the participant's frequent request that questions be repeated. Take the time in the beginning of each interview to let participants learn how to answer questions, and they will get faster as the interview proceeds and similar types of questions are asked. Time periods, question styles and response styles have all been standardized to facilitate this process.

Do Not Suggest Answers to the Respondent. It is easy to do this unintentionally. Even your facial expressions can reveal your reaction to the content of a response. It is inappropriate for an administrator to give any cues to the participant about whether or not he or she is shocked/approving/disapproving or make any other kind of value judgement regarding the participant's reported behavior. Keep in mind that participants are typically anxious to please the administrators and will (either on a conscious or subconscious level) try to shape their answers, if they feel the administrator does not approve of the behavior.

For the duration of the interview, you must step out of your role as counselor and become an unbiased reporter. Counselors in similar previous interviewing efforts have stumbled into two common pitfalls:

- C When a response conflicts with information the administrator/counselor already knows about the participant, some counselors have reacted by confronting the participant with the discrepancy. This is absolutely an inappropriate action for an administrator. It hinders the rapport between the participant and the administrator and puts the participant on the defensive. Remember that, as an administrator, your job is to record and report what the participant tells you. Discrepancies should be noted, and addressed in later stages of the GAIN protocol. For example, many women who say they trade sex for

drugs say they are not prostitutes. Similarly, there are both men who have sex with men who do not identify themselves as “gay” and men who do identify themselves as “gay,” but who are not having sex with other men. Some counselors may see these statements as contradictory at first glance, but on reflection they may not be, and are not uncommon. Less predictable are complicated situations that lead participants to give unexpected answers that turn out to be valid. In short, don’t rush to confront participants until you have all of the information.

- C When a participant uses less appropriate terms to discuss a subject area (e.g., slang, name calling), some counselors have reacted by mirroring the language used by the participant. An extreme example of this occurred when a participant was asked how many children he had. The participant replied that he had "four brats at home." In a subsequent question that referred to those children, the administrator replaced the word "children" with the word "brats" when asking the question. An administrator should never modify a question in this manner. While it is the participant's prerogative to refer to his or her own kids as brats, it violates Rule No. 1 and can easily become an insult when done by the administrator.

Your opportunity to use your skills as a counselor will come after the initial assessment (i.e., the part that would normally be self-reported) is completed and you have the full picture. While you are administering the assessment, try to avoid these pitfalls and remain an unbiased recorder and reporter of the information the participant gives you. Remember, here you are trying to do a standardized assessment; counseling is the next step.

Use Introductory or Transitional Statements as They are Printed in the Assessment. These occur at points throughout the assessments and should be read as worded. They are particularly important for reassuring participants prior to asking about sensitive information, such as illegal activities, sexual activity, or abuse.

Use Neutral Probes Only as Necessary. For most questions, probe only as necessary to obtain a clear response that meets the question specifications. Do not probe to the negative unless you are instructed to "Check all that apply" ("Probing to the negative" means to continue to ask the participant for answers until he or she indicates there are no more answers--an example is, "What else?") Various types of probes are useful. The most frequently used probes are:

- C Expectant pauses -- wait for a few seconds and see if the participant elaborates.
- C Re-reading the question -- sometimes the participant simply did not completely hear the question.
- C Repeating the answer choices -- sometimes the participant does not understand the kind of answer you are looking for.
- C Neutral comments -- "Tell me more about that," "Please explain that further," "Please give me an example."

On some questions, you may need to help clarify and categorize the participant's answers. In these cases, it is often useful to ask questions like:

- C      What kinds of things did you do?
- C      Can you give me an example of that?
- C      Could you tell me what you meant by \_\_\_\_\_?

Listen to the Responses. Asking questions properly is important, but no more important than listening carefully to the response. A participant may respond to what he or she thought you were about to ask, imagining a question that includes a key word that caught his or her attention. By listening carefully to your participant's answers you can reduce this type of error.

Another common and important situation is when a participant is trying to tell you something but does not know when or whether you will be asking about it. Do not ignore this important message! Tell the participant if you will be getting to it later and/or offer to write a note to make sure you “cover that.” You can do this openly (i.e., between reading and recording answers). Since this was important to the participant, take the opportunity to demonstrate you are listening. Stop what you are doing, make a note, then get them refocused on the interview. If the participant is telling you something very complicated, be certain to read back your note to the participant to make sure you have captured the essence of what he or she was saying (without getting into a detailed discussion about it).

Use Common Sense. For 30 years, standardized interviewing was largely based on the concept of classical learning theory. The questions were the stimuli and the answers were the response. The more standardized the administration, the more reliable the answers (i.e., you get the same answer twice). The catch was that if the participant misunderstood the question, you often got the same “wrong” answer twice. Concerns with increasing validity have, therefore, led the field and us to encourage administrators to use some common sense. For example, let’s say an adolescent participant is asked if he/she has been involved in the criminal justice system and says no. If that participant was brought in handcuffs by a probation officer, it would make sense to repeat the questions and ensure that the participant understands that the question includes detention. Similarly, if a participant says she used marijuana in the past week but then says she used it on none of the past 90 days, it is appropriate to clarify (in a non threatening way) the responses. This said, if the participant wants to stay with a contradictory or unlikely answer - you should do this and move on.

### 3. Basic Administration

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#### 3.1 Basic Anatomy of the GAIN You Need to Know First

The actual GAIN is relatively straightforward to administer. There are, however, several things you need to know about its structure in order to avoid confusion and be ready to answer questions that come up from staff or participants. You should read and understand this section before attempting to administer the GAIN.

Question and Variable Naming Conventions. To facilitate administration, scoring, interpretation and subsequent analysis, a GAIN question is numbered and formatted the same, regardless of the version, as follows.

- The first letter refers to the relevant section: Background and Treatment Arrangements, Substance Use, Physical Health, Risk Behaviors and Health Prevention, Mental and Emotional Health, Environmental and Living Situation, Legal, Vocational, Aministration, Z for end or across(X) data set ID information.
- In documentation, the next numbers and letters refer to the question number within a section, and subletters (e.g., S1, S1a, S1b) imply that questions are interrelated either because of a common stem question or a skip out.
- The next numbers refer to a subresponse “Circle all that apply” type question and follow either the subquestion letter (e.g., S2a1, S2a2) or are separated by an underscore (e.g., S3\_1, S3\_2) multiple response question. The latter is done to avoid confusing question 3, subresponse 1 with question 31.
- If there is an instruction to “please describe” and a line starting with a “v” after it, then in addition to the main variable there is a text variable with the same name plus a “v” (e.g., S7b99 and S7b99v).

You and/or participants may also notice that the letters “i, o, and l” are always skipped in the question numbering. This was done intentionally to avoid confusion in documentation and analysis with the numbers “0 and 1”. As much as possible, responses have been preprinted to minimize writing. We have also included an “other” in most categorical responses and given it a value of “99” so that other categories could be added for a special population or study. Finally, note that the “v” also means that any text written there will be printed “verbatim.”

Question Formats. There are three main types of questions in this assessment: (1) questions that ask you to answer in your own words; (2) questions that ask you to circle one answer in a list of answers; and (3) questions that ask you how many days or times something happened. Questions in your own words do not need to be long, but write neatly so others can read it. For questions that ask you to circle one, participants are asked to pick the one that best fits. An “Other” option is often given with a place to describe what is meant. Questions that ask you how many days or times something happened should always be answered with a number. If the answer is no, none, never or 0, please print a 0 in the open box.

Instructions. Where instructions are given, they appear in **(bold and parentheses like this)**. After a participant answers some questions there may be several more below it that do not apply. When this happens there will be a note between **[SQUARE BRACKETS WITH BOLD CAPITAL LETTERS LIKE THIS]**. It will tell you to go to the next question that does apply to you. Never skip farther than the next question number.

Layout of Questions. The sections are ordered by ASAM dimension except that (a) dependence occurs at the end of the substance use section, b) relapse and treatment motivation scales are collected within the substance abuse section, (c) we have added a section on risk behaviors (and health) prevention related to infectious diseases after the physical health section, and (d) we added legal and vocational sections after the environment section. Within each section, questions are ordered as follows: problems, services, attitudes/beliefs, and help wanted. To minimize the length of actual administration, the GAIN checks for the existence and recency of any problems. Detailed symptom counts (used for diagnosis) are collected only if the problem occurred in the past year and detailed behavior counts (used for in- and post-treatment monitoring) are only collected if the behavior occurred in the past 90 days.

Optional Questions. Throughout the questionnaire there are several places where questions are optional depending on the specific needs of the clinician, program or study. These questions are in boxes labeled for staff use only. If you want the participant to do these questions you will need to mark them and tell the participant to do so (or just orally administer them). Note that the boxes also include other staff questions that should always be done, including the coding of the primary, secondary and tertiary substances of abuse and the ratings of treatment need, denial and misrepresentation at the end of each section.

Asterisks (\*). To the left of several questions are single or double asterisks. The single \* identifies a subset of questions for a split or quick assessment. For the initial/intake version, these questions are answered to do substance use diagnosis, placement and a preliminary bio-psycho-social. The rest of the questions can be completed while the participant is in treatment -- but should be completed within 14 days. Note that the \* questions include several questions in the optional boxes: these questions are very desirable for a bio-psycho-social but are not required if the interview is only being done for research. For the follow-up version, the single \* questions are a quicker version of the questionnaire used if trying to complete an interview with a participant who is NOT willing to complete the whole instrument.

Don't Know and Refuse. If the participant is not sure about an answer, he/she is asked to try and give us a best guess. If they or the staff person changes the answer, they should cross through the old answer and circle the new answer. If they simply do not know, just mark "DK" to the right of the boxes. If they refuse to answer any question simply write "RF" next to any question. It is important that they either answer the question or write DK or RF. Otherwise, we will think you missed the answer by mistake and will ask you about it again. If the participant needs a break, write down the time the person stops and the time he/she starts again on the page you are on at the time of the break.

Correcting Misunderstandings and Mistakes as Part of Clinical Review. Contrary to the role of "administrator", once the initial set of answers has been reviewed, the goal *is to resolve* any major inconsistencies and check on unusual answer patterns. While this process might take one or two days, it should not be extended over more than a week as it will increasingly include actual changes in status - not just corrections. A critical role of the clinical staff reviewing the initial participant responses is to look for

inconsistencies and potential misunderstandings of the questions or skip outs. This includes incorporating information gained from collaterals, urine test results, and/or other documents while the participant was doing the assessment. When this occurs the counselor should help clarify and/or correct responses. If the participant appears to have misunderstood the core or skip out question, the clinician should ask (i.e., force) the symptom questions in order to directly define and measure the actual problems.

### **3.2 General Preparations**

Prior to conducting the assessment, you need to verify and complete the information on the cover page and calendar (discussed below). Also, identify a quiet place with a desk or table (or at least a clip board) where the participant can complete the assessment. If necessary, you can provide a space within your main office as long as it is quiet and no one else can easily see what the participant is marking on the assessment. The administration must be proctored. This means that a staff person is available to answer questions, monitor the participant for signs of acute distress and/or be able to step in and help administer it if there are literacy problems. With this provision, it can otherwise be given to a group of participants. The following items are needed for administration of the assessment: a GAIN with the completed cover page, a participant worksheet (calendar), and a pencil or black pen for the participant to use (do not use colored pens or pencils as these will be used for editing). The GAIN itself can be on 3-ring paper held together with rings or in a notebook, stapled, or otherwise bound, but you should make sure the participant can open it flat while using it and that you can put it into your files without much effort. We also strongly recommend that you make arrangements for the participant to have access during the assessment to: (a) juice, soda or coffee; (b) a washroom; and (c) a place to take a smoke break. For adolescents, correctional or other controlled participant populations, the latter may require arrangements for someone to supervise the participant.

### **3.3 Required Information on the Cover Page**

The information on the cover page of the GAIN must be completely filled out for this record to be processed. Use preprinted labels whenever they are available. If changes are necessary, strike through the old information and write the new information to the right. It is the staff person's responsibility to have this information completed, not the participant's!

- Version [GVER].\* This is preprinted under the title on the cover page. Because there are multiple similar forms, you need to verify you have the right version.
- Site ID [XSITE].\* Put the study or system's site 3 digit ID here for the organizational location of the assessment. (See attachment for study-specific list.)
- Local Site [XSITEa] (Optional): Use this for a secondary site ID for a site with multiple facilities or a special study or other reporting system. Otherwise put "00" here. (See attachment for study specific list.)
- Staff ID [XSID] & Staff Initials [XSIN]: Put the staff ID and initials of the person with primary responsibility for the initial administration and "interpretation" of the assessment here. In a study, this will typically be a research assistant and a study-specific ID. In a central intake situation this person will be the person responsible for making the

placement decisions. If the site has no staff IDS, use the last five digits of the staff person's social security number. (See attachment for study specific list.)

- Participant ID [XPID] and Name [XPNAM]:\* Use the participant's study ID or 0000. Record name (First, Middle, Last) on the lines marked. This is the ONLY place on the questionnaire where the participants name should be used. In all other notes refer to the participants by initials or the abbreviations or PX for patient. (For follow-up, use the ID that came with the assignment.)
- Treatment Program ID [XTPID]:\* Use the participant's treatment program ID or 00000. (For follow-up, use the ID that came with the assignment.)
- (Optional) Social Security Number [XSSN]: Enter the participant's social security number. (For follow-up, use the ID that came with the assignment.)
- (Optional) Other/State ID [XSIDA]: Enter the participant's state or other ID used for reporting. (For follow-up, use the ID that came with the assignment.)
- Assessment observation [XOBS]: Because interviews are not always done on time, it is important to document to which wave of data collection a particular assessment belongs. (For follow-up, use the ID that came with the assignment.)
- (Follow-up Version only) Participant Confirmation Code [XCHK]: The participant confirmation code consists of two letters and two numbers telling you the gender (Male/Female), race (Asian, Black, Hispanic, Native American, White, or Other), and the last two digits of the participant's year of birth (such as 59 for 1959). The purpose of this code is to avoid accidental mis-administration since the participant's name does not and should not appear on this form.
- DE Staff ID [XDESID] and Initial Key Date [XDEDT]. When you enter the data it will ask you to identify yourself and verify the date the record is being keyed. In addition to keying this information, please write in the facility linking it with the rekey records. Because we are approaching the year 2000, please use the new mm/dd/yyyy format (e.g., 03/06/1996 for March 6, 1996). (See attachment for study-specific list.)
- Rekey Staff ID [XRKSID] and ReKey Date [XRKDT]. When you enter the data for the second time, the computer may not be able to tell it is a re-key entry if the initial key was on a different machine. To help link records, please key in both the initial and rekey information. (See attachment for study-specific list.)

Note that unless the above information with the asterisks (\*) is complete, you will not be able to create a record and key the data in the assessment. While you can use a "0" for either the participant ID or the treatment program, one of them must be a unique and non-zero number or the assessment cannot be keyed or filed appropriately.

Once the interview is about to begin you will also need to answer questions A1a-d (also on the cover page) giving the start time and date. Do not fill these out in advance as there are often last minute changes. Please use hours of 1-12 for time and then circle am or pm. Note that A1c is used to generate a system variable XOBSDT that is essential to the software - it must be filled out.

### 3.4 Introduction and Getting Participant Started

The initial steps of administering the GAIN are to (a) explain the purpose of the GAIN, (b) verify that the person is not too impaired cognitively or in terms of literacy to do the assessment on their own, and (c) provide general instructions for completing the assessment. Each of these steps is described below.

**Purpose and Introduction.** Paraphrase the information covered in the section of the GAIN labeled “purpose and introduction” (pages 2-4). You can vary from this script, but should cover the following points:

- **The length of time necessary to complete the assessment.** Until more precise estimates are available, allow at least 1 ½ hours for the GAIN-I and 40 minutes for a GAIN-M90. With few exceptions, the initial participants completed the assessment within 10 minutes plus or minus of this time. However, in scheduling time with the participant it is important to make sure you schedule enough time overall to get through the whole assessment. (See attachment for study-specific information on the best total time to schedule.)
- **Part of treatment.** It is important that the GAIN-I be presented to the participant as the first part of treatment (i.e., “It is designed to help you tell us what your problems are, how they are related, and what you want from us. Together we will use it to decide what to work on first.”) For the GAIN-M90, it should be presented as something to help us evaluate ourselves and see how we can improve our program.
- **The use of the data for treatment and research only.** It is important that the participant know “why” the data is being collected and “how” it will be used.
- **Rights to privacy.** Let them know that you can be sued for releasing information about them without their consent or a court order.

It is also important to recognize the clinical role of assessment. At a minimum, a relevant assessment should help define a participant’s problems and prioritize the many potential avenues of treatment planning. Ideally it provides a preliminary brief intervention because, in doing the assessment, the participant is forced to take stock of his or her own life by starting to define problems more objectively and reduce denial by being shown the larger picture and inconsistencies. The counselor feedback and interpretation is particularly important for the latter.

**Setting Expectations.** Below is a table with data on the time to complete for 168 adolescents

and 73 adults. As noted above, there is considerable range in the expected duration of the GAIN depending on population, mode and level of care/severity. Adults, people in adult outpatient and adolescent short-term took longer. Oral administration was always faster - often by 20% or more.

Time to Administer the GAIN by Population, Mode, and Level of Care					
Population/Mode/Level of Care	N	Minutes			
		Min	Median	90 <sup>th</sup> Percentile	Max
Adolescents (All)	168	15	69	120	795
Oral Administration (Across Levels)	73	27	60	113	780
Outpatient	27	27	53	88	105
Short term Residential	25	30	65	107	780
Long term Residential	21	45	72	135	735
Other Administration (Across Levels)	95	15	75	120	795
Outpatient	22	25	62	105	146
Short term Residential	28	30	100	150	795
Long term Residential	45	15	67	120	145
Adults (All)	73	30	86	127	360
Oral Administration (Across Levels)	2	30	45	.	60
Methadone	1	60	60	60	60
TASC Residential	1	30	30	30	30
Other Administration (Across Levels)	71	30	90	129	360
Outpatient	16	50	100	270	360
Methadone	36	30	95	130	232
TASC Residential	19	30	60	90	115
Combined	241	15	75	120	795
Oral Administration	75	27	60	112	780
Other Administration	166	15	80	125	795

**General Directions.** Whether you orally administer the GAIN or allow the participant to self-administer, it is important to cover the general directions section on page 2. The purpose of this section is to help the participant think of salient personal reference points for the statements “in the past year” and “in the past 90 days.” Research has shown that the most common inconsistency in self-reported data is to move events forward or backward in time because of the lack of salient reference points. You should explain this to the participant using the following script,

“Several questions will ask you about things that have happened during the past year or past 90 days. To help you remember these time periods, please look at the calendar near the end of this document. First, find today’s date and circle it. Next, count back 13 weeks to about 90 days ago and circle that date. Do you recall anything that was going on then? Now write down what you can remember about that date next to it. When we talk about things happening to you during “the past 90 days,” we are talking about things since that date.

Now, go back to a year ago and circle that date. Do you recall anything that was going on then? Write that down too. When we ask about things happening in the past year we mean since that date. Please keep this calendar handy and use it as we go through the interview to help you remember when different things happened.

As we go through the questionnaire we will either be circling an answer or filling in a box. It is important that you try to answer each question if you can and are willing to. We know that you will not always know the exact answer and may have to give us your best guess. For instance, when we ask you about the number of days or times something happened, we are trying to understand if something happened often, sometimes or never. You can also tell us if you simply “do not know” or if you do not want to or refuse to answer any questions.

Do you have any questions?”

The last two pages of the GAIN are the calendar and two show cards to help with oral administration if necessary.

**Impairment Checks.** Prior to administering the GAIN it is important to verify that the participant possesses the necessary cognitive and literacy skills to self-administer the assessment. Cognitive impairment may be the result of current intoxication or temporary or permanent mental or biological problems. Regardless of the cause, it is important and required by JCAHO (1995) to verify the participant’s ability to locate him or herself in place and time prior to an assessment. This can be done by directly observing participant performance on other tasks prior to the assessment or through some kind of mini-mental status exam - with the latter being greatly preferred by regulators and examiners primarily because it is documented. The GAIN has incorporated a modified version of the 10-item Short Blessed Scale of Cognitive Impairment (Katzman et al., 1983) shown in Exhibit 3-1. It should be administered whenever there is any question of impairment and/or if the GAIN is being used as the main bio-psycho-social at intake. Ask each question, then check off the points for the number of errors. If the points add up to more than 10, the person is too impaired to assess at this time. You will need to consult with your supervisor to determine whether to reschedule, assess in another way or proceed recognizing that the reports may not be as accurate.

It is not uncommon for participants (particularly adolescents, methadone, or detoxification participants) to score higher than 10 on the short blessed. If the main problem is intoxication or appears to be transitory, it is probably better to reschedule the interview if possible. If you do decide to proceed in spite of a higher score, you should

- C only administer the GAIN orally,
- C assume that the interview will more difficult and/or take longer, and
- C be very careful to avoid over-interpreting the responses

Some participants who miss points on saying the months backwards may just have knowledge deficits and still be able to complete the form. But in general, if a person cannot remember “any” of the iconic recall test (repeat a name and address) the interview will be very problematic and alternative means of assessment should be considered (e.g., relying on collateral report, psychiatric referral).

**Exhibit 3-1 Short Blessed Scale to Check for Cognitive Impairment**

**A2. Check for Cognitive Impairment**

Because we are going to ask you a lot of questions about when and how often things have happened, I need to start by getting a sense of how well your memory is working right now.

ERROR

SCORES

a. What year is it now? \_\_\_\_\_  
 (Circle 4 for any error) ..... 0 4

b. What month is it now? \_\_\_\_\_  
 (Circle 3 for any error) ..... 0 3

Please repeat this phrase after me: John Brown, 42 Mark Street, Detroit.  
 (No score -- used for 1f below)

c. About what time is it? \_\_\_\_\_  
 (Circle 3 for any error) ..... 0 3

d. Please count backwards from 20 to 1.  
 [20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1]  
 (Circle 2 for one error, 4 for 2 or more errors) ..... 0 2 4

e. Please say the months of the year in reverse order.  
 [Dec, Nov, Oct, Sep, Aug, Jul, Jun, May, Apr, Mar, Feb, Jan]  
 (Circle 2 for one error, 4 for 2 or more errors) ..... 0 2 4

f. Please repeat the phrase I asked you to repeat before.  
 [John/ Brown/ 42/ Mark Street/ Detroit]  
 (Circle 2 for each subsection of /text/ missed) ... 0 2 4 6 8 10

g. (Add up scores from a through f and record): ..... |\_|\_|

**(If total is greater than 10, the individual is experiencing some degree of cognitive impairment. You can attempt again later if intoxication is suspected, or proceed and take into account when making the interpretation. If you do this section over, record the original score below before revising.)**

h. (Original score) ..... |\_|\_|

Assuming the person is able to locate him or herself in place and time, the next issue is the participant's ability to self-administer the test. This will initially be determined in three ways. First, ask the participant about his or her ability to read and write using the questions and scale in Exhibit 3-2. Second, ask if he or she would prefer to try completing the assessment on his/her own or if he/she feels the need for help to complete it. People with literacy problems may take this natural out to avoid being embarrassed and use face saving excuses to help rationalize it (e.g., Yes, I forgot my glasses). Based on these initial questions, the final step is to document the initial decisions about whether and how to administer the GAIN. While it may be useful for the clinician who will be interpreting this assessment to administer the assessment orally a few times, most participants will actually prefer to self-administer it if they can because of the personal nature of many of the questions (e.g., about sex, violence, abuse, illegal activities, income). Regardless of administration route, many participants will simply not be ready to discuss all issues on the first pass through the assessment. Do not confuse this with a method effect or force it too much. First review what they are willing to reveal about themselves, and then decide how to proceed. A participant who will not admit to being raped in jail may admit to symptoms of PTSD and, in a discussion of these symptoms, later be willing to discuss it. (Review the attachment to determine the study-specific mode of administration and/or backup preferences).

**Exhibit 3-2 Literacy and Initial Administration Questions**

**A3. Literacy and Initial Administration Questions**

**a. How well can you read English in something like a newspaper or magazine? Would you say ...**

- Not at all ..... 0
- Slightly well ..... 1
- Moderately well ..... 2
- Considerably well ..... 3
- Extremely well ..... 4
- Not asked ..... 9

**b. How well can you write English in something like a job application or resume? Would you say ...**

- Not at all ..... 0
- Slightly well ..... 1
- Moderately well ..... 2
- Considerably well ..... 3
- Extremely well ..... 4
- Not asked ..... 9

**c. Would you prefer to try to answer these questions on your own, or would you like me to read them to you and help you fill it out?**

- Orally administered by interviewer ..... 0
- Self-administered ..... 2
- Not asked ..... 9

**(If a, b or c is 0 or 1 it is strongly recommended that you orally administer the GAIN. It is also recommended that you administer the assessment orally if you have any concerns about cognitive impairment, need to speed up the interview or plan to initially use only the split assessment items {\*} until you decide whether to admit the individual.**

**\*\* d. (Document your initial decision)**

- Done orally because of literacy or client choice . 0
- Staff chose in advance to administer ..... 1
- Self-administered (see ADM page) ..... 2
- Other (Describe) ..... 99

V. \_\_\_\_\_

Self-Administration. If you will be administering the assessment you can skip the self-administration instructions in the beginning of the GAIN since this will be your responsibility, not the participants. Assuming that you are prepared to allow the participant to initially self-administer the assessment, the next step is to make sure the participant understands how to complete the assessment. The directions themselves are relatively self-explanatory. In reviewing them with the participant, however, it is particularly useful to:

- physically mark the boxes you are talking about (marking over the preprinted marks) to demonstrate and focus the participant on what you are talking about;
- quickly demonstrate how to mark a refusal, don't know, or break;
- show them that they need to mark the answer before following a skip (some participants skip without documenting their answers);
- pull out and mark on the calendar provided to help the participant focus on "when" you are talking about;
- give the participant a chance to ask any questions and answer them;
- recap that they should ask if questions come up later, they can take a break if they need to, and they should try to answer every question.

Note that you should do the calendar with the participant even when you are going to let them do most of the assessment on their own.

### **3.5 Conducting the Assessment**

Time Rechecks. The first section (B) of the GAIN-I contains at least one of each type of question and relatively neutral questions. At the end of this section there is an instruction to the participant to tell you he or she has finished it. At this point you should do a field edit (discussed further below) to make sure that the participant correctly followed the instructions. In particular, you should look at whether circle one, circle all, and skip pattern instructions were followed. If not, explain the instructions again and correct. Also check for missing data and have the participant complete those questions. This process serves to avoid repeated mistakes throughout the questionnaire, puts the participant on notice that you are really going to be checking for missing data, and can identify people who got through the initial checks but may be unable to self-administer because of literacy, comprehension, attention-deficit, or other impairments. For the GAIN-M90 the participant will already have been through this kind of assessment before and should quickly become re-acclimated to the format.

If the GAIN is being self-administered, within the first 5 to 10 minutes and periodically thereafter, you should ask the participant "how is it going?" Throughout the administration you should also watch the participant for signs of distress, fatigue, or frustration and be available to clarify any questions the person may have. At any point, you can stop and help them through a question, section or the remainder of the assessment.

If the participant is still doing Section S after the first hour, we recommend that you evaluate how long the participant will be able to continue. Note that just because it is taking a particular participant a longer amount of time does not mean he or she cannot or does not want to finish. Remember that for many participants, particularly those with multiple interrelated problems, this is going to be a potentially “emotional” experience. If he or she is not able to continue, you may want to switch to a quick administration option (discussed below), try taking a break at the end of the current section, or consider completing it another time or day.

Main Sections. Though oral administration is faster and has some advantages (e.g., less missing data), there are also benefits to initially allowing participants to self-administer the GAIN. Namely this is because of the sensitive nature of the questions in Section S-V. It is essential that the participant realize that he or she can refuse to answer any questions. Never argue with a participant about this or an apparent inconsistency (or misrepresentation) during the assessment. The GAIN is set up to get at sensitive information in several ways. The first time through we are trying to find out just how much they are willing to share with us. Thus, even if a participant says alcohol or drug use is not causing problems at work, home, socially or with the law, in later sections we specifically ask about the most common problems in these areas related to drug use (without identifying them as such) and can come back to this topic in the debriefing phase and/or during treatment.

It is also important to realize that many of the questions have been written to match clinical criteria or other epidemiological data bases, to define or set up subsequent questions, and/or to take into account past experience with how people actually respond. While some questions may seem similar or unnecessary, past experience suggests that different participants respond to different questions. As noted earlier, a woman who says “no” to “are you a prostitute?” may say “yes” to “have you traded sex for food, money or drugs?”. Similarly, a man might say “no” to “are you a homosexual?” and “yes” to “have you had sex with other men?”. Conversely, a participant might self-define himself or herself as a prostitute or homosexual, but not have specifically engaged in the corresponding behaviors during a given time period. It is, therefore, important to ask each question and not “presume” the answer unless there is a skip instruction.

Helping and Oral Administration. If the GAIN is being administered orally, it is important to make sure the participant understands that the two of you are filling out a form together. While you may be familiar with the GAIN, it is often the participant’s first time. If the participant gives a long or inappropriate answer, try to bring them gently back to the task at hand with probes like “so do you want me to mark yes or no?”. Because many participants have personality disorders or other problems interpreting social cues, the administration will go more smoothly if you avoid overly directive statements that might be unintentionally perceived as “orders” or “disrespectful” (e.g., “Just limit your answers to yes or no. Can you just answer the question?”).

If the participant is trying to tell you something important, do not ignore it. Rather, say “let me make a note of it so we can come back to that,” but then try to get back on task. Resist the temptation to probe further about answers on critical issues like suicide ideation or abuse until after you have completed the assessment, are aware of the participant’s full circumstances, and/or have the appropriate clinical staff on hand to deal with any aftermath. This is very important because probing can often provoke an emotional response that will have to be addressed immediately, and is not an appropriate matter for clerical personnel to handle. Complicating matters further, it is not simply the obvious places (e.g., suicide ideation, victimization) that might provoke this response. Even questions about a child may lead to a

discovery about a recent death or an runaway or emotionally-charged custody issue. Furthermore, probing often leads to complex and interrelated responses (e.g., probes on PTSD symptoms lead to the discovery of a gang rape in jail not reported elsewhere) that need to be appropriately documented and possibly followed-up by the primary clinician.

If you administer the assessment orally, it is very important that you follow the 11 basic rules of administering standardized assessment shown earlier in Exhibit 2-1. In order to interpret or combine the results across participants, it is essential to present each person with the same set of questions. Like driving on the left or right side of the road, the central issue is to standardize the questions and procedures as much as possible. If you have never been formally trained in doing standardized assessments, you should review the detailed explanation of these rules in Section 2 before orally administering the GAIN.

Special Situations. There are many special situations in which you or someone else may need to orally administer the assessment and/or even simplify/modify questions. Some of these include participants who do not speak English or have weak English skills, are not literate, have a visual or auditory disability, are developmentally disabled or have brain damage, or have a severe mental illness. While you can do this, all modifications should be carefully documented in the methods section at the end of the questionnaire. Occasionally a participant may want to exercise the right to have a friend or relative (instead of a staff person) assist them with the assessment. When this occurs you should go through the instructions and all checks with both of them present and simply treat them as one person (e.g., like you would use an interpreter for a hearing impaired person). You should also document this in the methods section at the end of the assessment.

Quick Administration Option. The GAIN-I is designed to collect (at least a first pass of) as much of the information that would often be collected in the first few months in 45 min - 1 ½ hours of the first day. While it represents a reduction in the total time (which often involves the participant providing the same information repeatedly to several different people), this may still be too much at a given moment for administration and scoring. Some instances where this happens include (a) a peak day at a central intake unit, (b) a participant who is having a hard time because of intoxication, withdrawal or physical or mental distress, or (c) other time constraints of the process (e.g., need to assign by 5:00pm) or participant (e.g., child care, transportation). In addition to breaking up the assessment into multiple sessions, we have put an \* before a subset of participant questions (e.g., B1, B2), that would be sufficient for state reporting requirements and/or an initial ASAM placement.

The GAIN-M90 is designed to collect the major outcomes. Some people are not willing to sit through the full assessment but might be willing to complete part of it. If you are faced with this situation and do not believe you can convince the person to stay or come back, then you should try to get the participant to at least answer the questions with the \* in the M90 (a quick follow-up version).

Humane Administration. Whether self-administered or orally-administered, it is also useful to offer coffee, tea, juice or soda to help participants get through the assessment. Anyone, but particularly smokers and participants in active stages of withdrawal may need a break or two. Again, this is ok, just write down the stop and start time on the questionnaire so that you can figure out the total duration at the end. If possible, try to get people to take breaks at the end of a section before starting a new one rather than in the middle of a section.

### **3.6 Finishing Administration With the Participant**

Ending and Times. In the last section of the GAIN, the participant or you need to write down the completion time and any comments. We will use the times recorded at the start and finish of the assessment to calculate how long it took. If a participant takes a break during the assessment, it is important to also write in the total time spent on the assessment, after the stop time (see Z1). Whenever this information is provided, it will be used instead of the calculated time. You should check it carefully. If the participant has not documented breaks, you should estimate start and finish time (which tell us elapsed time) and the total time actually spent doing the assessment. Once this is done you may want to suggest the participant take a quick break (e.g., get a drink, go to the washroom, or have smoke) while you do the final check. If you use more than one session or a split assessment, make sure you put updated total time information in the administration section towards the end of the GAIN-I and GAIN-M90.

Quick Edit Checks and Closure. After the participant brings you the assessment, quickly scan the pages to make sure (a) no pages or questions were accidentally skipped, (b) skips and other instructions were followed, and (c) numbers and other handwriting is legible. Tag any questionable responses and when the participant comes back, try to resolve them. Recall that participants have the right to refuse to answer any question, or say he or she does not know the answer; if this is the case, however, it should be indicated with a “RF” or “DK” in the margin. Try to either get an answer or write in RF/DK for any incorrectly skipped questions. Check the last page for any questions the participant has written down and ask the participant if he or she has any further questions. Once you have done your quick check, thank the participant and let him or her know what happens next (e.g., going to a physician, when they will get feedback, when you will see them next) and make any arrangements for the transfer of participants in controlled environments requiring escorts. You should go through this process even when doing the assessment orally. Administrators are only human and occasionally miss a question or find that pages stick together.

Special Issues in Transition to Direct Interpretation. If the administrator and primary clinician are different people, the administrator should tag or point out any critical issues they noticed or mention anything that happened during the assessment (e.g., the participant seemed to be getting very upset) as part of the transfer process. If the same person is administering and interpreting, make sure that you take a minute to look through the answers before jumping in with the participant. Do not try to hide what you are doing, rather offer the participant a break while you quickly look over his or her answers. This is discussed further in Section 5. Before doing an assessment you should already be familiar with your organization or study’s policies on handling participants who are suicidal/homicidal, being abused, in crisis or requesting a treatment referral from you.

### **3.7 Making Clinical Ratings**

Treatment Urgency Ratings. At the end of each section the person administering the assessment will need to make a rating of “urgency” with which the participant needs services in a given area. The treatment urgency ratings (questions B10, S11, P14, R8, M8, E17, L11, V13) are the "clinician's" version

of the question directly above it that was asked of the participant. In each section you want you to give "your opinion" of the urgency of the participant's need for treatment in a given area using the scale shown in Exhibit 3-3. This is an important place to document any differences of opinion you may have with the participant. You may think the participant is in denial (e.g., does not consider heavy drinking or unprotected sex or hanging out with a gang to be a problem) or conversely, you may think that while something is a real problem it cannot realistically be addressed until other things are addressed first. Presenting these differences to the participant is discussed later in Section 6.

**Exhibit 3-3 Treatment Urgency Rating (UR) Card**

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How soon (if at all) do you need (more) help with your current situation?

- Right away . . . . . 4
- In the next 3 months . . . . . 3
- More than 3 months from now . . . . . 2
- Getting the help I need already . . . . . 1
- Do not need any help . . . . . 0

**For scores of 3 or more, you should indicate the nature of assessment or treatment need and preliminary steps to be taken.**

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When the participant and/or counselor do believe that there is a need for treatment in a given area it is important to operationalize these needs into concrete issues that can be addressed in treatment planning. Either right away or at a later session, staff may want to use the optional questions at the each sections to do this. These questions are adapted from Dennis and colleagues' (1995) Individualized Substance Abuse Counseling (ISAC) Manual and based on things that participants commonly ask for help with. If you are using the ISAC protocol it is actually preferable to ask these questions before making your own rating to help ensure that you understand what it is that the participant is asking for.

Denial and Misrepresentation Rating. The denial and misrepresentation ratings (questions B11, S12, P15, R9, M9, E18, L12, V14) are the "clinician's" ratings of the extent to which the participant appeared to be guessing, misunderstanding, denying and/or misrepresenting information using the scale in Exhibit 3-4. Recall that you will be correcting any simple factual errors during the second part of the GAIN protocol when it is reviewed with the participant. The purpose of this rating is to track the quality of responses by section, and overall. While some problems or denial in a given area are common, a systematic pattern over the whole assessment raises serious questions about the validity of the assessment, your confidence in any interpretations based on it, and the need to collect more data from collaterals and other sources.

### Exhibit 3-4 Denial and Misrepresentation (DM) Rating Card

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Clinical staff ratings of potential response issues in the participant's answers as:

None . . . . .	0
Some guessing or estimation . . . . .	1
Misunderstood some questions . . . . .	2
Appears to deny or underestimate . . . . .	3
Appears to be misrepresenting information . . . . .	4

**Scores of 0 or 1 are normal with an occasional 2. Higher scores in one section or moderate to higher scores across several sections suggest the potential for learning problems, anti-social tendencies, or denial that may interfere with treatment.**

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Axis 5 Ratings. After the participant's responses have been reviewed, the clinician will also make three ratings of the participants functioning using the main and two provisional scales of DSM-IV's Axis 5: the Global Assessment of Functioning (GAF), Global Assessment of Relational Functioning (GARF), and Social and Occupational Functioning Assessment Scale (SOFAS). Each scale goes from 1 to 100, with 1 being low functioning and 100 high functioning (the use of "0 - inadequate information" should only be used if there are major data quality problems).

- C For the GAF, you will use the scale shown in Exhibit 3-5 to rate the participant's functioning in terms of mental health/illness (e.g., danger to self, cognitive impairment, symptom severity, degree of remission), including substance use disorders.
- C For the GARF, you will use the scale shown in Exhibit 3-6 to rate the participant's functioning in terms of the quality of their core relationships, interaction and problem solving with family members and other very close friends (e.g., negotiating skills, communications, conflict resolution, boundaries), including the emotional climate in which they live (e.g., caring, mutual respect, satisfactory sexual relations).
- C For the SOFAS, you will use the scale shown in Exhibit 3-7 to rate the participant's functioning in terms of their ability to meet social and occupational expectations (e.g., hygiene problems, isolation, inappropriate interactions, problems, ability to interact/perform according to expectations in social, school and work settings).

While related, past research has demonstrated that functioning in these three areas can vary considerably (i.e., someone who is physiologically dependent, but still able to perform at home, work or school). Within a given program, however, participants at intake will often be clustered in a narrow range on each scale by design of the placement process (e.g., the lowest functioning will end up in psychiatric, medical or short-term detoxification; the next higher in inpatient; the next in intensive outpatient; and the highest in outpatient). Interpretation and use of these scales is discussed further in Section 4.

### **Exhibit 3-5 Global Assessment of Functioning (GAF)**

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Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness (*including substance abuse*). Do not include impairment in functioning due to physical (or environmental) limitations. How would you rate the individual's global functioning in the periods? (Use intermediate codes when appropriate, e.g., 45, 68, 72.)

- 91-100 SUPERIOR FUNCTIONING in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
- 81-90 ABSENT OR MINIMAL SYMPTOMS (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members), *and in full remission (e.g., no use or problems for six or more months)*.
- 71-80 *TRANSIENT SYMPTOMS ARE PRESENT* and are expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work), *and almost in full remission, working a lot on relapse prevention*
- 61-70 SOME MILD SYMPTOMS (e.g., depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships, *the minimum requirement still met for diagnosis of abuse and/or occasional lapses*
- 51-60 MODERATE SYMPTOMS (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with co-workers), *the minimum requirement for diagnosis of dependence and repeated lapses*.
- 41-50 SERIOUS SYMPTOMS (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job), *more than the required number of diagnostic symptoms and repeated lapses*
- 31-40 SOME IMPAIRMENT IN REALITY TESTING OR COMMUNICATION (e.g., speech is at times illogical, obscure, or irrelevant) or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed, avoids friends, neglects family, and unable to work; *beats up others, has most or severe symptoms*)
- 21-30 BEHAVIOR IS CONSIDERABLY INFLUENCED by delusions or hallucinations or serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) or inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
- 11-20 SOME DANGER OF HURTING SELF OR OTHERS (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) or occasionally fails to maintain minimal personal hygiene (e.g., smears feces) or gross impairment in communication (e.g., largely incoherent or mute).
- 1-10 PERSISTENT DANGER OF SEVERELY HURTING SELF OR OTHERS (e.g., recurrent violence) or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectation of death **[BRING TO IMMEDIATE ATTENTION OF CLINICAL SUPERVISOR.]**

0 Inadequate information

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Source: DSM-IV Axis V (APA, 1994, pp. 30-32) with expansions in italics; see also Endice, H.J., Spitzer, R.L., Fleiss, J.L., et al. (1976). The Global Assessment Scale (GAS). *Archives of General Psychiatry*, 33, 766-771.

### **Exhibit 3-6 Global Assessment of Relational Functioning (GARF) Scale**

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The GARF scale can be used to indicate an overall judgement of the functioning of a family or other on-going social relationship. In particular, it is based on the extent to which these core relationships demonstrate skills in problem solving (e.g., skills negotiating, communications, conflict resolution), organization (e.g., recognizable roles and boundaries), and emotional climate (e.g., quality of caring, empathy, mutual respect, satisfactory sexual relations). How would you rate the Individual's Global Assessment of Relational Functioning in the periods? (Use Intermediate Codes When Appropriate, e.g., 45, 68, 72.)

- 81-100     *SATISFACTORY* relational *social or family* or unit is functioning satisfactorily from self-report of participants and from perspectives of observers.
- 61-80     *SOME PROBLEMS* functioning of relational *social or family* unit is somewhat unsatisfactory. Over a period of time, many but not all difficulties are resolved without complaints.
- 41-60     *MAJOR IMPAIRMENT* relational *social or family* unit has occasional times of satisfying and competent functioning together, but clearly dysfunctional, unsatisfying relationships tend to predominate.
- 21-40     *SERIOUS AND PERSISTENT IMPAIRMENT* relational *social or family* unit is obviously and seriously dysfunctional; forms and time periods of satisfactory relating are rare.
- 1-20     *DETACHMENT AND ENDANGERMENT* relational *social or family* unit has become too dysfunctional to retain continuity of contact and attachment.
- 0         *Inadequate information*
- 

Source: DSM-IV Axis V (APA, 1994, pp. 758-759) with expansions in italics.

### **Exhibit 3-7 Social and Occupational Functioning Assessment Scale (SOFAS)**

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Consider social and occupational functioning on a continuum from excellent functioning to grossly impaired functioning. Include impairments in functioning due to physical limitations, as well as those due to mental impairments. To be counted, impairment must be a direct consequence of mental and physical health problems; the effects of lack of opportunity and other environmental limitations are not to be considered.

- 91-100     SUPERIOR FUNCTIONING in a wide range of activities.
- 81-90     GOOD FUNCTIONING in all areas, occupationally and socially effective.
- 71-80     SLIGHT IMPAIRMENT in social, occupational, or school functioning (e.g. infrequent interpersonal conflict, temporarily falling behind in schoolwork).
- 61-70     SOME DIFFICULTY in social, occupational, or school functioning, but generally functioning well, has some meaningful interpersonal relationships.
- 51-60     MODERATE DIFFICULTY in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
- 41-50     SERIOUS IMPAIRMENT in social, occupational, or school functioning (e.g., no friends, unable to keep a job) *in some areas*.
- 31-40     MAJOR IMPAIRMENT IN SEVERAL AREAS, such as work or school, family relations (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and failing at school).
- 21-30     INABILITY TO FUNCTION *socially or occupationally* in almost all areas (e.g., stays in bed all day; no job, home, or friends).
- 11-20     OCCASIONAL HYGIENE PROBLEMS, fails to maintain minimal personal hygiene; unable to function independently.
- 1-10     PERSISTENT HYGIENE PROBLEMS, inability to maintain minimal personal hygiene. Unable to function without harming self or others or without considerable external support (e.g. nursing care and supervision).
- 0         Inadequate information.

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Source: DSM-IV Axis V (APA, 1994, pp. 760-761) with expansions in italics; see also Goldman, H.H., Skodol, A.E., & Lave, T.R. (1992). Revising Axis X for DSM-IV: A review of measures of social functioning. American Journal of Psychiatry, 149, 1148-1156.

Detailed Diagnostic Worksheet. On page 23 of the GAIN is a worksheet for doing detailed diagnoses based on follow-up questions with the participant and/or information from other sources. The first step in using this with a participant is to identify each of the drugs used either on a copy of question S2a or a set of cards. Then for each symptoms endorsed in questions S9h-u, ask:

- C Can you tell me which substance ....(**read symptom from list**)?
- C About when did that happen? (**Using same categories from S9 and on Card B** )
- C Have you ever had this problem with any other substance?

With each answer you will record the time code (3=past month, 2=2-12 months ago, 1=1+ years ago, 0 or blank means never; 9 means “ever”) in the appropriate column. You will repeat these questions for each Symptom in S9 until no more are reported. For each substance with one or more symptoms reported you will ask:

- C At what age did you first use ...(drunk for alcohol) (**substance name**)?
- C How do you usually take ... (**substance name**)?

For the latter answers are recorded as:

- 1-oral
- 2-smoking
- 3-inhalation
- 4-intramuscular
- 5-intravenous
- 6-NA
- 7-other

You will then rank order the substances in terms of their clinical importance from 1 (most pressing) on up. Next you will use the criteria described in chapter 4 and summarized on the form to make a tentative diagnosis.

### **3.8 Administrative Ratings**

At the back of the GAIN is an Administrative (ADM) Rating page in the last box entitled “For Office Use Only,” you need to answer several additional questions about how the assessment was administered. The questions are abbreviated on the GAIN, so you will need the key in Exhibit 3-8 (this and earlier exhibits are all repeated in administration cards in Appendix A). While the instruments have been designed to provide flexibility in administration and scoring, different methods of administering the assessment may affect the results. This information is also used to meet reporting requirements for a “method” section of the assessment summary (and are necessary to generate this part of the assessment by the computer). It is important to document any concerns so they can be followed-up at the next step.

**Exhibit 3-8 Administrative Rating Key [ADMa-n]**

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- a. What was the primary mode of administration (MOA)?
  - Computer-administered with sound tape (CAS) . . . . . 1
  - Computer-administered (CA) . . . . . 2
  - Self-administered with sound tape ( SAS) . . . . . 3
  - Self-administered ( SA) . . . . . 4
  - Orally-administered by staff (ORS) . . . . . 5
  - Orally-administered by other ( ORO) . . . . . 6
  - Telephone-administered by staff (TEL) . . . . . 7
  
- b. What was the primary language in which it was conducted (LNG)?
  - English (ENG) . . . . . 1
  - Spanish (SPN) . . . . . 2
  - Other (OTH), please describe . . . . . 99
  
- c. Were there any indications that the client might have learning disabilities that interfered with his or her ability to respond or participate in treatment or, in general, indications of developmental disabilities (IDD)?
  - No/none (NO) . . . . . 0
  - Minimal (MIN) . . . . . 1
  - Moderate ( MOD) . . . . . 2
  - Major ( MAJ) . . . . . 3
  
- d. Was there any evidence that the person could not place himself or herself in place or time or, in general, any evidence of cognitive impairment or dementia (ECD)?
  - No/none (NO) . . . . . 0
  - Minimal (MIN) . . . . . 1
  - Moderate ( MOD) . . . . . 2
  - Major (MAJ) . . . . . 3
  
- e. Was there any evidence of the following observed participant behaviors (OCB)? **(Check all that apply)**
  - Depressed or withdrawn (DEP) . . . . . 1
  - Violent or hostile (VIO) . . . . . 1
  - Anxious or nervous (ANX) . . . . . 1
  - Bored or impatient (BOR) . . . . . 1
  - Intoxicated or high (INT) . . . . . 1
  - In withdrawal (WIT) . . . . . 1
  - Distracted (DIS) . . . . . 1
  - Cooperative (COP) . . . . . 1

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(Continued)

**Exhibit 3-8 (continued).**

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- f. Did the individual's appearance suggest...(APP).  
No/none (NO) ..... 0  
Poor hygiene?( PH) ..... 1  
Unkempt appearance (UNK)? ..... 2  
Inadequate clothing (INA)? ..... 3
- g. What is was the main location of the assessment?  
Treatment unit (Tx) ..... 1  
Specialized intake unit (INT) ..... 2  
Correctional setting (COR) ..... 3  
School (SCH) ..... 4  
Employment or work setting (EMP) ..... 5  
Home (HOM) ..... 6  
Other (**Please describe**) (OTH) ..... 99  
v. \_\_\_\_\_
- h. What administration protocol was followed?  
Full/Regular (FULL) ..... 1  
Quick version (\*), then going back over it (QUICK) ..... 2  
Converted to quick boxes, followed up later (CONV) ..... 3  
Screener/Quick boxes completed never followed up (SCR) ..... 4  
Partial assessment never completed (PAR) ..... 5  
Full administration in multiple sessions (MUL) ..... 6  
Other (**Please describe**) (OTH) ..... 99  
v. \_\_\_\_\_
- j. Do you have any additional comments about the administration of the assessment or things that should be considered in interpreting this assessment (AC)? **Be sure to document any critical collateral information that you did or think should be considered during interpretation (or cross-reference where it is documented).**
- k-p. If you do the assessment over multiple sessions, also add the date of the FINAL assessment, the total number of breaks (within and between sessions), the total minutes (across all sessions), and the staff ID of the person completing the assessment.
-

Note that question ADM\_e actually involves multiple possible answers each of which can be checked or not. Also, if the assessment occurred over multiple sessions and/or had to be partially redone it is very important to answer questions k, m, n and p to provide updated information for tracking administration time.

Updating Assessments. If the assessment is completed at a later time or updated, you can update the total number of sessions and time in questions k-p.

Special Studies. One of the last pages of the GAIN also provides a section for special studies (XSSN). This last set of fields is not regularly used and is only provided to allow quick and inexpensive processing of data for special studies or to document other information (e.g., urine tests, collateral reports, tests).

## 4.0 Diagnosis of Substance Related Disorders

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“Substance Related Disorders” is the general description of drug and alcohol diagnostic criteria and it is an independent line on a rank with Schizophrenia, Mood Disorders and other classes in Axis 1 of DSM-IV (APA, 1994). “Substance Related Disorders” is then broken down into “Substance Use Disorders” and “Substance Induced Disorders.” The first of these two terms describes the criteria necessary to make a diagnosis of “Dependence” or “Abuse” and the second, the criteria necessary to diagnose disorders such as intoxication, withdrawal and a number of psychiatric syndromes such as dementia, psychoses, delirium, mood disorders and others which are caused by the effects of intoxicants, either directly or in withdrawal. DSM-IV embeds “Substance Induced Disorders” along with the syndromes which they cause (e.g. Substance Induced Dementia is described in the section on Dementia, Substance Induced Mood Disorder is described in the Mood Disorders section). Note that DSM-IV no longer describes “Organic Brain Syndromes” because of the belief that all psychiatric syndromes have organic/biologic determinants or consequences. We focus below on the diagnosis of substance use disorders and how they are related to substance induced disorders.

**Terminology and Relationship to the GAIN.** Exhibit 4-1 compares the verbatim criteria from DSM-IV (APA, 1994) for dependence and abuse with the primary GAIN question associated with each criteria. Responding yes to these questions will typically be sufficient, but may not be necessary (e.g., an adolescent may not report being in trouble with the law much, but the collateral may report three prior drug-related arrests that would be sufficient for a clinician to consider this criteria as being met). The GAIN and Exhibit 4-1 also include additional questions related to substance induced health and emotional problems, as well as other common early indicators of substance use problems that may suggest the need for further probing if the core items are not endorsed. Together, these symptoms form the GAIN’s Substance Problem Index (SPI, Cronbach’s alpha of .9) - a dimensional scale of severity. As with all GAIN scales, the symptoms are presented in order of increasing severity/rarity— with the more items being endorsed the more severe the problem. When multiple criteria are met, the order of precedence is dependence, abuse, problems. Below are brief descriptions of each of these conditions.

- ! **Dependence:** These are symptoms suggesting that as a consequence of use, the client’s body has been physiologically changed, that the client is losing control of his/her own body and behaviors and that substance use activities are displacing normal activities, relationships and responsibilities. They suggest the need for treatment and the high likelihood of relapse in response to physiological conditions (e.g., withdrawal, cravings) and environmental cues (e.g., classical conditioning or situations that trigger cravings).
- ! **Abuse:** These are symptoms suggesting that substance use activities are causing episodic problems and/or role failures that are interfering with the client’s life. When criteria are not met for dependence, there are still sufficient reasons to initiate treatment and indicate the high likelihood of relapse in response to stress (e.g., arguments, distress from physical illness, distress of mental illness or trauma), environmental contingencies (e.g., operant conditioning or pressure from peer groups), and risk of developing dependence.
- ! **Problems:** These are substance induced disorders and other problems associated with substance dependence and abuse. When the criteria are not met for dependence or

abuse but these problems exist, further assessment is strongly recommended to verify that the client understood the questions and/or that there were not some kind of special circumstances that need to be taken into account (e.g., temporary abstinence due to pregnancy or being in a controlled environment).

It should be noted that while the order of these symptoms is correlated with severity, there is considerable variation in their presentation. Tolerance (a symptom of dependence), for instance, is often one of the earlier symptoms to appear while repeated problems with the law (an abuse symptom) occur early in some and late in others. Thus, a person can have dependence and still be functional at home, school or work. Conversely, first time offenders referred from the court system actually have lower substance use severity on average than those who seek treatment on their own (but typically have other more severe behavioral/legal problems).

The questions for alcohol and drug use disorders are initially collapsed in the GAIN because many people use multiple substances and acknowledging a symptom/problem is often faster, easier, and more reliable than trying to get the individual to attribute the problem to a specific substance. This is particularly the case for a person using multiple substances and/or whose pattern of use has changed over time. This said, it is often useful clinically either at the time of the assessment or during the subsequent weeks to attempt a more a more detailed diagnosis. The following sections provide more detail on doing this and assumes that you have already administered the detailed worksheet that follows S9 according to the guidelines presented earlier in the chapter 3.

**Exhibit 4-1. Crosswalk from DSM IV Criteria to GAIN**

DSM-IV Criteria	Primary GAIN question from S9
<b>General screening questions (use diagnosis below if possible, if not check other information or probe later)</b>	
Screener	c. you tried to hide that you were using alcohol or drugs?
Screener	d. your parents, family, partner, co-workers, classmates or friends complained about your alcohol or drug use?
Screener	e. you used alcohol or drugs weekly?
Substance induced psychological problems	f. your alcohol or drug use caused you to feel depressed, nervous, suspicious, uninterested in things, reduced your sexual desire or caused other psychological problems?
Substance-induced health problems	g. your alcohol or drug use caused you to have numbness, tingling, shakes, blackouts, hepatitis, TB, sexually transmitted disease or any other health problems?
<b>For “Substance Abuse,” client must <u>NOT</u> meet criteria for dependence, and must meet one or more of the following:</b>	
A1. Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home	h. you kept using alcohol or drugs even though you knew it was keeping you from meeting your responsibilities at work, school, or home?
A2. Recurrent substance use in situations in which it is physically hazardous	j. you used alcohol or drugs where it made the situation unsafe or dangerous for you, such as when you were driving a car, using a machine, or where you might have been forced into sex or hurt?
A3. Recurrent substance-related legal problems	k. your alcohol or drug use caused you to have repeated problems with the law?
A4. Continued substance use despite social or interpersonal problems caused or exacerbated by use	m. you kept using alcohol or drugs even after you knew it could get you into fights or other kinds of legal trouble?

DSM-IV Criteria	Primary GAIN question from S9
<b>“Substance Dependence” requires 3 or more of the following 7 criteria from DSM-IV (APA, 1994, p. 181):</b>	
D1. Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or (b) markedly diminished effect with continued use of the same amount of the substance.	n. you needed more alcohol or drugs to get the same high or found that the same amount did not get you as high as it used to?
D2. Withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome for the substance, or (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.	p. you had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems?
D3. The substance is often taken in larger amounts or over a longer period than was intended.	q. you used alcohol or drugs in larger amounts, more often or for a longer time than you meant to?
D4. There is a persistent desire or unsuccessful effort to cut down or control substance use	r. you were unable to cut down or stop using alcohol or drugs?
D5. A great deal of time is spent in activities necessary to obtain the substance, or recovering from its effects	s. you spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?
D6. Important social, occupational or recreational activities are given up or reduced because of substance use	t. your use of alcohol or drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events?
D7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by use.	u. you kept using alcohol or drugs even after you knew it was causing or adding to medical, psychological or emotional problems you were having?

Source: Column 1 is from the American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4<sup>th</sup> ed.). Washington, DC: Author.

**Detailed Diagnoses.** Clinically it is also important to identify whether the substance use disorders are being caused by one or multiple substances, particularly when multiple substances have been used in the past year. Exhibit 4-2 provides a cross-walk from the 11 main DSM-IV alcohol and drug categories to the 13 main GAIN categories and, as an example, to the state of Illinois' 24 categories. Note that tobacco abuse/dependence and caffeine intoxication are not included here because they are not normally sufficient for admission to a substance abuse program, are not generally part of state reporting requirements and are handled elsewhere in the GAIN. The detailed worksheet will allow you to identify which of the 11 substance categories in DSM-IV appear to be related to the criteria reported. Where criteria for dependence or abuse can be met for multiple substances, multiple diagnoses should be given. Where criteria for dependence are met overall, but not for any single drug, then and only then should "304.80 Polysubstance dependence" be used. Note that this term is often misused to indicate people who use multiple substances (e.g., a speedball, karachi) – however, these should be coded under the individual substances or "other" substance columns.

It is also desirable to specify the presence or absence of "physiological dependence" in the diagnosis because of its importance for predicting withdrawal, cravings and relapse. This occurs when the criteria for dependence are met and there is evidence of tolerance (criterion 1; GAIN question s9n) or withdrawal (criterion 2; GAIN question S9p). Thus, in the bottom of the work sheet you will classify each of the 11 substances with sufficient symptoms as one of the following (in descending order or precedence):

1. Dependence w/Physiological Symptoms (Symptoms n or p and 3 + total symptoms in n-u for the substance)
2. Dependence w/out Physiological Symptoms (3+ Symptoms in rows n-u for the substance)
3. Abuse (1+ symptoms in h-m for the substance)

Note that the DSM-IV rules create a diagnostic orphan when someone reports 1-2 symptoms of dependence and no symptoms of abuse. In this case there is technically no diagnosis. But in most cases there is sufficient other information in the GAIN or full assessment to complete the diagnosis.

**Exhibit 4-2 . Crosswalk of DSM IV Diagnostic Codes to GAIN and State Reporting Drug Codes**

<b>DSM IV Substance Use Diagnoses</b>	<b>GAIN Substance(s) in S2</b>	<b>State of IL Substance(s)</b>
303.90 Alcohol Dependence 305.00 Alcohol Abuse	S2a1. Any kind of alcohol (such as beer, wine, whisky, gin, scotch or mixed drinks)	B1 Alcohol
304.40 Amphetamine Dependence 305.70 Amphetamine Abuse	S2a11. "Speed," "uppers," amphetamines, methamphetamine or other stimulants (such as Biphetamine, Benzedrine, crystal, Desoxyn, Dexedrine, ice, Methedrine or Ritalin)	E1 Amphetamines E2 Methamphetamine E6 Other stimulants
304.30 Cannabis Dependence 305.20 Cannabis Abuse	S2a2. Marijuana, hashish, blunts or other forms THC? (herb, reefer, weed)	H1 Marijuana H2 Hashish
304.20 Cocaine Dependence 305.60 Cocaine Abuse	S2a3. Crack or free base cocaine S2a4. Other forms of cocaine	E3 Cocaine E4 Base cocaine E5 Crack
304.50 Hallucinogen Dependence 305.30 Hallucinogen Abuse	S2a9. "Acid" or other hallucinogens ( such as ecstasy/MDMA, Ketamine, LSD, mushrooms, mescaline, peyote, psilocybin or shrooms)	I1 Other hallucinogens
304.60 Inhalant Dependence 305.90 Inhalant Abuse	S2a5. Inhalants (such as correction fluids, gasoline, glue, lighters, spray paints or paint thinner)	G1 Inhalants (note this is not specifically limited to petroleum based products like DSM-IV)
304.00 Opioid Dependence 305.50 Opioid Abuse	S2a6. Heroin S2a7. Pain killers, opiates, or other analgesics (such as codeine, Darvocet, Darvon, Demerol, Dilaudid, "Karachi," Percocet, Propoxyphene, street methadone, morphine, opium, Talwin, or Tylenol with codeine).	A1 Heroin A2 Karachi (opiate or opioid + depressant) A3 Non-Rx methadone A4 Dilaudid A5 Other opioids
304.90 Phencyclidine Dependence 305.90 Phencyclidine Abuse	S2a8. PCP or angel dust (Phencyclidine)	F1 PCP or Phencyclidine

DSM IV Substance Use Diagnoses	GAIN Substance(s) in S2	State of IL Substance(s)
304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse	S2a10. Anti-anxiety drugs or tranquilizers (such as Ativan, Deprol, Equanil, Diazepam, Klonopin, Meprobamate, Librium, Miltown, Serax, Valium or Xanax) S2a12. "Downers," "sleeping pills," barbiturates or other sedatives (such as Dalmane, Donnatal, Doriden, Flurazepam, GHB, Halcion, liquid ecstasy, methaqualone, Placidyl, Quaalude, Secobarbital, Seconal, Rohypnol or Tuinal)	A2 Karachi (opiate or opioid + depressant) D1 Benzodiazepines D2 Barbiturates D3 Other non-barbiturate sedatives/ hypnotics D4 Other tranquilizers
304.80 Polysubstance Dependence	See text, reported by drug.	Reported by drug
304.90 Other Substance Dependence 305.90 Other Substance Abuse	Some other drug (Please describe) (such as amyl nitrite, cough syrup, nitrous oxide, Nyquil, "poppers" or Rorbitussin)	J1 Over the counter K1 Other (describe)

Source: Column 1 based on American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4<sup>th</sup> ed.). Washington, DC: Author; Column 3 based on Illinois Department of Alcoholism and Substance Abuse (1995, July) DARTS Record layouts & descriptions manual. Chicago, IL: Author.

Once a client has ever met criteria for dependence (as evidenced by above or prior assessments) it is useful to include a course specifier when making the diagnosis. It is also useful to do this if the client has been on agonist therapy, in a controlled environment or transferred from another level of care or treatment program. Once a client has a history of dependence, DSM-IV (APA, 1994; pp. 179-180) provides six "Course Specifiers" that should be used. These all assume lifetime dependence (3+ lifetime symptoms in S9n-u) and are paraphrased below in descending order of precedence.

1. In a Controlled Environment is defined for a person who is in an environment with no access to drugs such as a therapeutic community, locked psychiatric ward, or prison. (44+ on GAIN S2d5 “days in controlled environment”)
2. On Agonist Therapy: Defined as no criteria present for abuse or dependence for at least one month but the person is taking methadone, L-Alpha-Acetyl-Methadol or analgesics on a prescribed and controlled basis. (44+ on GAIN S7e5 “days in methadone treatment”)
3. Sustained Full Remission: Defined as no criteria for abuse or dependence have been met for more than 12 months. (No past year symptoms in S9n-u )
4. Early Full Remission: Defined as no criteria for abuse or dependence have been met for at least one month, but have been met within the past 12 months. (No past month symptoms in S9n-u)
5. Sustained Partial Remission: Defined as some criteria (1 or 2) for dependence have been met but not enough for a diagnosis. (1-2 past year symptoms in S9n-u)
6. Early Partial Remission: Defined as one criteria for abuse or dependence has been met for at least one month but not more than 12 months. (1-2 past month symptoms in S9n-u)

The first two specifiers are used to highlight reasons why the number of problems or frequency of use are lower than what might otherwise be expected. Question S7 includes information on the history of treatment with methadone, LAAM or other opioid treatment over the client’s lifetime and past 90 days, whether the client is taking any medications for alcohol or drug problems, whether the client is currently in treatment, and for how long the client has been in treatment. Such medications should also be part of the treatment record and/or a referral from another provider and should certainly be known by the client.

For a “controlled environment” specifier, the check above refers to the general/combined time

in any controlled environment where the client could not use alcohol or drugs (S2df). In the course of doing the whole assessment you may find further evidence that the client has been in several types of control environments, including: detoxification (S5a), hospital, inpatient or residential programs (S7k-n), physical health hospitals (S11n), inpatient mental health treatment (M5n), supervised or institutionalized housing (E1), and time in jail, prison or juvenile detention (L6c-d). Because clients might have gone from one institution to another (e.g., hospital to jail to inpatient treatment), the GAIN also asks about “total” time in places where “you could not come and go as you pleased” (EU2f). Note that while time in a controlled environment suppresses the rate of use, it does not eliminate it. Despite the prohibitions and constraints, some clients will still explicitly report some use in jails, treatment programs, hospitals and virtually all controlled environments.

**Withdrawal.** In general, someone in an extreme state of withdrawal (and intoxication) is going to be referred to a detoxification or medical unit before the GAIN is done or will be screened out during the initial cognitive screener. However, people may come in while still high (e.g., a heroin addict who has used within the last four hours) and be at significant risk for withdrawal. Withdrawal requires recent cessation of use after a prolonged period of heavy use (criteria A), a set of overlapping substance-specific symptoms (criteria B), that these symptoms cause significant distress or impair social or occupational functioning (criteria C) and that the symptoms are not better understood solely as a result of another medical or psychological condition. Substance-specific symptom patterns have been defined by DSM (APA, 1994) for Alcohol (p. 198-199), Sedative, Hypnotic, or Anxiolytic drugs (p. 266), Cocaine (p. 225-226), Amphetamines (p. 209), and Opioids (p. 251). However, a substance specific withdrawal diagnosis was not defined in DSM-IV for Cannabis, Hallucinogens, Inhalants, PCP, or Other drugs. As with abuse/dependence, the GAIN collects all of the symptoms together to save time and because clients often have difficulty attributing their symptoms to a specific substance when more than one are involved. Exhibit 4-3 provides a crosswalk between DSM-IV withdrawal symptoms (which vary by substance) and the GAIN withdrawal scale items in S3. The cells further indicate which of the substance specific criteria the symptom/item maps onto.

**Exhibit 4-3. Crosswalk of DSM-IV substance specific and general withdrawal symptoms with GAIN Current Withdrawal Index**

DSM-IV symptom	If the client cut down, tried to stop or stopped... S3c. <u>When you did this</u> , did you have any of the following <u>withdrawal symptoms or problems</u> ?	Alcohol (p.198-199)	Sed./Hyp./Anx. (p.266)	Cocaine (p.225-6)	Amphetamine (p.209)	Opioid (p.251)	Cannabis (n.d.)	Hallucinogen (n.d.)	Inhalant (n.d.)	PCP (n.d.)	Other (n.d.)
psychomotor retardation	1. Move and talk much slower than usual			(b5)	(b5)						
yawning	2. Yawn more than usual					(b7)					
fatigue	3. Feel tired			(b1)	(b1)						
vivid, unpleasant dreams	4. Have bad dreams that seemed real			(b2)	(b2)						
insomnia or hypersomnia	5. Have trouble sleeping, including sleeping too much or not being able to sleep	(b3)	(b3)	(b3)	(b3)	(b9)					
dysphoric mood	6. Feel sad, tense or angry					(b1)					
anxiety	7. Feel really nervous or tense	(b7)	(b7)								
psychomotor agitation	8. Fidget, pace, wring your hands or have trouble sitting still	(b6)	(b6)	(b5)	(b5)						
hand tremors	9. Have shaky hands	(b2)	(b2)								
grand mal seizures	10. Have convulsions or seizures	(b8)	(b8)								
increased appetite	11. Feel hungrier than usual			(b4)	(b4)						
nausea or vomiting	12. Throw up or feel like throwing up	(b4)	(b4)			(b2)					
diarrhea	13. Have diarrhea					(b6)					
muscle aches	14. Have muscle aches					(b3)					

DSM-IV symptom	If the client cut down, tried to stop or stopped... S3c. <u>When you did this</u> , did you have any of the following <u>withdrawal symptoms or problems</u> ?	Alcohol (p.198-199)	Sed./Hyp./Anx. (p.266)	Cocaine (p.225-6)	Amphetamine (p.209)	Opioid (p.251)	Cannabis (n.d.)	Hallucinogen (n.d.)	Inhalant (n.d.)	PCP (n.d.)	Other (n.d.)
lacrimation or rhinorrhea	15. Have a runny nose or eyes watering more than usual					(b4)					
autonomic hyperactivity; pupillary dilation, piloerections or sweating	16. Sweat more than usual, have your heart race or have goose bumps	(b1)	(b1)			(b5)					
fever	17. Have a fever					(b8)					
transient visual, tactile or auditory hallucinations or illusions	18. See, feel or hear things that are not real	(b5)	(b5)								
General symptom of withdrawal	19. Forget a lot of things or have problems remembering	GEN	GEN	GEN	GEN	GEN	GEN	GEN	GEN	GEN	GEN
Criteria C	20. Have any of these withdrawal problems kept you from doing social, family, job or other activities	C	C	C	C	C	C	C	C	C	C
General symptom of withdrawal	21. Use the same or another drug to stop or avoid having any of these withdrawal symptoms	GEN	GEN	GEN	GEN	GEN	GEN	GEN	GEN	GEN	GEN
General symptom of withdrawal	99. Some other problem ( <b>Please describe</b> )	GEN	GEN	GEN	GEN	GEN	GEN	GEN	GEN	GEN	GEN

n.d.: Substance specific withdrawal symptoms not defined.

Source: Adapted from the American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4<sup>th</sup> ed.). Washington, DC: Author

**Substance Induced-Disorders**. One of the most significant shifts in DSM-IV is in the treatment of co-occurring conditions which might be either “substance induced” or independently caused. In the past, earlier versions had recommend detoxifying a client and keeping them off substances for six weeks or more and only treating these other conditions if they did not go away. DSM-IV now recommends treating them and checking later to see if they go away as treatment is withdrawn. There are two major reasons for this reversal. The first is humanitarian - rapid and effect treatment is available to relieve many of the symptoms (e.g., depression, anxiety, behavioral disorders). The second reason is practical – failure to relieve the symptoms may prevent recovery, increase the likelihood of relapse, and/or make the client more difficult to treat (e.g., untreated attention deficit disorder or impulse control problems). By substance, the main substance-induced disorders recognized in DSM-IV (APA, 1994; p.177) are:

- C Alcohol - persisting dementia, persisting amnestic, psychotic, mood, anxiety, sexual dysfunction and sleep disorders;
- C Amphetamines - psychotic, mood, anxiety, sexual dysfunction and sleep disorders;
- C Cannabis - psychotic and anxiety disorders;
- C Cocaine - psychotic, mood, anxiety, sexual dysfunction and sleep disorders;
- C Hallucinogens - psychotic, mood, and anxiety disorders;
- C Inhalants - persisting dementia, psychotic, mood, and anxiety disorders;
- C Opioids - psychotic, mood, sexual dysfunction and sleep disorders;
- C Phencyclidine (PCP) -psychotic, mood, and anxiety disorders;
- C Sedatives, Hypnotics or Anxiolytics - persisting dementia, persisting amnestic, psychotic, mood, anxiety, sexual dysfunction and sleep disorders;

All of the above drugs are also associated with substance-induced delirium during intoxication and two (alcohol, sedatives/hypnotics/anxiolytics) are associated with substance-induced delirium during withdrawal.

## 5. Level of Care Placement

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A primary goal of the GAIN is to conduct a standardized bio-psycho-social to facilitate placing a client into the most appropriate treatment situation. It does this in several ways. First, the GAIN is specifically designed to map onto the American Society of Addiction Medicines (ASAM, 1996) patient placement criteria for specific levels of care. This approach assumes that the system is actually a continuum of care along which the clients move and that treatment may involve multiple segments of care at different levels and/or multiple episodes of care. Second, the GAIN is designed to help prioritize treatment and make more effective referrals based on the approach outlined in the Individualized Substance Abuse Counseling (ISAC) manual (Dennis et al., 1995). This approach (addressed in the next chapter on treatment planning) assumes that within a level of care it is also important to address the individual's specific needs and/or deal with differences between the priorities of the individual and the priorities of the staff/agencies involved.

**ASAM Patient Placement Criteria (PPC) Terminology.** The PPC criteria are an evolving set of criteria for placing, continuing and discharging clients from several different levels of care. The existing ASAM guidelines do not differentiate adolescent levels of care as much as adult programs or address correctional or specialized programs at all, although many states and actual treatment systems do. The expanded typology we use includes:

- C **Outpatient Assessment/Outreach.** This is a state funding category to cover initial assessments to determine where to place clients in the continuum of care. It can be in a program, part of an outreach effort or part of a centralized intake unit.
- C **Level 0.5 Early intervention.** This level is targeted at clients who do not meet criteria for abuse or dependence or for whom additional information is being collected. It might include a school-based program or educational program for first-time driving-under-the-influence (DUI) offenders.
- C **Level I Outpatient services.** This level is targeted at individuals meeting criteria for abuse or dependence who have stable or manageable symptoms of withdrawal and medical or psychological problems, recognize their problems, appear to be able to resist use, and do not have a hostile home environment. Care is typically provided for less than nine hours per week.
- C **Opioid maintenance therapy** can be a service in any of the above levels of care and/or is often provided in a specialized outpatient setting. It is targeted at clients who meet criteria for opioid dependence, have repeatedly failed earlier treatments, are at high risk of relapse, or are pregnant and/or likely to engage in behaviors that would put them or others at severe risk.
- C **Level II Intensive outpatient services.** This level is targeted at clients meeting criteria for abuse or dependence who require multiple supportive contacts per week to avoid relapse, are having any medical or psychological problems addressed through consultation/referral, or who have continued to use substances during outpatient care. Treatment can be either an evening program for clients with some structure at home, work or school (ASAM Level II.1; 9-20 hrs/wk) or partial hospitalization/day treatment for those who lack structure or are in a more

hostile environment (ASAM Level II.5; 20+ hrs/wk). Treatment consists primarily of counseling and education about alcohol and other drug problems with ready access (within 24 hours by phone) to psychiatric, medical and laboratory services. In our facilities, they also typically cover coping, nutrition and vocational issues and may use multi-systemic therapy interventions instead of group work.

- C **Level III Residential/medically monitored inpatient services.** This level targets clients who have unsafe living environments, need time to develop their recovery skills, and have manageable medical or psychological problems. Residential services can include halfway houses (ASAM Level III.1 clinically-managed low-intensity), extended care with wraparound services (ASAM III.3 clinically managed medium intensity), short-term, long-term and therapeutic communities (ASAM III.5 clinically-managed high intensity), or programs that are designed to also treat medical or psychological problems (ASAM III.7 medically monitored intensive inpatient). A diagnosis of dependence is required for adults; abuse or dependence for adolescents.
- C **Level IV Medically managed intensive inpatient services.** This level is targeted at clients meeting criteria for dependence who have acute biomedical, emotional or behavior problems requiring on-site medical/psychiatric care 24 hours per day. Typically, this is limited to short-term hospital-based care.
- C **Correctional programs.** These are typically therapeutic communities (see Barthwell et al. 1995) and most are similar to Level III.5, but are targeted at clients who may currently be in remission only because they are in a controlled environment. Typically, these programs are a precursor to early release on parole and are targeted toward non-violent offenders.
- C **Detoxification Units.** These can be freestanding units or services associated with a larger unit. They focus on treating intoxication and withdrawal. Depending on both risk of harm and willingness to comply, detoxification can be provided in a setting with 24-hour medical management (Level IV-D), 24-hour medical monitoring (Level III.7-D), 24-hour clinical management or “social detoxification” (Level III.2-D), outpatient ambulatory care under close monitoring by a credentialed and licensed nurse (Level II-D), and/or outpatient without extended monitoring (Level I-D).
- C **Specialized service delivery units.** These units that typically serve clients across multiple treatment units and provide additional medical (including HIV counseling and testing), psychiatric (including further assessment), family (preservation, childcare/head start, contraception), and wrap around (transportation, housing, training, employment, financial, legal) services. (Dennis, Godley, et al., under review).

Other typologies can be used as long as the organization agrees on how they will relate the ASAM criteria to the various levels of care.

ASAM PPC 2 (1996) provides a detailed description of the criteria for intaking, continuing or

discharging clients from each level of care. Many organizations further adapt this to their specific levels of care and/or take into account other placement issues (e.g., the court, employers, financing). It should be noted that these are less fixed decision rules than they are a set of overlapping “principals” upon which to base placement. The common or core criteria include one diagnostic criteria (A) and six dimensional criteria (B1. Acute Intoxication and Withdrawal Potential; B2. Biomedical Conditions and Complications; B3. Emotional/ Behavioral Conditions and Complications; B4. Treatment Acceptance/Resistance; B5. Relapse Potential; and B6. Recovery Environment). It should be noted that the first three dimensional criteria tend to be associated with the need for placement in levels of care that can provide the appropriate other (e.g., detoxification, medical, psychiatric) services/monitoring. The second three are actually more associated with distinguishing between who needs outpatient vs. inpatient and/or more structured substance use treatment. Moreover, most programs will also consider a range of other issues include the extent of illegal activities, vocational activities, victimization, psycho-social stressors, and time in controlled environment. Finally, it should be recognized that in addition to what the staff person recommends, actual placement has to address what the client is willing to do, what is available and what the funders will pay for. Below we have summarized the intent of each criterion and attached a copy of the box from the GAIN that can be used for hand scoring of the core issues and/or to facilitate immediate interpretation. If you are doing the interview on-line or keying it, the software can also calculate these field directly. These explanations are followed by a discussion of other criteria (including the asterisks and check marks that appear in some versions of the GAIN).

**Criterion A. Diagnosis.** While anyone can be referred for assessment or early intervention, formal treatment should be directed at those meeting DSM-IV (APA, 1994) criteria for abuse or dependence. Inpatient levels of care will typically be limited to those meeting criteria for dependence. The one exception might be someone in an acute state of intoxication or withdrawal requiring detoxification services before diagnosis can be ascertained. The prior chapter contains a detailed discussion of substance related diagnoses.

**Criterion B1. Acute Intoxication and Withdrawal Potential.** Current intoxication should be evaluated to determine the need for either ambulatory, social or medical detoxification. Where there is risk of severe withdrawal, placement is directed towards facilities capable of addressing medical/psychological needs. Where there is opioid dependence, consideration should be given to the use of methadone therapy as an adjunct to treatment. More recent work suggests the desirability of considering naltrexone for heavy alcohol users. Below is the placement check box for this criterion from the GAIN.

<i>For Staff Use Only (Optional Withdrawal Risk Placement Detail)</i>	
S3d. Significant withdrawal risk (Check more severe of conditions met below)	
1. Clinical (Check if any history of seizures [S3a=1] or current withdrawal symptoms [1+ in Sx S3c1 to S3c99])	
2. Acute (Check if high for most of past 48 hours [S2b=6], using daily [S2d1 GT 44], using opioids weekly [S2g5 or S2g6 GT 12], acute number of current withdrawal symptoms [12+ Sx in S3c] , history of seizures and current withdrawal symptoms [1+ symptoms in S3c and S3a=1], or current d.t.s or seizures [S39 or S3c10=1])	

**Criterion B2. Biomedical Conditions and Complications.** The goal here is to identify the nature of any major biomedical problems, the extent to which they are already being appropriately managed and the extent to which they pose challenges for the effective delivery of care. For managed conditions, these may simply require minor modification (e.g., allowing a diabetic to have a snack during group) or referral and monitoring. For others (e.g., withdrawal combined with a weak heart, or seizures), it may imply the need for more medically managed and/or inpatient care. Below is the placement check box for this criterion from the GAIN. P10 also includes a simple nursing assessment to check for a lifetime history of several health problems that might need to be monitored or addressed further.

<i>For Staff Use Only (Optional Biomedical Placement Detail)</i>	
P10t. Acute Biomedical Issues (Check if high levels of past year biomedical problems [7+ Sx in P3, P3a-k] or current biomedical problems that frequently interfere with meeting responsibilities [ P9b GT 12] or medical services needed to participate in treatment [P10=1])	

**Criterion B3. Emotional/Behavioral Conditions and Complications.** The goal here is to identify the nature of any major emotional/behavioral problems, the extent to which they are already being appropriately managed and the extent to which they pose challenges for the effective delivery of care. For managed conditions, these may simply require minor modification (e.g., allowing someone who is depressed to take appropriate medication) or referral and monitoring. For others (e.g., active suicide ideation/attempts), it may imply the need for more psychologically managed care and/or inpatient placement. There are actually multiple check boxes related to emotional/behavioral issues that might impact placement – each is shown below. Obviously, many may be substance induced and reviewed for their duration/pattern and monitored to see if they go away with abstinence. M1c includes a short scale to assess the severity of homicidal/suicidal thoughts and should be used to make effective referrals should this be necessary.

<i>For Staff Use Only (Optional General Mental Distress Diagnostic Detail)</i>	
M1h. Rule out Other Axis I Diag. (Check if 3+ Sx in M1c , 13+ Sx in M1a-d, M1f GT 12 or M1g Gt 1)	

<i>For Staff Use Only (Optional Stress Diagnosis Detail)</i>	
M2r. Rule out Traumatic Stress Disorder (Check if 5+ Sx in M2a-p or M2q = 13+ Days)	

<i>For Staff Use Only (Optional Behavioral Diagnosis Detail)</i>	
M3d. Attention Deficit Hyperactivity Disorder (Check first possible Row)	
1. ADHD - Combined Type ( 6+ Sx M3a1-9 and 6+ Sx in M3a10-18 and 1+ in M3c)	
2. ADHD - Inattentive Type ( 6+ Sx in M3a1-9 and 1+ in M3c)	
3. ADHD - Hyperactive Type ( 6+ Sx in M3a10-18 and 1+ in M3c)	
M3e. Conduct Disorder if adolescent or rule out ASPD/BPD if adult	
1. CD (Check if 3+ Sx in M3b1-15 and 1+ days in M3c)	
2. CD-Severe (Check if 9+ Sx in M3b1-15 and 1+ days in M3c)	

<i>For Staff Use Only (Optional Personality Coping Styles Index)</i>	
y. Rule out Axis II Diagnosis (Check yes if 16+ in a-x)	

<i>For Staff Use Only (Optional Gambling Problem Index)</i>	
n. Pathological Gambling Diagnosis: (Check if 6+ in a-m):	

**Criterion B4. Treatment Acceptance/Resistance.** The goal here is to identify the extent to which the individual is internally and/or externally (e.g., court/family/other pressure) motivated to go into treatment and issues that might make it difficult (regardless of motivation) for the individual to do so. Outpatient treatment assumes the person is sufficiently motivated and able to manage their participation/attendance – though they might need support or encouragement. Methadone and more intensive outpatient programs assume that more support and/or structure is needed in order for the client to successfully participate. This may also include court or employer mandates. Inpatient treatment is often indicated if there is increasing resistance and/or poor impulse control. Either after inpatient or another controlled environment, or with a court order, outpatient treatment may also be combined with a halfway house or sober living/recovery home to achieve this goal. Below is the placement check box for this criteria from the GAIN. B4 (pressure to be in treatment) is also useful in assessing this dimension.

<i>For Staff Use Only (Optional Treatment Acceptance/Relapse Placement Detail)</i>	
S8x. Acute Treatment Acceptance/Resistance Issues (Check if high resistance [3+ Sx in S8a-d] or no motivation [All 0 in S8e-j])	

<p>◦ S8y. <b>Acute Relapse Potential</b> (Check if low self efficacy to resist [3+ Sx in S8m-q], low problem orientation [S8r=1 and all 0 in S8s-w], daily use [S2d1 GT 44], using opioids weekly [S2g5 or S2g6 GT 12])</p>	
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**Criterion B5. Relapse Potential.** The goal here is to identify people who may need more intensive levels of care because of their risk of relapse. This may be because of low self-efficacy to resist substance use, lack of a sufficient understanding of how substance use is related to their problem (or that it is a problem), or the failure to stop using in a lower level of care. It is also correlated with higher numbers of symptoms, the use of opioids, and lower ages of first use (particularly under age 15). Higher relapse potential would indicate the need for more intensive/structure treatment including inpatient treatment. Those with opioid dependence often require methadone therapy to avoid relapse. Above is the placement check box for this criteria from the GAIN.

**Criterion B6. Recovery Environment.** The goal here is to evaluate the extent to which the recovery environment will support outpatient treatment or if a more structure and/or controlled environment is required. This includes understanding the risk from the clients living, work/school, and social environment (e.g., extent to which people are using alcohol/drugs, violent, engaged in illegal activity, and/or engaged productively), the availability of social support (e.g., self help, someone who is in recovery, someone to help deal with day to day stress), and/or satisfaction with current situation/relationship. People with systemically hostile environments (e.g., everyone around them involved in substance use or illegal activities) will often require more treatment and (re)habilitation into a new environment and lifestyle over a longer/sustained period of time. Below is the placement check box for this criteria from the GAIN.

<b><i>For Staff Use Only (Optional Environmental Placement Detail)</i></b>	
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<p>◦ E15g. <b>Acute Environmental Issues</b> (Check if, there is weekly alcohol use, drug use, or violence in home [13+ on E2d, e or f], a hostile environment [ 12+ in E5a-f, E6a-f, or E7a-f or 40+ across them], the participant is being violent weekly (13+ on e8p), the participant has been victimized recently [1+ on E9u] or the participant is not satisfied with environment (a total of 5 or less on E15a-f)</p>	
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**Other tools/guides.** In addition to the check boxes, the GAIN has also been set up to facilitate placement by ASAM in several ways. First, the sections are largely in order of ASAM – covering both the symptoms and services received related to them. Second, in some versions of the GAIN we have included symbols like ° , \*, or ~ to indicate additional information. Typically, the check mark is used to indicate red flag questions that are associated with higher severity cases. This is useful because over 80% of the people in the U.S. treatment system are sent to and seen in outpatient settings, with all of the other settings dividing up the rest. These cases typically require further assessment and/or review. The asterisks are typically used to indicate required items and/or the core items for split assessment. In the most common scenario, the asterisked items are done in an initial screening (often in a jail, school or offsite) to make an initial diagnosis and placement recommendation. The whole GAIN is only completed if the client then goes to one of the participating program. This is

typically done to reduce the cost of assessing people who do not become clients for whatever reason.

Exhibit 5-1 provides a worksheet to facilitate the interpretation of the core ASAM placement scales in the GAIN. These are set up so that they can be either hand-scored or computer-generated. In each case, the ranges of the scale/questions have been trichotomized into low, clinical, and acute ranges. Placement and treatment planning typically focus on issues in the clinical or acute range. Issues in the acute range typically cannot be easily ignored and should be considered very carefully in the placement decision. Appendix A contains a summary of their calculation and interpretation. Appendices B and C contain the norms for the ASAM scales for adolescents and adults respectively based (see Dennis, Scott et al., 1999 for more detailed norms by level of care).

Exhibit 5-1. ASAM Placement Profile Worksheet							
ASAM Criteria/Gain Scale	GI1299 Page	Question Items	Score	Low	Clinical	Acute	
<b>A. Diagnosis</b>							
Substance Problem Index (SPI)	I-23-24	S9c-u		0	1 2 3 4 5 6 7 8 9	10 11 12 13 14 15 16	
<b>B1. Intoxication and Withdrawal</b>							
Substance Frequency Index (SFI7p)	I-15-16	S2d1-3, S2e1, S2f1, S2g4-5		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	
Recency of Use	I-14	S2a_1-99, S2b, S2c		0 1 2	3 4 5	0.06	
Days of Opioid Use	I-16	S2g5		0	1--10--20--30--40-44	45-50-60-70-80-90	
Current (past week) Withdrawal Index (CWI)	I-18	S3c1-99		0	1---3---5---7---9---11	12-13-15-17-19-21-22	
<b>B2. Biomedical</b>							
Health Distress Index (HDI11)	I-27	P3, P3a-k		0 1 2	3 4 5 6	7 8 9 10 11 12 13 14	
Health Problem Index (HPI3p)	I-30	P9, P9a-b		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	
<b>B3. Psychological</b>							
General Mental Distress Index (GMDI)	I-39-40	M1a1-4, M1b1-6, M1c2, M1d1-10		0 1 2 3	4 5 6	7-10-13-15-18-21	
Behavior Complexity Index (BCI)	I-42-43	M3a1-18, M3b1-15		0 1 2 3 4 5	6-8-10-12-14-16-18	19 --20--25--30--32	
Emotional Problem Index (EPI7p)	I-40--43	M1e-g, M2, M2q, M3, M3c		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	
<b>B4. Treatment Acceptance and Resistance</b>							
Treatment Resistance Index (TRI)	I-22	S8a-d		0	1 2	3 4	
Treatment Motivation Index (TMI)	I-22	S8e-j		5	4 3	2 1	
<b>B5. Relapse Potential</b>							
Self Efficacy Index (SEI)	I-22	S8k-reversed, S8m-q		5	4 3	2 1	
Problem Orientation Index (POI)	I-22	S8s-w		5	4 3	2 1	
<b>B6. Environment</b>							
Environmental Risk Index (ERI6)	I-53	E5a-f, E6a-f, E7a-f		0-4-8-12	13--20--24--28--39	40---50---60---72	
General Social Support (GSSI)	I-58	E12a-j		9 8 7 6 5	4 3 2	1 0	
Recovery Environment Risk Index (RERI12p)	I-19-59	S6a-reversed, E1b, E2c-e, E3, E8, E8p, E9t. E9u. E14a-reversed. E14b		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	
<b>Other</b>							
Illegal Activities Index (IAI3p)	I-62-63	L3, L3v-w		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	
Employment Activity Index (EAI5p)	I-72	V6k, V6m, V6npr, V6ppr, V6qpr		0	.01--.04-.13-.30-.59	.60-.70-.80-.90-1.00	
Training Activity Index (TAI5p)	I-69	V3k, V3m, V3npr, V3ppr, V3qpr		0	.01--.04-.13-.30-.59	.60-.70-.80-.90-1.00	
<b>Other scales in Change table</b>							
Substance Abuse Treatment Index (SATI7p)	I-21	S7e1-99		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	
Physical Health Treatment Index (PHTI4p)	I-32	P11f-j		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	
Mental Health Treatment Index (MHTI3p)	I-46	M5f-h		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	
Criminal Justice System Index (CJSI4p)	I-65	L6a-d		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	
Controlled Environment Index (CEI7p)	I-21-65	S7e1, S7e2, P11g, M5g, E2f, L6c, L6d		0	.01--.04-.07-.10-.12-	.13-.30-.60-.90-1.00	

## **6. Individualized Treatment Planning**

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This section presents guidelines for working with your clients to develop individualized treatment plans using a standardized needs assessment and for promoting consistency in the manner in which treatment plans are developed. Most of the materials in this section are directly adapted from our earlier manual on Individualized Substance Abuse Counseling (Dennis et al., 1995). A basic tenet of that work and this section is that client involvement is essential to developing meaningful and useful treatment plans (Dennis et al., 1995; Sobell, Sobell, and Nirenberg, 1988). Active client involvement in treatment planning and goal setting can help:

- C provide the counselor with important information about the desirability, feasibility, and ease with which various treatment strategies can be implemented;
- C increase clients' motivation to participate and continue in counseling;
- C ensure that treatment goals have been mutually determined; and
- C boost the morale of clients, giving them a sense of mastery over their problems.

Below are some general recommendations and guidelines for developing an initial treatment plan with client involvement over the course of the first few counseling sessions. It is important to keep in mind, however, that treatment planning is not limited to the initial formal encounters with a client. On the contrary, treatment planning is a dynamic process that typically evolves well beyond the first few sessions and should span the entire course of counseling and treatment.

**Relationship Between Assessment and Treatment Planning.** Ideally, assessment should flow directly into treatment planning. In practice, however, most assessments focus on diagnosis and do not always take the necessary steps to facilitate treatment planning. In the prior chapters we talked about administration, scoring, diagnosis and placement. Now we turn to the question of what to do with the person once he or she has arrived at a primary treatment location. The assessment should provide a general overview of problems in specific areas (i.e., logistics, substance use, physical health, risk behaviors, mental health, environment, legal, vocational). In our experience, many instruments can provide sufficient detail to obtain a general picture of the problem presented by a particular client. The advantages of picking one instrument and standardizing its administration are that it (a) allows counselors to communicate more effectively with each other and their clinical supervisor in case conferences, consultation, and supervision, (b) minimizes the loss of information when cases are transferred between counselors, and (c) allows for better program planning to meet the needs of clients (including tools to reduce paperwork or make it more clinically useful). The additional advantages of the GAIN over other instruments are that it was designed to (a) lead directly into problem definition and treatment planning and (b) facilitate communication with specialists and

agencies outside of the

participating system (i.e., medical, psychiatric, or vocational referrals) by using their standards and language.

**Transitioning From Assessment to Planning.** By clearly communicating that the GAIN will be used for “treatment planning” and then reinforcing this perspective during the assessment you will get better data. Through the assessment and debriefing phase you should have established that you “listened” to the client and established your understanding of the clients situations and desires. This is an essential step in becoming an effective agent for change. In addition, during the assessment process you will have already been making notes in preparation for treatment planning and possibly have consulted with other staff about specific requests the client will make of you. This means you can reduce your response time. Finally, it is important for you to realize that the assessment process itself is helping the client define and communicate problems and desires which he or she might not have otherwise been able to discuss. This is very different from many diagnostic assessment that focus more on trying to categorize people.

Even before developing a formal treatment plan, it is essential to start informal treatment planning from the very first session. At the most pragmatic level it is important to check for immediate threats or barriers to the client's (a) return for the next session, (b) personal safety, and/or (c) short-term sobriety. After the assessment is completed (or at the end of the first session), you should review the information available to date and the client's plans after leaving the assessment, the plan between now and the next session, and that for coming to the next session. Some clients may require admission to one of the ASAM levels of detoxification before they can even complete the assessment or be ready for primary treatment. You will also want to carefully probe for any barriers to returning like those found in section B of the GAIN (e.g., transportation difficulties, child care, work schedules, insurance). Clarify any concerns about possible suicidal thoughts (section M of the GAIN) or threats to personal safety (Section E of the GAIN). Next, make sure that the client has thought through a plan for coming back for the next session (e.g., how will he or she get there, who will watch the kids, is there anymore paperwork or documentation required). Finally, it is often desirable to provide some level of intervention and/or make sure the client has access to some kind of drug-free environment to reduce the risk associated with relapse between this and the next session (e.g, detoxification, a sponsor or friend in recovery).

Effective resolution of some barriers to care might involve arranging a joint meeting with the client and a wrap around coordinator, vocational services coordinator, case manager, or other staff member. For example, if the client is concerned about being unable to keep the next few appointments because of unmet child care needs, meet with the client and the case manager together immediately (if possible) to assist the client in finding a suitable solution to this problem. It is particularly important to cover this issue for new clients where the assessment is being done in their first or second session.

**Preparation.** If possible, review the GAIN with the client prior to the next session. The ASAM PPC, other scales, and measures of service utilization are generally set up to give you information about a given problem in three dimensions:

13. **Recency** - has this problem occurred and, if so, when did it last occur? Things that happened in the past week or 90 days will typically play a greater role in current treatment than those that happened 3-12 months or 1+ years ago.
2. **Breadth** - how widespread/diverse is the presentation of clinical symptoms or pattern of service utilization? Typically more diverse presentations are associated with higher severity. For clinical problems, the focus is on the past year (or since the last interview in follow-up assessments). For services, the focus is on the lifetime pattern of service utilization.
3. **Current Prevalence** - how often has this happened in the past 90 days? Typically things that happen more frequently (particularly if they interfere with responsibilities at home, work/school or socially) are going to be more important than those that happened only once or twice

All three of these dimensions can interact. Obviously a recent problem, with a broad presentation and high current prevalence is going to be the most acute situation. A broad presentation of symptoms over the past year that has not been problematic recently (or only infrequently) has probably been addressed, but should still be monitored. However, a narrow presentation and low prevalence may still be important given the specific symptoms in question (e.g., suicide attempts). The goal of this review of the GAIN is to identify “where” the problems are, “prioritize” which are the most acute, and identify what additional information should be sought during the second session to make an effective treatment plan and/or referrals.

**Feedback and Targeting of Problems.** We recommend that the second session be dedicated to conducting a face-to-face review of the assessment with your client. This review gives you the opportunity to:

1. Identify and correct errors, misperceptions, and miscodings regarding answers to specific questions.
2. Allow the client to clarify and expand upon the information recorded in the standardized assessment.

3. Provide the client with a concise overview of his or her problems in eight important areas of functioning.
4. Provide a format for comparing and discussing the severity of problems as viewed by the client and you.
5. Provide a logical starting point for developing an individualized treatment plan with active client involvement.

Begin this session by telling the client that you would like to review the findings from the standardized interview that was completed in the previous session. Mention that you expect this review will be helpful in developing a plan to address the problems in his or her life that are related to drug use. We recommend that you review all modules of the assessment, including modules in which the client and you agree that few or no problems exist. We believe that a complete review of the assessment often provides the client with a clear "snapshot" of his or her life that points out areas of relative strength as well as problem areas that may require treatment of some kind.

Introduce each module of the assessment with a brief statement such as "We began the interview with a number of questions about your substance use," or "In this next section, we discussed your involvement with the legal system." Short statements such as these should help focus the client's attention on the information to be covered in that module. Briefly review the client's response to each section of the assessment modules, including the client's and your ratings of the severity of problems in each area. Encourage the client to provide additional information that might clarify the nature of problems in each area. This information can be recorded directly onto the GAIN assessment. Counselors vary in how much additional detail they seek at this point, but most seek to understand any complex situation or what appear to be inconsistent or unlikely answers. Most start by looking at the overall picture in each section and only go item by item in the critical areas identified by the client. Our experience indicates that most GAIN reviews should be completed within a single session.

At first glance this review may seem redundant to you because it is covering the same information as the original assessment (particularly if it was orally administered). For a given client, however, it is often a therapeutic experience because it directly demonstrates that you actually listened, and it provides a comprehensive picture of his or her life and situation. Many clients have never taken stock of their own lives, and virtually none have confided so much information to a single person. This review process is a fundamental part of empowering you as someone who understands the client and facilitates your role as an agent of change.

**Prioritizing General Areas for Treatment Planning.** The next step is to prioritize the general areas of potential treatment needs and identify specific areas on which to work. Exhibit 6-1 shows both the client and counselor ratings on one of the GAIN profiles. Both clients and counselors have been asked to rate the extent to which a client needs help in each area; the last line is the sum across areas. In summarizing both the client's rating and your own, it is important to acknowledge both your areas of agreement and disagreement. While you do not want to dwell on or be sidetracked by areas of disagreement, acknowledging such areas helps to establish the appropriate level of rapport. In other words, be supportive but honest.

In many cases you will find several areas which you and the client will agree are very important and some which you will agree are relatively unimportant. But often there will also be one or more areas in which you think the client is either underestimating the extent of the problem or is perhaps even in a state of denial. Some common examples of this include clients who do not recognize:

- C their heavy alcohol use as a problem;
- C the extent to which alcohol or drug use is causing their problems;
- C the risk caused by needle practices or sexual behaviors; or
- C their level of aggressive behaviors, conflict, or level of victimization.

Treatment needs also vary over time as clients progressively deal with different issues related to their stage of recovery. In TEP (Dennis et al., 1995) it was found that counselor problem severity ratings are also about the same or higher than the client's self-rated needs. Female clients (and their counselors) viewed themselves as having more severe drug and mental health problems. Also note that counselors are often much more concerned about the social or coping situations of women (1 out of 5 of whom were reporting being physically or sexually abused in the past 90 days or being at imminent risk for such abuse). Hispanic clients are more likely to report greater need for assistance with legal problems and with physical and mental health problems, though their counselors only seemed to consider them to be at greater risk for mental health problems. In terms of time in treatment, only drug and alcohol problem severity (the focus of treatment) appears to be significantly reduced as time in treatment increased--virtually all other problems and forms of help needs remain unchanged/unmet. This overall pattern is a salient reminder of the need for more comprehensive treatment and the constant weight of other problems that are pressing in on clients.

**Exhibit 6-1 Individualized Treatment Planning Profile**

Page	Item	Treatment or Problem Area by	Score	Do Not Need Help	Get-ting Help OK	Need Help In 3+ Mos	Need Help 0 to 3 Mos	Need Help Right Away	Specific Assistance Sought
I-11	B9	Client Tx Arrangement Urgency Rating	4	0	1	2	3	(4)	Wants assistance with transportation and housing
I-11	B10	Staff Tx Arrangement Urgency Rating	4	0	1	2	3	(4)	
I-26	S10	Client Substance Use Urgency Rating	4	0	1	2	3	(4)	Wants inpatient treatment
I-26	S11	Staff Substance Use Urgency Rating	4	0	1	2	3	(4)	
I-33	P13	Client Physical Health Urgency Rating	0	(0)	1	2	3	4	
I-33	P14	Staff Physical Health Urgency Rating	0	(0)	1	2	3	4	
I-38	R7	Client Risk Behavior Urgency Rating	0	(0)	1	2	3	4	Talk about unprotected sex
I-38	R8	Staff Risk Behavior Urgency Rating	2	0	1	(2)	3	4	
I-47	M6	Client Mental Health Urgency Rating	2	0	1	(2)	3	4	Wants help with anger, needs help controlling behavior
I-47	M7	Staff Mental Health Urgency Rating	3	0	1	2	(3)	4	
I-60	E16	Client Environmental Urgency Rating	0	(0)	1	2	3	4	In a shelter now
I-60	E17	Staff Environmental Urgency Rating	1	0	(1)	2	3	4	
I-67	L10	Client Legal Urgency Rating	0	(0)	1	2	3	4	
I-67	L11	Staff Legal Urgency Rating	0	(0)	1	2	3	4	
I-78	V12	Client Vocational Urgency Rating	3	0	1	2	(3)	4	Wants a job
I-78	V13	Staff Vocational Urgency Rating	3	0	1	2	(3)	4	
Client SUM		Total Client General Urgency Rating	8	0	8	0	16	24	32
Staff SUM		Total Staff General Urgency Rating	0	0	8	16	24	32	

Note: Clinician ratings of 4 should be addressed in the first phase of treatment (typically 7-14 days for residential, 4-6 weeks for outpatient); needs rated at 3 should be part of the individualized portion of the treatment plan for the first 30-90 days; needs rated 1 or 2 should be reviewed at major treatment reviews, transfers, and continuing or aftercare plans; those of 0 should still be periodically rechecked/monitored for change at least every 90 days.

Getting more specific about what clients want. After starting with the areas that both you and the client think are the most important, the next step is to look at the specific kinds of help that the client wants. Each section of the GAIN ends with a list of specific services the client may want help with from this program, either directly or through referral (see Dennis et al., 1995 for a detailed presentation of their endorsement). You should start by noting what the client wants and keep in mind that what people want changes over time and/or in response to discussions like these. Even long-term residential or methadone clients will typically have things they want, but may have had a difficult time articulating them in the past.

In addition to the client-identified needs, it is also important for you to identify, note or raise other critical clinical issues that may put the client, the client's family, and/or society at considerable risk of drug relapse or other forms of harm. Some of these other issues are:

- C homelessness, unstable housing, or living situations with a lot of drug/alcohol use and illegal activity;
- C food problems, including going without food;
- C having young children, particularly a first child, children under 3 years of age, or children with custody issues;
- C whether other people in the client's living situation are engaged in socially productive and/or supportive behaviors;
- C whether other people in the client's work/school situations are engaged in socially productive behaviors;
- C illegal activities, including arrests and relying primarily on illegal income for support;
- C involvement in civil or criminal justice proceedings that may produce stress, legal, or financial consequences;
- C major infectious diseases related to drug use, including hepatitis, tuberculosis, AIDS, and other sexually transmitted diseases;

- C risk behaviors related to spreading infectious diseases, including needle use and unprotected sex;
- C medical or dental problems, particularly those that may require coordinated care such as pregnancy or taking prescribed drugs;
- C current mental health problems, particularly suicidal thoughts or attempts, or problems that may require coordinated care;
- C whether peers are engaged in socially productive and/or supportive behaviors;
- C recent avoiding, arguing, or fighting with family, friends, or coworkers;
- C recent weapon, physical, sexual, or emotional attacks, including concerns that they might happen again soon;
- C high rates of using violence to resolve conflict situations;
- C victimization or fear of abuse;
- C lack of problem orientation or productive coping skills;
- C antisocial or borderline personality behaviors related to family, school, work, treatment, and societal restraints in general;
- C low overall functioning or deteriorating functioning.

The GAIN is designed to screen for each of these problems. If they are encountered, however, you will need to probe to clarify the nature of each problem and the specific ways in which it is expressed in the client's life. You can ask the client to describe any situations, events, and mood states that tend to precede, follow, or co-occur with each target problem. The goal here is to identify conditions that potentially trigger and/or maintain the undesired problem. For example, it would be important to ask a client who injects cocaine and heroin ("speedballs") if certain things tend to co-occur with his or her use of these drugs. Asking such questions as "When

you cook your works, are others usually around?" and "How are you usually feeling before you shoot up?" may prompt the client to report information of critical importance to the treatment plan that is not typically obtained from general assessments. For example, by sensitively asking probing questions, you may find out that a client tends to abuse heroin and cocaine in combination on the weekends, when hanging out with certain partners, or when he or she is feeling depressed and isolated from family members, especially his or her children. This additional information may be critical to the development of a meaningful and effective treatment plan.

**Objectively Defining Problems.** As previously noted, the GAIN tells you “where” there are problems but you often need to work further with the client to define the exact nature of the problem. This is a particularly important component of the kind of problem-solving counseling that is typified in most substance abuse treatment programs. Clients often come to treatment with unspecified, vague, or very general complaints (e.g., "my nerves are shot and I need some help," "my old man/lady is driving me nuts"). A major function of the treatment plan that you developed during the first few counseling sessions was to identify and clarify problems in specific problem areas. As such, the process by which you worked with the client to define and formulate target problems during the development of the treatment plan can serve as a model of how this process might occur. The overall goal of this stage of problem-solving counseling is to teach clients to be able to define and formulate problems on their own and in a manner that permits the implementation of subsequent steps. As noted by Nezu et al. (1989), this goal may be accomplished by showing the client how to do the following:

- C seek all available facts and information about the problem,
- C describe the facts in clear and unambiguous terms,
- C identify those factors that actually make the situation a problem,
- C differentiate relevant from irrelevant information and objective facts from unverified assumptions and interpretations, and
- C set realistic problem-solving goals.

As recommended by D'Zurilla (1986), this task can be facilitated by asking the following who, what, when, where, and why questions about each problem: Who is involved? What happens (or does not happen) that bothers you? When does it happen? Where does it happen? Why does it happen (i.e., known causes or reasons for the problem)? What is your response to the situation (i.e., actions, thoughts, and feelings)?

More information on individualized treatment planning, developing specific goals, objectives and treatment plans (as well as problem solving counseling) can be found in the Individualized Substance Abuse Counseling (ISAC, Dennis et al., 1995) manual.

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