Global Appraisal of Individual Needs: 
Administration Guide for the GAIN 
and Related Measures

(Version 5)

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First Author’s Preface to Version 5

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. In 1986, Chestnut 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 members. Chestnut staff members have a long history of using standardized assessments and training, which have helped it to repeatedly achieve “commendation status” (top 10%) in reviews by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), and it has been identified as one of the best practice programs by several reviews (Drug Strategies, 2003; Stevens & Morral, 2003).

The development of the GAIN is part of a multipronged response to major changes in substance abuse treatment over the last several years. These changes include new diagnostic criteria (DSM-IV, APA, 1994; DSM-IV-TR, APA, 2000), new accreditation standards (JCAHO, 1995, 2003), new patient placement criteria (PPC-2, ASAM, 1996; PPC-2R, ASAM, 2001), integration into managed behavioral health care, and an increasing emphasis on outcome monitoring. One effect of these changes is that at the same time substance abuse treatment staff members are doing more work with assessing and documenting, they are given fewer resources and time to do so, let alone have time to treat clients. Dissatisfied with available instruments and the nature of others under development, Chestnut 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 one) and outcome-monitoring data to guide decision-making. Third, it is conducting a series of studies on how to develop more effective and cost-effective approaches to treatment.

A secondary goal of this work was to develop scientifically rigorous tools that mapped well onto DSM-IV for diagnosis and PPC-2 for placement, followed JCAHO for integrating assessment into treatment planning, and integrated well into 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.

In addition to the co-authors, this document would not have been possible without the contributions of Rod Funk and Melissa Ives (formerly McDermeit), who developed much of the syntax and documentation used in analyzing the GAIN; Kathy Rourke, who worked on earlier versions of the standardized assessment chapter; Jim West, Gerry McKean, Jim Ma, and Randy Lucas, who worked on an earlier version of the software and computer applications; and Bryan Garner, Lora Passetti, and Susan Godley, who helped develop several of the computerized reports.

I need to thank Jerry Jaffe for getting me started on this issue; Peter Delany for encouraging me to develop a paradigm for integrating research and clinical assessment; Mark
Godley and Chris Scott for bringing me to Chestnut, helping me to see this become a reality, and being great colleagues and friends; 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; Bill White, Ed Senay, and Wilson Compton for providing countless insights and recommendations that influenced the instrument in more ways than they probably realize; Loree Adams, Rick Risberg, Mychele Kenney, Al Sodetz, and the staff members of both Chestnut and Interventions for contributing so much when the returns were so far downstream for them; Tom Babor, Guy Diamond, Jean Donaldson, Susan H. Godley, Jim Herrell, Yifrah Kaminer, and Frank Tims for choosing to use the GAIN in the Cannabis Youth Treatment Experiment; and Randy Muck for supporting the ongoing development and dissemination of the GAIN for substance abuse treatment evaluations.

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 some who made one or more suggestions that led to a major change in the instrumentation: Doug Anglin, Jim Becnel, Mike Bohlig, Arthur Bonito, Ken Bossert, Mike Boyle, Barry Brown, Marlene Burk, Juesta Caddell, Betty Cavanaugh, Wilson Compton, Ward Condelli, George Deleon, Sam DiMenza, Seth Esienberg, John Fairbank, Mark Fishman, Pat Flynn, Mark Foss, Mike French, Dean Gerstein, John Guyett, Lilia Hristova, Paul Ingram, Georgia Karuntzos, Rick Lennox, Bruce MacDonald, Lou Mattia, Tom McLellan, Andrew Morral, Deb Oberg, Valley Rachal, Ed Ravine, Scott Ray, Pat Shane, Richard Straw, Sally Stevens, Chris Roebuck, Joyce Roland, Joe Rosenfeld, Bill Schlenger, Dwayne Simpson, Murray Strauss, Holly Waldron, Randy Webber, Wendee Wechsberg, Gail Woods, Jim Wrich, and Gary Zarkin.

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1. Introduction, Questions, and Organization

1.1 Introduction and Organization of the Manual

This manual provides instructions for administering and using the Global Appraisal of Individual Needs (GAIN), version 5. The GAIN is actually a series of related instruments that share the same general instructions, questions (and variable names in most cases), scoring, interpretation, and clinical decision trees. This manual focuses on two main instruments:

- **The GAIN-Initial (GAIN-I)** is a full biopsychosocial assessment, meeting major reporting requirements, that integrates research and clinical practice for diagnosis, placement, individualized treatment planning, and program evaluation. Administration time to complete the full GAIN-I is approximately 120 minutes (see chapter 3 for reasons behind variations in administration time).

- **The GAIN–Monitoring for 90 Days (GAIN-M90)** is a quarterly follow-up to monitor how participants respond to treatment as well as how they do after they have been discharged. It is largely a subset of the GAIN-I, so many items in the full GAIN-I are skipped in the M90. (Item numbers remain the same for the items that appear in both.) Administration time for the full GAIN-M90 is 45-60 minutes.

Also available for the GAIN-I and GAIN-M90 are different core versions that contain all the major information contained in the full GAIN but that do not go into as much depth in collecting details. These core versions are often study-specific versions of these instruments with different subsets of questions or added questions and are about two-thirds the length of the full GAIN. Administration time for the GAIN-I Core is about 60-90 minutes and about 30 minutes for the GAIN-M90 Core, depending on which core version is used and whether any additional items have been added. A critical point here is that the GAIN-M90 monitoring instrument is set up primarily for quarterly administration. Because participants go through a great deal of change in the first three months after treatment, we strongly recommend against skipping this data point. If you do skip quarterly intervals (intake, 3, 6, and 12 months; or intake, 6, and 12 months), it is important to a) use the questions about services since the last interval and b) have another way to document the services provided in the first phase of treatment.

The GAIN-I and GAIN-M90 measures are also frequently supplemented with one or more of the following instruments:

- **The GAIN-Quick (GAIN-Q)** is a subset of items from the GAIN’s core pathological, outcome, and service utilization scales and is designed to make the referral process more efficient. Responses to the GAIN-Q can also be used to support brief interventions and can be imported into the GAIN-I. Administration time for the GAIN-Q is approximately 20-30 minutes.
The GAIN-Short Screener (GAIN-SS) is designed for use in general populations to quickly and accurately identify people who would be flagged on the full GAIN as having a drug dependency or mental health disorder. The GAIN-SS is a much shorter instrument, only two pages, containing one total scale (20 symptoms) comprising four subscales for internal disorders, behavioral disorders, substance use disorders, and crime and violence. It is designed to screen for people with clinical disorders among general populations of adolescents and adults. The subscales are based on a series of exploratory and confirmatory factor analyses of psychiatric symptoms and disorders among clinical samples. Administration time for the GAIN-SS is approximately 5 minutes.

The Collateral Assessment Form for Intake (GCI) and Follow-up (GCM) is given to parents, guardians, spouses, or other collaterals to help validate participant self-reports and check for any areas of denial. The GCI and GCM have the same cover page and administration conventions as the GAIN, and where applicable, items have the same item numbers.

The Supplemental Assessment Form for Intake (SAF-I) and Follow-up (SAF-F) are used to add additional scales or to document the results of urine tests. The SAFs have similar cover pages and administration conventions but are limited to questions that do not overlap with the GAIN. They vary from study to study and are used to convey administration and data entry information over multiple small forms. There is no single SAF form available; “SAF” is a generic term often used to describe additional measures used with the GAIN.

Copies of these instruments, as well as additional tools and psychometrics, are available at http://www.chestnut.org/li/gain. These instruments are copyrighted, and a current GAIN license is required for their use (see section 1.4 for information on licensing).

Below is a summary of the manual’s other chapters.

- **Chapter 2** provides background and rules for semistructured assessments. It reviews the rules for conducting standardized assessments for reliability (getting the same answer to a question when asked by different people or at different times) as well as common-sense reasons for loosening the rules in order to maximize validity.
- **Chapter 3** provides information on the GAIN’s internal organization, conventions, and general administration, including an alphabetical crosswalk of substances to GAIN class and diagnostic groups.
- **Chapter 4** presents the GAIN’s model of quality assurance, an essential component for maximizing both reliability and validity.
- **Chapter 5** describes the use of the GAIN for diagnosis based on the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000).

Chapter 7 describes the use of the GAIN to support individualized treatment planning and is based in part on the Individualized Substance Abuse Counseling protocol (ISAC; Dennis, Fairbank et al., 1995) and the Joint Commission on the Accreditation of Healthcare Organizations standards (JCACHO, 1995, 2003).

Chapter 8 describes our protocols for training, certification, and clinical supervision of research and clinical staff members on the use of the GAIN.

Chapter 9 summarizes our progressive and integrated approach to assessment and program evaluation.

The GAIN’s frequently asked questions appear as an appendix after the references at the end of the manual. Updated FAQs are also regularly posted at http://www.chestnut.org/LI/gain/index.html (approximately two-thirds of the way down the page).

The training CD that comes with this manual includes a wealth of supplementary material, including blank copies of the instruments, training cases, PowerPoint presentations given at national GAIN trainings, crosswalks of the scales and indices in the GAIN, licensing information, SPSS syntax, and much more. The directory showing all the files on the CD can be found as a stand-alone pdf on the CD itself.

The remainder of this introduction is comprised of a short history of the evolution of the GAIN, including a list of additions to the current version (section 1.2); a short summary of the GAIN’s internal organization and psychometrics, which you have permission to use in whole or part in other articles, chapters, or reports (section 1.3); and an overview of the services provided by the GAIN Coordinating Center (GCC), including where to get GAIN-related questions answered (section 1.4).

1.2 The Evolution of the GAIN and Summary of Changes for Version 5

The genesis of the GAIN was a conversation with Jerry 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. This led to a conversation about the paradox that standardized measures were often more reliable but less valid than clinical assessments and the feasibility of making a short standardized assessment battery that was psychometrically sound and clinically valid and relevant. Subsequently, Schlenger and colleagues (1989) developed the initial version of the Individual Assessment Profile (IAP) based on the Addiction Severity Index (McLellan, Luborsky, et al., 1985; McLellan, Kushner, et al., 1992) and an early version of the Client...
Assessment Profile (CAP, developed for NIDA’s Methadone Quality Assurance Treatment System; Phillips, Hubbard, et al., 1995). Designed as a common measure across their local and cross-site demonstration evaluations, this early version was never used. Instead it was revised well over two dozen times and resulted in the concurrent development of the GAIN and several other instruments used in the National Treatment Improvement Evaluation Study (NTIES; Gerstein et al., 1997), the Individual Assessment Profile (IAP; Flynn et al., 1995), and some of the Target Cities demonstration projects (Stephens, Scott, & Muck, 2003).

The first official version of the Global Appraisal of Individual Needs was developed in 1993-1995 as part of a collaboration between researchers, administrators, and clinicians at the Research Triangle Institute and at three methadone clinics (PBA the Second Step in Pittsburgh, PA, Pathways/Sisters of Charity in Buffalo, NY, and the Santa Clara County Health Department in San Jose, CA) under a NIDA-funded Training and Employment Program (TEP) study to Dennis (R01 DA07964). Starting with the then-current version of the IAP (Flynn et al., 1995), sections were revised to use more symptom count scales, behavior or service utilization counts (e.g., number of days or times the participant engaged in certain behaviors), and to add questions on what the client “wanted” in order to help with treatment planning. There was also an intentional shift away from lifetime epidemiology toward current functioning. Where possible, recommendations from NIDA’s diagnostic sourcebook (Rounsaville, Tims, Horton, & Sowder, 1993) were followed in selecting symptom counts or critical assessment areas.

However, review of taped assessments and counseling sessions identified several gaps in participants’ histories that needed to be addressed further, including physical and mental distress, violence, environment, problem solving, and victimization. These items were developed and pilot-tested in collaboration with clinical staff members. Question formats were simplified to reduce respondent burden, and information was added for immediate hand-scoring by clinicians. Evaluation of this measure (Dennis, Fairbank et al., 1995) suggested that it had matched or improved the psychometrics of several existing scales, but they were still only mediocre (alpha = .7) and did not map well onto clinical paperwork or decisions. Parts of this version of the GAIN were used to evaluate CSAT’s New Orleans Target Cities Project (NOTCP; McDermeit & Dennis, 1999) and Target Chicago project (Scott, Foss, & Sherman, in press), and NIDA’s North Carolina Cooperative Agreement to do AIDS outreach (Reif, Wechsberg, & Dennis, 2001). Though the NOTCP’s version of the evaluation primarily used version 1, it also introduced the GAIN’s substance problem scale, based on DSM-IV (APA, 1994) and done on the primary, secondary, and tertiary substances of abuse.

Version 2.0 of the GAIN was developed from 1995-1996 under a grant from the Interventions Foundations, called the Drug Outcome Monitoring Study (DOMS), and a contract from the Illinois Criminal Justice Information Authority (ICJIA) to evaluate the Madison County Alternative Treatment and Court. This version was revised to better map onto the prevailing diagnostic criteria (DSM-IV, APA, 1994), accreditation standards (JCAHO, 1995), and patient placement criteria (PPC-2, ASAM, 1996). This version was adapted for use with adults as well as adolescents. It incorporated several scales from the National Household Survey on Drug
Abuse (NHSDA) and National Health Interview (NHI) survey to facilitate comparisons with existing epidemiological data in the public domain, and it also incorporated items designed in collaboration with Dr. Michael French to facilitate comparisons with economic analysis. The adaptation for use with adolescents, including new questions, scales, and interpretative tools, was developed and tested with the help of senior clinical staff members from Chestnut and Interventions (particularly Loree Adams, Seth Esienberg, Mychele Kenney, Ed Ravine, Rick Risberg, Joe Rosenfeld, Ed Senay, Al Sodetz, Randy Webber, and Bill White) and an external advisory board (Mike Boyle, Wilson Compton, Sam DiMenza, Mike French, Rick Lennox, Holly Waldron, and Jim Wrich). While version 1 of the GAIN placed a great deal of emphasis on using scales that had been widely published, it produced a bias toward older measures that did not do as well statistically or map onto clinical needs. As we shifted our criteria toward the latter, it was clear that many of the scales in the NHSDA or developed by clinical staff members worked much better. The substance problem scale (collected here for alcohol and again for other drugs), for instance, had an alpha of .9 (compared to alphas of .7 in other screeners) and mapped directly onto the diagnostic criteria. The DOMS effort was singled out by the Institute of Medicine (Lamb, Greenlick, et al., 1998) as a model for bridging the gap between research and practice. It led to a NIDA white paper on the integration of research and clinical assessment (Dennis, 1998), demonstrated the feasibility of predicting ASAM placement decisions made by clinical staff members (Dennis, Scott, et al., 1998, 2000), and produced some of the first norms of a single assessment battery across adult and adolescent levels of care (Dennis, Scott, et al., 1999).

Version 3.0 of the GAIN was developed in 1997-1999 with funding from several grants, including the Assertive Aftercare Program (AAP) experiment by Drs. Godley, Godley & Dennis (NIAAA grant no. RO1 AA10368), the 5 CSAT Cannabis Youth Treatment (CYT) cooperative agreement grants by Drs. Dennis (TI-11320), Babor (TI-11324), Tims (TI-11317), Godley (TI-11321), & Diamond (TI-11323), and the 10 CSAT Adolescent Treatment Model (ATM) grantees by Drs. Bennett (TI-11423), Fishman (TI-11424), Stevens (TI11422 & TI11892), Morral (TI-11433), Shane (TI-11432), Liddle (TI-11871), Stewart-Sabin (TI-11888), Godley (TI-11894), and Battjes (TI-11898) and the Multisite Analytic Center (CSAT contract no. 270-98-7047). The primary focus of these revisions was to further adapt the GAIN to work with adolescents, add items to meet CSAT’s reporting requirements, and incorporate the feedback from researchers and clinicians who had used the earlier version. The substance problem scale was revised into a single scale (across alcohol and drugs) that could be used as a measure of change and for course specifiers, and a grid (initially developed by Rick Risberg) was added to do detailed diagnoses by substance. This version also led to the development of parallel versions for family members or other collaterals, the shorter Quick version (Titus & Dennis, 2000), and numerous psychometric studies summarized below and in appendix 3.

Version 4.0 of the GAIN involved the development or revision of several key modules related to substance use, motivation, relationships, and illegal activity. It was done with support from the Early Re-Intervention (ERI) experiment by Drs. Dennis and Scott (NIDA grant no. DA11323), the Mothers at the Crossroads (MAC) evaluation by Dr. Godley (IL state grant no PI 00567), the
Persistent Effects of Treatment Study (CSAT contract no. 270-97-7011), and the Bloomington ATM site (Dr. Godley, TI-11894). The ERI and subsequent PETS version incorporated several of the items from Dr. Scott’s earlier Target Chicago evaluation (which became the 10-year Pathways to Recovery longitudinal study funded under NIDA grant and R01 DA15523) and Dr. Godley’s MAC and ATM versions, which incorporated modules to address information gaps, identified by clinical staff members, related to insurance and clients coming from controlled environments. Some of the other key developments in version 4.0 included collecting information on peak substance use and substance use patterns, a more detailed treatment history grid, the addition of items to better cover several diagnostic criteria (for tobacco dependence, major depression, generalized anxiety disorder, and conduct disorder), a more detailed illegal activity grid (which also captured whether illegal acts were done under the influence or to obtain substances), and the addition of several individual questions on house arrest, electronic monitoring, public assistance benefits received, and service needs. While most of these modifications improved the measure, no project had all of the modules in use.

Version 5.0 of the GAIN is designed to incorporate the best of these modules and to take advantage of many valuable lessons we have learned from doing quality assurance work with clinicians and researchers in a wide range of settings. Some key changes in version 5.0:

- Improved wording of questions that confused interviewers and participants.
- Changes in interviewer instructions that confused some interviewers and were often the focus of quality assurance review comments.
- Incorporation of transitional statements used by several interviewers to let participants know when the response set was changing.
- Simplifying the cognitive-impairment screener to use days of the week instead of names of the months (which raised literacy questions).
- Expansion of the gender and race questions to address federal guidelines and allow self-identification of gender, race, ethnicity, and tribal identity.
- Simplifying the literacy questions and moving them before the anchoring/general directions section to improve the flow of the interview.
- Simplification of insurance questions (which many participants could not answer).
- Removing a skip-out before barriers to access to care that was often problematic.
- Expanding the list of drug codes and ordering by DSM-IV.
- A more detailed grid on substance use and peak use that has a different skip-out pattern to better measure adult usage patterns.
- Adding a module to get at the date of the participant’s last use of individual substances and the amount they last used (for insurance and comparison to urine tests).
- Adding a module to capture pre–controlled environment use where necessary.
- Adding questions about the use of halfway houses and recovery homes.
- Simplification of the types of substance abuse treatment and the addition of a more detailed treatment history to allow better tracking of treatment careers.
- Adding process questions on treatment in general, treatment groups, and family nights.
• Adding the reasons for quitting (RFQ) questions from Sampl and Kadden (2001) to allow the generation of a personal feedback report (PFR) for use with motivational interviewing.
• Collecting information on pregnancies “caused” by male participants.
• Collecting information on HIV status (where allowed by law).
• The addition of questions to track medication management related to health problems.
• Incorporating a diagnostic module for tobacco dependence.
• Incorporating new items to more accurately assess major depression, generalized anxiety, and conduct disorder.
• The addition of questions looking at the extent to which mental health symptoms appear to interact with substance use.
• The addition of questions to assess past and ongoing problems with cutting and other forms of self-mutilation.
• The addition of questions to facilitate medication management related to mental health problems.
• Adding questions about access to other people in recovery (regardless of whether they are in self-help groups or treatment).
• Adding a question about the age of first victimization.
• Adding questions about the frequency of participating in religious or spiritual activities.
• Removing most of the Likert scales to reduce administration time.
• Changing questions about illegal acts from yes/no to number of times and asking about problems while involved in the criminal justice system to facilitate economic analysis of the cost to society.
• Adding questions about house arrest and electronic monitoring (both of which are becoming increasingly common).
• Adding questions on participation in Temporary Assistance for Needy Families (TANF) and any loss of such benefits.
• Reordering and revising the income questions to make them flow better.
• Spelling out the administrative rating sections to make them easier to use for new staff members and changing the administrative ratings to make them easier to understand.
• Adding administrative ratings on the degree of privacy that was established for the interview.
• Adding an item on whether the participant was required or mandated to go to treatment.
• Changes to the S7 treatment history grid requiring information on whether the participant is still in treatment and the length of stay in number of days (in addition to the dates that were previously required).
• Adding a question in the Legal section on whether the participant is awaiting charges for crimes.

The changes were done in a way that maintains comparability across the core scales in versions 2 to 5 and for many of the simple behavioral counts back to version 1. Version 5 of the GAIN has been and continues to be used in several major studies, including multiple grants from CSAT’s
Strengthening Communities for Youth (SCY), CSAT’s Adolescent Residential Treatment (ART), CSAT’s Effective Adolescent Treatment (EAT), Assertive Adolescent Family Treatment (AAFT), the Young Offenders Reentry Program (YORP), and Drug Court, as well as individual grants to work with adults and adolescents from CSAT, NIAAA, NIDA, and the Robert Wood Johnson Foundation (RWJF). Version 5 has also been set up for computer assisted interviewing using the Assessment Building System (ABS; Hodgkins & Dennis, 2002), a collateral assessment form (GAIN-CM), and the GAIN-Q (Titus & Dennis, 2002).

### 1.3 Summary of Psychometrics

The Global Appraisal of Individual Needs has been normed on both adults and adolescents (Dennis, Scott, Godley, & Funk, 1999, 2000; Dennis, Titus, Diamond, Donaldson, Godley, Tims, et al., 2002; Dennis, Scott, & Funk, 2003), is used as the biopsychosocial clinical assessment in several major treatment agencies (e.g., Chestnut Health Systems, Fayette Companies, Operation PAR), and is currently one of the most widely used measures in adolescent treatment studies in the U.S. (Dennis, Dwaud-Noursi, Muck & McDermeit, 2003; Dennis & White, 2003). It has been used in over 500 agencies and research projects, including over two dozen CSAT grants with the Cannabis Youth Treatment experiment (CYT; Dennis, Titus, Diamond et al., 2002), the Adolescent Treatment Model (ATM; Stevens & Morral, 2003), and Strengthening Community for Youth (SCY), as well as dozens of Adolescent Residential Treatment (ART) and Effective Adolescent Treatment (EAT) grants and several individual grants funded by NIDA, NIAAA, and RWJF. This work includes sites with large number of adolescents, females, African Americans, Hispanics, and Native Americans, as well as clients who are pregnant, homeless, injection drug users, or have co-occurring mental disorders. From a systems perspective the GAIN is used across levels of care, as well as by student and employee assistance programs, criminal and juvenile justice agencies, mental health agencies, and child protective service and family service agencies.

**Scales and Internal Consistency.** The GAIN is based on a measurement model that combines both classical scales (i.e., truth + error) and summative indices (i.e., effect indicator or formative sums of unique variance) into a hierarchical system that gives clinicians and researchers information to look at overall severity, major sources of variation (substance use severity, internal distress, external behavior problems, crime/violence), clinically orientated subscales (e.g., dependence, depression, anxiety, ADHD, conduct disorder), and even the item level for salient issues (e.g., suicide attempts). The internal consistency of the classical scales has been consistently good to excellent across over two dozen studies with populations varying by gender, race, age, and geography, as well as across levels of care and several clinical subgroups (e.g., pregnant woman, injection drug users, homeless people, people with co-occurring mental disorders). The summative indices have also been demonstrated to be both reliable and predictive across this range of populations (see Bollen & Lennox, 1991; Dennis, Lennox, et al., under review; and Nunnally & Bernstein, 1994, for a further discussion of the issues involved in evaluating summative indices).
Key indices (and their alphas for adolescents and adults where applicable from DOMS) are:

<table>
<thead>
<tr>
<th>Scale Index</th>
<th>Adolescent alpha</th>
<th>Adult alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Impairment Scale</td>
<td>Summative</td>
<td>Summative</td>
</tr>
<tr>
<td>Substance Frequency Scale</td>
<td>.80</td>
<td>.77</td>
</tr>
<tr>
<td>Current Withdrawal Scale</td>
<td>.92</td>
<td>.95</td>
</tr>
<tr>
<td>Treatment Resistance Index</td>
<td>Summative</td>
<td>Summative</td>
</tr>
<tr>
<td>Treatment Motivation Index</td>
<td>Summative</td>
<td>Summative</td>
</tr>
<tr>
<td>Self-Efficacy Scale</td>
<td>.71</td>
<td>.72</td>
</tr>
<tr>
<td>Problem Orientation Scale</td>
<td>.92</td>
<td>Summative</td>
</tr>
<tr>
<td>Substance Problem Scale—Lifetime</td>
<td>.90</td>
<td>.89</td>
</tr>
<tr>
<td>Health Distress Scale</td>
<td>.73</td>
<td>.79</td>
</tr>
<tr>
<td>Health Problem Scale</td>
<td>.73</td>
<td>.86</td>
</tr>
<tr>
<td>Internal Mental Distress Scale</td>
<td>.94</td>
<td>.97</td>
</tr>
<tr>
<td>Traumatic Stress Scale (subscale of the Internal Mental Distress Scale)</td>
<td>.92</td>
<td>.96</td>
</tr>
<tr>
<td>Behavior Complexity Scale</td>
<td>.94</td>
<td>.96</td>
</tr>
<tr>
<td>Emotional Problem Scale</td>
<td>.79</td>
<td>.86</td>
</tr>
<tr>
<td>Environmental Risk Scale</td>
<td>.71</td>
<td>.63</td>
</tr>
<tr>
<td>General Conflict Tactic Scale (subscale of the Crime and Violence Scale)</td>
<td>.85</td>
<td>.89</td>
</tr>
<tr>
<td>General Victimization Scale</td>
<td>.82</td>
<td>.86</td>
</tr>
<tr>
<td>Personal Sources of Stress Index</td>
<td>Summative</td>
<td>Summative</td>
</tr>
<tr>
<td>Other Sources of Stress Index</td>
<td>Summative</td>
<td>Summative</td>
</tr>
<tr>
<td>General Social Support Index</td>
<td>Summative</td>
<td>Summative</td>
</tr>
<tr>
<td>Illegal Activities Scale</td>
<td>.82</td>
<td>.86</td>
</tr>
<tr>
<td>Employment Activity Scale</td>
<td>.92</td>
<td>.96</td>
</tr>
<tr>
<td>Training (School) Activity Scale</td>
<td>.93</td>
<td>.91</td>
</tr>
<tr>
<td>Recovery Environment Risk Index</td>
<td>Summative</td>
<td>Summative</td>
</tr>
</tbody>
</table>

Most of these scales have two to four subscales as well (Dennis, Scott, et al., 1999, 2000). The GAIN also includes individual questions designed for comparison to the National Household Survey on Drug Abuse (OAS, 1996) and have been or are currently being “valued” for adults and adolescents at the unit level (e.g., day, time) by Dr. Michael French under separate grants from NIAAA, NIDA, and CSAT.

**Factor Structure.** Using data from 1,028 adolescents from 14 outpatient and residential programs (Dennis, Dwad-Noursi, Muck, & McDermeit [now Ives], 2003), we found that the GAIN scales replicated earlier results in terms of high internal consistency on both the summary dimension scales and their more specific subscales, including:

- **Substance Problem Scale (SPS; 16 items, alpha = .90)** and its subscales: Substance
Issues Index (SII; 5, .67), Substance Abuse Index (SAI; 4.70), Substance Dependence Scale (SDS; 7, .83), and Substance Use Disorder Scale (SUDS; 11, .87).

- **Internal Mental Distress Scale (IMDS; 43 items, alpha = .94)** and its subscales: Somatic Symptom Index (SSI; 4 items, α = .69), Depressive Symptom Scale (DSS; 9 items, α = .77), Homicidal Suicidal Thought Scale (HSTS; 5 items, α = .83), Anxiety/Fear Symptom Scale (AFSS; 12 items, α = .77), Traumatic Stress Scale (TSS; 13 items, α = .92), and General Mental Distress Scale (GMDS; 26 items, α = .88).

- **Behavior Complexity Scale (BCS; 33 items, alpha = .91)** and its subscales: Inattentive Disorder Scale (IDS; 9 items, α = .88), Hyperactivity-Impulsivity Scale (HIS; 9 items, α = .81), Conduct Disorder Scale (CDS; 15 items, α = .82), and ADHD Scale (ADHDS; 18 items, α = .90).

- **Crime/Violence Scale (CVS; 31 items, alpha = .90)** and its subscales: General Conflict Tactic Scale (GCTS; 12 items, α = .89), Property Crime Scale (PCS; 7 items, α = .75), Interpersonal Crime Scale (ICS; 7 items, α = .67), Drug Crime Scale (DCS; 5 items, α = .53), and General Crime Scale (GCS; 19 items, α = .84).

More recently, Dennis, Scott, Lennox, Funk, and Ives (under review) have used data from 2,968 adolescents and adults entering substance abuse treatment in 61 clinics in 17 cities to conduct a psychometric meta-analysis for four subgroups: adolescent outpatient, adolescent residential, adult outpatient, and adult residential. In each of these four groups the GAIN’s General Individual Severity Scale and the four scales that are hypothesized to represent its core dimensions (Substance Problem Scale, Internal Mental Distress Scale, Behavior Complexity Scale, and Crime/Violence Scale) had alphas over .9. Alpha was over .7 in all but 1 of 32 evaluations (four groups x. eight subscales) of the classical scales that were hypothesized to be internally consistent. Alpha factor analysis confirmed the presence of the hypothesized four factors. The only deviations from the hypothesized structure suggested by the above scales were that a) hyperactivity symptoms were a function of both internal and external distress and b) conduct disorder symptoms were a function of both external behavior complexity and crime and violence. Maximum likelihood confirmatory factor analysis supported a single general severity second-order factor as the source of the covariance among the first-order factors that justified a single total score, but at the same time it supported the uniqueness of the first-order factors, and individual subscales hypothesized in the GAIN’s mixed measurement model. There was strong evidence of invariance across adolescent and adult populations and across outpatients and residential treatment settings in terms of the Comparative Fit Index (CFI = .97 constrained vs. .98 constrained) and root mean square error of approximation (RMSEA = .04 vs. .04). The results suggest that the structure of the GAIN’s psychopathology measures are valid and capable of supporting scoring across populations at the level of the general score, factor score, and subscale level.

**Test-Retest Reliability.** A 1- to 3-day test-retest study with 75 adults 2 years after intake revealed good reliability in terms of the need for treatment (kappa = .78), frequency of use (r = .94) and substance problems (r = .81), recovery environment risk (r = .75; Dennis, Scott, & Funk, 2003;
Scott, Dennis, & Foss, under review). A test-retest study of the days of use in the past 90 days and lifetime DSM-IV abuse/dependence symptoms over 48 hours or less with 210 adolescent outpatients revealed consistent but increasing numbers of days of marijuana use (r = .74, 31 vs. 34 days), days of alcohol use (r = .74, 6 vs. 7 days), abuse/dependence symptoms (r = .73, 4.6 vs. 5.3 lifetime), and lifetime diagnosis (kappa = .55, 40% vs. 44% lifetime dependence; Dennis, Titus, et al., 2002). We have also reported that self-reported data on treatment utilization from the GAIN was largely consistent with agency records (r = .78; Godley et al., 2002). Further test-retest studies with an adult sample are currently underway as part of the ERI study.

Validity Studies. In the CYT sample (n = 600), adolescents were more likely than family members or other collaterals to report a greater number of days of any substance use (39 vs. 31 days, t(527) = 7.0, p < .001) and cannabis use (37 vs. 30, t(505) = 6.0, p < .001) during the preceding 90 days. They reported slightly fewer days of alcohol use (7 vs. 8, t(505) = -2.2, p < .05) and about the same number of abuse and dependence symptoms during the preceding month (2.4 vs. 2.6 of 11 symptoms, t(594) = -1.6, n.s.d.), preceding year (4.6 vs. 4.6 symptoms, t(594) = 0.1, n.s.d.), and lifetime (5.1 vs. 5.2 symptoms, t(594) = -0.9, n.s.d). Consistent with the assessment of other psychiatric disorders (see Ezpeleta et al., 1997), family members reported somewhat different symptoms, particularly role failure, tolerance, and substance-induced psychological problems.

Adolescent self-reports were consistent (kappa in the .7 to .9 range) with parent reports and on-site urine tests for any cannabis metabolite (THC 5ng/ml, n = 600) and for gas chromatography/mass spectrometry (GC/MS, n = 74) tests specifically for delta-9-tetrahydrocannabinol (△9-THC 50ng/ml; Dennis, Titus, Diamond, et al., 2002). In a study of 143 adolescents entering residential treatment we found that adolescent self-reports on the GAIN were largely consistent (kappa = .53 to .69) with collateral reports and on-site urine testing (Godley, Godley, Dennis, Funk, & Passetti, 2002).

In a sample of 308 adult outpatient and residential clients at 24 months after intake, self-reports on the GAIN were found to be consistent with a multimethod estimate (based on any self-report or positive urine or saliva) for any drug (kappa = .56), cocaine (kappa = .52), opioids (kappa = .55) and marijuana (kappa = .75; Dennis, Scott, & Funk, 2003). While the prevalence rates by self-report (56%), urine (62%), and saliva (57%) were not significantly different, they were not always produced by the same people and were each substantially lower than the combined estimate (76%). Relative to the combined estimate, urine appeared to miss the fewest people for cocaine (12% false negative), saliva for opioids (6%), and self-report for marijuana (12%). Each method was largely consistent with the combined estimate (kappa of .59 for self-report, .69 for urine, and .56 for saliva).

A preliminary cross-validation of the main symptom counts (e.g., internal distress, external distress, conduct disorder) in the GAIN’s GCM (completed by 600 parents) to the Child Behavior Checklist (CBCL; Achenbach, 1991; Achenbach, Howell, McConaughy, & Stanger, 1995) has found that the similar scales were correlated around .6, while ones that were not related were
generally correlated from 0.0 to 0.4 (Dennis, Titus, Diamond, et al., 2002). Additional comparisons of client and collateral symptom counts among adults are currently underway in an evaluation of Chestnut’s residential program being conducted by Drs. Godley and Titus.

Using data from the GAIN-I for 187 adolescents admitted to residential treatment in the Oakland ATM site (Shane, Jasiukaitis, & Green, 2003), we were able to use discriminant analysis to accurately predict independent and blind staff psychiatric diagnoses of co-occurring psychiatric disorders including ADHD (kappa = 1.00), mood disorders (kappa = .85), Conduct Disorder/Oppositional Defiant Disorder (kappa = .82), Adjustment Disorder (kappa = 0.69), or the lack of a non–substance use diagnosis (kappa = .91) and to discriminate the co-occurring disorders across these conditions (kappa = .65). These analyses are currently being replicated with other samples of adolescents and adults.

1.4 Overview of the GAIN Coordinating Center (GCC)

To support the use and dissemination of this instrument, we have created the GAIN Coordinating Center (GCC). The goal of the GCC is to help bridge the gap between science and practice by:

- Providing a core set of tools for measuring and using information related to diagnosis, placement, treatment planning, outcomes, costs, and benefits.
- Facilitating the use of these tools in research, program development and evaluation, and individual practice.
- Facilitating the pooling of data for replication, benchmarking, meta-analysis, and comparison to epidemiological data and to answer new questions.
- Translating assessment into usable, clinician-friendly reports that support evidence-based decisions about diagnosis, placement, interventions, and program planning.

Currently there are over 500 licensed agencies and research projects using the GAIN across the U.S. and Canada. GAIN research projects managers and coordinators assist agencies and projects using the GAIN to meet these needs via communication, coordination, and follow-through and act as the first point of contact for anyone interested in using the GAIN. We also provide a password-protected website for licensed GAIN users that provides updates and information. See the GAIN contacts handout on the CD for more information.

Core Service Areas

The following sections provide a brief description of the GCC’s four core services areas: product registration and information, training services and quality assurance, software development and technical assistance, and data management and analytic services. This is followed by descriptions of two cross-cutting services (training and certification, product and
report development) and attachment 1-1, a short glossary of several key roles referred to throughout this manual.

**Product Registration and Information.** This core service area pertains to licensing for the GAIN (see the CD for further information) and the GAIN ABS online application (see separate GAIN ABS manual for further information), registration and arrangements for our national train-the-trainer events (see “Training Services and Quality Assurance” below for more information), accreditation of trainings so that trainees can obtain Continuing Education Credits (CEUs), and GAIN website materials. A signed license agreement and usage agreement is required for use of the GAIN and its materials. Questions about starting a regional implementation project, multisite licenses, purchasing a license to use the GAIN or GAIN ABS, or completing the license agreements should be directed to GAINInfo@chestnut.org.

**Training Services and Quality Assurance.** This core service area pertains to scheduling, planning, and materials reproduction for national training events and on-site GAIN trainings, quality assurance review and certification services, and GAIN support help. Our comprehensive quality assurance and services rely on a pool of quality assurance reviewers that conduct reviews of taped administrations and a core team that oversees certification decisions, issues certificates, answers questions, and maintains records of reviews and certifications. The pool of reviewers are very important to the ability of the GCC to provide feedback on taped submissions within one week of tape receipt and to manage the large number of tapes received, especially following a major training. This pool of reviewers includes several part-time consultants drawn from experienced Local Trainers in agencies and sites already using the GAIN, acts as a network that provides cross-agency assistance, provides an opportunity for these reviewers to advance their skills. Details on our training and certification models are discussed further below. Questions about training, quality assurance, and certification should be directed to our GAIN support team at GAINSsupport@chestnut.org.

**Software Development and Technical Assistance.** This core service area includes the GAIN ABS applications. Services include application development, application testing, software training, and software support. A separate manual is available (see http://www.chestnut.org/li/abs for more information) and is included in the national training package. Questions about GAIN ABS should be directed to ABSSupport@chestnut.org.

**Data Management and Analytic Services.** This core service area focuses on helping Agencies and sites using the GAIN by setting up useful management reports that track assessment and treatment receipt and referral and by collaborating with clinical agencies and multi-site research projects to collect, clean, prepare, and store analytic data files. Services include data receipt and tracking, data cleaning, preparation of analytic datasets, production and distribution of cross-site reports for multisite research studies and regional training centers, answering questions related to datasets, and analytic services for data collected using the GAIN. Interest in setting up ongoing data collection, cleaning, report, or analysis services should be
directed to GAINInfo@chestnut.org. Questions regarding GAIN datasets, management reports, and analytic services should be directed to DataSubmit@chestnut.org.

**Cross-Cutting Services: Training and Certification.** We strongly recommend training and certification when using the GAIN, both as a way to more easily transition into using the instrument at an agency or site and to maintain quality service and records management. Our national train-the-trainers model is designed to help two or three staff members to return to their site and become Local Trainers (see role descriptions in attachment 1-1) who can then train and supervise others at their site to administer the GAIN. The 4 days of training comprehensively cover the GAIN, the GAIN-Quick, and the GAIN ABS user manual. For more information and to view training agendas for upcoming training, see our website at http://www.chestnut.org/LI/gain/GAIN%20Training/index.html. The tuition for this training includes a preset amount of follow-up technical assistance with the software and instrument. The process to reach these certification levels is described in detail in chapter 8 of this manual; below is an overview.

- **Coursework certification** is issued to all trainees completing at least 23 of the 26 hours of national training.

- **Administration certification** is issued to those with Coursework certification who complete the process of submitting audiotapes and assessments for review and feedback until mastery of the instrument is achieved. This process is described in detail in chapter 4.

- **Local Trainer certification** is issued to certified Administrators who then train local staff (to be certified as Site Interviewers, similar to Administrators; see below) to administer the GAIN, review taped submissions of these trainees’ administrations, and submit to the GCC the trainee’s tapes, assessments, and feedback for a blind rereview to determine the Local Trainer’s ability to train and provide feedback.

- **Site Interviewer certification** can be recommended by certified Local Trainers by submitting only a trainee’s feedback (no tapes or assessments) to the GCC with their request to review for certification. The main difference between a certified Administrator and a certified Site Interviewer is that an Administrator has completed coursework in a train-the-trainer event and is therefore eligible to continue on to Local Trainer certification, whereas a Site Interviewer cannot go on to any other levels of certification without first completing train-the-trainer coursework.

This model allows for GAIN-licensed agencies and sites to receive initial training, technical assistance, and certification from the GCC, but it also prepares them to competently train staff and therefore “detach” from the GCC and become self-sufficient in using the GAIN. The GCC can also provide a range of customized training options for a given agency or region. Some examples of on-site customized trainings models that we have conducted include:

- Trainings for clinical divisions that are using the GAIN and are interested in advanced...
training in scoring and interpretation.

- **Advanced trainings on our online applications.** While the national training model includes user training and basic administrator training, the GCC can also provide more advanced GAIN ABS administration training and developer training so that agencies can then produce their own local clinical and management reports using GAIN ABS.

- **Administrator trainings to support clinical line or research interviewers,** including QA review support and certification, which is often done to help an agency get started even if they have a Local Trainer who will then be responsible for ongoing supervision and training, such as in the event of staff turnover.

- **Trainings specifically on the GAIN-Quick** (for agencies that want to use this version rather than the full GAIN assessment), which may include training on the online applications.

- **Quality assurance follow-up trainings** for agencies that have done the initial Coursework training of their local staff to use the GAIN but find themselves pressed for time to do all of the follow-up quality assurance work to reach initial certification (which typically involves two to four taped submissions and 4 to 8 hours to review each submission).

These examples are a sample of what we can do to help your agency or research site use the GAIN. For further questions or to inquire about holding training in your area, please contact **GAINInfo@chestnut.org.**

Both the national training model and our on-site training assume use in a single agency or research project. The GCC also works with county, regional, and state agencies interested in using the GAIN throughout their systems. In these situations there is often a middle group (e.g., an agency or university) interested in becoming a regional GAIN training center for which the GCC provides initial training and support with the goal of having the regional center become the primary source of support for the region’s ongoing needs, with the GCC providing backup support as needed. Some examples of regional GAIN training centers include:

- A state department of family services interested in implementing the GAIN in all of its agencies that prefer to have a more local source of GAIN support, such as a university or head agency for the department.

- A state or regional health department interested in using the GAIN for assessment and evaluation among all substance abuse treatment agencies, mental health agencies, and child protective service agencies.

- A state or county department of justice seeking to implement the GAIN-Quick to assess both adolescents and adults for drug court, centralized intake systems, or probation services and the full GAIN to assess those for whom services are recommended for referral and placement.

- A community agency interested in using the GAIN to coordinate services for adolescents...
and adults for screening, referral, placement, treatment planning, diagnosis, and evaluation across their school system, juvenile justice system, mental health services system, department of family services system, health clinic system, state or local public assistance system, and substance abuse treatment system.

For more information on starting a regional GAIN training center, please contact GAINInfo@chestnut.org.

**Cross-Cutting Services: Product and Report Development.** A second cross-cutting area is the GCC’s ongoing commitment to develop new assessment products (such as GAIN-I Core versions and GAIN collateral versions) and reports to use the information they gather. Currently we are working on translating the instruments into Spanish and identifying adaptations to make them more appropriate for use with Native Americans and in rural settings. In the near future we also hope to adapt a version to American Sign Language. Some of the clinical reports that have already been developed include:

- **GAIN Recommendation and Referral Summary (GRRS):** a narrative report designed to approximate a biopsychosocial summary of the interview for diagnosis and placement decision-making.
- **Instrument Report:** provides the ability to print out a hard copy of each instrument with the participant’s responses for when the interview is done online but there is a need to review or transmit a hard copy.
- **Validity Report:** used to identify bad data or inconsistencies across items. This report can be run at the end of the assessment and used to clarify responses before the participant leaves the interview.
- **Individual Clinical Profile (ICP):** provides detailed information on diagnosis, placement, and treatment planning. It includes the core scale scores, detailed tables, and notes about the questions and conditions that met the various criteria.
- **Government Performance and Results Act (GPRA) Report:** designed to subset, reorganize, and collapse the data into CSAT’s reporting requirements under GPRA.

We are currently collaborating with several agencies to refine these reports and add knowledge gained from benchmarking diagnosis and placement decisions from GAIN data collected to date. Product and report development is a team effort of many people inside the GCC and Chestnut Health Systems, who help alpha-test changes, updates, and new products and reports, as well as collaborating agencies who help beta-test products and reports before they are distributed. This team is led by Michael Dennis, senior research psychologist and primary developer of the family...
of GAIN instruments and clinical reports. The GAIN-Quick development, translation, and cultural adaptation development is led by Janet Titus, research psychologist.

1.5 Getting Started

If your agency or research project is interested in using the GAIN, please contact

GAIN Coordinating Center
Chestnut Health Systems
448 Wylie Drive
Normal IL 61761-0078
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Attachment 1-1: Definition of key GAIN roles and terms

- **Administration Quality Assurance (A-QA)** – A process by which someone submits audiotaped assessments for review and feedback and continues submissions until mastery level is achieved (see chapter 4 for more information on the QA model).

- **GAIN Administrator** – Someone certified to administer the GAIN assessment. This person must have been trained through the national training model, received Coursework certification, and completed the QA review process for administering the GAIN as described in chapter 8.

- **GAIN Local Trainer** – Someone certified to conduct GAIN training for interviewers at a local site. This person must already be a certified Administrator and have completed the Local Trainer process described in chapter 8.

- **GAIN Site Interviewer** – Someone trained by a Local Trainer and certified to conduct interviews using the GAIN. This person cannot pursue Local Trainer certification without attending a national training.

- **Administration GAIN QA reviewer** – A person who conducts quality assurance reviews of GAIN Administrators and Site Interviewers. Initially, this role is performed by the GAIN Coordinating Center (GCC), though a certified Administrator can conduct reviews while working toward Local Trainer certification. A certified Local Trainer performs the ongoing role of QA review at the site level.

- **GAIN Coordinating Center (GCC)** – assists agencies and research sites using the GAIN.

- **GAIN Assessment Building System (GAIN ABS)** – An online assessment application that can be used for computer-assisted interviewing and data entry for multiple instruments and reports. The former stand-alone version is now referred to as Legacy ABS.

- **GAIN ABS administrator** – A staff member at a local site who maintains the site’s GAIN ABS account, performing required maintenance and troubleshooting.

- **Local Data Manager** – A person (may be the same or different from the ABS Administrator, above) who works with field staff using ABS to either data enter or administer the GAIN to get data in and is responsible for determining who has access to which assessments and coordinating with the GCC regarding data export and submission.

- **GAIN ABS developer** – A person trained and certified to develop additional local clinical and management reports using GAIN ABS as well as develop third-party ActiveX components.
2. Conducting a Semistructured Assessment

2.1 The GAIN as a Semistructured Assessment

The goal of any assessment is to collect reliable, valid data. Reliable data is data that doesn’t waver; for instance, if we ask the participant the same question twice, we will get the same answer twice. Valid data is truthful data, accurate data, data that precisely captures and describes the phenomena that we intend to measure. Neither is sufficient by itself. Participants in an interview can reliably give an invalid answer because they misunderstand the question. Conversely, a clinical insight by one interviewer might lead to further clarification of a participant’s response, thereby increasing its validity, but this same response may not be replicated when the same question is asked by a different interviewer.

The “old school,” classical-learning theory of assessment administration in the field focused on collecting reliable data at the expense of valid data. This administration style is a very rigid “stimulus-response” model. The interviewer asked the question exactly as printed (stimulus), and whatever the participant answered was recorded (response). Why? Because this administration style leads to the most reliable answers. It didn’t matter whether the participant misunderstood the item or had a question about the item or gave an answer that didn’t make sense—the focus was strictly on stimulus-response and reliability. So what happened? Answers were reliable, but not necessarily valid. Because of concerns about validity, the field now encourages interviewers to incorporate some common sense into assessment administration in order to increase validity.

The GAIN is a semistructured assessment, a cross between a clinical interview and a highly structured, standardized assessment (see exhibit 2-1). Although a clinical interview typically contains a series of topic areas to cover or even a list of general questions, the clinical data-gathering session follows the participant’s lead. Follow-up questions are based on information provided by the participant, and areas needing further explanation are probed. On the other end of the spectrum, a highly structured, standardized assessment like one of the Wechsler intelligence scales (e.g., Wechsler, 1997) has very rigid rules of administration. The focus is on reliability of administration so that all participants experience the same test. Attentiveness to standardized administration is in response to the need to compare answers against a set of norms that were collected under identical testing conditions.

Conducting a GAIN assessment, on the other hand, balanced the reliability needs of a standardized assessment against the validity needs of a clinical interview.

Exhibit 2-1. The Continuum of Assessment Administration Styles

<table>
<thead>
<tr>
<th>Low structure</th>
<th>Medium structure</th>
<th>High structure</th>
</tr>
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<tbody>
<tr>
<td>Clinical interview</td>
<td>GAIN assessment</td>
<td>Wechsler scales</td>
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Several aspects of the field of substance abuse treatment are propelling clinical practice toward moderately structured assessments such as the GAIN. First, although the clinical interview is a powerful data-gathering approach, its lack of structure invites room for error in the hands of less experienced staff members. The field of substance abuse treatment has a high rate of staff turnover, and many clinicians lack experience. Although an experienced clinician can quickly hone in on a participant’s major difficulties and can use probes effectively to conceptualize problems and gain insights into the client, clinical interviewing skills take time to develop, sometimes longer than a staff member may choose to stay in the field. Moreover, the average substance abuse participant presents with multiple interacting problems that even experienced clinicians have trouble reliably identifying as the primary problem. In a continuum-of-care model the staff member conducting the intake assessment may not be the primary counselor or is just one member of a larger team. It is thus difficult for other team members to know what information was or was not asked, leading many teams to conduct redundant assessments (costing time, money, and the goodwill of the participants) or to have to “discover” things as they go along. For these reasons, the field is pushing clinical practice toward more structured assessments.

In the pages to follow, a set of GAIN administration guidelines will be introduced. However, each will also be tempered with a dose of common sense. Keep in mind that with the GAIN assessment the focus is on standardization of understanding over strict standardization of administration. Our goal is for participants to understand the items as we intend so that they can give valid answers. Sometimes we will need to deviate from our administration guidelines if those guidelines prevent the participant from understanding an item. Knowing when and how to deviate from the assessment guidelines is the true challenge in GAIN administration.

For the sake of clarity the instrument or inventory will be referred to as the “assessment.” The person administering the assessment, usually a clerk, intake worker, counselor, administrator, or research assistant, among others, will be referred to as the “interviewer.” The person answering the questions, elsewhere referred to as the patient, client, or person who has since left treatment, will be referred to as the “participant.”

2.2 Ten-Plus-One Guidelines for Assessment Administration

Exhibit 2-2 lists guidelines for administering the GAIN assessment. The first ten guidelines are relevant to administering most assessments. The eleventh guideline, “Use common sense,” is specific to conducting a semistructured assessment such as the GAIN. Using material adapted from Dennis, Rourke, and colleagues (1995), each of these guidelines is discussed in this section along with examples illustrating why they are so important. The admonition to use common sense will be woven throughout the discussion, using examples from actual GAIN administrations.
Exhibit 2-2. Ten-Plus-One Guidelines for Assessment Administration

1. Ask the items exactly as printed.
2. Ask the items in the exact order as printed.
3. Ask every item (unless there is a skip instruction to follow).
4. Read each item completely.
5. Read introductory or transitional statements.
6. Read the items using an appropriate tempo.
7. Repeat items that are misunderstood.
8. Listen to responses (keep in mind possible inconsistencies with previous responses).
9. When needed, use neutral probes.
10. Do not suggest answers.

+1. Use common sense.

1. Ask the items exactly as printed. This guideline ensures that all participants are responding to the same set of items—in essence, that everyone is taking the same assessment. It is very easy to change the meaning of an item by changing a word, leaving out a word, or reordering the words. Even slight changes affect meaning, which in turn affects responses and, ultimately, the validity of the data. For example, think how profoundly the meaning of item S8f (Do you currently feel that you can get the help you need in an alcohol or other drug treatment program?) changes if the interviewer accidentally inserts the word “not” after “can”: “Do you currently feel that you cannot get the help you need in an alcohol or other drug treatment program?”

Some of the items on the GAIN are long because they contain a list of signs and symptoms of various psychological conditions. However, it is important that words are not dropped from the items. For instance, dropping “a lot” from item M1d4 (During the past year, have you had significant problems with getting into a lot of arguments and feeling the urge to shout, throw things, beat, injure, or harm someone?) or the last few signs and symptoms (such as reading only “have you had significant problems with getting into a lot of arguments and feeling the urge to shout or throw things?”) yields a different item than intended.

When a participant uses alternative terms, like slang, to discuss a subject area, some interviewers have reacted by mirroring the language used by the participant. However, interviewers should not modify questions in this manner. An 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 interviewer replaced the word “children” with the word “brats.” While it is the participant’s decision to refer to his own kids as “brats,” it changes the meaning of the item and can easily become an insult when done by the interviewer.

Bowing to common sense, there are a couple of situations where not reading the item exactly as printed would be appropriate. One such situation involves GAIN items that are intended to be open-ended items. That is, the interviewer asks the question, the participant answers, and
the interviewer codes the answer from a list of options, clarifying if necessary. These items are indicated on the hard copy of the GAIN assessment by parenthetical directions such as *(Clarify and code response)*. One such item is item E1, “What kind of housing do you currently live in?” Rather than reading the entire list of responses as printed, the interviewer allows the participant to answer, asking any follow-up questions to clearly narrow down the participant’s response. For instance, suppose when asked item E1, the participant answers, “an apartment.” Although at first glance it appears that the response should be coded as response choice 1, “A house, apartment, or room that you, your spouse, your partner, or your parents rent or own,” the interviewer needs to clarify whether it’s an apartment that the participant (or spouse, partner, or parents) rents or owns (response choice 1), a foster-home apartment (2), a rent-subsidized apartment (3), or a friend or relative’s apartment (4). The interviewer could read the entire list of possible responses, but to save time and allow for a more natural interactive flow, in this situation it is preferable to deviate from the guideline.

Another deviation involves incorporating into the items information that you know or learn about the participant. For instance, suppose that when asking the S2 items (When was the last time, if ever, you used [various substances]?) you learn that the only substance the participant has used in the past 90 days is alcohol. Subsequent items in the S2 series inquire about the participant’s use of “alcohol or drugs” during the past 90 days. In this situation, you can shorten the item stem to reference only alcohol, especially if the participant reminds you that he has used only alcohol during the past 90 days. This communicates to the participant that you are listening to his responses.

2. Ask the items in the exact order as printed. The items on the GAIN are ordered intentionally. Thus the meaning of any particular item may change or be unclear if asked out of sequence. It is also possible to miss some items entirely if the prescribed order is not followed. Is the entire assessment ruined if the interviewer unintentionally skips an item? No, though hopefully the interviewer notices the skipped item and goes back to it. It may be necessary to explain to the participant that an item was skipped and that you’re going back to it, especially if the assessment has moved to an unrelated set of items. It would be worse if an interviewer skipped an item and didn’t realize it or skipped an item but kept recording answers as if the item was not skipped, thereby recording responses for the wrong items.

Some items on the GAIN are intentionally skipped depending on the participant’s responses to earlier questions. For instance, if a participant is age 18 or older, it would not make sense to ask who has custody of her. Following the instructions on the GAIN is important to avoid asking items that should be skipped and thus prevent violation of the guideline to ask items in the order printed.

3. Ask every item (unless there is a skip instruction to follow). It is not unusual for an interviewer to have basic information about a participant before that participant shows up for an assessment. Likewise, during the assessment the interviewer learns a lot about the participant, either through casual comments or answers to items. Sometimes this information appears to answer items that appear later in the assessment. To avoid looking like she wasn’t listening or perhaps to avoid provoking the participant, an interviewer may be tempted to enter the answers to items without asking them. It is important that interviewers resist this
temptation to assume a participant’s responses. It is not unusual for an interviewer to get only partial information to a previous item, and the participant may very well answer more fully when asked a seemingly redundant item.

The following strategy can be used to help interviewers resist this temptation. When the interviewer receives information that seems to answer a later item, it can be recorded in the margin near the item where it was received. Later, when the related item occurs, the interviewer could acknowledge to the participant that she remembers what was said earlier. For example, the interviewer 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 item asks....” Then the item should be asked exactly as it is worded in the assessment.

4. Read each item completely. Some of the items on the GAIN are so long because they contain lists of specific examples or signs and symptoms of various conditions. If a participant interrupts, offering an answer before the interviewer is finished reading the item, it may not be a valid answer. For example, item S9j asks, “When was the last time you used alcohol or other 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?” Notice how there is unique information throughout the item. If the participant answers “no” to that item before the interviewer has a chance to finish reading it, there is no way to know whether the answer is really accurate. For example, if the participant heard only through “driving a car,” he wouldn’t hear “using a machine” or “where you might have been forced into sex or hurt,” both of which could change his response if his initial answer was “no.”

It’s not unusual for a participant to answer before the interviewer is done reading the item, but then upon hearing the rest of the item, say, “Oh, no, the answer should be ‘yes.’” When this happens, let the participant know that you must read the items through to the end. Do not accept a premature response to an item.

However, there is one situation where reading the entire item is not necessary. Using the example above, “When was the last time 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?” if the participant answers “yes” to the item before the interviewer is finished reading the item, the interviewer can stop reading the item and the answer can be accepted (because the participant has already responded to at least one factor in the item). Answering “yes” to a partial list of signs and symptoms is sufficient for answering the item. However, answering “no” to a partial list of signs and symptoms is not sufficient, and the interviewer would need to finish reading the item before an answer was accepted.

5. Use introductory or transitional statements. The introductory and transitional statements are printed on the GAIN instruments. They are important to include because they provide delimiting or defining information (e.g., defining the word “significant” at the beginning of the Mental Health section; focusing the participant on treatment only for drug and alcohol use (S4-S7), only for physical health problems (P11), or only for psychological problems (M5)) as well
as a natural shift between scales that cover different topics. Interviewers should include these statements during administration.

Although it is not acceptable to paraphrase items, paraphrasing of introductory or transitional statements is acceptable if all of the important information provided in the statements is included in the paraphrase. For instance, the introduction to the GAIN is written around an outline of important points. Any paraphrase of that information must cover all points. It is strongly suggested that if one plans to deviate from the introductory statements as printed on the GAIN, one uses a script that is tailored to a project’s specific population and includes all necessary information. Paraphrasing on the fly is difficult to do and often results in confusion for the participant. A sample script written for introducing the GAIN-I to an adolescent population is found in attachment 4-4 in chapter 4 (“Quality Assurance in GAIN Administration”).

6. **Read the items at an appropriate tempo.** This is very important. Sometimes as interviewers get more and more familiar with the assessment, or in an attempt to move an assessment along quicker, they start to speed up. Keep in mind that even though it may be the fortieth time that the interviewer has read the assessment, it is the participant’s first time hearing it. The participant needs time to consider individual words and phrases as well as the complete item in order to provide the information requested. Studies have shown that the reading pace established by the interviewer is one of the critical elements of the assessment. A pace of about two words per second is considered optimal. This allows the interviewer time to enunciate every word carefully and gives the participant time to listen and formulate a careful response.

When interviewers read questions slowly and carefully, they are demonstrating desirable behavior that should be copied by the participant. If the interviewer seems to race through the assessment, the participant will probably respond by providing short, terse responses. One clear indication of delivering items too rapidly is the participant’s frequent request that items be repeated. Take the time in the beginning of each interview to let participants learn how to answer items and they will move faster as the interview proceeds and similar types of questions are asked.

7. **Repeat items that are misunderstood.** Sometimes participants don’t understand particular items or even words within the items. In highly structured assessments, interviewers are not allowed to explain items that are clearly misunderstood; the items are simply repeated. However, because our focus is on collecting valid data, interviewers should repeat items that are misunderstood and provide further clarifying information if necessary. It may be necessary to define words or give examples, but in doing so the interviewer must be very careful not to change the meaning of the item. Definitions offered should be accurate, and examples should be relevant. The interviewer should do what is needed to help the participant understand the item. However, after offering a definition or example and being assured that the participant understands, the interviewer should repeat the original item.

A dialogue between an interviewer (I) and participant (P) regarding an item on a personality assessment (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) is offered as an example.
I: Yes or no: during the past year, did you think that it’s not necessary to follow certain rules or social conventions when they get in your way?
P: What do you mean by “social conventions”?
I: Let me give you an example. Do you have rules you have to follow at your school?
P: Yeah, like we aren’t supposed to chew gum in the classroom.
I: Okay. Do you follow that rule?
P: No.
I: (Interviewer circles “no” on assessment.)

In this example, the interviewer elicited from the participant an example of a social convention that the participant does not follow. However, rather than returning to the original item, she recorded the answer to the example as if it were the answer for the item on the assessment. She should have used this example constructively by returning to the original item:

I: Okay, so no gum-chewing in class is an example of a social convention in your school, and it happens to be a social convention that you don’t follow. Now let’s go back to this item and think more generally. Yes or no: during the past year, did you think that it wasn’t necessary to follow certain rules or social conventions when they get in your way?

If a participant offers an illogical answer to an item, a simple repetition of the item is often sufficient for the participant to understand his error and reconsider his response. If an illogical answer is offered a second time, define any necessary words or explain the meaning of the item, ending with a repetition of the original item.

8. Listen to responses (keep in mind possible inconsistencies with previous responses). Asking items properly is important, but so is listening carefully to the responses. By listening carefully, the interviewer will be clued in as to whether or not the participant understood the item or was paying attention. For instance, suppose the interviewer asks, “During the past 90 days, on how many days did you use any alcohol, marijuana, or other drugs?” and the participant answers, “Forty times.” Note that the participant answered with a number of times, not a number of days. If an interviewer wasn’t listening carefully, she might miss that subtlety and enter “40” and move on.

Sometimes participants offer inconsistent answers across items on the GAIN. If an interviewer doesn’t mentally track the participant’s answers, opportunities to follow up on inconsistencies would be missed. When they occur, inconsistencies should be inquired about in a nonthreatening manner. For example, suppose for item S2c that a participant says she last used marijuana 3-7 days ago. However, when later asked, “During the past 90 days, on how many days did you use any kind of marijuana or hashish?” she answers, “none.” The interviewer should clarify these inconsistent responses. For instance, the interviewer could say, “Okay, on the item where I asked you when you last used marijuana, you said that it was 3 to 7 days ago. But then when I asked you on how many days out of the past 90 you used marijuana, you said none. Can you see how those don’t add up?” The interviewer could then re-ask both items for consistent responses.
Another example of an apparent inconsistency that should be clarified occurs between observed facts about the participant and the participant’s answers. Let’s say that an adolescent participant is brought to the assessment in handcuffs by a probation officer. When asked whether he has been involved in the criminal justice system, he answers, “no.” Under the “old school” an interviewer would record this answer and move along. But common sense tells us that things don’t add up. In a situation like this the interviewer should ask about the inconsistency in a nonconfrontational way, perhaps by letting the participant know that involvement with the criminal justice system includes juvenile detention, and then the interviewer should repeat the item. This said, if the participant wants to stay with a contradictory or unlikely answer, allow him to and move on. Don’t get into a fight with the participant, but note the inconsistency under (for instance) the Administration ratings section (item XADMj) at the end of the GAIN-I or in the “Additional Comments” section at the end of the GAIN-Quick.

There are situations when questioning an inconsistency is not recommended. For instance, suppose that the interviewer knows a fact about the participant through a trusted source, such as a probation officer. If the participant offers a response that does not line up with the information as reported by the probation officer, do not confront the participant on his answer. Rather, in the case of the GAIN-I and similarly structured GAIN instruments, note the inconsistency in the Denial and Misrepresentation area and the Administration ratings (item XADMj) at the end of the assessment. In the case of the GAIN-Quick, note the inconsistency in the Additional Comments area at the end of the assessment.

A final important situation that calls for careful listening occurs when a participant wants to tell the interviewer something in earnest that may or may not be covered on the assessment. Since the topic is important to the participant, the interviewer should take the opportunity to demonstrate that she is listening but avoid getting into a long discussion. In this situation, the interviewer should let the participant know whether or not the topic will be covered later. If it will, the short discussion could be engaged in at that time. During the discussion, the interviewer should offer to write notes on the assessment to help convey the participant’s message, read them back to the participant to make sure that what the participant wants to say is recorded correctly, and then refocus the participant on the interview. If the topic is not covered on the assessment, let the participant know but offer to write a brief note on the assessment to make sure the assigned counselor discusses the situation with him. Avoid getting into a detailed discussion about it, and refocus the participant on the interview.

9. When needed, use neutral probes. As mentioned above, sometimes participants give less than clear answers. In these situations the interviewer needs to clarify the participant’s answer in a neutral way without suggesting an answer to the participant. Remember, the answers need to come from the participant, not the interviewer. Following are some ways to do this.

- **Neutral comments:** “Tell me more about that”; “Please explain that further”; “Can you give me an example?”
- **Repeating the response choices:** “Would that be ‘yes’ or ‘no’?”; “How would you answer using the response choices on this card? Past month, 2-12 months ago, 1 or more years ago, or never?”
• **Rereading the item:** It could be that the participant didn’t hear the entire item.

• **Expectant pauses (“pregnant pause”):** Wait for a few seconds and see whether the participant elaborates.

Probe only as necessary to obtain a clear response that meets the item specifications. If the item has an instruction that reads “MENTIONED” (analogous to “circle all that apply”), probe to the negative. That means the interviewer should continue to ask the participant for answers (e.g., “Anything else?”) until he says that there are no more.

10. **Do not suggest answers.** Suggesting answers to the participant is an easy pitfall to stumble into and can happen through the interviewer’s verbal and nonverbal behaviors.

In the verbal realm, remember that the responses need to come from the participant, not the interviewer. Sometimes a participant will offer a response that is not within the set of defined response choices. For example, in response to a yes/no item, the participant may respond, “sometimes.” In these situations it’s important that the interviewer clarify the response with the participant without offering an answer. Saying “Would that be ‘yes’ or ‘no’?” or “So should I put ‘yes’ or ‘no’?” are two possible responses for the interviewer. Note that the interviewer is clarifying by offering several options (yes or no) rather than proposing only one option (yes). It would not be appropriate to offer to the participant, “So do you want to go with ‘yes’?” or worse, to assume that the participant meant “yes” and circle that response without asking for clarification.

For items that make use of response cards, if the participant offers a response that is not one of the available responses on the card, clarify rather than assume: “So using this card, what would your answer be?” It typically takes only a few requests for clarification until the participant routinely consults the card for a response.

As a third example, suppose in response to an item that begins, “During the past 90 days, on how many days did you…?” the participant says, “About half the days.” If the interviewer responds with “45 days?” she is asking for clarification, but her clarification also suggests the answer. Better ways to clarify would be, “So how many days would that be?” or “So how many days should I put?” If the participant asks you to work out the math for him, that is fine as long as you confirm the response with the participant: “You used on half the days, so 90 divided by 2 is 45, does that sound okay to you?”

As a final verbal example, when giving qualitative, open-ended answers—referred to on the GAIN as verbatim responses—sometimes participants will offer sketchy responses. The interviewer should follow up with the participant, asking appropriate clarifying questions in order to get a response that clearly answers the question. The interviewer may understand what the participant meant, but someone else coming along after the fact to code verbatim responses may have no idea what was meant if only a few cryptic notes that don’t appear to answer the question are recorded.

Suggesting answers nonverbally can be very subtle yet can have powerful effects. For the duration of the assessment, the interviewer needs to wear the “data gatherer” hat. This requires
being an unbiased reporter and suppressing value judgments or the natural instinct to help. Facial expressions can very easily reveal reactions to the content of a response. Interviewers should avoid giving any cues to the participant about whether she approves or disapproves of a participant’s response. Keep in mind that participants are typically anxious to please interviewers and will, on a conscious or unconscious level, try to shape their answers if they feel that the interviewer does not approve of a behavior. If the interviewer is a clinician, remember that the opportunity to use clinical skills will come after the initial assessment. While administering the assessment, try to avoid these pitfalls and remain an unbiased recorder and reporter of the information that the participant offers. Remember, during the assessment the interviewer is simply trying to gather reliable, valid data; counseling is the next step.

+1. Use common sense.
3. Basic Administration

This chapter is arranged by topic into the following sections: General Information (3.1), Preparing to Administer the GAIN (3.2), Completing the Cover Page (3.3), Getting Started with the Participant (3.4), Self-Administration (3.5), Additional Administration Instructions (3.6), Substance Use Grids (3.7), Finishing the Assessment (3.8), and Treatment Urgency and Denial-Misrepresentation Ratings (3.9). Attachment 3-1, at the end of the chapter, provides a detailed crosswalk of substances (listed alphabetically) to GAIN class and DSM-IV-TR diagnostic group.

Many of the instructions in this chapter are based on administration of the paper version of the GAIN-I instrument. While GAIN ABS differs slightly in its administration, the general administration guidelines apply to all interviews. Instructions specific to GAIN ABS are noted where applicable.

3.1 General Information

GAIN administration is a relatively straightforward process. To begin, there are several things you need to know about the structure of the GAIN in order to avoid confusion and be ready to answer questions from staff members or participants.

Item and Variable Naming Conventions. To facilitate administration, scoring, interpretation and subsequent analysis, GAIN items are numbered and formatted the same, regardless of version.

- The first letter refers to the relevant section:
  - Administration
  - Background and Treatment Arrangements
  - Substance Use
  - Physical Health
  - Risk Behaviors and Disease Prevention
  - Mental and Emotional Health
  - Environmental and Living Situation
  - Legal
  - Vocational
  - Z (end)
  - X (across dataset ID information)
- The first number is the question number within a section. Subquestions, marked by letters after the number (e.g., S1a, S1b), denote that questions are interrelated.
- Subresponses generally follow alternate numbers and letters in outline format: S2, S2a, S2s2, S2s1a, etc. Some subresponses are separated by an underscore (e.g., L3_1) to avoid confusing question 3, subresponse 1 with question 31.
- On the paper version, 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). Note that the v also means that any text written there should be verbatim, repeating the participant’s words as closely as possible.

- The letters i, o, and l are always skipped in the item 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 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.
- Dates should be recorded in mm/dd/yyyy format, e.g., 03/06/1996 for March 6, 1996.

**Types of Questions.** There are four main types of questions in this assessment:

- Questions that ask the participant to choose one answer from a list. For example, the interviewer may ask the participant for the last time he used a certain substance, and the participant chooses one of six time frames ("Within the past 2 days," "3 to 7 days ago," etc.). Other lists are as simple as choosing yes or no. If the participant’s response could fit in multiple categories, ask the participant to decide which response choice comes closest. Say that in response to a question asking the last time the participant did something, the participant is asked to respond using card A but instead responds, “a year ago.” Because “a year ago” could be either “4 to 12 months ago” or “more than 12 months ago,” the interviewer should ask the participant to pick which one fits best.
- Questions that ask the participant to answer with a number, such as the number of times he did something within the past 90 days.
- Questions that ask the participant to give as many appropriate responses as he can (referred to as Mentioned items). For instance, the participant may be asked, “What forms of contraception do you or your partner try to use to avoid pregnancy or sexually transmitted diseases?” The participant then responds and the interviewer marks the corresponding items on the GAIN. The interviewer asks “Any others?” and enters the participant’s responses until the participant answers, “no.” Each item in a Mentioned item must be entered as either yes or no, so when the participant finally answers “no,” be sure to enter “no” for all the unmentioned responses.
- Questions that ask the participant to answer the question in his own words, referred to as verbatim items. In this case the participant may be asked a question like, “Which people, agencies, or things do you consider to be your most important sources of social support?” and the interviewer enters the response as closely to the participant’s own words as possible. For most verbatim items, like with Mentioned items, the interviewer also asks “Any others?” until the participant says, “No.”

**Administration Instructions.** Where instructions are given, they appear in **(bold and parentheses).** 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] telling you to skip over those questions and continue the interview with the next applicable question (e.g., [GO TO S8]). Never skip further than directed. (GAIN ABS skips to the next appropriate question automatically.)
**Layout of Questions.** The sections are ordered by ASAM dimension except (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 Risk Behaviors section, related to infectious diseases and health care, 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 and beliefs, and help wanted. To minimize administration time the GAIN checks first for the existence and recency of any behaviors. Subsequently, detailed symptom-counts (used for diagnosis) are collected only if the behavior occurred in the past year, and detailed behavior counts (used for in- and posttreatment monitoring), are collected only if the behavior occurred in the past 90 days.

**Nature of Questions.** Many of the questions in the GAIN have been written to match clinical criteria or other epidemiological databases, to define or set up subsequent questions, 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. A woman who answers “no” to the question “Are you a prostitute?” may answer “yes” to “Have you traded sex for drugs, gifts, or money?” Similarly, a man might answer “no” to “Are you a homosexual?” but “yes” to “Have you had sex with other men?” Conversely, a participant might self-define 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 (unless there is a skip instruction) and not presume an answer.

**Core Administration Option.** The GAIN-I is designed to collect as much information in 90-120 minutes on the participant’s first day of treatment as would often be collected in their first few months of treatment in other programs. This saves time and reduces redundancy. Still, under some circumstances (time constraints, intoxication, etc.) it may not be possible to complete the full GAIN in one sitting. If there is a desire to administer a shorter comprehensive assessment, use the GAIN-I core version available from [http://www.chestnut.org/LI/gain/GAIN_I/GAIN-I_v_5-4/Index.html](http://www.chestnut.org/LI/gain/GAIN_I/GAIN-I_v_5-4/Index.html) or on the CD that accompanies this manual. The standard GAIN-I Core is a subset of items from the full GAIN. There are many different core versions already in use for different purposes (such as for a basic regional clinical assessment or a residential setting assessment). Many programs also choose to build their own customized core version (contact [ABSSupport@chestnut.org](mailto:ABSSupport@chestnut.org) for more information). Where there is a need for an even shorter assessment or significant time gap before completing the assessment it would be better to consider using the GAIN-Quick (GAIN-Q) as an initial assessment (Titus & Dennis, 2002).

**Scale and Index Names.** To facilitate hand-scoring and interpretation, the abbreviations of the scales and indices in the GAIN are identified by capital letters to the left of the start of the first question of each subscale. This is not part of the item number but a reference for interpretation.

**Types of Administration.** For in-person administration the GAIN can be orally administered to a participant by a staff member using either the online GAIN ABS version or the paper and pen version; orally administered by another person; or, rarely, self-administered by the participant.
GAIN ABS online administration please refer to the GAIN ABS handbook or contact ABSSupport@chestnut.org for assistance.

GAIN administration should ideally be proctored regardless of the administration method chosen. This means that a staff member should be available to answer questions, monitor the participant for signs of distress, and be able to step in and help administer the assessment if the participant has literacy or other problems. The clinical supervisor or research project coordinator should specify whether you must use a certain administration type or whether you can choose the type of administration. The next sections of this chapter contain required information no matter which administration type you use.

3.2 Preparing to Administer the GAIN

Prior to conducting the assessment, find a quiet place with a desk or table where the participant can complete the assessment. The following items are needed for administration of the assessment:

- The GAIN with completed cover page.
- An up-to-date calendar (copies of which can be downloaded from http://www.chestnut.org/LI/gain/GAIN_QxQ/index.html#CALENDAR).
- A set of response cards (see page 11 of this chapter for more information).
- Pens (not pencil). Preferably, a black pen is used for administration and colored pens are used for editing and quality assurance review comments.

The hard copy of the actual GAIN assessment can be printed on 3-ring paper held together with binder rings or in a notebook, or it can be stapled, clamped together, or loose, but you should make sure that it can be opened flat (which makes it easier to use during the interview) and that it can be filed easily. Note that if you are using GAIN ABS, you will still need the calendar, response cards, and writing utensils and paper. We strongly recommend keeping a full paper copy of the assessment on hand even when using GAIN ABS in case of technical problems.

We also strongly recommend that you make arrangements for the participant to have access to juice, soda, or coffee; a restroom; and a place to take a smoke break (if possible). For adolescents or correctional or other controlled populations, some of these may require approval from supervisors or arrangements for someone to supervise the participant during a restroom or smoke break.

3.3 Completing the Cover Page

The cover page should be completed before the interview (or, if time is tight, immediately after the interview) to document important identifying information about the assessment. The identification numbers for the cover page must be defined by the facility or study that uses it. An example of such a document (Study-Specific Guidelines for Administration of the GAIN and Related
Measures) is available as appendix GA in the GAIN-I Manual folder of the training CD that accompanies this manual.

The following fields of the cover page should be completed before the assessment begins:

- **Site ID [XSITE]**: Document the ID of the research study or clinical site using the GAIN. This number can be up to 6 digits long.
- **Local Site Name [XSITEa] (optional)**: This field can be used for a secondary site ID for a site with multiple facilities or a special study or other reporting system. The field represents the actual place at which the assessment takes place, such as the participant’s home, the treatment location, or other location. This number can be up to 6 digits long.
- **Staff ID [XSID] & Staff Initials [XSIN]**: Document the staff ID (up to 6 digits) and initials of the person who administers the assessment. In a research 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 ID numbers, use the last 4 digits of the staff member’s Social Security number.
- **Participant ID [XPID]**: Document the participant’s study ID or treatment ID number (up to 6 digits in length).
- **Last name, first name, middle initial [XPNAM] (optional)**: Document the participant’s last name, first name, and middle initial if your agency’s protocol requires it. This is the only place on the GAIN where the participant’s full name should be written. In all other notes refer to participants by initials, ID, or “Px” for “participant.” If mailing a copy of the assessment, be sure to remove the participant’s identifying information prior to sending.
- **Treatment Program ID [XTPID] (optional)**: Document the participant’s treatment program ID (up to 6 digits in length). For follow-up assessments, use the ID that came with the assignment.
- **Social Security number [XSSN] (optional)**: Enter the participant’s Social Security number. This field does not appear on the GAIN-M90.
- **Other/State ID [XPIDA] (optional)**: Enter the participant’s state or other ID used for reporting up to 9 digits in length. (For follow-up assessments, use the ID that came with the assignment.) This can also be used for a temporary ID. This field does not appear on the GAIN-M90.
- **Assessment observation wave [XOBS]**: This field tells which wave of data collection the assessment represents. On a GAIN-I (initial assessment), XOBS will always be 0. On GAIN-M90s it represents the wave number as designated by the study protocol or clinical supervisor. The timing of follow-up waves should be recorded in the study-specific attachment (see the example in the Study-Specific Guidelines document on the training CD). If there is anything unusual about the observation timing, it can be recorded in the verbatim field (v.______) that follows the XOBS field.
- **Check digit [XCHK] (M90 only)**: The check digit, a participant confirmation code, consists of two letters and two numbers describing the gender (male, female, transgender,
or other), race (Asian, black, Hispanic, Native American, white, multiracial, or other), and the last two digits of the participant’s year of birth. The purpose of this code is to avoid misadministration, since the participant’s name does not and should not appear on the M90.

- **First GAIN Assessment Date [XFRSTDT] (M90 only):** Record the date (in mm/dd/yyyy format) when the GAIN-I was administered to the participant.

The rest of the fields at the top of the cover page are completed after the assessment (Edit Staff ID, Edit Date, Data Entry Staff ID, Initial Key Date, Rekey Staff ID, Rekey Date). Information on completing these fields is located in section 3.7, “Finishing the Assessment.”

Do not read the disclaimer information on the cover page to the participant. Below are some other helpful hints before filling out the cover page.

- It is a good idea to use preprinted information or labels whenever available. Some sites print labels with all of the cover page’s required items to place on the first page of the GAIN, which helps prevent errors.
- Leave blank any fields that your facility or study decides not to use, other than the required fields listed above.
- Remember to check that you are using the correct version of the GAIN. The version number is preprinted under the title on the cover page.
- Note that it is the staff member’s responsibility to complete the cover page, not the participant’s.

Once the interview is about to begin you will also need to complete items A1a-e, located at the top of the second page. Do not fill these out in advance because there are often last-minute changes.

- **Time (A1a and A1b):** Please write the time you are starting the assessment in HH:MM (standard time, not military time) and record whether AM or PM.
- **Today’s Date (A1c, XOBSDT):** This is the date on which the assessment is conducted and should be the same as the treatment intake date if possible, or the randomization date if the assessment is being used only for a research study. As with all dates on the assessment, it is recorded as mm/dd/yyyy.
- **Reference Date if Different (A1d, XRFDT):** The reference date is the date from which the past-90-day and past-12-month time frames used in the GAIN count back from (usually this is the date on which the participant came into treatment). The default reference date is the date of the assessment, in which case this field can be left blank. In rare instances the reference date may be several days earlier than the date of the interview (e.g., the participant entered detox as soon as he entered treatment and wasn’t able to complete the GAIN-I until a couple of days later), in which case the reference date is used to refer to the time period prior to when the participant entered treatment.
• **Date of Last GAIN Assessment (A1e, XLSTDT) (M90 only):** Record the date in mm/dd/yyyy format on which the most recent GAIN assessment was completed with the participant.

### 3.4 Getting Started with the Participant

The initial steps of administering the GAIN are to explain the purpose of the GAIN, verify that the participant is not impaired cognitively and has adequate literacy skills, and provide general instructions for completing the assessment. Each of these steps is described below.

**Introduction.** The introduction (p. 2 of the paper version) should be read to the participant word for word. You must cover the following important points:

- **Purpose.** It is important for the participant to understand why their information is being collected and how it will be used. It is also important to recognize the clinical role of assessment. At a minimum, an 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 own life by starting to define problems more objectively and reduce denial by being shown the larger picture and inconsistencies.

- **Content.** The GAIN asks questions about what the participant has done, what services they are using, and what they currently want from a treatment program.

- **Time.** In general the GAIN-I Full takes approximately 120 minutes to complete, the GAIN-I Core takes about 60-90 minutes depending on the version, and the GAIN-Quick takes about 20-30 minutes. The GAIN-M90 Full takes about 45-60 minutes and about 30 minutes for the M90 Core. However, there is considerable range in the expected duration of the GAIN depending on population, mode of administration, problem severity, and level of care. In general, participants with higher severity (such as those going into residential or methadone treatment) will take longer than other participants. An interview conducted with GAIN ABS can be completed about 20% faster than oral administration. Interviewers proficient with the paper version but not proficient with the online GAIN ABS version will find that the oral administration choice may be faster, but the added time to data-enter the responses will make oral administration slower in the long run. New interviewers often take longer than average to administer a GAIN-I because of their unfamiliarity with the instrument, but with appropriate quality assurance and feedback, they should reduce administration time to the average range within 3 to 4 interviews.

- **Confidentiality.** It is very important to tell the participant about any situations in which confidentiality may be broken. For example, mandated reporting situations require divulging confidential information if the participant reports child abuse or is a danger to himself or others.

**Check for Cognitive Impairment.** Prior to administering the GAIN it is important to verify that the participant possesses the necessary cognitive skills to complete the assessment. Cognitive
impairment may be the result of current intoxication or either temporary or permanent mental or physical problems. Regardless of the cause, it is important and required by JCAHO (1995) to verify the participant’s ability to locate himself 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 Test for Cognitive Impairment (Katzman et al., 1983) shown in exhibit 3-1. It should be administered with every assessment unless specified by your clinical or research protocol. To administer, ask each question and, for each error, circle the appropriate code. Note that each error does not equal one point: for instance, getting the year wrong is worth 4 points, while each error when reciting the names of the week in reverse order is worth 2 points. At the end of the test, add up the scores and record the total in A2g. It is not uncommon for participants (particularly adolescent, methadone treatment, or detoxification participants) to score higher than 10 on the Check for Cognitive Impairment. If the problem is intoxication or appears to be transitory, it is probably better to reschedule the interview, if possible.

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

<table>
<thead>
<tr>
<th>ERROR SCORES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>a. What year is it now? ________________  (Circle 4 for any error)</td>
</tr>
<tr>
<td>b. What month is it now? ________________  (Circle 3 for any error)</td>
</tr>
<tr>
<td>c. About what time is it? ________________  (Circle 3 for any error)</td>
</tr>
</tbody>
</table>
| 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 days of the week in reverse order.  
  [Sat, Fri, Thurs, Wed, Tues, Mon, Sun]  
  (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 decide to proceed in spite of a higher score, you should assume that the interview will be more difficult and will probably take longer, and you should be very careful to avoid
overinterpreting the responses. In general, if a participant cannot remember any of the recall test (the John Brown phrase), the interview will be problematic and alternative means of assessment should be considered, such as relying on collateral report or psychiatric referral. You will need to determine whether to reschedule, assess in another way, or proceed while recognizing that the participant’s responses may not be completely accurate.

During an M90 follow-up or a later readmission to treatment, it is not uncommon for some people to recite the whole John Brown phrase before the interviewer can read it! Usually this can be interpreted as a sign that there are few (if any) recall problems.

**Timeline.** Memory anchors should be established with the participant to help him answer questions about what was going on in his life during the past 90 days or past 12 months. The most common inconsistency in self-reported data is a result of moving events forward or backward in time because of a lack of concrete reference points. Use the calendar provided with your training materials (updated copies can be downloaded at no charge from [http://www.chestnut.org/LI/gain/GAIN_QxQ/index.html#CALENDAR](http://www.chestnut.org/LI/gain/GAIN_QxQ/index.html#CALENDAR)) to help the participant think of salient personal reference points, referred to in the GAIN as “anchors,” for the past-90-day and past-12-month time frames. It is important that these reference points be positive or neutral because the participant will be thinking of them throughout the assessment to help recall the time frames for the questions. If the participant is unable to recall a specific event or holiday to use for a reference point, ask about what was going on in his life at that time, e.g., where the participant was living, working, or going to school.

**Initial Literacy Questions and Administration Decision Point.** After establishing the anchors, items A3b1-5 must be administered to the participant to determine their ability to read, write, and understand English. If the participant states that they do have English literacy problems, you will need to determine whether you should orally administer the assessment, manage a foreign-language problem by rescheduling the interview with a bilingual interviewer, or end the assessment early after consulting with a supervisor, coordinator, or PI, if necessary.

Note that item A3c (Document your initial administration decision) is not administered to the participant. Instead, the interviewer or proctoring staff member records how the GAIN will be administered. If you are administering the GAIN orally because of literacy or participant choice, or if your facility or research project chose in advance to orally administer the GAIN to the participant, circle the appropriate code and proceed to read the additional instructions for oral administration at the bottom of the same page. If the participant will be self-administering the GAIN or there is any other mode of administration, circle the appropriate code and proceed with the participant to the next page of the paper assessment for the additional instructions for self-administration.

**Additional Instructions for Oral Administration.** Like the instructions, the additional instructions for oral administration should be read to the participant word for word. If you choose to paraphrase, be sure to cover the following points:

- **How to administer.** Let the participant know how you will record responses.
• **Don't know.** Inform the participant that if he does not know an answer, that you will ask him/her to give the best guess.

• **Refuse.** Let the participant know that he can refuse to answer any item.

• **Breaks.** Remind the participant that he can ask for a break at any time and show him the location of restrooms, snack machines and other conveniences.

• **Response cards.** Give the participant the set of cards and explain how they are used. Response cards are distributed as laminated sets at Chestnut-sponsored GAIN trainings and can be purchased from [http://www.chestnut.org/LI/BookStore/index.html#GAIN](http://www.chestnut.org/LI/BookStore/index.html#GAIN) or copied from the training CD accompanying this manual. Using response cards for specific response sets reduces administration time and helps the participant understand response sets.

• **Questions.** Be sure to ask the participant whether they have any questions before you begin. Making sure that all participant questions are answered before the assessment begins will save time in the long run.

### 3.5 Self-Administration

Assuming that you are prepared to allow the participant to self-administer the assessment, the next step is to make sure that they understand how. The directions are self-explanatory. In reviewing them with the participant it is useful to do the following:

• Demonstrate how to mark responses.

• Quickly demonstrate how to record a refusal, a “don’t know” response, and a break.

• Show the participant how to follow skips and how to mark responses before doing so (some participants skip without documenting their answers).

• Mark on the calendar to help the participant focus on the period the questions refer to. Demonstrate how to use the calendar with the participant even when you are going to let them complete most of the assessment on their own.

• Discuss the staff boxes and optional items depending on the specific needs of the clinician, program, or study. It is a good idea to cross off questions that you do not want the participant to answer.

• Give the participant a chance to ask questions.

• Recap that you will be available at any time to answer questions, that the participant can take a break if needed, and that they should try to answer every question.

**Progress Checks.** If the GAIN is being self-administered, within the first 5 to 10 minutes and periodically thereafter you should check in with the participant. Throughout the administration you should also watch the participant for signs of distress, fatigue, or frustration and be available to clarify any questions that arise. At any point, you can stop and assist the participant.
The first full section of the GAIN-I (the Background section) contains at least one of each type of question, and the questions in this section are relatively neutral in subject. At the end of the Background section the participant is instructed to tell you that they have finished the first section. At this point you should conduct a field edit (discussed later in this chapter) to ensure that the participant correctly followed the instructions. In particular, you should look at whether “circle one,” Mentioned, and skip instructions were followed correctly. If not, explain the instructions again and correct any mistakes. Also check for missing data and have the participant complete any missing questions. This review helps the participant avoid repeated mistakes and lets them know that you will ask them for missing items, and it can also identify people who got through the initial checks but may be unable to self-administer because of literacy, comprehension, attention deficit, or other impairments.

If the participant is still working on the Substance Use section after the first hour, we recommend that you evaluate how much longer they will be able to continue. Note that just because it is taking a participant longer does not mean they cannot or do not want to finish. For many participants, particularly those with multiple interrelated problems, a GAIN assessment may be an emotional experience. If the participant is not able to continue, you may want to try taking a break or consider completing the assessment at another time.

While self-administration can be efficient and reliable, it typically leads to more missing data and may have less validity (e.g., because questions may be incorrectly interpreted). Thus the proctor should check the completed GAIN carefully upon return and not simply accept it as is.

3.6 Additional Administration Instructions

There are three major administration areas to attend to: administering the instrument, documenting participant responses, and engaging the participant. These areas (along with the instructions, already covered in this chapter) match the key points of the quality assurance review discussed in chapter 4. Two additional administration issues, both pertaining to the GAIN-M90, are also covered in this section: using the past-90-days time frame when the follow-up assessments are not 90 days apart and administering “since last assessment” items.

**Documentation.** Be sure that responses are legible because someone else may enter the data and will need to interpret your handwriting. Other than writing in the direct response from the participant, you need to know how to document the following responses:

- **Don’t know:** when participants respond that they don’t know an answer, first ask them to give their best guess. If they still don’t know, write “DK” to the right of the response choices for that question. (“Don’t know” responses can be selected as a response choice in GAIN ABS.)

- **Refuse:** if the participant refuses to answer a question, record “RF” to the right of the response choices for that question. (Refused responses can also be selected as a response choice in GAIN ABS.)
• **Taking a break:** write the start and stop time of all breaks in the margin of the assessment at the point where the break begins. This not only helps mark your place, but at the end of the assessment the break time is subtracted from the overall administration time and is used to calculate the total time of the assessment.

• **Making changes:** if the participant changes a response or you record the wrong response, draw an X through the incorrect response and write the correct response next to it along with your initials and the date that the change was made.

**Items.** It is very important to follow the basic rules of administering a semistructured standardized assessment described in chapter 2. This is particularly critical for oral administration. In order to interpret or combine the results across participants, it is essential to standardize the questions and procedures as much as possible and present each participant with the same set of questions.

During administration be sure to ask the items in the order they appear on the assessment and follow all skips correctly. Be sure to read questions as they are written, since making one small word change can change the meaning of the question. Words in parentheses need be read only if the participant seems confused or needs clarification. Following are some other important guidelines for oral administration.

• **Clarification of participant responses.** Clarification is one of the most basic and important skills to have in order to ensure accurate information. Participants frequently respond to items outside the required format: when asked a question that requires answering with a number, participants will respond, “10 or 20” or “about 3 times” or with similarly ambiguous responses; or when asked to give a response from a card they’ll give a different response. In these situations, the response must be clarified (a term that comes up frequently in GAIN administration and quality assurance).

It’s important to clarify unsatisfactory responses early in the interview. If the participant responds to a card A recency question with “about a week ago,” for instance, and his response isn’t clarified, the participant may well continue to respond outside the required format, and the accumulated information collected by the GAIN won’t have the same validity as an interview in which the participant was instructed early on to give a response from the cards. Clarifying unsatisfactory responses early in the interview will help shape the participant’s responses, ensuring valid information.

The interviewer should also be sure to clarify in such a way that she doesn’t suggest a response to the participant. If the participant responds to a frequency question with, “I don’t know, about 25 or 30,” the interviewer should give the question back to the participant: “Would you like me to put down 25, 30, or something else?” The interviewer should never enter “25” or “30” without first checking with the participant, and the interviewer should never average the response range (such as by entering “27”) to get an answer. All responses must come from the participant, not the interviewer.
There are many different situations in which the participant’s response will have to be clarified. Here are some of the most common:

- If the participant gives a range of numbers when responding, such as “about 4 or 5,” clarify by asking, “Would you like me to put down 4 or 5 or some other number?”
- Participants will also occasionally respond “never” or “no” when they mean “zero.” Clarify these responses by asking something like, “So if I asked you to give me a number…?”
- If the participant uses vague words when responding, e.g., “about 15,” “probably around 15,” or “maybe 15,” clarify by confirming the response: “So would you like to go with 15?”
- After instructed to respond using one of the cards, participants will sometimes give an answer that doesn’t appear on the card. For instance, on card B the response choices are “within the past month,” “2 to 12 months ago,” “1+ years ago,” and “never.” However, participants will occasionally answer, “a year ago,” which could mean “2 to 12 months ago” or “1+ years ago.” In this case the interviewer should redirect the participant to the card by asking, “Okay, if I were to ask you to give me an answer from card B, which one would you say best fits?”
- Yes/no questions must be answered with a yes or no. “Sometimes,” “sort of,” “I guess so,” “probably not,” “I don’t think so,” and similar responses should be clarified for a firm yes or no. Similarly, “yeah,” “yep,” “nope,” “uh huh” and “uh uh,” and “mm-mmm” and “hm-mmm” should be clarified as well.
- See chapter 4 for more on clarification.

- **Administering sensitive items.** Many of the questions on the GAIN are of a sensitive nature, and the participant may be embarrassed to respond. The best way to deal with such questions is to be matter-of-fact when administering the items. If the participant refuses to answer, do not argue; simply record the refusal (RF).

- **Responding to apparent misunderstandings and inconsistencies.** Inconsistencies are, along with responses needing clarification, one of the most common causes of invalid information and one of the most important things for an interviewer to catch and resolve during the interview. An inconsistency arises when a participant’s responses to two items can’t simultaneously be true: e.g., for one item a participant states that he hasn’t used marijuana for more than a year, but then for a later item he says that he used marijuana on 45 of the preceding 90 days; or a participant reports last seeing a doctor for a physical health problem within the preceding 90 days, but then he reports seeing a doctor zero times during the preceding 90 days. The GAIN is set up to catch apparent inconsistencies during the assessment by asking similar questions in different ways and in different places throughout the assessment. In most cases a participant doesn’t mean to give inconsistent responses and isn’t trying to deceive the interviewer or give deliberately faulty information; the GAIN is a long assessment, and it can be difficult for a participant to remember the precise numbers given for each response.
Many inconsistencies can’t be resolved without the participant’s input, which makes it important to catch them during the interview. If you notice that one of the participant’s responses conflicts with a prior response, do not respond in a confrontational manner. Instead, gently remind the participant of his earlier response and ask which response he would like you to record. For instance, say that the participant reports having several of the psychological problems described in items M1a-M1d within the past year, but then when asked item M1e (When was the last time, if ever, that your life was significantly disturbed by nerve, mental, or psychological problems or that you felt you could not go on, including those things we just talked about?) he answers, “never.” The interviewer could resolve this inconsistency by saying, “Alright, I might have recorded something wrong here—for these items [give examples] I think you said that you’d had them in the past 12 months, but then when I asked you this last question you said that you’d never had these problems. Do you see what I mean? Do you think that your last answer should be something besides ‘never’ or do you think it’s been longer than 12 months that you’ve had the problems you mentioned?”

In the above example the interviewer takes the pressure off the participant by shouldering the responsibility for the inconsistency. It can be easy for the participant (especially if he has personality disorders or other problems interpreting social cues) to mistake clarification as an accusation of lying, so it’s a good idea to make resolving inconsistencies as low-stress as possible. The interviewer can help do this by telling the participant that the inconsistency might have been a result of a miscode, that the interviewer might have misunderstood the participant and written down the wrong response, acknowledging that getting all of the answers consistency can be tricky, etc. It’s important to be patient during the clarification process and help the participant understand why the items are inconsistent and how to resolve them.

If an inconsistency can’t be resolved—if the participant can’t understand why two responses are inconsistent or refuses to change his responses—the interviewer should keep the responses in place but make a note explaining what happened. If the participant shows a pattern of misunderstanding items in a given section, the interviewer can also mark the Denial-Misrepresentation rating accordingly. (See section 3.9 for information on Denial-Misrepresentation ratings.) The interviewer can also make a note in XADMj at the end of the assessment (Do you have any additional comments about the administration of the assessment or things that should be considered in interpreting this assessment?) explaining anything that she feels anyone interpreting the interview should know about its administration.

- **Appropriate handling of participant-initiated questions.** If a participant does not understand an item, repeat it. It is likely that they simply weren’t paying close enough attention and simply did not hear the question. If repeating does not work, rephrase the question without leading the participant to a response. For example, when asking an adult participant for the last year completed in school, if the participant responds, “What?” do not reply with an assumption, such as “You at least finished high school, didn’t you?” Instead, ask again what grade level the participant last completed.
**Engagement.** The interviewer should try to develop good rapport with the participant because doing so encourages the participant to respond reliably. There are several ways to develop rapport during the assessment:

- Be friendly and professional. This does not mean telling the participant your life story or trying to be their best friend. It does mean being friendly and respectful and properly introducing yourself at the start of the interview.

- Conduct the interview at an appropriate tempo. A good flow is essential to the participant’s ability to complete the assessment. If you speak too quickly, they will not understand everything and may rattle off responses just to finish the assessment quickly. If you speak too slowly, the participant may become bored and will not be attentive. A good way to establish an appropriate tempo is to practice by yourself and then with others before administering your first assessment with a real client. You may need to adjust your tempo to fit each participant’s abilities.

- Appropriate voice articulation and inflection. Administering the assessment in a monotone makes it difficult for the participant to be attentive. Again, practicing before administering your first non-mock assessment is the best way to develop proper inflection and articulation.

- Use of encouraging or motivational statements. It is a good idea to encourage the participant along the way by saying things like, “Hang in there, we’re about halfway through,” or “We’ve got one more section to get through and then we’re done.” Check in with the participant from time to time: “How are you doing? Do you need anything?” Be sure not to make evaluative statements such as, “Good job!” that might encourage the participant to alter responses to please you rather than giving honest responses.

- Sensitivity to the participant’s needs. If the participant seems very bored or restless, offer a break even if he has not asked for one. If possible, try to offer breaks at the end rather than in the middle of a section (returning from a break to start a new section makes it seem like more progress is being made than returning from a break to resume a section). Also, if the participant is trying to tell you something important that is not relevant to the current items, do not ignore it. Instead, 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, or have the appropriate clinical staff member on hand to deal with any aftermath.

**Using the “past 90 days” time frame when the M90 follow-up is not exactly 90 days later.**
While follow-up interviews are frequently scheduled every 90 days, they are not always administered exactly 90 days apart. There is no perfect way to handle this problem. In general, if there’s a week or less difference between the scheduled date of the 90-day follow-up and the actual date of its administration, we define the past 90 days as “since the last interview.” If the difference between interviews is much greater or much smaller (e.g., a follow-up window of 110 or 45 days), we ignore the overlap or gap and still ask about the actual past 90 days. In either case, ask the items
as written to avoid confusion and increase the ability to compare GAIN responses across a set of participants.

**Administering “since last assessment” items on the M-90.** Some items on the follow-up version of the GAIN ask the participant about behaviors and problems since their last GAIN assessment rather than in the past 90 days or past year. To help the participant remember that time frame, item S2z should be filled out ahead of time with the date of the last assessment and the number of days it has been since that assessment. This, along with the calendar, makes administering “since last assessment” items easier.

### 3.7 Substance Use Grids, Recreating Time Outside a Controlled Environment, and Substance Quantity Conversion

The GAIN-I uses a grid format for items S2, S7, and S9. Each of the grids is unique, but all are administered from left to right, top to bottom. Following are some specific instructions for administering each of these three grids.

**Completing the S2 Substance Use Frequency Grid.** In most versions of the GAIN-I, the S2 grid is a three-page series of related questions. The first two pages are required item sets, while the third page is used by insurance or researchers to look at the recency and amount of last use (primarily for comparison to urine test results). An interviewer administers the first page of the grid by going down the rows and asking the recency of use for every substance. For any substance with no use in the past 90 days, cross out the corresponding rows on the next two pages of the grid. Then, on the second and third pages of the grid, administer only the rows for which there was use reported in the preceding 90 days on the first page. For example, if alcohol use was reported in the past 90 days on the first page, you would administer item S2a on the next page by asking:

1. “During the past 90 days, on how many days have you used any kind of alcohol?”
2. “What were the most drinks you had in one day?”
3. “Over how many hours did you drink them?”
4. “With how many other people were you sharing those drinks?”

Then you would move to the next row for which the participant reported past-90-day use. After all appropriate rows had been administered, you would move to the third page of the grid and ask:

5. “On what date did you last use any kind of alcohol?”
6. “About how much did you drink on that day?”

If your agency or research site does not use the items on the third page, you would ask only questions 1-4.
Note that when you get to items S2j-r, you no longer ask questions 2, 3, and 4. Instead, ask 5v: “What did you use?” In item 5v you can list multiple substances used in the past 90 days, but in item 6 you should list only the amount and specific substances used on the date in column 5.

Participants may identify substances that you have to clarify into one of the GAIN’s substance categories. It is important to recognize that there are several ways to organize substances, and some substances (such as Karachi and ecstasy) could be legitimately counted in several categories. We have tried to be consistent, when possible, with DSM-IV-TR, the National Household Survey on Drug Abuse (NHSDA), and the way that drugs show up on common laboratory urine tests. Notably, MDMA or ecstasy is classified as a hallucinogen in the NHSDA but shows up in urine tests (if at all) as an amphetamine. On the GAIN we classify it as an amphetamine. On the page before the S2 grid on the paper version of the GAIN-I is a list of substances arranged by DSM-IV drug class, which can help for a quick reference (this list is also viewable in GAIN ABS). In addition, attachment 3-I, located at the end of this chapter, provides a more thorough list of common substance names and cross-references them to GAIN categories. While this list includes some relatively stable slang terms, many are not included because their meaning varies by population, time, and geography. If you do not find a slang term in this list, clarify with the participant what he means by asking for another word for the substance he reports using.

**GAIN Substance Quantity Conversion Worksheet.** Column 2 on the second page of the S2 grid asks the participant to report the largest amount of each substance used in the preceding 90 days. The substances have to be recorded in standardized amounts:

- Alcohol = drinks
- Marijuana/other THC = joints
- Crack/freebase = rocks
- Powdered and other forms of cocaine = quarters (quarter grams)
- Inhalants = huffs
- Heroin = dimes (tenths of a gram)

Oftentimes the participants’ responses to these items will have to be clarified in order to standardize the amounts that they report. One way to do this is to restate the question by asking for the standardized amounts. If, for example, a participant reports drinking a pint of whiskey, the interviewer can ask how many drinks that would equal; or if the participant reports smoking a couple of blunts, the interviewer can ask the participant how many joints were in each blunt, and the number of joints can be calculated from there.

If the interviewer is unable to get a standardized response, she can use the quantity conversions listed at the bottom of the second page of the grid (explained further below). Note that the conversions include norms for each substance, which were determined by looking at 3,000 cases of adults and adolescents across different levels of care and using average of cases at the 90th percentile. The norms are useful here because if the participant reports using more than the norm, it’s a cue to the interviewer to probe and clarify the response. Adolescent participants in particular often overestimate the amount of alcohol that they consumed; it’s also possible that a
participant has used more than the norm, but any amount greater than the norm should be confirmed with the participant.

**Alcohol**
- One standard drink = 1 beer = 1 glass of wine = 1 mixed drink = 1 shot.
- One 40-ounce beer or malt liquor = 4 drinks.
- If the participant had a large mixed drink (e.g., a Long Island iced tea), ask him approximately how many shots of alcohol it contained.
- A fifth of hard alcohol = up to 26 drinks, but clarify the size of the bottle, whether it was full when the participant started, and whether it was empty when he finished.
- Record amounts and convert to standard units, if necessary, based on the participant’s estimate of what he alone consumed. If the participant can report only an amount that he shared with others (such as passing a bottle around with others at a party), record that amount and, in column 4, the number of people with whom he shared.
- If the participant reports using more than the norm (1-20 drinks), probe for accuracy. Reports of 20 or more drinks are rarely reliable for most participants. If the participant did drink a higher than usual amount, probe to find out over how long a period the participant drank, whether he threw up at any point, whether he got his stomach pumped or had alcohol poisoning, etc.

**Marijuana**
- There is considerable variation in converting marijuana to standardized amounts, particularly when the participant reports using blunts and bowls, so use the participant’s estimate where possible. If he does not know, the median conversion rates (and common ranges) that people report are:
  - Ounce = 25-30 joints
  - Dime = 4-5 joints
  - Nickel = 2-3 joints.
  - 1 blunt = 2-6 joints
  - 1 gram = 1-2 joints
  - 1 bowl = 1 joint
  - 10 one-hitters (small single-use pipes) = 1 joint
- Convert amounts to joints based on the participant’s estimate of what he alone consumed. If he can report only an amount that he shared with others, record that amount and, in column 4, the number of people with whom he shared.
- If the participant reports using more than the norm (1-20 joints), probe for accuracy.

**Crack, rock, or freebase**
- A pebble is another word for a rock (some participants use “pebble” to imply a small rock). If the participant reports consuming a large number of pebbles, ask how many rocks that would equal. One method of converting pebbles to rocks is to ask how much a pebble
would cost and how much a rock would cost and then calculate the number based on how many pebbles could be purchased for the price of one rock.

- There is considerable variation in converting crack and other solid forms of cocaine to standardized amounts, so use the participant’s estimate where possible. If he does not know, our best estimate (based on talking with former users) is:
  - 8 ball = 32 rocks.
  - Teen = 16 rocks.
  - Gram = 10 rocks.
  - Dime = 1 rock.
  - Nickel = 1 hit = ½ rock (round up to the nearest whole number; there is no smaller reporting unit than 1 on the GAIN).
- If the participant reports using more than the norm (1-20 rocks), probe for accuracy.

Other forms of cocaine
- Convert amounts to grams based on the participant’s estimate of what he alone consumed. If he can report only an amount that he shared with others, record that amount and, in column 4, the number of people with whom he shared.
- There is considerable variation in converting powdered cocaine to standardized amounts, so use the participant’s estimate where possible. If they do not know, there are approximately 2 to 5 lines of cocaine in a quarter gram, and 4 quarters = 1 gram.
- If the participant reports using more than the norm (1-10 grams), probe for accuracy.

Heroin
- Convert amounts to dime bags based on the participant’s estimate of what he alone consumed. If he can report only an amount that he shared with others, record that amount and, in column 4, the number of other people with whom he shared.
- There is considerable variation in converting heroin to standardized amounts, so use the participant’s estimate where possible. If he does not know, our best estimate (based on talking with former users) is 1 gram = 10 dime bags
- If the participant reports using more than the norm (1-10 dime bags), probe for accuracy.

Recreating Time Outside a Controlled Environment. Item S2x asks the participant for the number of days in the past 90 that he has been in a controlled environment, such as an inpatient treatment facility or jail, in which he could not (or was not supposed to) use substances. If the participant responds that he has been in such a controlled environment for 13 or more of the past 90 days, you must complete the Pre-Controlled Environment Use items (S2x1-4 and S2y_a-r). To complete these items, use the calendar to highlight the 90 days prior to the first day that the participant was in the controlled environment(s). Once established, explain that the next set of items will refer to that time period. After the last item from this set of items is administered, let the participant know that you have finished talking about the new time period and will return to the original 90-day and 12-month time frames for the rest of the interview.
Completing the S7 Detailed Treatment History Grid. The purpose of this grid is to get a sense of the participant’s prior treatment history. Helpful information (Summary of Treatment History and Directions and Codes) for completing the grid is located on the page following the grid on the paper version (see figure on p. 3-23). To administer the S7 items, remember to start asking about the first treatment ever received and work up to the most recent treatment received. Because the participant’s memory may not make this an easy task, it is best to have a piece of scratch paper to record prior treatment and review with the participant to make sure none was missed and they are in correct order. Each level of care within a treatment episode should be recorded on a separate row in the S7 treatment history grid. Therefore, there can be more rows completed than number of episodes reported in item S7.

Once you feel comfortable transferring the information to the GAIN-I, it is important to put the correct information in the correct columns:

b. Program Name. Enter the name of the program attended. For example, if the participant had attended Chestnut Health Systems’ outpatient program, enter “Chestnut Health Systems.”

b1. Program Code. The program code is a numeric code that your site or research project creates for each treatment facility reported. It is important to first have a list of common local program codes to insert in the summary page of the S7 grid (or to bring on a separate page) to help code column A. We recommend using existing state codes to create this list, if possible. Keep a master list of the facility codes and what they stand for to prevent duplicating codes and for later interpretation. For example, if the following was your list to work with:

<table>
<thead>
<tr>
<th>Code</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>AACI</td>
</tr>
<tr>
<td>102</td>
<td>ACT</td>
</tr>
<tr>
<td>103</td>
<td>Addiction Services Healthcare</td>
</tr>
<tr>
<td>200</td>
<td>Al-Anon</td>
</tr>
<tr>
<td>201</td>
<td>B-City Mission</td>
</tr>
<tr>
<td>202</td>
<td>C-House</td>
</tr>
<tr>
<td>203</td>
<td>Community Health Center</td>
</tr>
<tr>
<td>210</td>
<td>F Hospital Program</td>
</tr>
<tr>
<td>250</td>
<td>Fresh Start</td>
</tr>
<tr>
<td>300</td>
<td>Hospital P Recovery</td>
</tr>
<tr>
<td>301</td>
<td>Chestnut Health Systems</td>
</tr>
</tbody>
</table>

—and the participant reported attending Chestnut Health Systems, Addiction Services Healthcare, and Fresh Start (in that order), then for S7_1a you would code “301,” for S7_2a
you would code “103,” and for S7_3a you would code “250.” (If a participant reports a new program not already on your list, you would have to add a new row to your master list.)

c. **What type of treatment was this?** The S7 summary page has a list of general level of care codes to complete this column. For example, if the participant stated they were in an outpatient program, code “10.”

d. **On about what date did you start?** There are date guidelines on the S7 summary page in case the participant does not remember the exact date. Remember that this grid is trying to get a general idea of how much and what kind of treatment the participant has had, so it is not critically damaging to the interview if they don’t remember exactly. For estimating the day, ask the participant whether it was around the beginning (use the 5th), middle (use the 15th), or end (use the 25th) of the month. If the participant doesn’t remember the day at all, use the middle (15th). If they don’t remember the exact months, use the guidelines (March for early in the year, July for middle of the year, and October for later in the year). If they don’t remember the year, ask how old they were at the time and count back, or ask if they remember anything happening historically to help pinpoint the year.

d1. **Are you still in treatment?** Circle 1 for yes if the participant is still in treatment at the time the assessment is given and circle 0 if the participant is not in treatment. If yes, skip items e and g, ask whether the participant had any other treatment episodes, then repeat the preceding steps on the next row of the grid.

e. **On about what date did you leave?** Use the same guidelines as described for item d (see above).

g. **About how many days were you there?** This is one of the few times on the GAIN where an item can be asked out of order to make it easier for the participant. Enter the total number of days in treatment for that row’s treatment episode. However, if the participant remembers when they started treatment but not when they left, it is a good idea to ask about how many days they were there, figure the end date, verify it with the participant and record it.

**Row 99 (index treatment).** This field is completed only on the GAIN-M90 to reference the treatment that corresponded with the participant’s GAIN-I or entry into a research study.

**Sample Summary of Treatment History and Directions and Codes.** Exhibit 3.2 shows an example of local program codes and names for use with the S7 Detailed Treatment History Grid. Pre-entering these commonly used codes on the GAIN makes coding much easier for interviewers.
Completing the S9 Detailed Substance Use Disorder Worksheet (the S9 grid). For each of items S9h-u that the participant endorses (gave a response other than “never”), you will ask the corresponding items in the grid. First mark the items in the grid that you will ask, based on the participant’s responses from the previous page, then ask the following:

- “Can you tell me which substance…[complete the rest of the question you are asking]?”
- For the first substance the participant mentions, ask “About when did this happen (using card B)?” Code the response in the correct box.
- Then ask, “Have you had this problem with any other substance?” and repeat the preceding steps for any affirmative responses.

3.8 Finishing the Assessment

The key issues in finishing administration with the participant are completing section Z (End) of the GAIN, completing the Administration Ratings, completing a field edit, and completing any remaining documentation on the cover page. After the participant leaves, you will also need to data-enter the assessment and record the details on the cover page.
Completing Section Z of the GAIN. When the assessment is complete, thank the participant for his time and document how long the assessment took in section Z. If the GAIN is not being self-administered, the interviewer completes items Z1-Z1d without administering the items to the participant.

- **Z1. What time is it now?** Record the time the assessment was finished in the same format as on the cover page (HH:MM).
- **Z1b. Is it AM or PM?** Write down AM or PM.
- **Z1c. How many breaks did you take to finish this?** Write down the number of breaks taken.
- **Z1d. Not counting breaks, how long did it take you to finish this?** To calculate, first figure out how much time was spent from the beginning to the end of the assessment, then subtract the number of minutes spent on break to get the total time on task. For example, say that you started an assessment at 1:00 pm and finished at 2:45 pm (105 minutes) and took one break from 1:50 to 2:00 (10 minutes) and a second break from 2:25 to 2:30 (5 minutes). You would add the two breaks together, which would be 15 minutes of total break time, and subtract that from the overall assessment time (105 minus 15) to arrive at a final time to complete of 90 minutes. You would then record “90” for item Z1d.
- **Z2. Are there any other special issues we need to know about to help you or help you come to treatment? Do you have any additional comments or questions?** It is very important to remember to ask this question. The time to complete this question is not considered in the total time to complete (item Z1d).
- **Z3. Signatures (optional).** Use as required by your clinical supervisor or research project coordinator.

If you are administering the GAIN over more than one day, please refer to XADMh (below) for further instructions.

**Administrative Ratings.** At the end of the GAIN is an administrative rating section (XADM) marked “For Staff Use Only.” Here you need to answer several additional questions about how the assessment was administered. This information is also used to meet reporting requirements for a “method” section of the assessment summary and can be used to compare assessments in research studies. The items and their responses are spelled out completely.

- **XADMa1-2 (mode of administration):** Code who administered the interview (XADMa1a-z) and how it was administered (XADMa2a-z).
- **XADMb (language):** Code the language in which the interview was administered.
- **XADMc (indications of developmental disabilities):** Code whether the participant showed any signs of learning or other developmental disabilities.
• **XADMd (evidence of cognitive impairment or dementia)**: Code whether the participant showed signs of being unable to place himself in place or time or had other indications of severe cognitive impairment.

• **XADMe (observed participant behaviors)**: Mark yes or no for each behavior observed. (There can be more than one yes.)

• **XADMf (appearance)**: To help distinguish between “unkempt appearance” and “inadequate clothing,” unkempt is more than a style of dress often worn by adolescents and young adults. It is noticeably disheveled, or deficient in neatness. Inadequate clothing refers to problems such as not wearing a coat or shoes in the winter.

• **XADMg (participant’s location during the assessment)**: Code from one of the options listed or use “other.” If your site regularly has an Other location, discuss this with your clinical supervisor or research project coordinator.

• **XADMg1-5 (location context issues)**: Mark yes or no for each issue that might have had a context effect on the interview. If the problem was a limited and managed interruption (e.g., a single phone call that required a break but did not disrupt the interview process or the participant’s behavior), it does not need to be documented. These issues are only a concern if they persist, occur multiple times, upset the participant or lead to a change in the participant’s attention, candor, or behaviors during the interview.

• **XADMh (administration protocol)**:
  - If you administered only part of the assessment or didn’t complete the assessment at the time the XADM items are coded, select “Partial assessment/incomplete to date” (5).
  - If you have administered the full assessment or otherwise followed the usual administration standards, select “Regular site protocol” (6).
  - If the regular site protocol was followed but the interview contained additional sections of the GAIN, such as I need an example, code “Regular site protocol supplemented with additional questions” (7).
  - The OTH code (99) can be used with the advice of your clinical supervisor or research project coordinator to cover any other administration protocol not covered by the other choices.

**XADMh1-h1d (administration over multiple days)**:
  - If you conduct the assessment over multiple days, record 1 (yes) in item XADMh1 and complete items XADMh1a-c, and d. If not, code 0 (no) in item h1 and skip down to item XADMj.
  - To complete item XADMh1a record the final revision date (so, for example, if you administer in three sessions, write down the last date of administration).
  - For item XADMh1b record the total number of breaks across all days. Be sure to count the time between days as a break: e.g., if you spend 40 minutes administering the GAIN on March 12 with no break, then stop and don’t start again until March 14, at which time you administer the GAIN for 60 more minutes with 1 break, then you would record 2 breaks in item XADMh1b.
• To complete item XADMh1c, record the total number of minutes spent administering the GAIN across all days, not counting break time (only time on task).
• To complete item XADMh1d, record the staff ID of the person finishing the interview.
• Note that if you take a break during the first day of the assessment and come back 6 hours later, it equals one 6-hour break; you are still doing the assessment in one day, and only Z1-Z1d need to be coded. If you administer the assessment over more than one day, fill out section Z after ending on the first day, then fill out items XADMh1a-d at the end of the second day. If administering the assessment over more than two days, fill in items XADMh1a-d when the interview is finally completed, keeping track of the duration of the interview and all breaks along the way.
• XADMj (Additional comments): This is the place for the staff member administering the assessment to write any comments that should be considered in interpreting or data entering the assessment. Although there are only two lines are on the paper version, interviewers should feel free to write more on a separate page if necessary, and there is much more room in the data entry program. Also, remember that the margins can be used to take notes as well.

**Conducting a Field Edit**. After finishing the assessment, whether self-administered or orally administered, offer the participant a break so you can 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 the participant has the right to refuse to answer any question or say that they do not know the answer; if this is the case, however, it should be noted with an RF or DK in the margin. Try to either get an answer or write in RF/DK for any incorrectly skipped questions, and be sure to ask the participant if he has any further questions. Once you have completed your quick check, thank the participant and let him 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.

**Documentation on the Cover Page**. There are several fields on the cover page that should be filled in only after the assessment has been completed.
• **Edit Staff ID (XDESID) and Edit Date (XDEDT)**: This is the staff ID number (up to 6 digits) of the person who does the field edit (as described above).
• **DE Staff ID (XDESID) and Initial Key Date (XDEDT)**: When the assessment is data entered into your database the program will ask you to identify yourself and verify the date the record is being keyed. This information is also recorded in these fields.
• **Rekey Staff ID (XRKSID) and Rekey Date (XRKDT)**: When the assessment is data entered for a second time, GAIN ABS may not be able to tell that it is a rekeyed entry if the
initial key was on a different computer. To help link records, please key in both the initial and rekey information.

3.9 Treatment Urgency and Denial-Misrepresentation Ratings

At the end of each major section of the GAIN-I, the interviewer is asked to make two clinical ratings, one on the treatment urgency (UR) with which the adolescent needs services in the given area and one on denial and misrepresentation (DM), or the extent to which the participant appeared to be guessing, misunderstanding, denying, or misrepresenting information in the given area. Both of these ratings reflect the interviewer’s opinion; they are used as flags for the clinician as they communicate pressing problem areas and can be used to guide treatment planning.

**Treatment Urgency Ratings**. The treatment urgency ratings (items B10, S11, P14, R8, M7, E17, L11, V13) are nearly identical to the card E items (How soon, if at all, do you need help with…) that appear near the end of almost every major section of the GAIN. In each section, the interviewer rates the urgency of the participant’s need for treatment or services in each 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 that 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 in opinion to the participant is discussed later in the chapter on treatment planning.

**Exhibit 3-3 Treatment Urgency Ratings (UR)**

<table>
<thead>
<tr>
<th>How soon (if at all) do you need (more) help with your current situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right away (NOW) .......................................................... 4</td>
</tr>
<tr>
<td>In the next 3 months (0-3 MON) ........................................ 3</td>
</tr>
<tr>
<td>More than 3 months from now (GT 3 MON) .................. 2</td>
</tr>
<tr>
<td>Getting the help I need already (ALREADY) ................ 1</td>
</tr>
<tr>
<td>Do not need any help (NONE) ........................................... 0</td>
</tr>
</tbody>
</table>

Use the following as a general guideline for completing treatment urgency ratings.

- **NOW**: Problems need to be addressed immediately or within the next 24 hours: emergencies such as no housing, no safe housing, no food, suicidal, reports coughing up blood, etc.

- **0-3 MON**: Needs help with problems in an area, which should be addressed within the 3 months following the interview through the treatment plan or referral.

- **GT 3 MO**: There are problems in an area, but they can wait to be addressed for more than 3 months from the time of the interview or after treatment.

- **ALREADY**: The participant is already receiving services in an area.
• **NONE**: The participant does not appear to need any help in an area.

Below are some considerations for rating each major section of the GAIN-I. When coding the ratings, feel free to make any clarifying staff notes that you think are necessary.

• **B10. Access to Treatment Urgency Rating [BUR]**. If the participant-self reports problems that are likely to arise in accessing treatment (e.g., transportation) or you know of any specific problems, check the appropriate box.

• **S11. Substance Abuse Treatment Urgency Rating [SUR]**. Most participants presenting for substance abuse treatment will be in the 0-3 MON category because of their use, past-month problems, desire for substance abuse treatment services, or a legal mandate for them to attend treatment. If the participant is transferring from a controlled environment or residential program but had a prior pattern of use, it is still appropriate to check 0-3 months.

• **P14. Physical Health Treatment Urgency Rating [PUR]**. Health problems become more frequent the older the participant and the longer the treatment history. Adolescents typically report asthma or some other medical condition (reported in item P9) that is already being treated or managed (as evidenced by medication or current treatment). As participants become young adults, sexually transmitted diseases and pregnancy increasingly become problems that may require additional services. Older adults have other conditions (e.g., diabetes, heart) that may or may not have been addressed. In these cases it is important to verify whether they are being managed sufficiently or identify them as something to be reviewed in the first 90 days. If the problem appears to be stable and well managed or involves a long-term risk that does not require immediate attention (e.g., a family history of a condition), check GT 3 MO and review again at the time of discharge to make sure that there is no change. If there are 13 or more days of health problems that interfere with meeting responsibilities or 45 or more days of health problems or a desire for health services, check 0-3 MON.

• **R8. Risk Behavior Treatment Urgency Rating [RUR]**. If the participant does not use needles, have unprotected sex, or smoke, you will generally check NONE. If the participant reports needle use (R1), has multiple sexual partners (R2), unprotected sex (R2), smoking (R4) or a desire for health prevention services (R7), you will generally check 0-3 MON. Across ages, many programs also make testing and counseling referrals for HIV and other infectious diseases if someone injects drugs (R1) or has multiple sex partners (R2).

• **M7. Mental Health Treatment Urgency Rating [MUR]**. If there are no problems or no treatment history is reported, check NONE. If the participant reports some problems but appears to be getting help (e.g., Ritalin is used to help with ADHD symptoms), check ALREADY. However if there still are substantial problems, problems without treatment, or the participant desires mental health services, check 0-3 MON. If the participant reports any current homicidal or suicidal thoughts, consider checking NOW.

• **E17. Environmental Urgency [EUR]**. If the participant reports a history of emotional abuse but is getting help and has no current problems, check ALREADY. If they report alcohol use, drug use (E2), or violence in the home (E8); family problems (E3); or violent behavior (E8), check 0-3 MON. If they report a history of homelessness, victimization
(E9), or high rates of stress, check GT 3 MO and review at discharge to make sure that there is no new risk.

- **L11. Legal Urgency [LUR].** If the participant is already on probation or parole and is stable, check ALREADY. If they are involved in ongoing civil proceedings (L1), has payments to make (L2), has several arrests (L5), is involved in ongoing criminal justice proceedings (L7), or owes restitutions (L9), check GT 3 MO or 0-3 MO (depending on severity) because the situation needs to be monitored. If the participant is currently involved in illegal activity (E3), check 0-3 MON.

- **V13. Vocational Urgency [VUR].** If the participant is not in work or school, does not need/want to be working (e.g., a homemaker or someone who is retired), and does not have financial problems, check NONE. If the participant is engaged in and doing well at school or work, check NONE. If the participant is below grade level and has a past-year history of school (V3) or work (V6) problems but none in the past 90 days, then check GT 3 MON because the issue should be monitored. If the participant’s grades are Cs or lower, they miss school or work for a substantial number of days, have school- or work-related problems (e.g., detention, suspension, lay off, fired) in the past 90 days (V3 and V6), or financial (V8) or gambling (V9) problems, check 0-3 MON. Normally you would not check NOW in the Vocational section unless there is an immediate problem that puts the participant at risk, such as borrowing and losing gang money through gambling.

**Denial-Misrepresentation Ratings.** The denial and misrepresentation ratings (items B11, S12, P15, R9, M8, E18, L12, V14) are the interviewer’s ratings, using the scale in exhibit 3-4, of the extent to which the participant appeared to be guessing, misunderstanding, denying, or misrepresenting information. The purpose of this rating is to track the quality of the participant’s responses. A systematic pattern of denial or misrepresentation 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. (Recall that you will correct any simple factual errors when reviewing the GAIN with the participant, which should not count as denial or misrepresentation but may count as misunderstanding or guessing or estimating.)

**Exhibit 3-4 Denial and Misrepresentation (DM) Ratings**

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

- None (NONE) ................................................................. 0
- Some guessing or estimation (SOME) .......................... 1
- Misunderstood some questions (MISUNDER) ............. 2
- Appears to deny or underestimate (DENIAL) .............. 3
- Appears to be misrepresenting information (MISREP) .... 4

Use the following as a general guideline for completing the Denial-Misrepresentation ratings.

- **NONE:** The participant shows no signs of guessing, estimating, misunderstanding, denying, or misrepresenting.
• **SOME**: The participant understands the questions but has to guess or estimate the answer.

• **MISUNDER**: The participant doesn’t understand the questions even after attempts at clarification.

• **DENIAL**: The participant understands the questions but doesn’t see their own problems.

• **MISREP**: The participant understands the questions and sees the problem but doesn’t want the interviewer to see the problem.

Ratings across a single GAIN tend to be primarily NONE (0) and SOME (1), and an occasional MISUNDER (2) is normal. High scores in one section or moderate to high scores across several sections suggest the potential for learning problems, antisocial tendencies, or denial that may bias the assessment and interfere with treatment. The most common problems with truthfulness arise when reporting illegal activity and substance use. Systematically high rates in the Legal and Substance Use sections across interviews suggest that interviewers may not be creating a sufficiently private and confidential atmosphere for their clients.

When rating substance use, it is important not to confuse denial with perceptions of a problem. It is relatively common for participants (particularly adolescents and young adults) to freely report problems using concrete terms but not see themselves as having related problems. This is a clinical issue and not does not need to be expanded on here; instead we are interested in people who appear to be systematically minimizing the extent of their problems even on concrete questions.

In general less than 5% of participants have any sections rated DENIAL or MISREP. When administering a GAIN in a criminal justice setting, some participants may overstate their substance use symptoms and understate their mental health systems. This occurs when jailhouse lawyers or others have advised them that there is generally “diversion” for substance abuse treatment but not for mental health problems. Inconsistencies in participants’ mental health scales (e.g., no problems reported in the M1 items but problems reported in M2) should be reviewed closely and may warrant a DENIAL rating. As noted earlier, if you have concerns about the validity of the assessment or a specific question, be sure to document them with a short note in the assessor’s comments (XADMj) at the end of the GAIN.
<table>
<thead>
<tr>
<th>Drug name</th>
<th>GAIN-I (version 5) item/class</th>
<th>DSM-IV-TR diagnostic group</th>
</tr>
</thead>
<tbody>
<tr>
<td>acid</td>
<td>S2m. Acid or other hallucinogens</td>
<td>304.50 Halucinogen Dependence 305.30 Halucinogen Abuse</td>
</tr>
<tr>
<td>Adderall</td>
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<td>304.40 Amphetamine Dependence 305.70 Amphetamine Abuse</td>
</tr>
<tr>
<td>alcohol</td>
<td>S2a. Any kind of alcohol</td>
<td>303.90 Alcohol Dependence 305.00 Alcohol Abuse</td>
</tr>
<tr>
<td>alprazolam</td>
<td></td>
<td>303.90 Alcohol Dependence 305.00 Alcohol Abuse</td>
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<tr>
<td>Alurate</td>
<td></td>
<td>303.90 Alcohol Dependence 305.00 Alcohol Abuse</td>
</tr>
<tr>
<td>amobarbital</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>amphetamine</td>
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<tr>
<td>amyl nitrite</td>
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<td>angel dust</td>
<td>S2k. PCP or angel dust (phencyclidine)</td>
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</tr>
<tr>
<td>Drug name</td>
<td>GAIN-I (version 5) item/class</td>
<td>DSM-IV-TR diagnostic group</td>
</tr>
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<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
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<td></td>
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<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
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<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
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<td>beer</td>
<td>S2a. Any kind of alcohol</td>
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<td></td>
<td>305.00 Alcohol Abuse</td>
</tr>
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<td>Benzedrine</td>
<td>S2pb. Speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants</td>
<td>304.40 Amphetamine Dependence</td>
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<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
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<td>Biphetamine</td>
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<td>304.40 Amphetamine Dependence</td>
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<tr>
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<td></td>
<td>305.70 Amphetamine Abuse</td>
</tr>
<tr>
<td>blunts</td>
<td>S2c. Marijuana, hashish, blunts or other forms of THC</td>
<td>304.30 Cannabis Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.20 Cannabis Abuse</td>
</tr>
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<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
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<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>butabarbital</td>
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<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
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<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Drug name</td>
<td>GAIN-I (version 5) item/class</td>
<td>DSM-IV-TR diagnostic group</td>
</tr>
<tr>
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<td>---------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
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<tr>
<td>butalbital</td>
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<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence&lt;br&gt;305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
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<tr>
<td>Butisol</td>
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<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence&lt;br&gt;305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>cannabis</td>
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<td>304.30 Cannabis Dependence&lt;br&gt;305.20 Cannabis Abuse</td>
</tr>
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<td>chlordiazepoxide</td>
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<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence&lt;br&gt;305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
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</tr>
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<td>clorazepate</td>
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<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence&lt;br&gt;305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>cocaine</td>
<td>S2e. Other forms of cocaine</td>
<td>304.20 Cocaine Dependence&lt;br&gt;305.60 Cocaine Dependence</td>
</tr>
<tr>
<td>codeine</td>
<td>S2j. Painkillers, opiates, or other analgesics</td>
<td>304.00 Opioid Dependence&lt;br&gt;305.50 Opioid Abuse</td>
</tr>
<tr>
<td>Concerta</td>
<td>S2pb. Speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants</td>
<td>304.40 Amphetamine Dependence&lt;br&gt;305.70 Amphetamine Abuse</td>
</tr>
<tr>
<td>correction fluids</td>
<td>S2f. Inhalants</td>
<td>304.60 Inhalant Dependence&lt;br&gt;305.90 Inhalant Abuse</td>
</tr>
<tr>
<td>cough syrup</td>
<td>S2r. Some other drug</td>
<td>304.90 Other Substance Dependence&lt;br&gt;305.90 Other Substance Abuse</td>
</tr>
<tr>
<td>crack</td>
<td>S2d. Crack or freebase cocaine</td>
<td>304.20 Cocaine Dependence&lt;br&gt;305.60 Cocaine Dependence</td>
</tr>
<tr>
<td>Drug name</td>
<td>GAIN-I (version 5) item/class</td>
<td>DSM-IV-TR diagnostic group</td>
</tr>
<tr>
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<td>-----------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>crystal</td>
<td>S2pa. Methamphetamine, crystal, ice, glass, or other forms of methedrine</td>
<td>304.40 Amphetamine Dependence 305.70 Amphetamine Abuse</td>
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<tr>
<td>d-propoxyphene</td>
<td>S2j. Painkillers, opiates, or other analgesics</td>
<td>304.00 Opioid Dependence 305.50 Opioid Abuse</td>
</tr>
<tr>
<td>Dalmane</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Darvocet</td>
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<td>304.00 Opioid Dependence 305.50 Opioid Abuse</td>
</tr>
<tr>
<td>Darvon</td>
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<td>304.00 Opioid Dependence 305.50 Opioid Abuse</td>
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<td>Demerol</td>
<td>S2j. Painkillers, opiates, or other analgesics</td>
<td>304.00 Opioid Dependence 305.50 Opioid Abuse</td>
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<td>Diphenylhydantoin sodium</td>
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<td>304.90 Other Substance Dependence 305.90 Other Substance Abuse</td>
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<td>Dexedrine</td>
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<td>Drug name</td>
<td>GAIN-I (version 5) item/class</td>
<td>DSM-IV-TR diagnostic group</td>
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<tr>
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<td>diphenhydramine</td>
<td>S2r. Some other drug</td>
<td>304.90 Other Substance Dependence</td>
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<tr>
<td></td>
<td></td>
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<tr>
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<td>or other sedatives</td>
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<td>or other sedatives</td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
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<td>downers</td>
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<td></td>
<td>or other sedatives</td>
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<td>d-pam</td>
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<td>ephedrine / pseudoephedrine</td>
<td>S2r. Some other drug</td>
<td>304.90 Other Substance Dependence</td>
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<td>305.90 Other Substance Abuse</td>
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<td>S2n. Anti-anxiety drugs or tranquilizers</td>
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<td>ethchlorvynol</td>
<td>S2q. Downers, sleeping pills, barbiturates,</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
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<td></td>
<td>or other sedatives</td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
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<tr>
<td>Euhypnos</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
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<td>Fioricet</td>
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<td>flunitrazepam</td>
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<td>freebase cocaine</td>
<td>S2d. Crack or freebase cocaine</td>
<td>304.20 Cocaine Dependence 305.60 Cocaine Dependence</td>
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<td>gasoline</td>
<td>S2f. Inhalants</td>
<td>304.60 Inhalant Dependence 305.90 Inhalant Abuse</td>
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<td>GHB/GBL</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
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<td>glue</td>
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<td>304.60 Inhalant Dependence 305.90 Inhalant Abuse</td>
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<td>S2c. Marijuana, hashish, blunts or other forms of THC</td>
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<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
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<td>S2pa. Methamphetamine, crystal, ice, glass, or other forms of methedrine</td>
<td>304.40 Amphetamine Dependence</td>
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<td>305.70 Amphetamine Abuse</td>
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<td>S2f. Inhalants</td>
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<td>305.90 Inhalant Abuse</td>
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<td>S2d. Crack or freebase cocaine</td>
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<td>305.60 Cocaine Dependence</td>
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<td>injected cocaine</td>
<td>S2d. Crack or freebase cocaine</td>
<td>304.20 Cocaine Dependence</td>
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<td>Ketalar</td>
<td>S2m. Acid or other hallucinogens</td>
<td>304.50 Hallucinogen Dependence 305.30 Hallucinogen Abuse</td>
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<td>S2m. Acid or other hallucinogens</td>
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<td>S2f. Inhalants</td>
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<td>liquid ecstasy</td>
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<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
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<td>lorazepam</td>
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<td>Lorcet</td>
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<td>304.00 Opioid Dependence 305.50 Opioid Abuse</td>
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<td>304.30 Cannabis Dependence 305.20 Cannabis Abuse</td>
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<td>MDMA</td>
<td>S2pb. Speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants</td>
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<td>Mebaral</td>
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<td>meperidine HCl</td>
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<td>mephobarbital</td>
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<td>Mogadon</td>
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<td>S2pa. Methamphetamine, crystal, ice, glass, or other forms of methedrine</td>
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<td>S2m. Acid or other hallucinogens</td>
<td>305.30 Hallucinogen Abuse</td>
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<td>S2. Any kind of alcohol</td>
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<td>S2e. Other forms of Cocaine</td>
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<td>305.60 Cocaine Dependence</td>
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<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
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<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
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<td>S2k. PCP or angel dust (Phencyclidine)</td>
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<td>peyote</td>
<td>S2m. Acid or other hallucinogens</td>
<td>304.50 Hallucinogen Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.30 Hallucinogen Abuse</td>
</tr>
<tr>
<td>phencyclidine (PCP)</td>
<td>S2k. PCP or angel dust (Phencyclidine)</td>
<td>304.90 Phencyclidine Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.90 Phencyclidine Abuse</td>
</tr>
<tr>
<td>Drug name</td>
<td>GAIN-I (version 5) item/class</td>
<td>DSM-IV-TR diagnostic group</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>phenobarbital</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Placidyl</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>PMA</td>
<td>S2m. Acid or other hallucinogens</td>
<td>304.50 Hallucinogen Dependence 305.30 Hallucinogen Abuse</td>
</tr>
<tr>
<td>polysubstance</td>
<td>Reported by substance</td>
<td>304.80 Polysubstance Dependence (Note: means having dependence symptoms across substance but not for any single substance. If symptoms met for multiple substances, they would each be listed.)</td>
</tr>
<tr>
<td>poppers</td>
<td>S2r. Some other drug</td>
<td>304.90 Other Substance Dependence 305.90 Other Substance Abuse</td>
</tr>
<tr>
<td>Pro-Pam</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>propoxyphene</td>
<td>S2j. Painkillers, opiates, or other analgesics</td>
<td>304.00 Opioid Dependence 305.50 Opioid Abuse</td>
</tr>
<tr>
<td>psilocybin</td>
<td>S2m. Acid or other hallucinogens</td>
<td>304.50 Hallucinogen Dependence 305.30 Hallucinogen Abuse</td>
</tr>
<tr>
<td>Quaalude</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>reefer</td>
<td>S2c. Marijuana, hashish, blunts or other forms of THC</td>
<td>304.30 Cannabis Dependence 305.20 Cannabis Abuse</td>
</tr>
<tr>
<td>Ritalin</td>
<td>S2pb. Speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants</td>
<td>304.40 Amphetamine Dependence 305.70 Amphetamine Abuse</td>
</tr>
<tr>
<td>Drug name</td>
<td>GAIN-I (version 5) item/class</td>
<td>DSM-IV-TR diagnostic group</td>
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</tr>
<tr>
<td>Rivotril</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Robitussin</td>
<td>S2r. Some other drug</td>
<td>304.90 Other Substance Dependence 305.90 Other Substance Abuse</td>
</tr>
<tr>
<td>Rohypnol</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>scotch</td>
<td>S2a. Any kind of alcohol</td>
<td>303.90 Alcohol Dependence 305.00 Alcohol Abuse</td>
</tr>
<tr>
<td>secobarbital</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Seconal</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>sedative, hypnotic, or anxiolytic</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Serapax</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Serax</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Serenid</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>shrooms</td>
<td>S2m. Acid or other hallucinogens</td>
<td>304.50 Hallucinogen Dependence 305.30 Hallucinogen Abuse</td>
</tr>
<tr>
<td>sleeping pills</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Drug name</td>
<td>GAIN-I (version 5) item/class</td>
<td>DSM-IV-TR diagnostic group</td>
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<td>-------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sompam</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Sopor</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>special K</td>
<td>S2m. Acid or other hallucinogens</td>
<td>304.50 Hallucinogen Dependence 305.30 Hallucinogen Abuse</td>
</tr>
<tr>
<td>speed</td>
<td>S2pb. Speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants</td>
<td>304.40 Amphetamine Dependence 305.70 Amphetamine Abuse</td>
</tr>
<tr>
<td>speedball (heroin and cocaine)</td>
<td>S2j. Painkillers, opiates, or other analgesics</td>
<td>304.00 Opioid Dependence 305.50 Opioid Abuse</td>
</tr>
<tr>
<td>spray paint</td>
<td>S2f. Inhalants</td>
<td>304.60 Inhalant Dependence 305.90 Inhalant Abuse</td>
</tr>
<tr>
<td>steroids</td>
<td>S2r. Some other drug</td>
<td>304.90 Other Substance Dependence 305.90 Other Substance Abuse</td>
</tr>
<tr>
<td>stimulants</td>
<td>S2pb. Speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants</td>
<td>304.40 Amphetamine Dependence 305.70 Amphetamine Abuse</td>
</tr>
<tr>
<td>street methadone</td>
<td>S2h. Nonprescription or street methadone</td>
<td>304.00 Opioid Dependence 305.50 Opioid Abuse</td>
</tr>
<tr>
<td>talbutal</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Talwin</td>
<td>S2j. Painkillers, opiates, or other analgesics</td>
<td>304.00 Opioid Dependence 305.50 Opioid Abuse</td>
</tr>
<tr>
<td>temazepam</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence 305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Drug name</td>
<td>GAIN-I (version 5) item/class</td>
<td>DSM-IV-TR diagnostic group</td>
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<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>tranquilizers</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Tranxene</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Trazepam</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>triazolam</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Tricam</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>tuazepam</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Tuinal</td>
<td>S2q. Downers, sleeping pills, barbiturates, or other sedatives</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Tylenol with codeine</td>
<td>S2j. Painkillers, opiates, or other analgesics</td>
<td>304.00 Opioid Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.50 Opioid Abuse</td>
</tr>
<tr>
<td>uppers</td>
<td>S2pb. Speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants</td>
<td>304.40 Amphetamine Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.70 Amphetamine Abuse</td>
</tr>
<tr>
<td>Valium</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
<tr>
<td>Vicodin</td>
<td>S2j. Painkillers, opiates, or other analgesics</td>
<td>304.00 Opioid Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.50 Opioid Abuse</td>
</tr>
<tr>
<td>weed</td>
<td>S2c. Marijuana, hashish, blunts or other forms of THC</td>
<td>304.30 Cannabis Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.20 Cannabis Abuse</td>
</tr>
<tr>
<td>Drug name</td>
<td>GAIN-I (version 5) item/class</td>
<td>DSM-IV-TR diagnostic group</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>whiskey</td>
<td>S2a. Any kind of alcohol</td>
<td>303.90 Alcohol Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.00 Alcohol Abuse</td>
</tr>
<tr>
<td>wine</td>
<td>S2a. Any kind of alcohol</td>
<td>303.90 Alcohol Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.00 Alcohol Abuse</td>
</tr>
<tr>
<td>Xanax (alprazolam)</td>
<td>S2n. Anti-anxiety drugs or tranquilizers</td>
<td>304.10 Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>305.40 Sedative, Hypnotic, or Anxiolytic Abuse</td>
</tr>
</tbody>
</table>
4. Administration Quality Assurance in GAIN Administration

4.1 What does “A-QA” mean?

In this context, administration quality assurance, or A-QA, is a process that consists of monitoring an interviewer’s skills at administering an assessment protocol and providing evaluative feedback. Once the interviewer’s skills reach a predetermined level of competence, the interviewer is “certified” in GAIN administration. Administration QA can also continue after certification to monitor ongoing adherence to protocol.

4.2 How does the A-QA process work?

The point about being trained and practiced before initiating the A-QA process is significant. Too often interviewers attempt to start the A-QA process, attempting to get certified in GAIN assessment administration, before they have had sufficient training and practice. This results in a longer, drawn-out A-QA process. It is suggested that, as part of training, the interviewer observes several assessment administrations before doing practice runs on her own. Once familiar and comfortable with the instrument, the A-QA process should begin.

Although it may be up to your clinical supervisor, project leaders, or funders whether quality assurance of assessment administrations will take place, we strongly recommend it, both for the initial certification of interviewers as well as for ongoing protocol monitoring. Interviewers vary widely both in terms of their prior experience and their interactive styles. For instance, some interviewers may be totally new to conducting assessments, some may have experience with interviewing adults but not adolescents, and even seasoned interviewers may have picked up less-than-optimal interviewing habits or their skills may have deteriorated over time. Because the quality of an assessment administration can affect the validity of the data, we are strong believers in setting up an ongoing quality assurance program as part of interviewer training. The size of the FAQ document alone indicates that questions on administering items in the GAIN are common, so having a program in place to support the quality of assessment administration is important. Because much of our work in quality assurance is done for distant sites, we typically use audio recordings for protocol monitoring and provide feedback either orally or in writing (though most often in writing).

Our A-QA model for quality assurance requires that first a trainee attend a national training (train the trainer) event. After training, the trainee submits audio-recorded submissions to Chestnut and receives written feedback. This process continues until mastery level is reached (see below for details). After reaching Administration certification, the Local Trainer candidate trains her own staff and uses our model to give feedback to their staff and follows a process with us to get certified as a Local Trainer. A certified Local Trainer can then choose their own model of A-QA for their staff. This may consist of use of the GCC’s feedback model, written feedback using a different form than the one we use, or in-person feedback (or a combination of the three). Chapter 8 in the GAIN manual provides information on the specifics of the certification process.
Below are two sample models for certified Local Trainers to consider when deciding how to conduct A-QA for their agency or research project. The advantages and disadvantages of each are included.

**Sample A-QA model #1 – Audio-recorded monitoring and written feedback**
This model is useful when the person conducting the A-QA reviews is not located at the same facility as the interviewer (such as when overseeing A-QA for distant project sites). It also works well with interviewers who may be negatively influenced by live monitoring as well as with a staff member new to assessment administration who may benefit from detailed documentation of feedback.

1) Once trained and practiced, the interviewer records the administration of an assessment from start to finish.
2) The interviewer submits the tape or electronic recording and a hard copy of the assessment documentation to whomever will be doing the A-QA review (called the “A-QA reviewer” in this and the next sample model).
3) The A-QA reviewer evaluates the audio-recorded administration and documentation using a predetermined set of specific criteria. These criteria are used to base judgments of quality.
4) The A-QA reviewer writes specific, behavioral, evaluative feedback for the interviewer on the quality of the assessment. Feedback should conform to the predetermined set of criteria.
5) Based on the quality of the interview, the interviewer may be “pending” or “certified” in the assessment administration. If pending, the steps above are repeated (taping → evaluation → feedback) until the assessment is of sufficient quality to merit certification. After each A-QA audio-recorded review, the interviewer incorporates the A-QA reviewer’s feedback into their next assessment.
6) Once certified, the interviewer provides recordings on a maintenance schedule, perhaps taping one to two assessments per month for review and feedback by the A-QA reviewer. (At this point in the process, either oral or written feedback works well.) This is done to prevent the deterioration of assessment skills, or “interviewer drift.” A variation is to have interviewers record all their assessments from which the A-QA reviewer randomly chooses one or two each month for review and feedback. This process encourages interviewers to maintain quality assessment administrations through a psychological phenomena known as “reactivity” (one is on one’s best behavior when aware of being monitored).

**Sample A-QA model #2 – Live monitoring and oral feedback**
This model works well when the A-QA reviewer and interviewer are both on-site. It also works well with interviewers who are already experienced in assessment administration because the amount of feedback may not be as substantial or detailed.

1) Once trained and practiced, the interviewer conducts an assessment while the A-QA reviewer observes. The A-QA reviewer should be seated at a distance and in sight primarily of the interviewer, not the participant; it is the interviewer who is being observed.

2) During the assessment administration, the A-QA reviewer records on a blank copy of the assessment (a) the participant’s answers and (b) notes on the quality of the administration, following the predetermined criteria for conducting a quality assessment. Notes on the quality of the assessment could also be recorded directly on a sheet that lists the A-QA criteria, which will make feedback easier and more organized. The A-QA reviewer should refrain from interjecting comments during the assessment administration.

3) At the completion of the assessment, the A-QA reviewer provides specific, behavioral, evaluative oral feedback to the interviewer on the quality of the assessment. Feedback should conform to the predetermined set of criteria.

4) The interviewer then submits the hard copy of the assessment to the A-QA reviewer, who will (either at that time or later) review it against the copy that they recorded. This is a check on the accuracy of documentation. The A-QA reviewer provides the interviewer with oral feedback on the quality of the documentation (again, using a predetermined set of specific criteria).

5) Based on the quality of the assessment administration and documentation, the interviewer may be “pending” or “certified.” If pending, the steps above are repeated (observing \( \rightarrow \) evaluation \( \rightarrow \) feedback) until the assessment is of sufficient quality to merit certification. After each A-QA review, the interviewer incorporates the A-QA reviewer’s feedback into the next administration.

6) Once certified, the A-QA reviewer should continue to observe the interviewer’s assessment administration, perhaps one to two times per month. As before, this is done to prevent interviewer drift.

4.3 What features do you look for when assessing the quality of an interview?

The essential features to focus on in GAIN administration are listed in a form called “GAIN Administration Quality Assurance Feedback Form,” reproduced as attachment 4-1 at the end of this chapter.

Although feedback forms are used to review all forms of the GAIN, the specific criteria to use will vary slightly by the particular assessment; this is so because the various GAIN assessments are not identically structured. The feedback form conforms to the structure of the GAIN-I, version 5. Given that the criteria for use with the GAIN-I are comprehensive, the feedback form can easily be adapted for use with other GAIN assessments. Any criteria that are not applicable are coded “NA.” There is also an A-QA feedback form tailored for the GAIN-Q instrument in the GAIN-Q administration and scoring manual (Titus & Dennis, 2003; available at http://www.chestnut.org/LI/gain/GAIN_Q/index.html.)
The GAIN-I feedback form is arranged in four main sections:

- Documentation
- Instructions
- Items
- Engagement

These four sections are assigned ratings in the feedback (detailed below). In addition, identifiers record ID and location of both the interviewer and the reviewer writing the feedback; an “other” section records notes and other feedback that don’t fit into the four main sections; and a certification status of pending or certified is assigned at the end of the feedback.

Each of the four major sections is further defined by specific criteria to apply to the assessment administration. (In defining the A-QA feedback sections and criteria, it is assumed that monitoring is done via audio recording and feedback is given in writing.)

**Documentation** – the recording of participant responses, clinical ratings, and identifying and administrative information. (The first four criteria are checked by consulting the hard copy of the assessment; the last three criteria require consulting the hard copy in concert with the audio recording.)

- **Cover page and staff use box on p. 2 (paper version)** – Check that all appropriate fields are recorded. In the top box all fields down to and including Edit Staff ID and Edit Date are candidates for immediate completion (depending on your site’s needs). Pertinent fields in the Administration Information section on the back of the cover page should also be completed.

- **Documentation and scoring of Check for Cognitive Impairment** – This subsection is important because it documents whether an assessment should take place. Check that it is correctly documented. Any miscodes should be corrected on the hard copy and in the database.

- **Documentation of anchors, literacy questions, and initial administration decision** – Check that items A3a1 (past-90-days anchor), A3a2 (past-year anchor), A3b1-5 (literacy items), and A3c (initial administration decision) are documented.

- **Time to complete** – Check that information in section Z is complete and accurate.

- **Urgency and Denial-Misrepresentation ratings** – Check to see that these ratings, at the end of each major section of the GAIN-I, are complete and appear accurate. As you listen to the audio-recorded assessment, you will get a better idea as to the accuracy of these ratings. Be on the lookout for ratings that are consistently NO or NONE because it can be a sign that what the participant said was not attended to or reflected in the ratings.

- **Administration ratings** – Several pages in the back of the assessment contain a series of Administration Ratings (XADM), explained earlier in section 3.8. Check that the ratings are complete. A few may be predetermined by your site (e.g., MOA, LNG, and LOC).

Note that MOA (mode of administration), OPB (observed participant behaviors), and PRI
(private environment) are the only items that can have more than one yes rating. As you
listen to the audio-recorded assessment, you will get a better idea about the accuracy of
the more qualitative ratings and whether there should be any additional comments noted in
item XADMj. As noted earlier, XADMh1 and its subitems are filled out only when an
administration takes place over more than one day.

- **Documentation of participant responses** – As you listen to the audio recording and go
through the hard copy of the assessment, check the following points:
  a) All items administered are documented correctly. Any miscodes should be corrected
     on the hard copy and in the database.
  b) “DK” and “RF” are used correctly (covered earlier in section 3.1).
  c) All responses are legible.
  d) Errors are documented appropriately: the wrong answer is crossed out, the correct
     answer is recorded, and the initials of the person making the change and the date of
     the change are recorded.

**Instructions** – the explanations, directions, and transitional statements provided to the
participant.

- **Introduction (purpose, format, length, privacy, confidentiality)** – Check that all parts
  (purpose, content, time, breaks, confidentiality) are clearly and completely presented.
  Paraphrasing in this section is okay as long as all parts are covered. (Paraphrasing
  directions can be fashioned to fit specific populations. See attachment 4-2 for an example
  appropriate for adolescents.)

- **Administration of Check for Cognitive Impairment** – Check that this is administered
  clearly and correctly.

- **Establishing time frames and anchors (main time frames and S2x)** – Check that this
  material is presented clearly. The interviewer should try to anchor the timeline with
  positive or neutral events.

- **Additional instructions for oral administration** – For oral administration, check that all
  parts are clearly and completely presented. Paraphrasing in this section is okay as long as
  all parts are covered. (See attachment 4-2 for an example that includes all required parts.)
  For self-administration check that all parts (types of questions, instructions with examples,
  documenting DK and RF, asking questions, break, any questions) are clearly and
  completely presented.

- **Reading scales and transitional statements** – Each major section of the GAIN starts
  with a brief explanation of that section and presents delimiting or defining information
  (e.g., defining the word “significant” at the beginning of the Mental Health section,
  distinguishing the participant between treatment for drug and alcohol use (S4-S7), health
  problems (P11), and psychological problems (M5)). Interviewers should include these
  statements during administration.

- **Using the cards and defining response choices** – Prior to starting a particular series of
  questions, the interviewer should introduce and define the response choices available,
using the appropriate card if there is one. For yes/no items the interviewer should simply ask the participant to answer yes or no.

- **Responding to participant questions about instructions** – Sometimes participants may not understand the instructions or introductory comments for a scale (e.g., they may constantly ask for repetition of instructions). Examples and definitions offered should be accurate and nonleading, and interviewers should remain patient while reexplaining material.

**Items** – the delivery and clarification of the items on the assessment.

- **Accurate following of item order and skips** – Check that items are delivered in the same order as on the assessment and all skips are followed correctly.

- **Accurate grid administration** – Comments about the interviewer’s administration and scoring of the grids are written up under this heading. Check to see that all required items were administered and that no required items were skipped. Make sure that the S2 and (if administered) S2x and S7 grids were administered correctly. Make sure that the interviewer administered only required items and substances in the S9 grid.

- **Accurate following of word order** – It is very easy to change the meaning of an item when the wording is changed. Minor changes in wording can be okay as long as they don’t change the meaning of an item; however, this is a slippery slope, and it is strongly suggested that items are read as written (with appropriate clarification if needed).

- **Appropriate use of stems and anchors** – Items often are introduced with a stem or time frame. Periodically, the interviewer should repeat the time frames, especially when a long list of subitems is included in the scale (e.g., M2, M3a, M4, L3a). In addition, periodic anchoring of the time frames using the personal events noted in the timeline should be offered.

- **Appropriate use of parenthetical statements** – Words in parentheses are optional, elaborative phrases that do not have to be read unless necessary, such as, for S2n, if the participant needs examples of substances that act as an antianxiety drug or a tranquilizer.

- **Clarification of participant responses for coding** – Sometimes participants will offer a response that is outside the set of defined response choices. Running through the available response choices, as mentioned previously, is one way to address this situation. Sometimes, though, further clarification of a response is necessary. For example, in response to a yes/no item, the participant may respond, “sometimes.” In these situations, it’s important that the interviewer clarifies the response with the participant without offering an answer. Saying “Would that be ‘yes’ or ‘no’?” or “So should I put ‘yes’ or ‘no’?” are two possible ways for the interviewer to respond.

Note that the interviewer is clarifying by offering both options (yes or no) rather than only one. It would not be appropriate to offer to the participant “So do you want to go with ‘yes’?” or to assume that the participant meant “yes” and circle that without asking for clarification. The responses need to come from the participant, not the interviewer. As a
second example, for items that make use of response cards, if the participant offers a response that is not one of the available responses on the card, clarify rather than assume: “So using this card, what would your answer be?” It typically only takes a few requests for clarification until the participant routinely responds within the set of available answers. As a third example, suppose in response to the item “During the past 90 days, on how many days did you…” the participant says “about half the days.” If the interviewer responds with “45 days?” then they are asking for clarification, but their clarification also falls on the line of suggesting an answer. Better clarifying responses would be “So how many days would that be?” or “So how many days should I put?” If options are presented, present several rather than focusing on only one (“So would that be 30 days, 40 days, 50 days? More or less? What would you like me to put?”) As a final example, when giving qualitative, open-ended answers, sometimes participants will offer sketchy responses. The interviewer should follow up with the participant, clarifying questions in order to get a response that clearly answers the question. The interviewer may understand what the participant meant, but someone else coming along to code qualitative answers may have no idea what was meant if only a few cryptic notes that don’t appear to answer the question are recorded.

• **Responding to participant questions about items** – As with the directions, sometimes participants do not understand the meaning of a word in an item or the meaning of an item altogether. In these situations, the interviewer should offer clear, accurate definitions or examples that do not lead the participant to answer in a particular way.

• **Resolving inconsistencies** – Sometimes participants will respond inconsistently to related items, such as answering that the last time they used alcohol was 4-12 months ago (S2a), but then later saying that they used alcohol 30 of the past 90 days (S2a1). Inconsistencies such as these should be questioned in a nonconfrontational way. In addition, apparent inattentiveness or misunderstandings should be checked out with the participant and clarified if needed.

**Engagement** – the quality of the interaction between the interviewer and the participant.

• **Flow of the interview** – This feature has to do with pacing. Is the interaction choppy or paced too fast for the participant? Or does it flow smoothly at an appropriate pace?

• **Appropriate voice articulation and inflection** – Pronunciation of words should be clear and appropriately paced. In addition, inflection of words and phrases is necessary as it adds meaning and helps with understanding, possibly positively influencing validity. Monotonic delivery is not appropriate.

• **Use of encouraging or motivational statements** – The GAIN-I is a long assessment. It’s not unusual for participants to show behavioral signs of fatigue (yawning, fidgeting, sighing, decreased voice tone, etc.) It helps when the interviewer offers encouragement or checks in with the participant.

• **Sensitivity to participant needs** – This is related to the above. How well does the interviewer appear to “read” and respond to the participant’s needs? Interviewers should periodically check in with the participant. Participants may need breaks for the bathroom,
for snacks, to shoot a few hoops, etc. These should be offered when they are clearly called for. (In addition, if the interviewer becomes fatigued, a break may be needed.)

- **Rapport** – How comfortably do the interviewer and participant appear to interact with each other?

## 4.4 How do you rate the quality of the four major A-QA sections of the GAIN?

At the end of each of the four main sections of the feedback form, a four-point rating scale (excellent, sufficient, minor problems, problems) is defined to help assign a summary rating of the quality of the administration in that section. The rating categories are qualitative in nature, so assigning a rating ultimately boils down to the informed judgment of the A-QA reviewer. Use the definitions of the rating categories in exhibit 4-1 to help assign summary ratings.

In general, problems are training issues, such as when an interviewer doesn’t know how to correctly complete the S9 grid (Detailed Substance Use Disorder Worksheet) on the GAIN-I. Minor problems are small technical errors that are easily cleared up with an interviewer, such as when an interviewer skips or changes a few words or does not explain the response choices to the participant. Sufficient means the delivery is accurate and clear, nothing is technically in error, and validity is not harmed. Excellent means going above and beyond, such as when an interviewer personalizes the delivery of items based on information she has learned about the participant, uses the personal anchors often to define the time frames, or provides documentation for the researchers or therapists to help them understand the participant’s answers or anything unusual about the assessment session.

**What does it take to be certified in GAIN administration?** In order to be certified, an interviewer should attain a rating of sufficient or better in all four rated sections of the feedback form. This *usually* happens within four submissions to the GCC.

### Exhibit 4-1. Rating Scales for Quality Assurance Reviews

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Summary rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excellent:</strong></td>
<td>Use of legible selective notes to facilitate later review by clinicians or researchers</td>
</tr>
<tr>
<td><strong>Sufficient:</strong></td>
<td>Everything is completed accurately and clearly</td>
</tr>
<tr>
<td><strong>Minor problems:</strong></td>
<td>Some missing or incorrect items or minor problems in documentation</td>
</tr>
<tr>
<td><strong>Problems:</strong></td>
<td>Major sections not done or not done correctly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instructions</th>
<th>Summary rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excellent:</strong></td>
<td>Interviewer’s instructions are individualized and used to better engage the participant, particularly on anchoring events in time</td>
</tr>
<tr>
<td><strong>Sufficient:</strong></td>
<td>Everything is completed and instructions are not incorrect</td>
</tr>
<tr>
<td><strong>Minor problems:</strong></td>
<td>Some missing or incorrect items or minor problems in instructions</td>
</tr>
</tbody>
</table>
Problems: Major sections not done or not done correctly

Items
Summary rating
Excellent: Interviewer appropriately repeats items and time frames, defines terms, or does other things to increase the validity of the responses
Sufficient: Absence of problems impacting validity
Minor problems: Some changes in meaning, missing words, or changes in time frames
Problems: Repeated difficulties that introduce missing data or problems with validity

Engagement
Summary rating
Excellent: Interviewer engages participant and manages well, thereby increasing validity and making it less burdensome on the participant
Sufficient: Nonproblematic, acceptable rapport; good reading ability
Minor problems: Ignoring inattentiveness, misunderstandings, or inconsistencies; not offering encouragement where needed; reads too fast or too slow
Problems: Arguing with participant, ignoring participant’s questions or emotional state

How do you balance an overall great performance against a very few minor errors?
Sometimes an interviewer will do a fantastic job with an assessment, but technically there will be a few minor errors (e.g., skipped a few administration ratings, changed a few words on the items that didn’t seriously affect meaning, forgot to define response choices once). It seems senseless to have the interviewer and A-QA reviewer go through another round of A-QA just for a few things that may be easily remedied. If this happens, point out the few minor errors to the interviewer and provide additional clarification. As the A-QA reviewer, you may wish to check only those items on the next assessment hard copy, or review the next audio-recorded submission (or conduct another observation) listening mainly for those aspects that need to be remedied.

What’s the bottom line? Given the qualitative nature of the ratings, it helps to have a bottom line. A helpful guideline is this: Do you believe that the quality of the interviewer’s administration maintains or adds to the validity of the data?

4.5 How do you prepare A-QA feedback?

Regardless of the form of feedback (oral or written), the A-QA criteria and feedback form should be used to guide and document interviewers’ feedback. If feedback is written, a Microsoft Word version of the feedback form is available. This allows the A-QA reviewer to type in feedback under each section.
Steps for completing the feedback form

1) Complete the Identifiers section at the top of the form. Even if feedback is oral, this should be completed in writing because it documents the feedback session.
2) Complete the four main sections. To guide oral feedback, the A-QA reviewer should write brief notes under the appropriate sections of the feedback form. These notes can be completed during the observed assessment or during an audio review.
3) Add any additional comments in the “Other” section. This is a good place for feedback that doesn’t seem to fit anywhere else, for overall comments, or for a brief summary of things needing improvement in order to reach certification.
4) Provide an overall rating on certification status.

Guidelines for preparing feedback

- **Feedback details aspects of the interview done well and aspects that need improvement.** It’s important to give a balanced assessment of the interview, reinforcing those things that are done well and offering examples and options for those things that need work.
- **Feedback should be specific and behavioral.** Describe what happened (or needs to happen next time) in behavioral terms, including quoting actual dialogue. If improvement is needed, provide examples of how the situation could be handled. If the interviewer did a good job with something, describe how or why it was good. Just saying “great job” or “needs work” throughout the feedback does not provide the interviewer with useful information.

Sample completed feedback forms. Three sample completed feedback forms are provided to illustrate the kind of feedback given for a variety of skill levels.

- The first example (Amy Zing) is from an assessment whose interviewer needs more training (attachment 4-3).
- The second example (Cookie Doe) is from an assessment with a number of specific, easily remedied technical problems (attachment 4-4).
- The third example (Val Idity) is from an assessment that earned the interviewer his GAIN Administrator certification (attachment 4-5).

4.6 What are some common A-QA problems on the GAIN?

The most common errors in GAIN administration are listed in exhibit 4-2.

Exhibit 4-2. Common Errors in GAIN Administration and Documentation

1) Documentation
   a) Not completing the edit staff ID or edit date
   b) UR and DM ratings rated NO or NONE even though the participant reports problems or misunderstands items
   c) Miscodes—e.g., the participant answers “3” but the interviewer circles “2”
   d) Not documenting errors or changes in responses
2) Instructions
   a) Parts of the introduction, general directions, or additional instructions for oral/self-administration are omitted
   b) Using a negative event to anchor time frames
   c) Paraphrasing of directions that is awkward or incomplete
   d) Response choices are not defined for the participant

3) Items
   a) A skip is not followed
   b) Words in items are changed, omitted, or added such that the meaning of the item is changed
   c) Stems and time frames are not periodically repeated for longer items
   d) Unnecessary parenthetical phrases are read
   e) Failure of the interviewer to clarify ambiguous responses
   f) Leading or offering responses to the participant
   g) Not pointing out obvious or temporal inconsistencies

4) Engagement
   a) Pacing the interview too fast (and talking too fast)
   b) Failing to offer breaks or encouragement when they are clearly needed

Frequently Asked Questions. Important supplementary information on many GAIN items is located in the Frequently Asked Questions (FAQ) appendix in the GAIN manual. This document lists questions and answers about GAIN administration that have come up over time. The document is updated periodically and is also available at http://www.chestnut.org/LI/gain/index.html#Administration%20Manual.

4.8 Practice Session

As part of quality assurance training, we suggest listening to an audio-recorded example of a GAIN-I administration (either a full assessment or just a few sections), stopping every few pages to share comments on both things done well and things needing additional work. As part of Chestnut training, your site will be given a sample case to use. Or you could use a recording that your site makes for training purposes. For confidentiality reasons the audio recording and assessment you receive in training is not a real interchange, but a scripted one. However, it was written based on actual GAIN administrations. When listening to the taped example, consider the following questions:

1. What does the interviewer do well?
2. What does the interviewer need to work on?
3. Using the A-QA criteria as a guideline, what feedback would you give the interviewer? (Remember to keep it balanced.)
4. How would you rate the four main sections of the feedback form for this interviewer?
5. Should this interviewer be given certification based on this interview?
4.9 Attachments Referenced in the A-QA Chapter

Attachment 4-1  GAIN Administration Quality Assurance Feedback Form
Attachment 4-2  Introducing the GAIN-I to Adolescents – Oral Administration
Attachment 4-3  GAIN Administration Quality Assurance Feedback – Justin Case
Attachment 4-4  GAIN Administration Quality Assurance Feedback – Cookie Doe
Attachment 4-5  GAIN Administration Quality Assurance Feedback – Joe Oak
Attachment 4-6  Top Ten Inconsistencies on the GAIN-I
Attachment 4-7  GAIN Administration Quality Assurance Feedback Form Training Guide
Attachment 4-8  GAIN submission form
GAIN Administration Quality Assurance
Feedback Form

Identifiers

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<th>Reviewer site:</th>
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<td>Reviewer name:</td>
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Documentation

- Cover page and staff use box on page 2
- Documentation and scoring of Check for Cognitive Impairment
- Documentation of anchors, literacy questions, and initial administration decision
- Time to complete
- Urgency and Denial-Misrepresentation ratings
- Administration ratings
- Documentation of participant responses

Summary rating:

Instructions

- Introduction (purpose, format, length, privacy, confidentiality)
- Administration of Check for Cognitive Impairment
- Establishing time frames and anchors (main time frames and S2x)
- Additional instructions for oral administration
- Reading scales and transitional statements
- Using the cards and defining response choices
- Responding to participant questions about instructions

Summary rating:

Items

- Accurate following of item order and skips
- Accurate grid administration
- Accurate following of word order
- Appropriate use of stems and anchors
- Appropriate use of parenthetical statements
- Clarification of participant responses for coding
- Responding to participant questions about items
- Resolving inconsistencies

Summary rating:
Engagement

- Flow of the interview –
- Appropriate voice articulation and inflection –
- Use of encouraging or motivational statements –
- Sensitivity to participant needs –
- Rapport –

Summary rating:

Other

Certification status:

Pending: Any below sufficient
Certified: All sufficient or above on same interview
Attachment 4-2
Introducing the GAIN-I to Adolescents – Oral Adminstration

I) Introduction

1) **Purpose – Why are we doing the questionnaire?**
   “I’ll be spending the next couple hours with you to complete the first part of your
treatment or counseling. The first part of treatment and counseling is the data-gathering
phase. This is the part where we interview you to collect information about you, your
family, your substance use, and any problems you may be having. This information will be
used to help plan your treatment or counseling and also to evaluate our program.”

2) **Content – What is the questionnaire about?**
   “The questionnaire we’re going to work on is called the GAIN-I. It is designed to help us
track how you are doing before, during, and after treatment or counseling. It has questions
about you and your experiences, what services you may be using, and what you currently
want to get from treatment or counseling. You will be able to to say that you don’t know
or refuse to answer any question that you don’t want to answer.”

3) **Time – How long will it take to complete? Breaks – Can I take a break if needed?**
   “Depending on how much has been going on in your life, it will take about 1 to 2 hours to
complete. If you need a break at any time, just let me know.”

4) **Confidentiality**
   “Before we start, there are a few important things I want to tell you. First, everything you
tell me today is confidential. Do you know what ‘confidential’ means? (It means it’s
private.) All treatment and counseling staff members who will work with you and have
access to your information understand that it is confidential and have agreed to not share
your information. For instance, people like your mom, your dad, your teachers, and your
probation officer will not be told your answers without your prior written permission. The
confidentiality of your answers are protected by law. However, there are two exceptions:
we are required by law to report any instances of child abuse or situations in which you
are presently a danger to yourself or others. Also, officials from the federal government
have the right to audit our program to check that we have protected the confidentiality of
your answers.”

II) **Check for Cognitive Impairment**
   “I’ll be asking you lots of questions about when and how often things have happened to
you. So before I do that, I need to get a sense of how well your memory is working right
now.” [Go through items word-for-word and document score].

III) **Anchors**

1) **Timeline**
   “Third, some of the questions ask about things that have happened during the past year or
the past 90 days. To help you remember these time periods, please look at the calendar”
[give calendar to participant].

   a) **Today’s date**
“First, find today’s date and circle it.”

b) Anchor 90 days ago
“Next, count back 13 weeks to about 90 days ago and circle that date. Can you remember anything that was going on then? (Try to identify a positive personal anchor and write it on the instrument and calendar.) When we talk about things that happened to you during the past 90 days, we are talking about things since [anchor].”

c) Anchor one year ago
“Now, go back to a year ago and circle that date. Can you remember anything that was going on then? (Try to identify a positive personal anchor and write it on the instrument and calendar.) When I ask about things that have happened to you during the past year, I mean since [anchor]. Please keep this calendar handy to refer to as we go through the questionnaire to help you remember when different things happened.”

2) Literacy and initial administration questions
[These items are read as on the assessment.]

3) Additional instructions for oral administration
a) How we will proceed and record answers
“Here’s how we will proceed: I will read the items to you and record your answers right here on the questionnaire, by either circling an answer or filling in a box.”

b) Try to answer all, even if you have to guess.
“I am going to encourage you to answer all the items, and sometimes if you’re not sure of the answer, I’ll encourage you to take your best guess.”

c) It’s okay to say “I don’t know.”
“But if you really don’t know an answer, it’s okay to say ‘I don’t know.’”

d) You are free to refuse.
“And if there are some questions you don’t want to answer, you are free to refuse, although I will encourage you to try to answer all of them.”

e) Using the cards
“To answer some of the questions, you will need to consult a card. For instance, on this questionnaire we’re going to do, there are three cards (get sheet with cards): card A, card B, and card C. When we get to items that will need a card, I will let you know.”

f) Give the adolescent an opportunity to ask any questions.
“Before we start, do you have any questions?”
Attachment 4-3
GAIN Administration Quality Assurance
Feedback Form – Amy Zing (requires additional training)

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<td>Date of assessment (XOBSDT):</td>
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<td>559933</td>
<td>Assessment:</td>
<td>GAIN-I Full 5.6.0</td>
</tr>
</tbody>
</table>

**Documentation**
- Cover page and staff use box on page 2 –
  - The required fields were documented correctly. Great job!
  - The participant’s last name was left on the cover of the assessment. The interviewer should remove all personal information (e.g., last names, driver’s license number, etc.) from the assessment before submitting it for QA review.
- Documentation and scoring of Check for Cognitive Impairment –
  - The Check for Cognitive Impairment on page 3 was correctly scored and documented, with one exception:
    - The interviewer did not code an error score for A1a on page 2, but should have coded a score of “0” for no error.
    - For item A2f on page 3, the interviewer coded both “2” and “4,” but should have only coded “4” for this item.
- Documentation of anchors, literacy questions, and initial administration decision –
  - The 90-day and 12-month anchors were documented correctly. Good!
  - The literacy and initial administration questions on page 5 were documented correctly.
- Time to complete –
  - The time to complete could not be determined because the interviewer did not note the start and stop times of all of the breaks. The start and stop times of all breaks (noted in the margin where the break takes place) must be documented.
  - The start time (A1a on page 2) was documented correctly. Good!
  - The end time (Z1-Z1d on page 105) was not documented correctly. This page should be completed for the first day of the interview. The end time for the first day (Z1), total breaks from the first day (Z1c) and the total time to complete (Z1d) for the first day of administration should be recorded on page 105.
- Urgency and Denial-Misrepresentation ratings –
  - All of the Ratings appear to be correctly documented, with the following exceptions:
    - The Urgency ratings for the Background and Treatment Arrangements (page 12), Substance Use (page 40), and Environmental and Living Situation (page 84) sections were documented as “NOW.” However, since the participant did report needing help with some issues, but did not seem to have any emergency situations, a rating of “0-3 MON” would have been more appropriate for these sections. A code of NOW
indicates a life-threatening, emergency situation, such as coughing up blood, suicidal with plan, or another situation that would require immediate assistance.

- The Denial-Misrepresentation ratings for the Background and Treatment Arrangements (page 12) and Mental and Emotional Health (page 69) sections were documented as “MISUNDER.” However, since the participant did do some guessing and estimating in these sections, but did not show pervasive misunderstanding of items in these sections, a rating of “SOME” would have been more appropriate. A rating of “MISUNDER” applies when the participant consistently has trouble understanding items even after additional clarification is given.

- The Denial-Misrepresentation rating for the Substance Use (page 40) and Physical Health (page 50) sections was documented as “NONE,” but a rating of “SOME” would be more appropriate since the participant did some guessing and estimating in these sections.

- The Urgency rating for the Risk Behaviors and Disease Prevention section (page 58) was documented as “ALREADY,” but a rating of “0-3 MON” would have been more appropriate since the participant did not report receiving help in this area of his life.

- The Urgency rating for the Mental and Emotional Health section (page 69) was documented as “NOW,” but a rating of “ALREADY” would have been more appropriate since the participant reported that he was on medication and seeing a health professional for his mental health issues.

- **Administration ratings** –
  - The Administration Ratings were correctly completed, **with the following exceptions:**
    - Item XADMa2a on page 106 (What was the mode of administration? Done with Pen and paper) was documented as “No,” but should have been “Yes.”
    - Item XADMj on page 108 was not completed, but should have been. If the interviewer does not have any additional comments, “No” or “None” can be documented for this item.

- **Documentation of participant responses** –
  - The interviewer did a good job of legibly documenting the participant’s responses throughout the assessment.
  - Throughout the assessment, the interviewer did a very nice job of remembering to code all of the responses (both “Yes” and “No”) on MENTIONED items.
  - The interviewer did a great job documenting “3A/Marijuana” for items S1a and S1b on page 13. Great!
  - The interviewer did a great job documenting the participant’s verbatim responses throughout the interview. Nice!

- **Some items were not documented or not correctly documented.**
  - For item S4 on page 22 (Before today, have you ever had a breathalyzer or urine test…), the participant said, “Yes” but the interviewer documented, “No.”
  - For items S9h and S9k on page 38, the participant responded, “1+ years ago” but the interviewer coded “2-12 months ago.”
  - For item M5a on page 67, the interviewer coded, “0/Any condition reported” and “2/Attention-deficit/hyperactivity disorder” but should not have since the participant did not report any condition for this item.
• For item E1 on page 70, the interviewer documented “1/A house, apartment or room you, your spouse…rent or own” and “4/A friend or relative’s house, apartment or room”, but should have only coded “4/A friend or relative’s house, apartment or room” since the participant reported living at his cousin’s house. Additionally, only one response should be coded for this item.

• For items E3a2-99 on page 72, the interviewer coded, “8/Other relatives,” “10/Other children over the age of 12” and “99/Other” and recorded the participant’s verbatim response but should have only coded “8/Other relatives” and “10/Other children over the age of 12”.

• Item E3b2 on page 72 (What is your current marital status?) was not coded, but should have been coded as “8/Never married and not living as married” on the interviewer’s own.

• The changes to items E5 on page 76 and E12a10 on page 81 were not documented correctly. The interviewer should cross out the original response, document the new response (in the margin if necessary), and initial and date the change the date it was made.

• For item L5a on page 88, the participant said that he had been arrested for “Theft and running away” and the interviewer coded “99/Status or other offenses” and documented “theft and running away” on the verbatim line. However, the interviewer should have coded “5/Larceny or theft” for theft and documented “Running away” on the verbatim line for L5a99.

Summary rating: Problems

Instructions

• Introduction (purpose, format, length, privacy, confidentiality) –
  • All parts of the Introduction on page 2 were covered.
  • Note: The interviewer does not need to read the bolded items (e.g. Purpose, Format) in the introduction on page 2.

• Administration of Check for Cognitive Impairment –
  • The Check for Cognitive Impairment on page 3 was properly administered. Great!

• Establishing time frames and anchors (main time frames and S2x) –
  • The interviewer did a great job of probing for the participant’s 90-day and 12-month anchors, with the following exceptions:
    • For the 90-day anchor, the anchor date was May 7, 2008 and the anchor event that was used was, “My big brother’s birthday.” However, the participant said that his brother’s birthday was on May 12th. For the 90-day anchor, the interviewer should make sure that the anchor event occurs within two days of the anchor date. It would have been appropriate to suggest “5 days before my big brother’s birthday” be used for the anchor.
    • The interviewer did not read the statements, “When we talk about things happening to you during “the past 90 days/past 12 month,” we are talking about things that happened since about…” to the participant. These statements should be read to the participant after determining each anchor event.
• For the 12-month anchor, the participant said that he had gone “rafting with his uncle sometime around then.” The interviewer should have probed to determine when the participant went on the rafting trip to determine whether the event would be appropriate to use for the 12-month anchor. **Note:** The 12-month anchor event should occur within 7 days of the anchor date.

• **Additional instructions for oral administration** –
  - The Additional Instructions for Oral Administration on page 5 were read to the participant.

• **Reading scales and transitional statements** –
  - Scales and transitional statements were introduced for the participant, **with the following exceptions:**
    - The transitional statement above item M1j on page 61 (The next questions are about whether and how these problems have interacted with your drug and alcohol use) was not read to the participant but should have been.
    - The scale before item M3a on page 63 (Please answer the next questions using yes or no) was not read to the participant but should have been.

• **Using the cards and defining response choices** –
  - The interviewer did a good job of using the cards and defining the response choices throughout the interview, **with one exception:**
    - For item E7 on page 77, the interviewer did not limit the response choices, but should have since the participant reported regularly socializing with 1 person. **Note:** For items E5-E7 on pages 76-77, if the participant reports 1 person, the response choices should be limited to “None” and “All”; for 2 people, it should be “None,” “Some,” and “All”; for 3 or more people reported, all response choices should be left available.

• **Responding to participant questions about instructions** –
  - For item L3 on page 85 (When was the last time you did anything you thought might get you in trouble or be against the law besides using alcohol or other drugs?) the participant asked, “Are you going to tell my probation officer?” The interviewer said, “No, everything is 100% confidential.” However, the interviewer should have reminded the participant of the exceptions to confidentiality as explained in the Introduction.

**Summary rating: Minor Problems**

**Items**

• **Accurate following of item order and skips** –
  - The interviewer did a good job following the skip instructions [IF MALE, CIRCLE 0 IN P10u1 AND GO TO P11] at the top of page 47. Nice!
  - The interviewer did a great job following the skip instructions before item L2 on page 85 (Circle 0 if never married and no children).
  - The interviewer did a good job following the skip instructions at the top of page 96 [IF UNDER 17, CIRCLE 0 AND GO TO V5].
  - **Some skips were not followed; therefore, unnecessary items were administered.**
• The skip instruction following item S3a on page 21 [IF NO PAST WEEK USE, CODE NO] was not followed; therefore, item S3b on page 21 was administered unnecessarily.
• The skip instructions following item S9b1 on page 35 [GO TO S9c] were not followed; therefore, item S9b2 on page 35 was administered unnecessarily.
• Items P11f, P11g, and P11h on page 48 were administered but should not have been since the participant reported no lifetime service use in items P11a-c.
• Items M5f and M5g on page 68 were administered but should not have been since the participant reported no lifetime service use in items M5b and M5c.
• The skip instructions above item L7a on page 92 [Record 0 if no prior arrests] were not followed; therefore, item L7a on page 92 was administered but should not have been.
• **Some items were not administered but should have been.**
  • Item A4c on page 7 (What is this person’s relationship to you?) was not administered but should have been.
  • Item B5a on page 10 (What is the name of your insurance company or provider?) was not administered but should have been.
  • Item B5b on page 10 (Is your insurance publicly funded, privately funded, or mixed?) was not administered but should have been.
• **Accurate grid administration** –
  • The interviewer did a good job of administering the S2 grid on pages 15-17.
  • The S9 grid on p. 38 was administered correctly, **with the following exception:**
    • The interviewer asked, “Can you tell me when marijuana…” for each item, instead of asking, “Can you tell me which substance….?” The interviewer should ask each item as an open-ended question, and allow the participant to name which substances caused which problems.
• The interviewer administered the Pre-Controlled-Environment Use grid on page 20 but should not have since the participant reported 10 days for item S2x on page 19. **Note:** skip instructions for this item read: [IF 0-12, GO TO S3a]. Therefore, the grid should only be administered if the participant reports 13 or more days in a controlled environment for item S2x.
• **Accurate following of word order** –
  • The interviewer did a good job of following the word order throughout the assessment, **with the following exceptions:**
    • For item S2c2 on page 16, the interviewer asked, “What was the most you had in one day” but should have asked, “What was the most joints you had in one day?”
    • For item S9r on page 38, the interviewer said, “you were able to cut down on…” but should have said, “you were unable to cut down on…”
    • For item P3d on page 41, the interviewer said, “lost or gained 10 or more pounds when you were trying not to,” but should have said, “lost or gained 10 or more pounds when you were not trying to.”
    • For the instructions at the top of page 51, the interviewer said, “Do not include shots given by a doctor or nurse. Do not include if you were injected by…” but should have
said, “Do not include shots given by a doctor or nurse, but do include if you were injected by…”

- **Appropriate use of stems and anchors** –
  - The interviewer rarely referred to the participant’s personal anchors throughout the assessment.
  - Both anchors should be used early in the interview, throughout the early sections of the interview, and then periodically during the rest of it or whenever the interviewer feels that the participant needs reminding of the time frames.
  - The interviewer did a nice job of repeating the stems on long lists of items.

- **Appropriate use of parenthetical statements** –
  - Parenthetical material was used appropriately throughout the assessment. Great job!

- **Clarification of participant responses for coding** –
  - **Some of the participant's responses were clarified very efficiently.**
    - For item B2b on page 8, the participant said that his grandparents had legal custody of him and the interviewer clarified by asking, “Do they have legal custody or are you just staying with them?” Great job!
    - For item S1b on page 13, the participant said that he most needed treatment for “Drugs” and the interviewer asked, “Which ones?” Great!
    - For item S6b on page 24 (Have you ever stayed overnight in a recovery home or sanctuary?), the participant asked if jail would count and the interviewer clarified that jail would not be included for this item. Nice work!
    - For item P10 on page 45, the participant said that he did not need any medical attention to attend treatment and the interviewer asked if he needed treatment for his knee disorder.
    - For item P10s on page 46 (any other major medical problems or conditions other than those just mentioned?), the participant asked if “Bipolar” would count and the interviewer said, “No, this is more for your health in general.”
    - For item R1 on page 51 (When was the last time, if ever, that you used a needle to inject…), the participant asked if he should include a shot given by a doctor and the interviewer said, “Do not include shots given by a doctor or nurse.” Great!
    - For item V5 on page 96 (…how many times have you applied for a job?), the participant said, “5 or 6” and the interviewer asked, “How many times do you want me to put?” Nice!
  - **Some responses could have been clarified more efficiently.**
    - The interviewer did a very nice job of asking “Any others?” or “Anyone else?” after items that required it, such as MENTIONED items, verbatim items, E12b on page 81 (What do you consider to be your most important strengths as a person?) and E12d on page 81 (Which people, agencies, or things do you consider to be your most important sources of social support?), etc. Good work!
    - For some numerical responses, the participant said, “probably”, “like”, or “about”. The interviewer should make sure to clarify these responses by asking, “What number would you like me to put?” to ensure that the most accurate information is being collected.
• For item A4a on page 7, the participant said that he was coming to treatment for “Depression, drugs and alcohol, and getting my life together.” However, the interviewer should have clarified that this question is asking for the participant’s main reason for coming to treatment, and that only one response should be recorded.

• For item A4a on page 7, the interviewer coded the participant’s main reason for coming to treatment as “7/Pressure from criminal justice system.” However, the participant had said that he was coming to treatment for “Depression, drugs and alcohol, and getting my life together.” The interviewer should have clarified this item and coded a more appropriate response (e.g., “3/General personal motive”, “4/Health reasons”, etc).

• For item S2j on page 15 (painkillers, opiates, or other analgesics), the participant said, “No” and the interviewer asked, “Never?” but should have clarified by saying something like, “So using Card A, what would that be?”

• For item S2c5 on page 17, the participant said that he had used marijuana “Almost 2 months ago” and the interviewer said, “So around June 6th?” but should have let the participant determine the date.

• For item S7 on page 26 (How many times in your life have you been admitted to treatment...), the participant said, “I haven’t. Never” and the interviewer recorded, “00.” The interviewer should have clarified by asking for a number of days.

• For item P11d on page 47, the participant said that he was taking “Concerta”. The interviewer should have clarified that this question was asking if the participant was taking medication for physical health problems and that he should not include medication taken for mental health for this item.

• For item R4 on page 56 (When was the last time you smoked or used any kind of tobacco?), the participant said, “A year ago” and the interviewer said, “Okay, so 4-12 months ago?” However, the interviewer should have clarified by saying something like, “Using Card A, what would that be?”

• For item M1a1 on page 59 (headaches, faintness, dizziness, tingling, numbness, sweating, or hot or cold spells?), the participant asked what ‘significant’ meant and the interviewer said, “When you have it for two weeks,” but should have read the entire definition to the participant.

• For item M5a on page 67 (Has a doctor, nurse, or counselor ever told you that you have a mental, emotional, or psychological problem...), the participant said, “I think so, I take medicine to help me settle down” and the interviewer coded “2/Attention-deficit/hyperactivity disorder.” The interviewer should have clarified by asking if the participant had ever been told that he had a certain problem or condition and coded the condition accordingly.

• For item V7 on page 99, the participant said, “I don’t work” and the interviewer coded “6/Unemployed or laid off and not looking for work.” The interviewer should have clarified by asking the participant if he was still in school, on summer break, or in some other situation.

• Responding to participant questions about items –
  • There were no questions about items during the interview.

• Resolving inconsistencies –
  • Some inconsistencies or misunderstandings were caught and clarified efficiently.
• There was an inconsistency between items E9d on page 78 and E9t on page 79. On page 78, the participant said that he had been abused emotionally, but on page 79 said that he had never been attacked with a weapon, beaten, sexually abused, or emotionally abused. The interviewer pointed out that this item would include emotional abuse and the participant gave a more consistent response of “3-7 days ago” for item E9t. Great catch!

• Some inconsistencies or misunderstandings were not caught and clarified.
  • There was an inconsistency between items S2c5 on page 16 and S2s4 on page 18. On page 16, the participant said that he last used marijuana on “June 6th, 2008” but on page 18 said that he had not used any alcohol or other drugs for 76 days in a row in the past 90 days, which was approximately 60 days prior to the interview. The interviewer should have pointed out this inconsistency and re-administered the necessary items.
  • There was an inconsistency between items S9k on page 38 and S9k on page 39. On page 38, the participant said that his substance use had caused him to have repeated problems with the law “2-12 months ago,” but on page 39 said that that had happened “1+ years ago” for both “marijuana and huffing”. The interviewer should have pointed out this inconsistency and re-administered the necessary items.
  • This also happened for items S9n, S9q, S9s, and S9u on page 39.
  • There was an inconsistency between items P11e and P11j1 on page 48. In item P11e, the participant said that he had taken prescribed medication “1-3 months ago,” but in item P11j1 said that he had taken medication for a health problem for 80 of the past 90 days. The interviewer should have pointed out this inconsistency and re-administered the necessary items.
  • There was an inconsistency between item M1e on page 61 and the participant’s responses to items on pages 59 and 60. The participant reported having several significant issues within the past 12 months on pages 59 and 60, but on page 61 said that he had last been significantly disturbed by nerve, mental, or psychological problems “More than 12 months ago.” The interviewer should have pointed out this inconsistency and re-administered the necessary items.
  • There was an inconsistency between items M5d and M5e on page 68. In item M5d, the participant said that he was currently taking medication for mental, emotional, behavioral, or psychological problems, but in item M5e said that the last time he had taken medication for one of these problems was “1-3 months ago.” The interviewer should have pointed out this inconsistency and re-administered the necessary items.
  • There was an inconsistency between items V5a on page 96 and V6 on page 98. On page 96, the participant said that he had no job experience, but said on page 98 that he had worked at a civilian job or was self-employed “1-3 months ago.” The interviewer should have pointed out this inconsistency and re-administered the necessary items.

Summary rating: Problems

Engagement
• Flow of the interview –
  • The pace of the interview was appropriate for this participant.
• **Appropriate voice articulation and inflection** –
  • The interviewer used good voice articulation and inflection. Great!
• **Use of encouraging or motivational statements** –
  • The interviewer didn’t make any explicitly encouraging statements, but rapport was good and the participant seemed motivated to continue the interview without them.
  • Motivational statements like, “You’re doing a great job,” “We just finished that section,” etc. are important to keep the participant involved in the interview and motivated to continue.
• **Sensitivity to participant needs** –
  • The interviewer did a nice job of offering breaks to the participant. Good!
• **Rapport** –
  • The interviewer seemed friendly and approachable.

*Summary rating: Minor Problems*

**Other**

*Certification status: Pending*

  *Pending: Any below sufficient*
  *Certified: All sufficient or above on same interview*
Attachment 4-4
GAIN Administration Quality Assurance
Feedback Form – Cookie Doe (moderate, easily corrected issues)

Identifiers

| Site ID (XSITE): | 999999 | Reviewer site: | 500 |
| Staff name: | Cookie Doe | Reviewer name: | A-QA Team |
| Staff ID (XSID): | 191919 | Reviewer ID: | 1727 |
| Date of assessment (XOBSDT): | 11/08/2004 | Date of review: | 11/20/2004 |
| Participant ID (XPID): | 292929 | Assessment: | GAIN-I Full 5.6 |

**Documentation**

- **Cover page and staff use box on page 2** –
  - All of the required fields were correctly documented.
- **Documentation and scoring of Check for Cognitive Impairment** –
  - Legible, correctly documented, and correctly scored – great job!
- **Documentation of anchors, literacy questions, and initial administration decision** –
  - The anchors for the past 90 days and past 12 months were documented accurately.
  - The literacy questions and initial administration decision were documented correctly.
- **Time to complete** –
  - The time to complete was documented correctly.
  - There was one break taken during the assessment, which was correctly documented with the start and end times. Good work!
- **Urgency and Denial-Misrepresentation ratings** –
  - The Urgency and Denial-Misrepresentation ratings appear to be correctly documented, with the following exception:
    - For the Mental Health section, the interviewer coded an Urgency Rating of GT 3 MON on page 69. However, the participant did not report any problems or any history of mental problems, so a code of NO would be more appropriate. Please go back and change the code on the hard copy and in the database.
- **Administration ratings** –
  - The administration ratings were correctly completed.
- **Documentation of participant responses** –
  - The interviewer did a nice job of legibly documenting all the participant’s responses throughout the assessment.
  - The interviewer did a nice job of correctly documenting any change made to the GAIN by documenting her initials and the date that the change was made – good job!
  - The interviewer did a nice job of not including the participant’s last name on the cover page or the referrer’s last name for item A4b on page 7 (What is the name of the person who referred you to treatment?).
  - The interviewer did a great job of documenting the “no” responses for all Mentioned items. Nice work!
  - **A few items were not documented or not correctly documented.**
• The interviewer documented the participant’s verbatim response of “alcohol” for item S1b on page 13 (Between alcohol, marijuana, cocaine, heroin, and any other drugs, for which ones do you most need treatment?). However, the response was not coded using the detailed drug codes on page 13, but should have been coded as “1.” Please go back and document a code of “1” for this item both on the hard copy and in the database.
• The interviewer did not document the participant’s responses to items E12c7 and E12c8 on page 81. The interviewer should have documented “0/No” for both items. Please go back and make the change on the hard copy and in the database.

Summary rating: Minor problems

Instructions
• Introduction (purpose, format, length, privacy, confidentiality) –
  • All parts of the Introduction were covered.
• Administration of Check for Cognitive Impairment –
  • The Check for Cognitive Impairment was properly administered.
• Establishing time frames and anchors (main time frames and S2x) –
  • The interviewer did a good job of probing for the participant’s 90-day and 12-month anchors.
• Additional instructions for oral administration –
  • The interviewer read the additional instructions for oral administration to the participant. Great job!
• Reading scales and transitional statements –
  • Scales and transitional statements were read to the participant, with the following exceptions:
    • The scale (Please answer the next questions using the number of days) was not read before items B2c-d on page 8 but should have been.
    • The scale (Please answer the next questions using yes or no) was not read before items B9a1-7 on page 12 was not read to the participant but should have been.
• Using the cards and defining response choices –
  • The interviewer did a nice job of using the cards and defining the response choices for the participant, with the following exception:
    • For items E5a-g on page 76, the participant reported living with two people. Therefore the interviewer should have limited the response choices from Card C to “none,” “some,” and “all.”
• Responding to participant questions about instructions –
  • The participant did not ask any questions about instructions during the interview.

Summary rating: Sufficient

Items
• Accurate following of item order and skips –
  • The interviewer did a great job of following skips throughout the assessment.
• **Note:** It was not necessary for the interviewer to administer item P10n on page 46 (Female problems) because the participant was male. However, the interviewer did catch the mistake and apologized. Great catch!

• **Accurate grid administration** –
  - The interviewer correctly administered the S2 grid on pages 15-17.
  - The interviewer correctly administered the S9 grid on pages 38-39, **with the following exception:**
    - The interviewer administered item S9h on page 39, but should not have, since the participant responded “never” for item S9h on page 38.

• **Accurate following of word order** –
  - The interviewer did a nice job of following word order during the interview, **with the following exceptions:**
    - The interviewer omitted the words “to use” when reading item S1a on page 13 (Between alcohol, marijuana, cocaine, heroin, and any other drugs, which do you like to use the most?).
    - For item S9v in the S9 grid on page 39, the interviewer should have asked, “At what age did you first get drunk?” instead of “At what age did you first use alcohol?”
    - The interviewer read “high school” instead of “school” for item V1 on page 94 (What is the last grade or year that you completed in school?).

• **Appropriate use of stems and anchors** –
  - All stems and anchors were used appropriately throughout the assessment. Nice!
  - The interviewer occasionally incorporated the participant’s personal anchors but should have done so more often in order to remind the participant of the referenced time frame. Anchors should be used when switching between 90-day and 12-month time frames, after breaks, and at the beginning of new sections.

• **Appropriate use of parenthetical statements** –
  - Parenthetical material was used when necessary. Nice work!

• **Clarification of participant responses for coding** –
  - **Some items were clarified very efficiently.**
    - The interviewer appropriately asked, “Any others?” in order to clarify Mentioned and other open-ended items. Great job!
    - The interviewer did a nice job of probing for a response to item B2b on page 8 (Who currently has legal custody of you?). The participant initially responded, “my parents.” The interviewer asked whether his parents were living together or separated in order to clarify the response prior to coding.
    - When the participant responded, “5 or 6 beers” for item S2a2 on page 16 (What was the most drinks you had in one day?), the interviewer did a great job of clarifying by asking whether it was 5 or 6 beers, and then asking the participant the size of the beers.
    - For item P11j1 on page 48 (During the past 90 days, how many days did you take prescribed medication for a health problem?), the participant initially responded, “6 or
7.” The interviewer appropriately asked him, “Would you say 6, 7, or some other number?”

- For item V6m on page 98 (During the past 90 days on how many days did you work full time?) the participant said “no.” The interviewer reminded him to respond using a number of days, and then re-administered the item.

- **Some items could have been clarified more efficiently.**
  - For item B3a on page 9 (Which races, ethnicities, nationalities, or tribes best describe you?), the interviewer should have asked “Any others?” to ensure that all of the participant’s information had been collected.
  - For items E12b (What do you consider to be your most important strengths as a person?) and E12d (Which people, agencies, or things do you consider to be your most important sources of social support?) on page 81, the interviewer did not ask “any others?” to clarify the participant’s responses, but should have.
  - For item E1 on page 70 (What kind of housing do you currently live in?), the participant said, “with my parents.” The interviewer then asked, “With your parents in an apartment or house?” and participant responded, “In a house.” The interviewer should have also asked if the house was considered rent subsidized or public housing before coding a response.
  - For items V3p (During the past 90 days, on how many days did you get in trouble at school or training for any reason?) and V3q (During the past 90 days, on how many days were you suspended from school or training for any reason?) on page 95, the participant answered no, and the interviewer coded 0. However, the interviewer should have asked the participant to respond using a number of days before coding a response.

- Responding to participant questions about items –
  - The participant did not have any questions about items during the interview.

- Resolving inconsistencies –
  - **One inconsistency was not caught or clarified:**
    - For item M1e on page 61 (When was the last time your life was significantly disturbed by nerve, mental, or psychological problems or that you felt you could not go on, including those things we just talked about?) the participant said “Never.” However, he had answered yes to items M1b4, M1b6, and M1b7 on page 59, which count for M1e. The interviewer should have pointed out this inconsistency, explained that item M1e is specifically referring to the questions on the previous pages, and asked the item again.

_Summary rating: Minor problems_

**Engagement**

- Flow of the interview –
  - The pace of the interview was appropriate for this participant.

- Appropriate voice articulation and inflection –
  - The interviewer used good voice articulation and inflection.

- Use of encouraging or motivational statements –
• The interviewer did not make any encouraging statements during the assessment, but should have. The interviewer should use statements such as “Thank you for your patience” and “We’re about halfway done” in order to keep the participant motivated to continue.

• **Sensitivity to participant needs** –
  • The interviewer did not offer the participant any breaks during the interview, but should have.

• **Rapport** –
  • Rapport was good.

Summary rating: Minor problems

**Other**

Certification status: Pending
Attachment 4-5
GAIN Administration Quality Assurance
Feedback Form – Val Idity (certified)

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**Documentation**

- **Cover page and staff use box on page 2** –
  - All the required fields were correctly documented.
- **Documentation and scoring of Check for Cognitive Impairment** –
  - Legible and correctly documented and scored.
- **Documentation of anchors, literacy questions, and initial administration decision** –
  - The 90-day and 12-month anchors were accurately documented. Nice job!
  - The literacy questions and initial administration decision were documented correctly.
- **Time to complete** –
  - The time to complete (Z1d on page 105) was accurately calculated.
  - The start and stop times of breaks were documented on the assessment. Excellent!
- **Urgency and Denial-Misrepresentation ratings** –
  - All the ratings appear to be correctly documented.
- **Administration ratings** –
  - All administration ratings appear to be correctly documented.
- **Documentation of participant responses** –
  - The interviewer did a good job of legibly documenting the participant’s responses throughout the assessment.
  - The interviewer did a nice job of coding all responses on Mentioned items throughout the assessment.

- **Some items were not documented or not correctly documented.**
  - For some changes made to the GAIN (e.g., B2b on page 8), the interviewer did not include their initials, but should have.
  - Item V1av1 on page 94 (“What kind of services or program did you go to?” verbatim) did not need to be administered, but the interviewer did a nice job of noting the mistake and documenting that the error was clarified and corrected. Good catch!

**Summary rating: Sufficient**

**Instructions**

- **Introduction (purpose, format, length, privacy, confidentiality)** –
  - The introduction was read in its entirety.
• **Administration of Check for Cognitive Impairment** –
  • The Check for Cognitive Impairment was properly administered.
• **Establishing time frames and anchors (main time frames and S2x)** –
  • The interviewer did a great job of probing for the 90-day and 12-month anchors.
• **Additional instructions for oral administration** –
  • The interviewer read the additional instructions for oral administration.
• **Reading scales and transitional statements** –
  • All scales and transitional statements were read to the participant.
• **Using the cards and defining response choices** –
  • The interviewer did a good job of using the cards and defining the response choices throughout the interview.
• **Responding to participant questions about instructions** –
  • There were no questions about instructions during the interview.

*Summary rating: Sufficient*

**Items**

• **Accurate following of item order and skips** –
  • The interviewer did an excellent job of following item order and skips throughout the interview.
• **Accurate grid administration** –
  • The interviewer correctly administered the S2 grid on pages 15-17. Great!
  • The interviewer did a nice job of administering the S9 grid on pages 38-39.
• **Accurate following of word order** –
  • The interviewer did a fine job of following word order throughout the assessment.
• **Appropriate use of stems and anchors** –
  • Throughout the assessment the interviewer did a nice job of referring to the participant’s personal anchors.
  • The interviewer did a nice job of repeating the stems on long lists of items.
• **Appropriate use of parenthetical statements** –
  • Parenthetical material was used appropriately.
• **Clarification of participant responses for coding** –
  • **The interviewer did a good job of clarifying some of the participant’s responses.**
    • For item S2r on page 15 (When was the last time, if ever, you used any other drug that has not been mentioned?), the participant responded with more than one substance. The interviewer did a great job of asking her which substance she used most recently in order to code the most accurate time frame.
    • For item S4a on page 22 (During the past 90 days, how many times have you been given a breathalyzer or urine test to check for your alcohol or other drug use?), the participant responded, “24 or 25 times.” The interviewer asked, “Would you like me to put 24, 25, or something else?” before documenting a response. Great job!
    • The interviewer did a good job of clarifying the participant’s vague response to item E1 on page 70 (What kind of housing do you currently live in?) by offering her some of the response choices.
• For item V3k on page 95 (During the past 90 days, how many days did you go to any kind of school or training?) the participant said “Probably around 30 days.” The interviewer did a great job of asking, “would you like me to write 30 days or some other number?” before documenting a response. Great!
• The interviewer did a great job of explaining the meaning of item V11r on page 103 (During the past 90 days, about how much did you receive all together from each of the following sources?) by reading the transitional statement a second time.
• Some items could have been clarified more efficiently.
  • For item S7a99 on page 28 (How many of these times were you in any other kind of treatment program or working with some other kind of case manager for your alcohol or other drug use problems?), the participant said that she was attending AA. The interviewer initially wrote down this response but then crossed it out and wrote “0.” The interviewer should have explained that AA (and other self-help programs) would not be included, and then re-administered the item. The interviewer should not change a participant’s response without clarification.
  • After the participant gave one response to item E3a2-99 on page 72 (Who have you lived with?) it would have been a good idea for the interviewer to clarify whether the participant had lived with anyone else by asking, “Any others?”
  • It might have been a good idea for the interviewer to clarify that for item V7 on page 99 (Which of the following statements best describes your present work or school situation?) the participant should choose the situation she engaged in most often. Therefore, it probably would have been more appropriate to code 8 (In school or training) because the participant likely spends more time as school than at her part-time job.

• Responding to participant questions about items –
  • There were no questions about items during the interview.

• Resolving inconsistencies –
  • The interviewer did a nice job of catching and clarifying inconsistencies.
    • For item R2 on page 53 (When was the last time, if ever, that you had any kind of vaginal, oral, or anal sex with another person?), the participant responded that the last time was 1 to 3 months before the interview. However, for item R2p on page 54 (During the past 90 days, how many sex partners did you have who were male?) she answered “zero,” and for item R2r on the same page (During the past 90 days, how many times did you have any kind of vaginal, oral, or anal sex with another person?) she said she had not had any kind of sex during the past 90 days. The interviewer did a nice job of catching the inconsistencies between these responses and clarifying by explaining the inconsistencies, then re-administering the items.
    • The participant’s responses to items E8 on page 77 (When was the last time, if ever, that during an argument with someone else you swore, cursed, threatened them, threw something, or pushed or hit them in any way?) and E8p on page 78 (During the past 90 days, on how many days did you have an argument with someone else in which you swore, cursed, threatened them, threw something, or pushed or hit them in any way?) were inconsistent. For item E8, the participant responded, “1 to 3 months ago,” but for item E8p she said that she had not done any of those things during the past 90
days. The interviewer pointed out the inconsistency and then re-administered item E8p, and the participant changed her response.

Summary rating: Sufficient

**Engagement**
- Flow of the interview –
  - The pace of the interview was appropriate for this participant.
- Appropriate voice articulation and inflection –
  - The interviewer used good voice articulation and inflection.
- Use of encouraging or motivational statements –
  - The interviewer made several encouraging statements during the interview, such as “another section down,” “We’re getting close to the end,” “There are only two more sections left,” and “You’re doing a great job.” These statements are important to offer as to keep the participant motivated to continue – good job!
- Sensitivity to participant needs –
  - The interviewer did a nice job of offering breaks to the participant.
  - The interviewer also occasionally asked the participant, “how are you doing?” during the interview. Great!
- Rapport –
  - Rapport was excellent during the interview. The interviewer was friendly and professional throughout the interview.

Summary rating: Sufficient

**Other**

Certification status: Certified
Attachment 4-6
The Top 10 GAIN Inconsistencies

Pages correspond to the full GAIN-I 5.6.0

1. The time frame for the last time a substance was used (reported on the first page of the S2 grid) does not match the date of last use (reported on the third page of the S2 grid).
   **Example:** Say that today is 1/31/2006. For S2a on p. 15, the first page of the grid (When was the last time you used any kind of alcohol?), the participant answers, “1-4 weeks ago.” But then for S2_5a on p. 17, the third page of the grid (On what date did you last use any kind of alcohol?), his response is “1/30/2006.” The date reported for S2_5a doesn’t fit into the time frame reported for S2a. For these items to be consistent, the participant would have had to report either last using alcohol within the past two days (for S2a on the first page) or a date between 1/3/2006 and 1/24/2006 (for S2_5a on the third page).

2. Item S2s1a on p. 18 (During the past 90 days, on how many days did you go without using any alcohol, marijuana, or other drugs?) is not consistent with the days of use reported on p. 16 of the S2 grid.
   **Example:** For item S2_1a on p. 16, the second page of the S2 grid (During the past 90 days, on how many days have you used any kind of alcohol?), the participant answers, “75 days.” Then for item S2s1a on p. 18 he reports going 30 days out of the past 90 without using anything. If the participant has used alcohol on 75 days out of the past 90, it’s impossible for him to have also gone 30 days without using alcohol in the same 90-day time period (75 days of use + 30 days of nonuse = 105). The total days of use and nonuse within a 90-day period need to equal 90.
   Remember that multiple substances can be used on the same days, which may need to be clarified with the participant. For example, in the S2 grid the participant reports using alcohol on 60 days and marijuana on 60 days, and for S2s1a he reports going 30 days without using anything. If the interviewer clarifies and the participant says that he used both substances together every time he used them, then the items are consistent: 60 days of use + 30 days of nonuse = 90. But if the participant says that he used only alcohol on some days and only marijuana on others, the number of days of use is more than 60, which means that the responses are inconsistent and need to be clarified.

3. The time frame for the last use of a substance, reported on the first page of the S2 grid, is inconsistent with the time frame for the same substance as reported in the S9 grid on p. 39.
   **Example:** For item S2c on p. 15 the participant reports that she last used marijuana 4-12 months ago. But then for an item in the S9 grid on p. 39, the participant says that the last time marijuana caused her to have a problem was within the past month. The time frame reported for substances in the S2 grid need to correspond with the time frames reported for those substances in the S9 grid.

4. Time frames between the same items on the two pages of the S9 grid (pp. 38-39) are inconsistent.
**Example:** For item S9j on the page before the grid (p. 38) the participant says that the last time he kept using alcohol or drugs where it made the situation unsafe was within the past month. Then for item S9j in the grid itself (p. 39) he reports having used alcohol or drugs where it made the situation unsafe 1+ years ago. The time frame on the page before the grid (p. 38) is more recent than the time frame reported in the grid (p. 39), so the interviewer needs to explain the inconsistency to the participant and re-administer the items.

Another situation is if the time frames are reversed: on the first page (p. 38) the participant reports last using alcohol or drugs in an unsafe situation 1+ years ago, but then in the grid (p. 39) he reports using alcohol or drugs in an unsafe situation within the past month. These items, too, are inconsistent and need to be clarified.

Note: if in the grid the participant reports more than one substance for the same item, at least one of the time frames reported for those substances must match the general time frame reported on the page before the grid, and none of the time frames in the grid can be more recent than the time frame reported on the preceding page. For instance, on the page before the grid (p. 38) the participant reports having a problem 2-12 months ago, and then in the grid (p. 39) he reports that alcohol last caused the problem 1+ years ago and marijuana last caused the problem 2-12 months ago. These items are consistent because at least one substance caused the problem in the same time frame as reported on the page before the grid. But if the participant said that marijuana had last caused the problem within the past month, that item is inconsistent with the time frame reported on the page before the grid.

5. **The age of first time using drugs or alcohol, reported on the page before the S9 grid (p. 38), is inconsistent with the age of first use of individual substances reported in the grid (p. 39).**

**Example:** For item S9v on the page before the S9 grid (p. 38) the participant reports that she was 14 when she first got drunk or used any drugs. However, for S9v in the grid (p. 39) she reports first getting drunk at age 12. These responses are inconsistent and should be clarified by the interviewer.

    Note: however, that in some circumstances it’s possible for a participant to report a later age in the grid than on the page before. E.g., the participant first got drunk at age 12, but then in the grid she reports problems only with marijuana. She could say that she first used marijuana at 14, and because she didn’t report problems with alcohol, her age of first time drunk wouldn’t be asked in the grid itself.

6. **Item S2s3 on p. 18 (During the past 90 days, on how many days did alcohol or drug use problems keep you from meeting your responsibilities at work, school, or home?) is inconsistent with S9h on p. 38 (When was the last time you kept using alcohol or drugs even though you knew it was keeping you from meeting your responsibilities at work, school, or home?).**

**Example:** For item S2s3 the participant gives any number of days besides 0, but then for item S9h she reports either “1+ years ago” or “never.” For the items to be consistent, the participant would have had to report “past month” or “2-12 months ago” for S9h, or she would have had to answer “0” for S2s3. The interviewer should explain the inconsistency and re-ask the items.
7. Items in the M1a-M1d series on pp. 59-60 (mental health during the past 12 months) are inconsistent with M1e on p. 61 (When was the last time that your life was significantly disturbed by nerve, mental, or psychological problems or that you felt you could not go on, including those things we just talked about?).

**Example:** The participant endorses several items in M1a-M1d, but then for item M1e he says that his life has never been significantly disturbed by any mental health problems (or was last significantly disturbed more than 12 months ago). For the items to be consistent, the participant would have to say for M1e that he was last significantly disturbed by mental health issues sometime in the past 12 months. The interviewer should explain that the M1a-M1d items count for M1e and then re-administer M1e.

8. Time frames for card A or B items don’t match the participant’s responses to subsequent questions.

**Example:** For item P9 on p. 44 (When was the last time that you were bothered by health or medical problems or that they kept you from meeting your responsibilities at work, school, or home?) the participant says that she was last bothered by health problems or that health problems last kept her from meeting her responsibilities 1-3 months ago. But then for P9a and P9b the participant reports 0 days out of the past 90 on which she was bothered by health problems or that they kept her from meeting her responsibilities. The participant should have reported something for either P9a or P9b in order to for the items to be consistent with P9.

**Possible inconsistencies**

9. Item S3a on p. 21 (Have you ever had shaky hands, delirium tremens, convulsions, or seizures when you tried to stop, cut down on, or control your use of alcohol or drugs?) might be inconsistent with S9p on p. 38 (When was the last time you had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping…?).

**Example:** Because items S3a and S9p don’t ask about the same withdrawal symptoms, conflicting responses to the two items need to be clarified. For instance, for S3a the participant answers, “No,” but then for S9p he answers, “2 to 12 months ago” (or any response besides “Never”). The interviewer should clarify to see what symptoms the participant had—it’s possible that he threw up or had trouble sleeping, neither of which are asked about in S3a. Similarly, if the participant responds “Yes” to S3a but then answers “Never” to S9p, the interviewer should clarify to see whether the participant is reporting different withdrawal symptoms for the two items.

10. Items S2w5 and S2w6 on p. 19 (During the past 90 days, did you use alcohol or drugs while or within an hour prior to driving a vehicle / using knives, guns, equipment, or heavy machinery?) might be inconsistent with item S9j on p. 38 (When was the last time you used alcohol or drugs where it made the situation unsafe or dangerous for you?).

**Example:** For item S2w5 or S2w6 the participant says that she didn’t use while or within an hour of driving a vehicle or using dangerous equipment, but then for item S9j she says that within the past month or within the past 2-12 months she’s used where the situation was dangerous or unsafe. (Or vice-versa—the participant answers, “Yes” to S2w5 or S2w6 but then for S9j
answers, “Never.”) These items should be clarified to see whether the participant considers driving a vehicle or using knives, guns, equipment, or heavy machinery to be dangerous.
Attachment 4-7
A-QA Feedback Form Training Guide

<table>
<thead>
<tr>
<th>Identifiers†</th>
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<td>Cover page of paper version</td>
<td>Reviewer site:</td>
<td>Site ID of the person writing the feedback</td>
</tr>
<tr>
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<tr>
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<td>Page 2 of paper version</td>
<td>Date of review:</td>
<td>Date on which the reviewer completes the feedback</td>
</tr>
<tr>
<td>Participant ID (XPID):</td>
<td>Cover page of paper version</td>
<td>Assessment:</td>
<td>††</td>
</tr>
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† All fields should be completed.
†† Identify the assessment type (e.g., GAIN-I, GAIN-I Core, GAIN-M90). The specific version (e.g., ERI 5.6.0) can also be placed in this section but is not required.

**Documentation**
- **Cover page and staff use box on page 2**
  - Were the required fields (XSITE, XSID, XSIN, XPID, and XOBS) completed? If not, note which fields were not completed.
  - Was the participant’s name removed from the cover page (and from all other places that it appears, such as Z3a at the end of the assessment)? If not, explain why this should be done.
  - All other personally identifying information must be removed as well, such as any full names mentioned by the participant, the participant’s driver’s license number, etc.
  - Was the staff use box at the top of page 2 (items A1a-d) completed correctly?
  - Were all items on the cover page and page 2 legible?
  - Remember that IDs can contain only numbers, not letters.
- **Documentation and scoring of Check for Cognitive Impairment**
  - Was the Check for Cognitive Impairment scored correctly?
  - Did the interviewer circle the subsections of text that the participant missed for items A3d (Please count backwards from 20 to 1), A2e (Please say the days of the week in reverse order), and A2f (Please repeat the phrase I asked you to repeat before)?
  - Were the interviewer’s markings clear and legible?
- **Documentation of anchors, literacy questions, and initial administration decision**
  - Were the 90-day and 12-month anchors documented correctly?
  - Were the literacy questions (items A3b1 through A3b5)? coded correctly
• Was the initial administration decision (item A3c) coded correctly?

• **Time to complete**
  • Were the start and end times correctly documented in standard (not military) time?
  • Were all breaks documented in Z1c?
  • Were the start and stop times of each break documented in the margins of the assessment where the break occurred?
  • Was the total time to complete calculated accurately? If not, describe how the total time to complete should have been calculated.
  • If the assessment was completed over more than one day, please make any comments regarding the time to complete (section Z and XADMh1a-d) in this section.

• **Urgency and Denial-Misrepresentation ratings**
  • Were the UR and DM ratings coded appropriately?
  • If commenting on an interviewer’s rating, be sure to include the interviewer’s rating, the rating that may be a better choice, and the reason for the new rating.
  • Things to look for:
    • If all DM ratings are NO, some sections may not be coded correctly. Most participants will necessarily have to do some estimating in at least one or two sections because it’s difficult to remember exact figures for a 90-day period.
    • If a UR code of NOW is used, is it used appropriately?

• **Administration ratings**
  • Are the administration ratings (XADM) at the end of the assessment completed and accurately coded?
  • If not coded correctly, what is wrong and how should the item be coded? And why?

• **Documentation of participant responses**
  • Were all items documented legibly?
  • Were staff notes used to document additional information (if necessary)?
  • Were DK (don’t know) and RF (refused) used appropriately?
  • Comments on items that the interviewer is permitted to code on their own (e.g., the A4a1-99 “presenting concerns” code) should be placed under this subheading, as well as items that the interviewer should not code without asking the participant (such as presuming the participant’s response).
  • Were changes made correctly (original response cleanly crossed out, new response written neatly, and initialed and dated)? If not, note the correct way to make a correction. Include item numbers where corrections were made correctly and incorrectly.
  • Were all mentioned items not named by the participant coded “no”?
  • Any items that were miscoded should be placed in this section. For example, if the participant responded “yes,” but “no” was coded, it would be noted here.
  • Verbatim responses that were not documented correctly should be placed in this section. The reviewer should compare the participant’s actual statement to what the interviewer wrote down.
  • Any items that were administered but not documented should be noted in this section.
  • Any items that were documented but that were not administered should be noted in this section.
• Be sure to balance this section with both positive comments and suggestions for things that need improvement.

Summary rating: Choose one. Give only the rating, not the criteria for the rating that appears below.

Excellent: Use of legible, selective notes to facilitate later review by clinicians or researchers
Sufficient: Everything is completed accurately and clearly
Minor problems: Some missing or incorrect items or documentation errors
Problems: Major sections left incomplete or completed incorrectly

Instructions
• Introduction (purpose, format, length, privacy, confidentiality)
  • Were all major points of the introduction (page 2 on the paper version of the GAIN-I) explained? If not, note what was omitted.
  • Did the interviewer read “We have obtained a certificate of confidentiality…” unnecessarily? The statement should be read only when the interviewer’s site has actually obtained a certificate of confidentiality.
  • Did the interviewer conclude the introduction by asking the participant, “Do you have any questions?”
• Administration of Check for Cognitive Impairment
  • Were all parts of the Check for Cognitive Impairment administered correctly
• Establishing time frames and anchors (main time frames and S2x)
  • Were the instructions for establishing the anchors read completely?
  • Did the interviewer and participant count back 13 weeks (for the 90-day anchor) and 12 months to find the correct dates to establish the anchors?
  • Was the “When we talk about things happening during the past [90 days / 12 months]” statement read after each anchor was established?
  • Were the anchors established with the participant positive or neutral? Negative anchors (deaths, illnesses, breakups, etc.) should not be used because the participant will be reminded of the event throughout the interview.
  • If the S2x Pre–Controlled-Environment Use grid is administered, a comment on how well the interviewer established and anchored this time period would be noted in this section.
• Additional instructions for oral administration
  • Were all the additional instructions for oral administration (page 5 of the paper copy) read to the participant?
• Reading scales and transitional statements
  • Were all the scales read? Scales tell the participant how to respond to certain items: yes or no; number of times, days, or episodes; true or false; etc.
  • Were all the transitional statements read? These are the statements describing each section and what information should be included in the participant’s responses. For
example, in the Substance Use section the participant is instructed, “Please do not include any prescription drugs you use or used under the direction of a doctor.”

- **Using the cards and defining response choices**
  - Were cards used properly during the assessment?
  - If the participant responds initially with a number from a card, did the interviewer check to make sure that the number matches the intended response (e.g., the participant uses 1 to mean “more than 12 months ago”)? Did the interviewer clarify the response the first time that the participant used a number from a card to ensure that the participant was using the cards correctly?
  - Were response choices defined when necessary? That is, did the interviewer explain the different responses if the participant was having trouble understanding how to answer, or did the interviewer explain the differences between the different time frames?
  - Were the appropriate items (e.g., E1, V7) administered as clarify-and-code items? Were any items administered as clarify-and-code that should not have been?

- **Responding to participant questions about instructions**
  - Did the participant ask any questions about any of the instructions given during the assessment? If the participant asked questions, the inclusion in the feedback of the question and the response given by the interviewer, whether correct or needing improvement, would be helpful.
  - If the participant did not ask any questions about the instructions, it would be appropriate to write, “The participant did not ask any questions about the instructions” in this section of the feedback.

**Summary rating:** Choose one. Give only the rating, not the criteria for the rating that appears below.

- **Excellent:** Interviewer’s instructions are individualized and used to better engage the participant, particularly with regard to establishing the anchors
- **Sufficient:** All instructions are correctly followed
- **Minor problems:** Some missing or incorrect instructions
- **Problems:** Many missing or incorrect instructions

**Items**

- **Accurate following of item order and skips**
  - Were all skips followed throughout the assessment? If any skips were missed, list them in this section.
  - Was item order followed? When items are asked out of order, it should be noted in this section. (If the interviewer catches the error and administers the skipped item, it could be noted as a positive comment.)

- **Accurate grid administration**
  - Was the S2 grid administered correctly? When the participant reported using substances during the past 90 days, did the interviewer ask the corresponding items through the rest of the S2 grid?
• Be sure that items in column 2 of the S2 grid (About how many drinks/joints/etc. did you have in one day?) are clarified before coding. For example, if the participant reports having 12 drinks, did the interviewer clarify by asking what the participant was drinking and what size the drinks were, using the conversion chart at the bottom of the page to standardize the answer?
• If the S2x grid was administered, did the interviewer correctly ask the items as they pertain to the new time frame?
• If the S7 grid was administered, was it administered correctly? Did the interviewer start the grid with the participant’s first treatment episode and work toward their most recent?
• Was the S9 grid administered correctly? After the participant endorsed items on the first page, did the interviewer ask the corresponding items on the next page?

• **Accurate following of word order**
  • It is very important to include comments about wording changes that alter the meaning of an item. For example, if the interviewer reads item S2s1a as, “During the past 90 days, on how many days did you use any alcohol, marijuana, or other drugs?” instead of the correct “on how many days did you go *without* using any alcohol, marijuana, or other drugs,” the interviewer should note what the interviewer said and what should have been said.
  • Frequent word-order changes, even if they don’t affect the meaning of an item, should be noted to ensure that the interviewer doesn’t begin to change wording past the point of preserving the meaning of an item.

• **Appropriate use of stems and anchors**
  • Were stems read at the beginning of lists of items throughout the assessment?
  • Were stems repeated during long lists of items to remind the participant of the focus of the items?
  • Did the interviewer appropriately use the participant’s personal anchors during the assessment? Did the interviewer use the anchors frequently at the beginning of the assessment, when beginning a new section, or when switching between time frames?

• **Appropriate use of parenthetical statements**
  • Was parenthetical material used appropriately? Did the interviewer read only enough parenthetical material that seemed appropriate to help the participant (for example, if the participant appeared to need examples or asked for clarification)?
  • If all parenthetical material is being read and prolonging the assessment, address that issue in this section. Examples of this would be reading all the parenthetical material listing drug descriptions in the S2 grid or reading all the parenthetical descriptions of ailments for items P10a-s when doing so was clearly unnecessary.

• **Clarification of participant responses for coding**
  • Did the interview administer mentioned items correctly? Mentioned items should be administered by asking the item, then coding the participant’s responses (clarifying if necessary) and asking “Any others?” until the participant has nothing else to report.
  • Did the interviewer ask “Any others?” after verbatim items when necessary? For instance, if the participant gives a response to item P13a99 (Do you currently want help with anything else related to your health situation?), the interviewer should...
continue to ask, “Any others?” until the participant reports needing help for nothing else related to their health situation.

- Did the interviewer accidentally ask “Any others?” after items that don’t require it, such as item A4a (In a few words, can you tell me why you are here today? What is your main or most important reason for coming to treatment?) or item S9ad (What is your main or most important reason for wanting to quit now?)?
- Did the interviewer clarify vague responses correctly? If so, exact dialogue is helpful.
- Some examples of issues that would be included in this section:
  - If the participant used vague words such as “maybe,” “around,” etc., did the interviewer clarify for a more precise response by asking, e.g., “So what would you like me to put down”?
  - Did the interviewer clarify responses such as “four or five days” or “10 or 20 times” to get a firm response? Only one number can be recorded for any answer that requires a number.
  - If the participant answered with a fraction (“Five and a half hours”), did the interviewer clarify for a whole number?
  - If the item asked for a number of days and the participant responded using times instead, did the interviewer correctly clarify how many days the participant wanted coded?
  - If the participant responded outside the desired format, did the interviewer clarify the response? (For example, “uh-huh” instead of “yes,” “nuh-uh” instead of “no,” “none” instead of “zero.”)
  - If the participant responds, “every day,” “half,” “all of them,” “every other day,” “last night,” “yesterday,” “2 weeks,” “1 month,” etc., did the interviewer clarify to receive a number of days or a number of times in order to properly code the response?
  - If the participant answers, “a year ago” for a card A item, did the interviewer clarify to see whether the participant meant “4 to 12 months ago” or “more than 12 months ago”?
  - Similarly, for card B items, if the participant responded with “a year ago,” did the interviewer clarify for whether the participant meant “2 to 12 months ago” or “more than 12 months ago”?
  - Keep in mind that all responses should come from the participant. Sometimes interviewers may have information about the participant and will code items on their own or without sufficiently clarifying. Interviewers may also lead the participant to the correct response, or they will suggest the correct response and the participant will agree. It is still considered leading if the interviewer gives or suggests the correct response to the participant, even though the participant may agree.
  - Be sure that item B2b (Who currently has legal custody of you?) is clarified fully. For example, if the participant responds, “my mom,” and the interviewer codes “a single parent” without probing further, it might not be the correct response option for this participant’s situation because participants are more likely to name the parent they currently live with instead of who has custody of them. The interviewer should clarify the participant’s response in order to select the most appropriate code.
  - Be sure that item E1 (What kind of housing do you currently live in?) is clarified fully if more than one response may apply. Many times, the participant will offer only the
type of housing and whom they are living with, such as, “in an apartment.” Clarification is needed to see whom the participant lives with and whether the apartment is rent-subsidized or public housing.

- **Responding to participant questions about items**
  - Did the participant ask any questions about the items on the GAIN during the assessment? Such questions would include asking for a definition of a word, an explanation of what the question means, or examples of what would apply in a response.
  - If the participant asks a specific question, be sure to include the question and whether the interviewer answered it appropriately or how the question should be answered in the future.
  - If the participant did not ask any questions about the items, it would be appropriate to write, “The participant did not ask any questions about items” in this section of the feedback.

- **Resolving inconsistencies**
  - An inconsistency occurs when the participant’s answers to two separate items contain conflicting information that cannot simultaneously be true. The reviewer must write up all inconsistencies.
  - Example: for item E5 (During the past 12 months, how many people would you say you have regularly lived with?) the participant reports living with zero people, but for item V11r (How many people are there in your family household?) the participant says that there were six people in their family household. The two items conflict—it can’t be true that the participant both lived with no one during the past 12 months and currently had 6 people in her family household.
  - Placement in the feedback of comments about inconsistencies can get confused with the subheading “Clarification of participant responses.”
  - A clarification issue arises when a participant gives an ambiguous answer that must be clarified before it can be coded.
  - An inconsistency, as noted above, occurs when the participant’s answers to two separate items contain conflicting information, and both answers cannot simultaneously be true.
  - An inconsistency can also be identified from side conversation—for instance, the participant reports not having worked in the past 12 months but then offhandedly mentions having a job, which is a contradiction—so listen closely to any additional information that the participant gives during the interview.
  - The top 10 inconsistencies list (attachment 4-6 in the GAIN manual) can be very helpful with identifying inconsistencies. If you are not familiar with the items that correspond to one another and are most frequently the source of inconsistencies, the top 10 list is a valuable tool for writing clear, precise feedback.
  - When writing up a comment about an inconsistency, please include the item and page numbers of the inconsistent items (usually two but occasionally more), the responses that were given for each, and how to clear up the items in the future.
  - Inconsistencies that are caught and clarified can be included as positive feedback: include the item and page numbers of the inconsistent items, the responses that the participant gave for both, and the strategy that the interviewer used to resolve them.
• Possible inconsistencies should also be noted in this section. A possible inconsistency is when two or more items appear to be inconsistent but could actually be consistent, but there is not enough information to tell without further clarification. For instance, a participant might state for item A4c that their probation officer referred them to treatment, but then for item B4c they report feeling no pressure from their probation officer to go to treatment. The responses to the two items appear inconsistent, but the interviewer should clarify to make sure (for instance, it’s possible that the participant’s probation officer may have referred them to treatment but that they weren’t pressuring the participant to attend).

Summary rating: Choose one. Give only the rating, not the criteria for the rating that appears below.

Excellent: Interviewer repeats items and time frames, defines terms, or does other things to increase the validity of the responses

Sufficient: No problems with the administration of the items that would affect the validity of the recorded information

Minor problems: Some minor changes in meaning, item wording, or time frames; unclear clarification; missing issues that require clarification

Problems: Repeated difficulties that result in missing information or problems with validity

Engagement

• Flow of the interview
  • How was the rhythm of the assessment? Was the flow steady or were there long pauses, choppy reading, or pauses while reading instructions or finding the next item? Keep in mind that even the best interviewer will have some pauses while documenting items, turning the pages, and making staff notes.
  • Was the pace of the interview appropriate for the participant? The interviewer should speak fast enough that the participant stays engaged but not so fast that the participant has trouble keeping up.

• Appropriate voice articulation and inflection
  • Pronunciation of words should be clear.
  • Stressing boldfaced words and important words and phrases can help add meaning and comprehension.
  • Be sure to mention if an interviewer uses a monotone voice throughout the interview. Oftentimes the interviewer will not be aware of this issue until it is pointed out.

• Use of encouraging or motivational statements
  • Did the interviewer offer any encouraging or motivating statements to the participant? Examples include: “Thank you for your patience,” “We’re moving right along,” and “Thanks for hanging in there.”
  • Did the interviewer keep the participant informed of where they were in the assessment (e.g., “We just finished the longest section,” “We’re about halfway through,” “We’re starting the last section”)? Include the statements that the
interviewer makes, and make suggestions for positive comments that they can use in the future.

- Sensitivity to participant needs
  - Did the interviewer check in with the participant from time to time and make sure that they were doing well?
  - Did the interviewer offer breaks without the participant having to ask first?
  - If the participant had difficulty with a certain section, did the interviewer express empathy for the participant?

- Rapport
  - Did the interviewer act professionally?
  - Was the interviewer approachable and friendly?
  - Did the interviewer refer to the participant by name to add a more personal touch?
  - Was the interviewer patient when the participant did not understand an item?
  - Did the interviewer ever thank the participant for their responses?

Summary rating: Choose one. Give only the rating, not the criteria for the rating that appears below.

**Excellent:** Interviewer engages participant and manages the interview well, increasing validity and making the interview less burdensome on the participant

**Sufficient:** The interviewer engages the participant with good rapport

**Minor problems:** Ignoring inattentiveness, misunderstandings, or inconsistencies; not offering encouragement where needed; reading or moving through the interview too fast

**Problems:** Arguing with participant; ignoring participant’s questions or emotional state

**Other**
General comments that don’t fit any of the above categories, such as comments on the interviewer’s evaluative statements, the audibility of the recording, and supplemental questions that aren’t included as part of the regular GAIN interview, are included in this section.

**Certification status:** Pending or certified (choose only one)
  - Pending: Any summary ratings are below sufficient
  - Certified: All summary ratings are sufficient or above

**Notes**
- Remember the cardinal rule: every comment you write should help trainees understand where they made an error, how they made that error, and what they can do to avoid the same error in future interviews.
- Make sure that the feedback is balanced between positive comments and things that need improvement. Bear in mind that while feedback will detail primarily those areas in which the
interviewer needs improvement, each subsection of the feedback should include positive statements as well to act as positive reinforcement. Each comment should make it clear whether improvement is needed or whether the interviewer did a good job.

- Pay particular attention to the following subsections:
  - Documentation of participant answers
  - Accurate following of item order and skips
  - Clarification of participant responses for coding
  - Resolving inconsistencies

These tend to be the most important sections of GAIN A-QA feedback, so comments in should be written especially clearly and thoroughly.

- Be sure that comments read smoothly. It’s a good idea to complete the feedback, put it away for a couple of hours, and then come back to it fresh and make sure that every comment is clear. Feedback should be written so that someone only slightly familiar with the GAIN should be able to interpret all the reviewer’s comments without picking up the GAIN instrument itself, such as by including applicable item text.

- Each comment should use exact dialogue from the interview whenever possible to explain a situation, whether done well or needing improvement. For things that need improvement, be sure to note how the interviewer should make improvements by giving examples, or describe the situation that occurred and what the interviewer could have said or done differently in order to collect the most accurate information.

**Questions to consider before finalizing A-QA feedback**

- Were item and page numbers (if using the paper version of the GAIN) included with the comments?
- Were comments bulleted to provide clear information?
- Were enough positive comments included to balance the feedback?
- Are all the comments in complete sentences?
- Would the comments make sense to someone without a lot of experience with the GAIN?
- Ask yourself, “If I were reading this feedback, would I understand what I did wrong, why it was wrong, and what I should have done instead?”
GAIN Submission Form

Interviewer Name: ________________________________________________

Interviewer ID: _______________________

Business Address: ________________________________________________

Business Phone: _______________________

Business E-mail Address: __________________________________________

Project Name (if applicable):
(Grant or project type such as TCE/HIV, TDC, YORP, AAFT, or Wyoming)

Training Attended: ________________________________________________
(Date and location)

Site ID: _______________________

Site City/State: _______________________

Attempt Number: ________________________________________________
(Total number of submissions you have made for the Administrator OR Local Trainer certification process)

Have you made a COPY to submit and kept the original?
☐ YES ☐ NO

Have you written your name, return address, and phone number on the tape or tape case inserts?
☐ YES ☐ NO

Have you reviewed your documentation to make sure everything is complete and accurate?
☐ YES ☐ NO

Have you listened to your tape to determine whether the entire submission is audible?
☐ YES ☐ NO

For Local Trainer Submissions Only:

Local Trainer Name: ________________________________________________

Local Trainer ID: ________________________________________________

Please send tapes along with a COPY of the assessment to:

QA Team
c/o Chestnut Health Systems
448 Wylie Drive
Normal IL 61761-0078

1/14/2011
5. Diagnosis

As a biopsychosocial assessment battery for people entering substance abuse treatment, the GAIN is designed to help clinicians and researchers make diagnostic impressions about participants based on the APA’s *Diagnostic and Statistical Manual of Mental Disorders* criteria (DSM-IV-TR; 2000). In this chapter we will review the use of the GAIN for supporting the diagnosis of substance related disorders, other axis I disorders, and a full five-axis diagnosis. As stated earlier, the GAIN is a self-reported instrument; it should be combined with other information and interpreted by an appropriately trained clinician. Whether you administer the interactive GAIN ABS assessment or administer the paper version and then data-enter the information into GAIN ABS, the GAIN software will report both the diagnosis based on self-reports and the diagnostic impressions recorded by the clinical staff member in the GAIN’s Supplemental Diagnosis Section (XDIAG).

5.1 Diagnosis of Substance-Related Disorders

“Substance-related disorders” is the general description of drug and alcohol diagnostic and is an independent line on a rank with schizophrenia, mood disorders, and other classes in axis I of DSM-IV-TR. Substance-related disorders are 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, while the second describes 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 caused by the effects of intoxicants, either directly or in withdrawal. DSM-IV and DSM-IV-TR embed substance-induced disorders within larger syndromes. For example, substance-induced dementia is described in the section on dementia, and substance-induced mood disorder is described in the mood disorders section. Note that starting with DSM-IV the distinction of organic brain syndromes was dropped because of the belief that all psychiatric syndromes have organic or 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 5-1 compares the verbatim criteria for dependence and abuse from DSM-IV-TR with the primary GAIN item associated with each criterion. A response of “yes” to these questions is typically sufficient for making a diagnosis “by report” but may not be necessary. For example, an adolescent may not report being in trouble with the law, but his parent may report three prior drug-related arrests that would be sufficient for a clinician to consider this criteria as being met. Both the GAIN and exhibit 5-1 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 Scale (SPS), a dimensional scale of severity. As with all GAIN scales, the symptoms are presented in order of increasing severity and rarity. The more items endorsed, the more severe the
problem. When multiple criteria are met, the order of precedence is dependence, then abuse, then problems. Below are brief descriptions of each of these conditions.

- **Dependence**: These are symptoms suggesting that, as a consequence of use, the participant’s body has been physiologically changed; that the participant is losing control of his 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 or role failures that are interfering with the participant’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 participant understood the questions 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. Some amount of 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) occurs early with some participants and late with others. Thus a participant can have dependence but still be functional at home, school, or work. Conversely, first-time offenders referred to treatment from the court system actually have lower substance use severity on average then those who seek treatment on their own but typically have other, more severe behavioral or legal problems.

The questions for substance use disorders are initially collapsed across substances in the GAIN because many participants use multiple substances. For them, acknowledging a symptom or problem is often faster, easier, and more reliable than attributing the problem to a specific substance. This is particularly the case for a person using multiple substances or whose pattern of use has changed over time. That said, it is often clinically useful 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 accomplishing this and assume that you have already administered the S9 grid according to the guidelines presented in chapter 3.
### Exhibit 5-1. Crosswalk of DSM-IV-TR Criteria to the GAIN

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Primary GAIN question from S9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General screening questions (use diagnosis below if possible, if not check other information or probe later)</strong></td>
<td></td>
</tr>
<tr>
<td>GAIN-Quick c.</td>
<td>you tried to hide that you were using alcohol or other drugs?</td>
</tr>
<tr>
<td>GAIN-Quick d.</td>
<td>your parents, family, partner, coworkers, classmates, or friends complained about your alcohol or other drug use?</td>
</tr>
<tr>
<td>GAIN-Quick e.</td>
<td>you used alcohol or other drugs weekly or more often?</td>
</tr>
<tr>
<td>Substance-induced psychological problems f.</td>
<td>your alcohol or other drug use caused you to feel depressed, nervous, suspicious, uninterested in things, reduced your sexual desire, or caused other psychological problems?</td>
</tr>
<tr>
<td>Substance-induced health problems g.</td>
<td>your alcohol or other drug use caused you to have numbness, tingling, shakes, blackouts, hepatitis, TB, sexually transmitted disease, or any other health problems?</td>
</tr>
<tr>
<td><strong>For “Substance Abuse,” participant must not meet criteria for dependence and must meet one or more of the following:</strong></td>
<td></td>
</tr>
<tr>
<td>A1. Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home h.</td>
<td>you kept using alcohol or drugs even though you knew it was keeping you from meeting your responsibilities at work, school, or home?</td>
</tr>
<tr>
<td>A2. Recurrent substance use in situations in which it is physically hazardous j.</td>
<td>you repeatedly 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?</td>
</tr>
<tr>
<td>A3. Recurrent substance-related legal problems k.</td>
<td>your alcohol or drug use caused you to have repeated problems with the law?</td>
</tr>
<tr>
<td>A4. Continued substance use despite social or interpersonal problems caused or exacerbated by use m.</td>
<td>you kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?</td>
</tr>
</tbody>
</table>
Exhibit 5-1. Continued

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

**Detailed Diagnoses.** It is also clinically important to identify whether a participant’s substance use disorders are being caused by one or multiple substances, particularly when multiple substances have been used in the preceding year. Exhibit 5-2 provides a crosswalk from the 11 main DSM-IV-TR alcohol and drug categories to the 14 main GAIN categories. Note that tobacco abuse and dependence and caffeine intoxication are not included here because they are not normally sufficient for admission to a substance abuse program and are not generally part of state reporting requirements (tobacco use is covered in the Risk Behaviors section of the GAIN). The detailed worksheet will allow you to identify which of the 11 substance categories in DSM-IV-TR 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 substance, then and only then should “304.80 Polysubstance dependence” be used. Note that this term is often misused to denote people who use polysubstances (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 symptoms 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 item S9n) or withdrawal (criterion 2; GAIN item S9p). GAIN ABS classifies each reported substances as one of the following (in descending order or precedence):

1. Dependence with physiological symptoms (symptoms n or p and 3 + total symptoms in n-u for a substance)
2. Dependence without physiological symptoms (3+ symptoms in rows n-u for a substance)
3. Abuse (1+ symptoms in h-m for a substance)

Note that the DSM-IV-TR rules create a diagnostic orphan when someone reports one or two symptoms of dependence and no symptoms of abuse. In this case there is technically no diagnosis. But in most cases there is sufficient information in the GAIN or collateral information to complete the diagnosis. Some other key questions to review include reports of use in specific situations that are hazardous or constitute role failure (S2w), past-week withdrawal symptoms (S3), evidence of prior treatment episodes (S7), use in spite of acute medical (P3, P6, P10) or psychological (M1, M2, M3) problems, drug-related illegal activity (L3), drug related arrests (L5). The reports of parents or other collaterals are also much more likely to identify role failure, changes in behavior or mood, and repeated problems with the law.
### Exhibit 5-2. Crosswalk of DSM-IV Diagnostic Codes to GAIN

<table>
<thead>
<tr>
<th>DSM-IV-TR Substance Use Diagnoses</th>
<th>GAIN Substance(s) in S2</th>
</tr>
</thead>
</table>
| 303.90 Alcohol Dependence  
305.00 Alcohol Abuse              | S2a. Any kind of alcohol (beer, wine, whisky, gin, scotch, tequila, rum, or mixed drinks) |
| 304.40 Amphetamine Dependence     | S2pa. Methamphetamine, crystal, ice, glass, or other forms of methedrine (Desoxyn)  
305.70 Amphetamine Abuse          | S2pb. Speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants (Biphetamine, Benzedrine, Dextedrine, or Ritalin) |
| 304.30 Cannabis Dependence        | S2c. Marijuana, hashish, blunts, or other forms THC (herb, reefer, weed) |
| 305.20 Cannabis Abuse             |                                                                                      |
| 304.20 Cocaine Dependence         | S2d. Crack, smoked rock, or freebase cocaine  
305.60 Cocaine Abuse               | S2e. Other forms of cocaine |
| 304.50 Hallucinogen Dependence    | S2m. Acid, LSD, ketamine, special K, mushrooms, or other hallucinogens (mescaline, peyote, psilocybin, or shrooms) |
| 305.30 Hallucinogen Abuse         |                                                                                      |
| 304.60 Inhalant Dependence        | S2f. Inhalants or huffed (correction fluids, gasoline, glue, lighters, spray paints, or paint thinner) |
| 305.90 Inhalant Abuse             |                                                                                      |
| 304.00 Opioid Dependence          | S2g. Heroin or heroin mixed with other drugs  
305.50 Opioid Abuse                | S2h. Nonprescription or street methadone  
S2j. Painkillers, opiates, or other analgesics (codeine, Darvocet, Darvon, Demerol, Dilaudid, Karachi, OxyContin, Oxys, Percocet, Propoxyphene, morphine, opium, Talwin, or Tylenol with codeine). |
| 304.90 Phencyclidine Dependence   | S2k. PCP or angel dust (Phencyclidine) |
| 305.90 Phencyclidine Abuse        |                                                                                      |
| 304.10 Sedative, Hypnotic, or Anxiolytic Dependence  
305.40 Sedative, Hypnotic, or Anxiolytic Abuse | S2n. Anti-anxiety drugs or tranquilizers (Ativan, Deprol, Equanil, Diazepam, Klonopin, Meprobamate, Librium, Miltown, Serax, Valium, or Xanax)  
S2q. Downers, sleeping pills, barbiturates, or other sedatives (Dalmame, Donnatal, Doriden, Flurazepam, GHB, Halcion, liquid ecstasy, methaqualone, Placidyl, Quaalude, Secobarbital, Seconal, Rohypnol, or Tuinal) |
| 304.80 Polysubstance Dependence   |                                                                                      |
| 304.90 Other Substance Dependence | S2r. Some other drug (amyl nitrate, cough syrup, nitrous oxide, NyQuil, poppers, or Robitussin) |
| 305.90 Other Substance Abuse      |                                                                                      |

Once a participant shows a lifetime history of dependence, DSM-IV-TR 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**: Defined for a participant in an environment with no access to alcohol or other drugs, such as a therapeutic community, locked psychiatric ward, or prison. (44+ on GAIN S2x “days in controlled environment.”)

2. **On Agonist Therapy**: No criteria present for abuse or dependence for at least one month but the participant 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**: No criteria for abuse or dependence have been met for more than 12 months. (No past-year symptoms in S9h-u.)

4. **Early Full Remission**: 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 S9h-u.)

5. **Sustained Partial Remission**: Some criteria (1 or 2) for dependence have been met but not enough for a diagnosis. (One or two past-year symptoms in S9n-u.)

6. **Early Partial Remission**: One criterion for abuse or dependence has been met for at least one month but not more than 12 months. (One or two past-month symptoms in S9h-u.)

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

For a “controlled environment” specifier, the check above refers to the overall or combined time in any controlled environment where the participant could not use alcohol or drugs (S2x). In the course of doing the whole assessment you may find further evidence that the participant has been in several types of control environments, including detoxification (S5a), hospital, inpatient or residential programs (S7a2), physical-health hospitals (P11g), inpatient mental health treatment (M5g), supervised or institutionalized housing (E1), and time in jail, prison, or juvenile detention (L6c-f). Because participants 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” (E2f). Note that while time in a controlled environment suppresses the rate of use, it does not eliminate it. Despite the prohibitions and constraints, some participants will still explicitly report use in jails,
treatment programs, hospitals, and virtually all controlled environments.

**Withdrawal.** In general, someone in an extreme state of withdrawal or intoxication is going to be referred to a detoxification or medical unit before the GAIN is administered or will be screened out during the check for cognitive impairment. 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 that the participant has recently ceased using after a prolonged period of heavy use (criterion A), that they have a set of overlapping substance-specific symptoms (criterion B), that these symptoms cause significant distress or impaired social or occupational functioning (criterion 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-IV-TR for alcohol (p. 216 in the DSM-IV-TR), amphetamines (p. 228), cocaine (p. 246), opioids (p. 273), and sedative, hypnotic, or anxiolytic drugs (p. 289). However, a substance-specific withdrawal diagnosis is not defined in DSM-IV-TR for cannabis, hallucinogens, inhalants, PCP, or other drugs. DSM does not say what to do for the latter group or where multiple substances have been used together (which may present atypical patterns), both of which occur relatively frequently. Complicating matters further, no data for adolescents were considered when developing these patterns. To address these gaps, the GAIN collects all of the DSM-IV-TR symptoms of withdrawal across all substances. Asking the symptoms across substances is also useful because it saves time and because participants often have difficulty attributing their symptoms to a specific substance when more than one is involved. Exhibit 5-3 shows a crosswalk between DSM-IV withdrawal symptoms (which vary by substance) and the GAIN withdrawal-scale items in S3. The cells further show which of the substance-specific criterion the symptom or item maps onto.
### Exhibit 5-3. Crosswalk of DSM-IV-TR substance specific and general withdrawal symptoms with GAIN Current Withdrawal Scale

<table>
<thead>
<tr>
<th>DSM-IV-TR symptom</th>
<th>If the participant cut down, tried to stop, or stopped... When you did this, did you have any of the following withdrawal symptoms or problems?</th>
<th>Alcohol (p. 216)</th>
<th>Sed./Hyp./Aux. (p. 289)</th>
<th>Cocaine (p. 246)</th>
<th>Amphetamine (p. 228)</th>
<th>Opioid (p. 273)</th>
<th>Cannabis (n.d.)</th>
<th>Hallucinogen (n.d.)</th>
<th>Inhalant (n.d.)</th>
<th>PCP (n.d.)</th>
<th>Other (n.d.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychomotor retardation</td>
<td>1. Move and talk much slower than usual</td>
<td>(b5)</td>
<td>(b5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>yawning</td>
<td>2. Yawn more than usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(b7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fatigue</td>
<td>3. Feel tired</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(b1)</td>
<td>(b1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vivid, unpleasant dreams</td>
<td>4. Have bad dreams that seemed real</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(b2)</td>
<td>(b2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>insomnia or hypersomnia</td>
<td>5. Have trouble sleeping, including sleeping too much or not being able to sleep</td>
<td>(b3)</td>
<td>(b3)</td>
<td>(b3)</td>
<td>(b3)</td>
<td>(b9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dysphoric mood</td>
<td>6. Feel sad, tense, or angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(b1)</td>
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<td>anxiety</td>
<td>7. Feel really nervous</td>
<td>(b7)</td>
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<tr>
<td>psychomotor agitation</td>
<td>8. Fidget, pace, wring your hands, or have trouble sitting still</td>
<td>(b6)</td>
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<td>(b5)</td>
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<tr>
<td>hand tremors</td>
<td>9. Have shaky hands</td>
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<td>(b2)</td>
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<td>grand mal seizures</td>
<td>10. Have convulsions or seizures</td>
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<td>(b8)</td>
<td>(b8)</td>
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<td>increased appetite</td>
<td>11. Feel hungrier than usual</td>
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<td>(b4)</td>
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<td>nausea or vomiting</td>
<td>12. Throw up or feel like throwing up</td>
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<td>diarrhea</td>
<td>13. Have diarrhea</td>
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<td>muscle aches</td>
<td>14. Have muscle aches</td>
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<td>(b3)</td>
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<td>lacrimation or rhinorrea</td>
<td>15. Have a runny nose or eyes watering more than usual</td>
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<td>autonomic hyperactivity; pupillary dilation, piloerections, or sweating</td>
<td>16. Sweat more than usual, have your heart race, or get goose bumps</td>
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### Exhibit 5-3. Crosswalk of DSM-IV-TR substance specific and general withdrawal symptoms with GAIN Current Withdrawal Scale

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<tr>
<td>fever</td>
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<td>17. Have a fever</td>
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<td>transient visual, tactile, or auditory hallucinations or illusions</td>
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<td>18. See, feel, or hear things that are not real</td>
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<td>general symptom of withdrawal</td>
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<td>19. Forget a lot of things or have problems remembering</td>
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<td>20. Have any of these withdrawal problems kept you from doing social, family, job, or other activities</td>
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<td>21. Use the same or another drug to stop or avoid having any of these withdrawal symptoms</td>
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<td>99. Some other problem (Please describe)</td>
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n.d.: Substance specific withdrawal symptoms not defined yet.
GEN: General symptom

**Substance-Induced Disorders.** One of the most significant shifts in DSM-IV was in the treatment of co-occurring conditions that might be either “substance induced” or independently caused. In the past, earlier DSM versions had recommended detoxifying a participant and keeping them off substances for six weeks or more and treating these other conditions only if they did not go away. DSM-IV and DSM-IV-TR now recommend treating co-occurring conditions and checking later to see whether they go away as treatment is withdrawn. There are two major reasons for this reversal. The first is humanitarian: rapid and effective 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, or make the participant 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-TR (p. 193) are:

- **Alcohol** – persisting dementia, persisting amnestic, psychotic, mood, anxiety, sexual dysfunction, and sleep disorders.
- **Amphetamines** – psychotic, mood, anxiety, sexual dysfunction, and sleep disorders.
- **Cannabis** – psychotic and anxiety disorders.
- **Cocaine** – psychotic, mood, anxiety, sexual dysfunction, and sleep disorders.
- **Hallucinogens** – psychotic, mood, and anxiety disorders.
- **Inhalants** – persisting dementia, psychotic, mood, and anxiety disorders.
- **Opioids** – psychotic, mood, sexual dysfunction, and sleep disorders.
- **Phencyclidine (PCP)** – psychotic, mood, and anxiety disorders.
- **Sedatives, Hypnotics, and 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 and sedatives/hypnotics/anxiolytics) are associated with substance-induced delirium during withdrawal. Determining whether these conditions are due to substance use goes beyond the scope of this (or any) one-time assessment and requires time, observation, and clinical judgment.

5.2 **Supporting Other Axis I Disorders**

The GAIN also includes check boxes, text statements (via the GAIN Recommendation and Referral Summary, or GRRS, discussed further below), and codes (via the Individual Clinical Profile or ICP discussed further below) to created diagnostic impressions from the self-reported pattern of symptoms. Below is a list of the other axis I conditions that can be identified (criteria and item numbers are in [brackets]).
(Other) Substance-Related Disorders
- **Rule Out 304.90 Substance Dependence with other information** [13+ days of use in S2d1 and 3+ Sx in S9e-u]
- **305.10 Nicotine Dependence w/Physiological Sx.** [(3+ Sx in R4n-u) & (n or p)]
- **305.10 Nicotine Dependence w/out Physiological Sx.** [3+ Sx in R4q-u]
- **Rule Out 305.10 Nicotine Dependence** [R4a > 12]

Mood Disorders
- **296.90 Major Depressive Disorder (MDD)** [(5+ symptoms in M1a2, M1b1, M1b2, M1b3, M1b4, M1b5, M16, M1b7, M1b8, M1b9, M1b10, M1c2, M1d3) and (1+ symptoms in M1b1, M1b6, M1b8)]
- **Rule Out 296.90 Mood Disorder** [5+ Sx in M1b or 3+ Sx in M1c & M1f > 12 or M1g > 1]

Anxiety Disorders
- **300.02 Generalized Anxiety Disorder (GAD)** [(3+ symptoms on M1a2, M1a4, M1b3, M1b6, M1b7, M1d3, M1d11) and (M1d1 = 1) and (M1d12 = 1)]
- **Rule Out 300.00 Anxiety Disorder** [5+ Sx in M1d & M1f > 12 or M1g > 1]
- **Rule Out 309.81 Posttraumatic Stress Disorder, 308.30 Acute Stress Disorder or other disorder of extreme stress** [5+ Sx in M2a-p or M2q = 13+ days]

Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence
- **314.00 Attention Deficit Hyperactive Disorder - Inattentive Type** [(6+ Sx M3a1-9 & 1+ in M3c) or (M3d = 2)]
- **314.01 Attention Deficit Hyperactive Disorder - Combined Type** [(6+ Sx M3a1-9 & 6+ Sx M3a10-18 & 1+ in M3c) or M3d = 1]
- **314.01 Attention Deficit Hyperactive Disorder - Hyperactive Type** [(6+ Sx M3a10-18 & 1+ in M3c) or M3d = 3]
- **312.80 Conduct Disorder, Severe** [9+ Sx in M3b1-15, M3b17-19 & 1+ days in M3c]
- **312.80 Conduct Disorder** [3+ Sx in M3b1-15, M3b17-19 & 1+ days in M3c]

Other Axis I Disorders
- **Rule Out 300.81 Somatoform Disorder** [4 Sx in M1a & M1f > 12 or M1g > 1]
- **Rule Out 296.90 Mood Disorder, 300.00 Anxiety Disorder, or 300.81 Somatoform Disorder** [13+ Sx in M1a-d, M1f > 12 or M1g > 1]
- **312.31 Pathological Gambling** [5+ Sx in V9a-k]

Like any initial diagnosis, these should be treated as provisional. Symptoms of ADHD, for instance, could also be substance induced or caused by other things, like petit mal seizures. Thus these reports
should be combined with other available information and interpreted by a qualified clinician.

5.3 Axis II, III, IV, and V Diagnoses

**Axis II Personality Disorders.** The GAIN screens only for the presence of severe personality problems and does not try to differentiate specific diagnoses. Thus there is no “check box” for hand scoring. The GRRS and ICP, however, will generate one of two statements related to personality disorders:

- **Rule Out 301.70 ASPD or 301.83 BPD** 
  \[(3+ Sx in M3b1-15 & 1+ days in M3c) or (3+Sx in M4z1-3 or M4z > 0), and (16+ in M4a-x)\]
- **Rule Out 301.90 Personality Disorder NOS** 
  \[(16+ in M4a-x) or (3+ Sx in M4z1-3), or (M4z > 0)\]

The GAIN’s personality complexity scale is divided into three subscales (still experimental for individuals), based on earlier work by Chestnut Health Systems (2001). The subscales for three personality clusters (and their associated DSM-IV’s axis II diagnoses) are listed below.

- **Cautious Personality Index (CPI) for Cluster A** (Paranoid, Schizoid, and Schizotypal personality disorders) characterizes people who often appear odd or eccentric.
- **Impulsive Personality Index (IPI) for Cluster B** (Antisocial, Borderline, Histrionic, and Narcissistic personality disorders) characterizes people who often appear dramatic, emotional, or erratic and have a hard time picking up on social cues.
- **Worrying Personality Index (WPI) for Cluster C** (Avoidant, Dependent and Obsessive-Compulsive personality disorders) characterizes people who often appear anxious or fearful.

The questions in M4z are related to cutting, burning, and other forms of self-mutilation. While most prototypical of BPD or other cluster B diagnoses, it is important to realize that these behaviors may represent important problems even if they are below the clinical threshold for a diagnosis. Besides the obvious risk of harm to self, others may also quickly imitate such behaviors in treatment (particularly adolescents).

**Axis III Biomedical Conditions that Might Complicate Treatment.** The GAIN includes a general health screener for the past year (question P3) and the past 90 days (P9) and checks for disabilities (P4), pregnancy (P5), infectious diseases (P6), and lifetime histories of medical problems by ICD-9 (P10). There are also questions related to spreading infections through needle use and sexual behaviors, contraceptive use, and participation in prevention and testing programs. In addition to reporting specific medical problems, the ICP red flags several interactions between substance use and health problems, including:
• Use of alcohol \([S2a > 2 \text{ or } S2a1 > 0]\) may exacerbate health problems related to hepatitis \([P6a > 0]\)
• Use of alcohol \([S2a > 2 \text{ or } S2a1 > 0]\) may exacerbate health problems related to pregnancy \([P5b = 5]\)
• Use of alcohol \([S2a > 2 \text{ or } S2a1 > 0]\) may exacerbate nervous system problems \([S3a = 1 \text{ or } P10d = 1]\)
• Use of analgesics (heroin, methadone, other painkillers) \([S2g > 2 \text{ or } S2h > 2 \text{ or } S2j > 2 \text{ or } S2g1 > 0 \text{ or } S2h1 > 0 \text{ or } S2j1 > 0]\) may exacerbate dental problems \([P10b = 1]\)
• Use of analgesics (heroin, methadone, other painkillers) \([S2g > 2 \text{ or } S2h > 2 \text{ or } S2j > 2 \text{ or } S2g1 > 0 \text{ or } S2h1 > 0 \text{ or } S2j1 > 0]\) may exacerbate health problems related to injuries \([P10c = 1]\)
• Use of analgesics (heroin, methadone, other painkillers) \([S2g > 2 \text{ or } S2h > 2 \text{ or } S2j > 2 \text{ or } S2g1 > 0 \text{ or } S2h1 > 0 \text{ or } S2j1 > 0]\) may exacerbate skeletal problems \([P10q = 1]\)
• Use of analgesics (heroin, methadone, other painkillers) \([S2g > 2 \text{ or } S2h > 2 \text{ or } S2j > 2 \text{ or } S2g1 > 0 \text{ or } S2h1 > 0 \text{ or } S2j1 > 0 \text{ or } P14]\) may exacerbate skin problems \([P10r = 1]\)
• Use of any drug \([S2s1a < 90]\) may exacerbate health problems related to pregnancy \([P5b = 5]\)
• Use of crack \([S2d > 2 \text{ or } S2d1 > 0 \text{ or } P14]\) may exacerbate breathing problems \([P10f = 1]\)
• Use of crack \([S2d > 2 \text{ or } S2d1 > 0 \text{ or } P14]\) may exacerbate health problems related to tuberculosis \([P6b > 0]\)
• Use of marijuana \([S2c > 2 \text{ or } S2c1 > 0]\) may exacerbate breathing problems \([P10f = 1]\)
• Use of marijuana \([S2c > 2 \text{ or } S2c1 > 0]\) may exacerbate health problems related to tuberculosis \([P6b > 0]\)
• Use of sedatives \([S2q > 2 \text{ or } S2q1 > 0]\) may exacerbate nervous system problems \([S3a = 1 \text{ or } P10d = 1]\)
• Use of stimulants (cocaine, crack, amphetamines, other stimulants) \([S2d, S2e, \text{ or } (S2pa + S2pb) > 2 \text{ or } S2d1 \text{ or } S2e1 \text{ or } (S2pa1 + S2pb1) > 0]\) may exacerbate endocrine (diabetes, thyroid) problems \([P10h = 1]\)
• Use of stimulants (cocaine, crack, amphetamines, other stimulants) \([S2d, S2e, \text{ or } (S2pa + S2pb) > 2 \text{ or } S2d1 \text{ or } S2e1 \text{ or } (S2pa1 + S2pb1) > 0]\) may exacerbate heart/blood problems \([P10e = 1]\)
• Use of stimulants (cocaine, crack, amphetamines, other stimulants) \([S2d, S2e, \text{ or } (S2pa + S2pb) > 2 \text{ or } S2d1 \text{ or } S2e1 \text{ or } (S2pa1 + S2pb1) > 0]\) may exacerbate nervous system problems \([S3a = 1 \text{ or } P10d = 1]\)
• Use of tobacco \([R4 > 2 \text{ or } R4a > 0]\) may exacerbate breathing problems \([P10f = 1]\)
• Use of tobacco \([R4 > 2 \text{ or } R4a > 0]\) may exacerbate health problems related to pregnancy \([P5b = 5]\)
• Use of tobacco \([R4 > 2 \text{ or } R4a > 0]\) may exacerbate health problems related to tuberculosis \([P6b > 0]\)

**Axis IV Psychosocial Stressors.** The GAIN has questions targeted specifically at the major psychosocial stressors identified in DSM-IV (see GAIN items E10 and E11). The ICP checks for these as well as a variety of other major sources of stress, including:
• Academic problems [(B2a < 19) & (V1b > 2 or V1b = 99)]
• Any substance use among peers [E6d or E7d > 1]
• Any substance use by others in living situation [E5d > 0 or E2e > 0]
• Arrested in the past 90 days [L5c > 0]
• Birth or adoption of a new family member [E10_1]
• Death of a family member or close friend [E10_4 = 1]
• Discrimination in community, work, school, or transportation [E11_5 = 1]
• Fights with boss/teacher or coworkers/classmates [E10_5 = 1]
• Financially support self from illegal activity [L3w = 1+/90 days]
• Hard work or school schedule [E11_3 = 1]
• Health problem of family member or close friend [E10_2 = 1]
• Illegal activity among peers [E6b or E7b > 0]
• Illegal activity in living situation [E5b > 0]
• In jail, detention, or prison in the past 90 days [L6c or f > 0]
• Interruption or loss of housing, job, school, or transportation [E11_7 = 1]
• Involved in illegal activity [L3v = 1+/90 days]
• Isolated from other people in living situation and peer groups [E5 + E6 + E7 < 2]
• Lifetime history acute/traumatic victimization [4+ Sx in E9a-r]
• Lifetime history of combat exposure [V4a = 1]
• Lifetime history of victimization [1+ Sx in E9a-d]
• Major change in housing or bad housing [E11_1 = 1]
• Major change in relationships (marriage, divorce, separations) [E10_3 = 1]
• New job, position, or school [E11_2 = 1]
• No high school degree or GED [(B2a > 19) & (V2_1 & V2_2 = 0)]
• Not close to anyone who has been to treatment before [E5f & E6f & E7f = 4]
• On parole [L7_7 = 1]
• On probation [L7_4 = 1]
• Other changes or problems in family or primary support groups [E10_99 = 1]
• Other criminal justice system involvement [(L7_1-3, 5-6 or 8-99) = 1]
• Other environmental demands [E11_99 = 1]
• Participant DCFS involved [B2b = 7]
• Probation or parole violations in the past 90 days [L5v > 0]
• Problems with transportation [E11_4 = 1]
• Special or alternative education program [(B2a < 19, p7) & (V1a) = 1]
• Substance-related arrest in the past 90 days [L5r, L5s, or L5t > 0]
• Threat of losing current housing, job, school, or transportation [E11_6 = 1]
• Weekly fighting among peers [E7e > 0]
• Weekly fighting in living situation [E5e > 0]
• Weekly illegal activity [L3v = 13+/90 days]
• Weekly intoxication among peers [E6c or E7c > 1]
• Weekly intoxication by others in living situation [E5c > 1 or E2d > 12]
• Weekly substance use by others in living situation [E2e > 12]
• Currently pregnant [P5b1 = 5]
• Uncertain if currently pregnant [P5b1 = 4]
• Successful pregnancy within the past year [P5a1 < 5 and P5b1 = 1]
• Miscarriage within the past year [P5a1 < 5 and P5b1 = 2]
• Abortion within the past year [P5a1 < 5 and P51b = 2]
• Pregnancy within the past year [P5a1 < 5 and P5b1 = 6]
• Had low–birth-weight baby within the past year [P5a1 < 5, P5b1 = 1, P5c1 < 5 pounds]

**Axis V Ratings.** After the participant’s responses have been reviewed, the clinician will also make three ratings of the participant’s functioning using the main and two provisional scales of DSM-IV’s axis V:

- **Global Assessment of Functioning (GAF, Exhibit 5-4)** to rate the participant’s functioning in terms of mental health or illness (e.g., danger to self, cognitive impairment, symptom severity, degree of remission), including substance use disorders. Some programs substitute the Children’s General Assessment Form (CGAF; Shaffer et al., 1996) rating scale for the GAF.

- **Global Assessment of Relational Functioning (GARF, Exhibit 5-5)** to rate the participant’s functioning in terms of the quality of their core relationships and 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).

- **Social and Occupational Functioning Assessment Scale (SOFAS; Exhibit 5-6)** 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 or perform according to expectations in social, school and work settings).

Each scale goes from 1 to 100, with 1 being low functioning and 100 high functioning. The use of “0—inadequate information” should be used only if there are major data quality problems. While related, past research has demonstrated that functioning in these three areas can vary considerably (e.g., 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). To be useful, a group of clinicians should cross-rate several cases, resolve any differences, and repeat this process until they are largely consistent. Ideally this should be done in conjunction with a presentation of the diagnosis and symptoms in the rest of the GAIN so that the whole time increasingly anchors their ratings to levels of functioning.
**Exhibit 5-4 Global Assessment of Functioning (GAF)**

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.)

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<th>Score Range</th>
<th>Description</th>
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<td>91-100</td>
<td>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.</td>
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<td>81-90</td>
<td>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).</td>
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<td>71-80</td>
<td>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</td>
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<td>61-70</td>
<td>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 or occasional lapses</td>
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<td>51-60</td>
<td>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 coworkers), the minimum requirement for diagnosis of dependence and repeated lapses</td>
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<tr>
<td>41-50</td>
<td>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</td>
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<tr>
<td>31-40</td>
<td>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)</td>
</tr>
<tr>
<td>21-30</td>
<td>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).</td>
</tr>
<tr>
<td>11-20</td>
<td>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).</td>
</tr>
<tr>
<td>1-10</td>
<td>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.].</td>
</tr>
</tbody>
</table>

0 Inadequate information

Exhibit 5-5 Global Assessment of Relational Functioning (GARF) Scale

The GARF scale can be used to indicate an overall judgment 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 participant’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 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); (NOTE: Italics added to make it more specific and further delineate ratings.)
**Exhibit 5-6 Social and Occupational Functioning Assessment Scale (SOFAS)**

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.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-100</td>
<td>SUPERIOR FUNCTIONING in a wide range of activities.</td>
</tr>
<tr>
<td>81-90</td>
<td>GOOD FUNCTIONING in all areas, occupationally and socially effective.</td>
</tr>
<tr>
<td>71-80</td>
<td>SLIGHT IMPAIRMENT in social, occupational, or school functioning (e.g., infrequent interpersonal conflict, temporarily falling behind in schoolwork).</td>
</tr>
<tr>
<td>61-70</td>
<td>SOME DIFFICULTY in social, occupational, or school functioning, but generally functioning well, has some meaningful interpersonal relationships.</td>
</tr>
<tr>
<td>51-60</td>
<td>MODERATE DIFFICULTY in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).</td>
</tr>
<tr>
<td>41-50</td>
<td>SERIOUS IMPAIRMENT in social, occupational, or school functioning (e.g., no friends, unable to keep a job) in some areas.</td>
</tr>
<tr>
<td>31-40</td>
<td>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).</td>
</tr>
<tr>
<td>21-30</td>
<td>INABILITY TO FUNCTION socially or occupationally in almost all areas (e.g., stays in bed all day; no job, home, or friends).</td>
</tr>
<tr>
<td>11-20</td>
<td>OCCASIONAL HYGIENE PROBLEMS, fails to maintain minimal personal hygiene; unable to function independently.</td>
</tr>
<tr>
<td>1-10</td>
<td>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).</td>
</tr>
<tr>
<td>0</td>
<td>Inadequate information.</td>
</tr>
</tbody>
</table>

Note that for some adolescent programs substitute the Children’s General Assessment Form (CGAF; Shaffer et al., 1996) rating scale for the GAF. This scale is similar but contains more developmentally appropriate examples. If you use it, it is important note it above the axis IV ratings in the optional supplemental diagnostic impressions page at the back of the GAIN-I.

5.4 Using the GRRS and ICP to Support Diagnoses

If the GAIN-I has been done directly on the computer or after it has been data-entered into GAIN ABS, there are two parallel clinical reports that are used to support diagnosis:

- **GAIN Recommendation and Referral Summary (GRRS)** – A text-based narrative designed to be edited and shared with specialists, clinical staff from other agencies, insurers, and lay people. This report can be edited to suit the staff or organization’s preferences for tentative diagnoses.

- **Individual Clinical Profile (ICP)** – A more detailed report designed to help triage problems and help the clinician go back to the GAIN for more details if necessary (generally not edited or shared). This version has more detailed information in [brackets] specifying the rule by which self-reported data was used to print a given diagnostic statement.

Both reports allow the use of the client’s name, initials, or another term supplied by the person running the report. They can also use the site’s organizational name or another term supplied by the person running the report. Both reports have a section that provides an initial diagnostic summary based on the client’s self-report and any additional diagnoses or information that were put into the XDIAG section by the administrator. The clinician responsible for making the diagnosis will then have to eliminate duplicates, weigh in with other information, or decide what other information might be necessary to confirm or rule out a given diagnosis.

Note that many Core versions of the GAIN may include significantly less diagnostic information. Specifically, several Core versions:

- collect abuse/dependence symptoms for only “any substance” (skipping the S9 grid)
- do not collect lifetime history of health problems used in axis III (skipping P10)
- do not collect personality symptoms (skipping the M4 questions)
- do not collect the criteria for pathological gambling (skipping the symptoms in V9)

If you are using the GAIN for diagnosis you may want to add these items back into to your local Core or Full version.
6. Level of Care Placement

The GAIN is specifically designed to map onto the American Society of Addiction Medicine’s (ASAM) patient-placement criteria for specific levels of care (1996, 2001). In this chapter we will start by describing the continuum of care along which participants are expected to move. The second section walks through using the GAIN by specific ASAM criteria for placement. The third section discusses supporting these decisions with the placement sections of the GAIN Recommendation and Referral Summary (GRRS) and more detailed Individual Clinical Profile (ICP). Note that in the next chapter we will talk further about individualized referrals and treatment planning.

6.1 Continuum of Care

The patient-placement criteria are an evolving set of criteria for placing, continuing, and discharging participants along a continuum of care. In addition, there is also an increasing recognition of the need to incorporate screening, correctional, and specialized programs. In general an ideal continuum of care might include the following levels:

- **Outpatient Assessment/Outreach**. This is a state funding category to cover initial screening assessments to determine where to place participants in the continuum of care. It can be in a program, part of an outreach effort, or part of a centralized intake unit.

- **Level 0.5 Early Intervention**. This level is targeted at participants 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.

- **Level 1 Outpatient Services (OP)**. 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 able to resist use, and do not have a hostile home environment. Care is typically provided for less than 9 hours per week.

- **Opioid Maintenance Therapy (OMT)** can be a service in any of the above levels of care and is often provided in a specialized outpatient setting. It is targeted at participants who meet criteria for opioid dependence, have repeatedly failed earlier treatments, are at high risk of relapse, or are pregnant or likely to engage in behaviors that would put them or others at severe risk.

- **Level 2 Intensive Outpatient Services**. This level is targeted at participants 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 participants with some structure at home,
work or school (level 2.1 IOP; 9-20 hrs/wk) or partial hospitalization or day treatment for those who lack structure or are in a more hostile environment (level 2.5 PH; 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. Treatment also typically covers coping, nutrition, and vocational issues and may use multisystemic therapy interventions instead of group work.

- **Level 3 Residential/Medically Monitored Inpatient Services.** This level targets participants who have unsafe living environments and need time to develop their recovery skills, and it includes medical monitoring of manageable medical or psychological problems. It can include halfway houses or other low-intensity residential treatments that are typically part of continuing care (level 3.1 HH/LIRT), medium-intensity residential services that typically run fewer than 30 days (3.3 MIRT), longer-term residential treatment programs or therapeutic communities (3.5 LTR/TC), or high-intensity residential treatment or intensive inpatient programs that are designed to also treat medical or psychological problems (3.7 HIRT). A diagnosis of dependence is required for adults and typically (but not always) required for adolescents.

- **Level 4 Medically Managed Intensive Inpatient Services (MM/IP).** This level is targeted at participants meeting criteria for dependence who have acute biomedical, emotional, or behavioral problems requiring on-site medical or psychiatric care 24 hours per day. Typically, this is limited to short-term hospital-based care.

- **Correctional programs.** These are typically therapeutic communities (see Barthwell et al., 1995), and most are similar to level 3.5 but are targeted at participants 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 nonviolent offenders.

- **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 4-D), 24-hour medical monitoring (level 3.7-D), 24-hour clinical management or “social detoxification” (level 3.2-D), outpatient ambulatory care under close monitoring by a credentialed and licensed nurse (level 2-D), or outpatient without extended monitoring (level 1-D).

- **Specialized service delivery units.** These units typically serve participants across multiple treatment units and provide additional medical (including HIV counseling and testing), psychiatric (including further assessment), family (preservation, childcare, Head Start, contraception), and wraparound (transportation, housing, training, employment, financial, legal) services.

While many services need to be matched at the individual level (see the next chapter), these levels of care (as well as agency and geography) are often associated with access to “bundles of service.” 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. It should be noted that specific models of care
(e.g., manualized interventions, therapeutic communities) are somewhat tangential to this topology and may even cross its boundaries.

6.2 Using the GAIN to Address ASAM Patient-Placement Criteria

Both ASAM PPC 2 (1996) and PPC 2R (2001) provide a detailed description of the criteria for intaking, continuing, or discharging participants from each level of care. Many organizations further adapt this to their specific levels of care 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 core criteria include one diagnostic criterion (A) and six dimensional criteria (B1. Intoxication and Withdrawal Potential; B2. Biomedical Conditions and Complications; B3. Emotional/Behavioral Conditions and Complications; B4. Readiness for Change (formerly 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 services or monitoring of acute intoxication or withdrawal (e.g., detoxification, methadone) or other problems (such as treatment of medical or psychiatric problems). The second three criteria are actually more associated with distinguishing between who needs outpatient vs. inpatient or more structured substance use treatment. Moreover, most programs will also consider a range of other issues including the extent of illegal activities, vocational activities, victimization, psychosocial stressors, and time in controlled environment.

Like diagnosis, placement decisions should be made by a qualified clinician combining the information self-reported in the GAIN with information from other sources (e.g., laboratory tests, observations, family/collateral reports, prior treatment/service records, probation referrals, etc.). Since 80% of participants are seen in outpatient services (60% regular outpatient and 20% intensive outpatient), the discussion below and the ICP focus on identifying the smaller group that may need specialized or higher levels of care. Note that detailed knowledge of the service system available is often required to know whether a given program provides the needed services or can manage a particular type of problem. Finally, it should be recognized that in addition to what the staff member recommends, actual placement has to address what the participant is willing to do, what is available and what the funders will pay for. This said, below we have summarized the intent of each criterion and identified the elements of the GAIN that can be used for hand scoring of the core issues. As with Diagnosis, this is done automatically as part of the Individual Clinical Profile.

**Criterion A: Diagnosis.** While anyone can be referred for assessment or early intervention based on substance use, formal treatment is generally limited to those meeting DSM-IV criteria (APA, 1994) 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 determined. The prior chapter contains a detailed discussion of substance-related diagnoses. For placement (particularly when services are limited by diagnosis), it is often essential to review other
information when a participant’s self-report puts them just below the diagnostic threshold. Some common examples of this are listed below.

- Considering collateral reports of symptoms from family members, teachers, social workers, probation officers, prior treatment staff members, or medical staff members.
- Using prior assessments or treatment records or diagnoses.
- Using frequency and quantity information (S2) to infer that someone is using at a level that meets the dependence criteria of “tolerance.”
- Using past-week withdrawal symptoms (S3) to infer the dependence criteria of “withdrawal.”
- Using continued substance use from S2 in spite of substance related psychological (S9f, M1f-j), health (S9g, P6), or legal (L3, L5, L6) problems to meet the dependence criteria for being “unable to stop despite such problems.”
- Using reports of substance use while taking care of children, being in work, or school (S2w) as meeting the abuse criteria for “failing responsibilities at home, work or school.”
- Using reports of substance use while playing, driving, using equipment, knives or guns (S2w) as meeting the abuse criteria for “dangerous use.”
- Using reports of drug-related illegal activity (L3a15-19, L3d) or to cope with past trauma (M2h) as meeting the abuse criteria for “dangerous use.”
- Using multiple drug-related arrests (L5d15-19) to infer the abuse criteria of “repeated problems with the law.”

This kind of more detailed review is particularly warranted if a participant reports symptoms that are typically limited to people meeting criteria for dependence, including withdrawal (S9p) and substance-induced psychological (S9f) or health (S9g) problems. A limited review should also be considered for someone who reports symptoms that are much more common among people with an abuse or dependence diagnosis, including weekly use (13+ of 90 days in S2a-r1, S9e) or problematic use (S9d).

Note that in the GRRS narrative report (see appendix F), diagnosis is summarized only because it follows the five-axis diagnosis according to DSM-IV.

**Criterion B1: 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 toward facilities capable of addressing medical or 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 alchol users. Below is a list of the risk factors that the ICP will check for related to this dimension.
• High number of current withdrawal symptoms [12+ Sx in S3c]
• Moderate risk only: any current withdrawal symptoms [1+ in Sx S3c1 to S3c99]
• Moderate risk only: any history of seizures [S3a = 1]
• Current d.t.’s or seizures [S39 or S3c10 = 1]
• Getting drunk or high for most of the day weekly [S2s2 > 12]
• Drunk for most of past 48 hours [S2b = 6]
• History of seizures and current withdrawal symptoms [1+ symptoms in S3c and S3a = 1]
• Using daily [S2s1a < 45]
• Using opioids weekly [S2g1 or S2h1 or S2j1 > 12]
• Used in the past two days [S2a-r most recent/highest]
• In detoxification program during the past 90 days [S5a = 1+]
• In substance abuse treatment during the past 90 days [S7d > 2]
• In controlled environment for 13+ of the past 90 days [S2x = 13+ or E3f = 13+]
• In controlled environment for 1-12 days of the past 90 days [S2x = 1+ or E3f = 1+]

The GRRS will also print out a brief history of prior detoxifications, any current treatment or medication, an interpretative statement about the apparent need for detox or withdrawal related services, and any staff member comments or recommendations recorded in the supplemental patient placement module (XAS) on the GAIN.

**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 or inpatient care. Below is a list of the risk factors that the ICP will check for related to this dimension.

• High number of past-year biomedical problems [7+ Sx in P3a-k]
• Allergic to [text from p10av]
• Experiencing health distress in the past two days [P9 = 6]
• Frequent health problems in the past 90 days [P9a > 12]
• Current biomedical problems that frequently interfere with meeting responsibilities [P9b > 12]
• Health problems interfering with responsibilities in the past 90 days [P9b > 0]
• Requires medical assistance in order to attend treatment [P10 = 1 and text from P10v]
• Past-month history of hepatitis [P6a = 3]
• Lifetime history of hepatitis [P6a = 1-2]
• Past-month history of tuberculosis [P6b = 3]
• Lifetime history of tuberculosis [P6b = 1-2]
• Past-month history of other sexually transmitted diseases [P6c = 3]
• Lifetime history of other sexually transmitted diseases [P6d = 1-2]
• Past-month history of other infectious diseases [P6d = 3]
• Lifetime history of other infectious diseases [P6e = 1-2]
• Lifetime pattern of significant health care utilization [Sum P11a-c > 12]
• Emergency room utilization during the past 90 days [P11f > 0]
• Received physical health treatment during the past 90 days [P11e > 2]
• Medical services needed to participate in treatment [P10 = 1 and text from P10v]:
  • High needle risk during the past year [R1a-j{NPS} > 4]
  • Needle sharing in the past 90 days [R1m > 0]
  • Needle use in the past 90 days [R1k > 0]
  • High sex risk during the past year [R2a-n{SxRS} > 5]
  • Moderate risk only: Substantial sex risk during the past year [R2a-n{SxRS} > 1]
  • Multiple sexual partners in the past 90 days [R2p+q > 1]
  • Having sex without (barrier-based) protection in the past 90 days [R2r-s > 0]
  • Sexually active in the past 90 days [R2r-s > 0]
  • Needle use [R1k > 0] may exacerbate health problems related to infectious diseases [any of P6a-e > 0]
  • Not eating [R5a > 0] may exacerbate dietary problems [P10j = 1]
  • Currently pregnant [P5b = 5]
  • Uncertain if currently pregnant [P5b = 4]
  • Recovering from (successful) pregnancy within the past year [P5a < 5 and P5b = 1]
  • Significant health care utilization in the past 90 days [P11f-j = 1+ or P11k = 1]
  • Substance abuse tied to pain during intercourse [R2n = 1]
  • Use of alcohol [S2a > 2 or S2a1 > 0] may exacerbate health problems related to hepatitis [P6a > 0]
  • Use of alcohol [S2a > 2 or S2a1 > 0] may exacerbate health problems related to pregnancy [P5b1 = 5]
  • Use of alcohol [S2a > 2 or S2a1 > 0] may exacerbate nervous system problems [S3a = 1 or P10d = 1]
  • Use of analgesics (heroin, methadone, other painkillers) [S2g > 2 or S2h > 2 or S2j > 2 or S2g1 > 0 or S2h1 > 0 or S2j1 > 0] may exacerbate dental problems [P10b = 1]
  • Use of analgesics (heroin, methadone, other painkillers) [S2g > 2 or S2h > 2 or S2j > 2 or S2g1 > 0 or S2h1 > 0 or S2j1 > 0] may exacerbate health problems related to injuries [P10c = 1]
  • Use of analgesics (heroin, methadone, other painkillers) [S2g > 2 or S2h > 2 or S2j > 2 or S2g1 > 0 or S2h1 > 0 or S2j1 > 0] may exacerbate skeletal problems [P10q = 1]
  • Use of crack [S2d > 2 or S2d1 > 0] may exacerbate breathing problems [P10f = 1]
  • Use of marijuana [S2c > 2 or S2c1 > 0] may exacerbate breathing problems [P10f = 1]
• Use of marijuana \([S2c > 2 \text{ or } S2c1 > 0]\) may exacerbate health problems related to tuberculosis \([P6b > 0]\)
• Use of sedatives \([S2q > 2 \text{ or } S2q1 > 0]\) may exacerbate nervous system problems \([S3a = 1 \text{ or } P10d = 1]\)
• Use of stimulants (cocaine, crack, amphetamines, other stimulants) \([S2d, S2e, \text{ or } (S2pa + S2pb) > 2 \text{ or } S2d1 \text{ or } S2e1 \text{ or } (S2pa1 + S2pb1) > 0]\) may exacerbate endocrine (diabetes, thyroid) problems \([P10h = 1]\)
• Use of stimulants (cocaine, crack, amphetamines, other stimulants) \([S2d, S2e, \text{ or } (S2pa + S2pb) > 2 \text{ or } S2d1 \text{ or } S2e1 \text{ or } (S2pa1 + S2pb1) > 0]\) may exacerbate heart/blood problems \([P10e = 1]\)
• Use of stimulants (cocaine, crack, amphetamines, other stimulants) \([S2d, S2e, \text{ or } (S2pa + S2pb) > 2 \text{ or } S2d1 \text{ or } S2e1 \text{ or } (S2pa1 + S2pb1) > 0]\) may exacerbate nervous system problems \([S3a = 1 \text{ or } P10d = 1]\)
• Use of tobacco \([R4 > 2 \text{ or } R4a > 0]\) may exacerbate breathing problems \([P10f = 1]\)
• Use of tobacco \([R4 > 2 \text{ or } R4a > 0]\) may exacerbate health problems related to tuberculosis \([P6b > 0]\)
• Use of tobacco \([R4 > 2 \text{ or } R4a > 0]\) may exacerbate health problems related to pregnancy \([P5b = 5]\)
• Sexually active in the past 90 days \([R2r-s > 0]\) while having infectious disease \([P6a-d = 3]\)
• Sharing needles in the past 90 days \([R1m > 0]\) while having infectious disease \([P6a-d = 3]\)
• Legally deaf \([P4_3 = 1]\)
• Limited hearing \([P4_4 = 1]\)
• Legally blind \([P4_5 = 1]\)
• Limited vision \([P4_6 = 1]\)
• Lost limbs \([P4_7 = 1]\)
• Difficulties moving hands, feet, or body \([P4_8 = 1]\)
• Other physical impairment \([P4_99 = 1 \text{ and text from } P4_99v]\):
  • Lifetime history of convulsions, migraines or nervous system problems (such as epilepsy, seizures, strokes or blackouts) \([P10d = 1]\)
  • Lifetime history of heart, blood, or circulatory problems (such as high or low blood pressure, endocarditis, irregular heart beats, angina, heart attacks, blood diseases, abnormal bleeding or bruising) \([P10e = 1]\)
  • Lifetime history of asthma, shortness of breath, hoarseness, coughing up blood/phlegm or other respiratory problems, (such as bronchitis, pneumonia, emphysema, or wheezing) \([P10f = 1]\)
  • Lifetime history of diabetes, thyroid or other problems with how your body controls itself (low or high blood sugar, control of growth, weight, fluids; early or late body development, gland or hormone problems) \([P10h = 1]\)
  • Lifetime history of other major medical problems \([1+ \text{ in } P10b-c, \ g, \ j-s]\)
• Use of alcohol or other drugs \([S2d1 > 0]\) may cause problems for current pregnancy \([P5b = 5]\)

The GRRS will also print out a brief history of physical health treatment, any current treatment or medication, an interpretative statement about the apparent need for medical referral,
monitoring, or services and any staff member comments or recommendations recorded in the supplemental patient placement module (XAS).

**Criterion B3: Emotional/Behavioral Conditions and Complications.** The goal here is to identify the nature of any major emotional or 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 or monitoring (e.g., monitoring medication compliance). For others (e.g., active suicide ideation or attempts), it may imply the need to refer them for further psychiatric assessment or treatment, more psychologically managed care, or inpatient placement. There are actually multiple check boxes related to emotional and behavioral issues that might impact placement; each is shown below. Obviously, many may be substance induced and reviewed for their duration and pattern and monitored to see whether they go away with abstinence. Item M1c includes a short scale to assess the severity of homicidal or suicidal thoughts and should be used to make effective referrals should this be necessary. Items S9f, M1j, and M2h each attempt to get at the participant’s perception of whether their problems are substance induced. However, it is important to realize that they may not know. Moreover, substance use can make an existing problem worse (e.g., alcohol exacerbating depression (M1b), marijuana use exacerbating inattentiveness (M3a1-9), stimulants increasing impulsive/conduct problems (M3b) or aggression (E8)) or be a form of self-medication (e.g., cocaine use for symptoms of ADHD, heroin to reduce anxiety, heavy use to block out past trauma). The latter are particularly important because problems may actually get worse when substance use is initially stopped; this situation needs to be anticipated and managed (hopefully) and may require alternative treatment to be fully addressed and avoid relapse. In the GRRS this section is further divided into cognitive impairment, emotional conditions (e.g., problems related somatic, depression, suicide risk, anxiety, trauma), behavioral conditions (e.g., problems related to ADHD, conduct disorder), and crime and violence (e.g., illegal activity, violence). Below is a list of the risk factors that the ICP will check for related to this dimension.

- High internal (somatic, depression, anxiety) distress [13+ Sx in M1a-d, M1f > 12 or M1g > 1]
- High traumatic stress [5+ Sx in M2a-p or M2q = 13+ days]
- High number of behavioral problems in the past year [19+ in M3a-c or 9+ in M3b]
- High number of personality issues [16+ in M4a-x]
- High risk history of self-mutilation [2+ in M4z1-3 or 13+ in M4z4]
- Moderate risk only [1+ in M4z1-3 or 1+ in M4z4]
- Moderate risk only: homicidal thoughts in past year [M1c1 = 1]
- Experiencing mental distress in the past two days [6 in M1e, M2, or M3]
- Frequently bothered by emotional problems [12+ in M1f]
- Frequently bothered by traumatic memories [12+ in M2q]
- Frequently in trouble for behavioral problems [12+ in M3c]
- Experiencing mental distress in the past 90 days [3+ in M1e, M2, or M3]
- High suicidal risk in past year [3+ Sx in M1c]
- Moderate risk only: suicidal thoughts in past year [M1c2 = 1]
- Moderate risk only: having problems with traumatic memories in the past year [1+ in M2a-c]
- High number of behavioral problems in the past year [19+ in M3a-b or 9+ in M3b]
- Moderate risk only: many behavioral problems in the past year [6+ in M3a-b]
- Psychiatric emergency room utilization during the past 90 days [M5f > 0]
- Received mental health treatment during the past 90 days [M5e > 2]
- Lifetime history of mental health treatment [M5 = 1]
- High levels of criminal activity in the past year [4+ on L3a1-19 {GCS}]
- Interpersonal criminal activity in the past year [1+ on L3a8-14 {ICS}]
- Weekly illegal activity for money during the past 90 days [L3e = 13+/90 days]
- Illegal activity for money during the past 90 days [L3e = 1+/90 days]
- Illegal activity other than drug use in the past 90 days [L3d = 1+/90 days]
- Five or more arrests in the past 90 days [L5c > 4]
- Five or more arrests in lifetime [L5 > 4]
- Arrest in the past 90 days [L5c > 0]
- Lifetime history of arrest [L5 > 0]
- On probation during the past 90 days [L6a > 1 or L7_4 = 1]
- On parole during the past 90 days [L6b > 1 or L7_7 = 1]
- In jail/prison during the past 90 days [L6c > 1 or L7_5 = 1]
- In detention during the past 90 days [L6d > 1 or L7_8 = 1]
- Involved in the criminal justice system in the past 90 days [L5b > 2 or L7_1-99 > 1]
- History of 3 or more DUI convictions in the past 10 years [L7a > 2]
- Lifetime history of DUI arrests [L5a12 = 1 or L5d14 > 0 or L7a > 2]
- Outstanding warrants that need to be addressed [L8 = 1]
- Substantial illegal income during the past 90 days [V11k > $499]
- The participant reports high levels of aggression [7+ on E8a-n {GCTS}]
- The participant reports moderate levels of aggression [3+ on E8a-n {GCTS}]

The GRRS will also print out a brief history of mental health treatment, any current treatment or medications, an interpretative statement about the apparent need for medical referral, monitoring, or services and any staff member comments or recommendations recorded in the supplemental patient placement module (XAS).

**Criterion B4: Readiness for Change.** The goal here is to identify the extent to which the participant is internally and externally (e.g., court/family/other pressure) motivated to go into treatment and change their substance use, as well as issues that might make it difficult (regardless of motivation) for the participant to do so. Outpatient treatment assumes that the participant is sufficiently motivated and able to manage their participation and attendance, though they might need support and encouragement. Methadone maintenance programs and intensive outpatient programs assume that more support and structure is needed in order for the participant to successfully participate. This may also include court or employer mandates. Inpatient treatment is often indicated if there is increasing resistance 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 or recovery home to achieve this goal. While stages of change theory has traditionally focused on internal motivation, the GAIN views motivation more broadly to include both internal and external factors. If the situation is unclear, it is useful to further examine the participant’s perceived pressure to be in treatment (B4), expectations about the length of stay in treatment (B6), barriers to treatment (B7, B9a) and the substance abuse treatment services wanted (S10, S10a). Below is a list of the risk factors that the ICP will check for related to this dimension.

- Does not perceive a need for treatment \([B6 = 0]\)
- Does not perceive a need for more than minimal treatment \([B6 < 4] \text{ or } (S8g = 0)\)
- High resistance \([3+ Sx \text{ in } S8a-d]\)
- Low motivation \([2 \text{ or less in } S8e-j]\)
- Does not recognize alcohol/drug use as a problem when it is \([S8r = 0 \text{ and } S9h-u > 1]\)
- Does not perceive a need for treatment \([B6 = 0] \text{ or } (S8g = 0)\)

In the GRRS, the narrative will also comment on the extent to which the participant perceives a lot of pressure to be in treatment (including from whom), his readiness to quit (or stay abstinent), the reasons from a list that they identify as “good reasons to quit,” and any staff member comments or recommendations recorded in the supplemental patient placement module (XAS).

**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 due to 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. Relapse is also more likely if the participant has reported daily use (S2s1) or the weekly use of opioids (S2). 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. If a situation is unclear, it is often useful to further examine if the age of first use was under 15 (S9v), whether there is a history of prior treatment failures (S7), and if there is a pattern of poor impulse control (M3a16-18). Below is a list of the risk factors that the ICP will check for related to this dimension.

- Daily use \([S2s1a > 44]\)
- Low self-efficacy to resist \([3+ 0 \text{ Sx in } S8m-q]\)
- Low problem orientation \([2 \text{ or less in } S8r-w]\)
- Using opioids weekly \([S2g1, S2h1, \text{ or } S2j1 > 12]\)
- Using substances to forget about traumatic memories \([M2h = 1]\)
- First used substances or got drunk under the age of 15 \([S9v < 15]\)
- Reported 3 or more symptoms of dependence/abuse in the past month \([S9h-u > 2]\)
The GRRS will also focus on continued use in spite of current (or past) treatment and provide an interpretative statement, and any staff member comments or recommendations recorded in the supplemental patient placement module (XAS).

**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 structured or controlled environment is required. This includes understanding the risk from the participants living, work or school, and social environment (e.g., extent to which people are using alcohol/drugs, violent, engaged in illegal activity 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), or satisfaction with current situation or relationship. People with systemically hostile recovery 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. If the participant has spent 13 or more of the preceding 90 days in a controlled environment (S2x), it is often important to consider their pattern of use when they were in the community and able to use and how this community relates to the one where they would be in a given placement (or after discharge). In the GRRS narrative the report is further divided into family environment, substance use in the environment, school environment, work environment, sources of social support, personal strengths, spirituality, satisfaction with the environment, and victimization. Below is a list of the risk factors that the ICP will check for related to this dimension.

- Weekly family problems in the past 90 days [13+/90 days in E3]
- Participant DCFS involved [B2b = 7]
- Participant’s children involved with DCFS/state [E4a4 = 1, E4c > 0, or E4e > 0]
- Participant’s children have been living with someone else during the past 90 days [E4g > 0]
- Parent involved in life of children [1+ in E4j-p {CAS}]
- Parent perceives own children as having major problems [E4q-v < 12]
- No parent actively involved in adolescent’s life [All 0 in B2e-j {PAS}]
- Parent involved in adolescent’s life [1+ in B2e-j {PAI}]
- Significant time in a controlled environment during the past 90 days [E2f > 12]
- Some time in a controlled environment during the past 90 days [E2f 1-12]
- Weekly alcohol use by others in home [13+ on E2d]
- Weekly drug use by others in home [13+ on E2e]
- Drug use by others in home [1+ on E2e]
- Environment hostile to recovery [12+ in E5a-fg, E6a-g, or E7a-g or 40+ across them]
- Participant is not close to anyone in recovery [E5f, E6f, and E7f = 4 or skipped]
- The participant has been victimized in the past 90 days [1+ on E9u]
- Lifetime history of victimization [1+ on E9a-d]
- High levels of traumatic victimization [4+ on E9a-r {GVS}]
- The participant is not satisfied with environment [2 or less on E15a1-6]
• The participant reports multiple interpersonal psychosocial sources of stress in the past year [E10_1-99 > 1]
• The participant reports multiple environmental sources of stress in the past year [E11_1-99 > 1]
• Minimal to no sources of social support [E12a-j {GSSI} < 2]
• The participant is very satisfied with environment [E15a-f {GSI} > 17 ]
• The participant is not very satisfied with environment [E15a-f {GSI} < 7]
• Participant involved in civil proceedings [1+ in L1_1-99]
• May require special education services [B2a < 18 AND V1a = 1]
• In school during the past year [V3 > 1]
• High number of school problems during the past year [V3a-j > 5]
• In school during most of the past 90 days [V3k > 44]
• In frequent trouble at school during the past 90 days [V3p+q > 12 or V3r > 1]
• In trouble at school during the past 90 days [V3p, q or r > 1]
• Worked during the past year [V6 > 1]
• High number of work problems during the past year [V6a-j > 5]
• Worked during most of the past 90 days [V6k > 44]
• In frequent trouble at work during the past 90 days [V6p+q > 12 or V6r > 1]
• In trouble at work during the past 90 days [V6p, q or r > 1]
• High number of financial problems during the past year [V8a-k {FPI} > 5]
• Weekly financial problems during the past 90 days [V8m > 12]
• High number of gambling problems during the past year [V9a-k {PGI} > 5]
• Weekly gambling during the past 90 days [V9m > 12]
• Spending a third or more of income on alcohol or drugs [V11p+q/V11n > 0.33]

The GRRS will also focus on continued use in spite of current (or past) treatment and provide an interpretative statement, and any staff member comments or recommendations recorded in the supplemental patient placement module (XAS).

6.3 Using the GAIN Recommendation and Referral Summary (GRRS) and Individual Clinical Profile (ICP) to Support Placement Decisions

General Conceptualization of Placement Needs. The GRRS is organized based on the principals outlined by ASAM (2001) but has been expanded to address other things commonly included in treatment summaries to support review by insurance, Medicaid, and accreditation agencies (e.g., CARF, JCAHO) and treatment planning (discussed further in the next chapter). This includes several things that are consistent with but largely absent from the ASAM manual (e.g., pain assessment, victimization, illegal activity, criminal justice, school or employment mandates, personal strengths). It is also focuses more on placement in relations to specific services or treatment needs rather than overall levels of care. This is because the latter are just a proxy for the “bundles” of available service and may have little or nothing to do with what is actually available in any given community or to a given person. While intake severity is
important, it is also important to consider the interaction of each problem area with treatment and services over time. In assessing placement and treatment needs, figure 6.1 shows how information on the GAIN can be used to help understand whether someone has a current problem, a past history of problems, or no problem (the horizontal dimension) and whether they are currently in treatment, have a history of past treatment, or no treatment history (the vertical dimension). The type of service or treatment becomes more intense as you move from the upper left to lower right corner. Consider, for instance, a given level of current symptom severity. In the absence of any prior treatment history the clinician would generally be more likely recommend a less invasive treatment (e.g., buprenorphine vs. methadone, outpatient vs. residential, etc.). Reporting the same level of problems while already in treatment, in contrast, may be interpreted as a “nonresponse” to treatment and lead to a recommendation to increase the intensity or level of care. Past treatment requires consideration of the recency, speed with which the problem returned, and willingness of the person to try again. The latter is important because while 50% of people recover, most require three to four episodes of recovery before reaching at least a year of sobriety.
Past problems and past treatment suggest the need for increasing levels of monitoring for relapse. Past problems with current treatment suggest the potential readiness to step down or be discharged. No problems with reports of prior treatment suggest that the participant may be misunderstanding or misreporting their symptoms or treatment history and generally should be reviewed and reclassified.

At the end of the GAIN is an optional, supplemental ASAM impressions sheet (XAS) where staff can record their impression of placement in this scheme in ascending order of priority as:

1. No problem (regardless of treatment history)
2. Past problems (with or without treatment history, consider monitoring and relapse prevention)
3. Problems (with no treatment history, consider initial or low invasive treatment)
4. Problems w/past treatment (consider more intensive treatment and re-intervention strategies)
5. Tx w/no problems (responding to treatment, review for step down or discharge)
6. In Tx w/reduced problems (partially responding to treatment, review need to continued or step up)
7. In Tx w/problems (review need more intensive or assertive levels)

This rating would be made for the overall need for substance abuse treatment and for each of the specific ASAM dimensions in relations to the specific services (e.g., intoxication/withdrawal problem and detoxification history; health problems and health care utilization history; emotional/behavioral problems and mental health/legal intervention; readiness for change and motivational interventions; relapse potential and relapse prevention interventions; recovery environment and residential/environmental factors/interventions). There is also a place in the overall severity rating at the beginning to rate severity. While dependence and abuse are automatically drawn from the diagnosis section, the overall severity rating is useful for incorporating information from other sources, rating the need for early intervention, or identifying other relationships (e.g., codependent, collateral). At the bottom of the page is a place to note the overall placement recommendation using ASAM levels of care. After this and each of the specific ratings are places to add text related to specific service needs, program placement recommendations, availability, or other issues. This sheet can be used directly to meet most placement requirements or used to input data that will then be included in the two main clinical reports discussed further below.

**Organization and Use of the GAIN Recommendation and Referral Summary (GRRS) to Support Placement.** The GRRS (see sample in appendix F) includes a section to evaluate the specific need for treatment based on use, abuse, and dependence for ASAM criterion A and to review the six dimensional criteria for ASAM criteria B1 to B6. The GRRS also incorporates a substance use and treatment history (after diagnosis) and review of a detailed text narrative on age of first use, preferred substance, and substances for which the client perceives a need for
treatment. This is followed by a paragraph for each DSM-IV substance use disorder diagnosis (in order of clinical severity from the S9 grid).

- Diagnosis and specific symptoms reported in the past month, year and lifetime.
- Recency, frequency, and peak amount of use.
- The date and amount of last use (if collected; required for some insurance).
- Where a class of drugs (e.g., amphetamines), the specific drugs reported.

At the end of this section there is a list of other substance used (but for which diagnostic criteria are not met), a prompt to add more identified through biometric (e.g., urine, saliva, hair) testing or collateral reports, and a history of substance abuse treatment, including (if collected) a detailed treatment history (program, level of care, intake and discharge date).

The next sections of the GRRS are arranged by the six dimensions of ASAM criteria B reviewed above (Acute Alcohol/Drug Intoxication and Withdrawal Potential; Biomedical Conditions and Complications; Emotional, Behavioral, or Cognitive Conditions and Complications; Readiness to Change; Relapse, Continued Use, or Continued Problem Potential; Recovery Environment). Within each section the text reviews the lifetime history of problems in the area, including the severity of symptoms in the past year and prevalence of problems in the past 90 days. In order to better map onto insurance, state, federal, and accreditation requirements, the description of the problems in several large sections are further subdivided into labeled paragraphs listed below.

- **B3 (Emotional)** is further subdivided into emotional problems (e.g., somatic, depression, suicide, trauma); behavioral conditions (e.g., ADHD, conduct disorder, pathological gambling, other impulse control problems), violence (physical and verbal); illegal activity (property, interpersonal/violent, other drug related including possession, dealing, prostitution, gambling and probation violations); and cognitive conditions.

- **B4 (Readiness to Change)** includes an optional section on reasons for quitting that has implications for readiness and is also explicitly used to support motivational interviewing protocols.

- **B6 (Recovery Environment)** is further subdivided into family environment; home environment; school environment; work environment; sources of social support; personal strengths; spirituality; satisfaction with environment; and victimization.

Note that for illegal activity and history of victimization the descriptions in the GRRS are intentionally general to avoid creating legal problems or disclosure to potential perpetrators should the document be shared. Each of the above problem sections are then concluded with a summary of prior treatment, the ratings from the optional ASAM ratings page (if used) and prompts for treatment planning (discussed further in the next section).

The last section of the GRRS reviews needs for treatment coordination based on the reports above and the programs and levels of care that best meet the specific services that have been
recommended. While it is consistent with ASAM’s approach to placement, the focus here is much more on the specific services needed and the available programs that can best provide them. There are also prompts to identify and comment on less-than-ideal placements (e.g., placing someone into an OP program while waiting for the a residential slot or when the participant is not willing or able to go). If a specific recommendation or comments were made on the optional ASAM recommendation page they will come out here. Any notes keyed into the dataset during the interview or after (relevant to placement or not) will also come out on the last page of the GRRS and should be incorporated or deleted as part of editing the file.

**Organization and Use of the GAIN Individual Clinical Profile to Support Placement.** The ASAM Placement section of the ICP (see sample in appendix F) has three parts. The first part goes through the above dimensions and flags any problems or issues that might need to be reviewed or that relate to placement in a higher level of care. As with the diagnostic section discussed earlier, all sections of the ICP include information in brackets cross-referencing the questions and the criteria used to trigger printing the statement. There are several hundred potential statements (listed above), with the number used varying by participant. If there are few statements on the ICP, the participant did not self-report many problems. For a more complicated case the number of problems listed on the ICP often continues for several pages. While some of the information is redundant with the 5-axis diagnostic information, there is a different focus.

These narrative statements are followed by a second part called the ASAM Placement Profile. Organized the same way, this section provides a numeric and graphical summary of the participant’s responses. While less detailed, its format is constant across participants and is particularly useful for seeing patterns and prioritizing problems across sections. The scores go down the middle column and can be plotted to the right in low, moderate, and high ranges (formerly referred to as low, clinical, and acute). Within each section are rows to identify the recency, breadth, and prevalence of problems (discussed further in the next chapter). Rather than categorical or narrative statements, however, the focus is on dimensional measures using symptom counts, number of days or times, or recency. For substance problems severity is examined during the lifetime and past month in terms of any problems, specifically those related to dependence. Similarly, for the other areas each issue is presented in a continuous form. Any that reach into the high range trigger narrative statements printed in the previous section. However, here we also see those in the clinical or low range and can interpret severity in relation to other problems. Chapter 9 and the CD contain norms on most of the core psychopathology scales for adults and adolescents by level of care.

This profile is followed by a third section, Behavior and Service Utilization in the Past 90 Days. This is in order of the GAIN and includes all of the past-90-day questions. The behaviors are on the left and the services associated with them are on the right. It is important here to distinguish between a lack of problems and a lack of problems while the corresponding treatment and services are being provided.
7. Individualized Treatment Planning

This section presents guidelines for working with your participants to develop individualized treatment plans using the GAIN, GRRS, and ICP and to promote developing these treatment plans in a consistent manner. 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 participant involvement is essential to developing meaningful and useful treatment plans (Dennis, Fairbank, et al., 1995; Sobell, Sobell, and Nirenberg, 1988). Active participant involvement in treatment planning and goal setting can:

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

Below are some general recommendations and guidelines for developing an initial treatment plan with participant 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 participant. 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, the GAIN and GRRS or other initial assessment summary 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 participant once he has arrived at a primary treatment location.

The GAIN will provide a general overview of problems in specific areas (e.g., 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 participant. 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 information loss when cases are transferred between counselors, and (c) allows for better program planning to meet the needs of participants (including tools to reduce paperwork or make it more clinically useful). The GAIN has additional advantages over other instruments in that it was designed to lead directly into problem definition and treatment planning and facilitate communication with specialists and agencies outside of the participating system (e.g., medical,
psychiatric, or vocational referrals) by using their standards and language.

**Transitioning from Assessment to Planning.** Clearly communicating that the GAIN will be used for treatment planning and reinforcing this perspective during the assessment will result in getting better information. Throughout the assessment and debriefing phase you should make it clear to the participant that you are listening to them and understand their individual 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 members about specific requests that the participant will make of you. This means you can reduce your response time. Finally, it is important to realize that the assessment process itself is helping the participant define and communicate problems and desires which he might not have otherwise been able to discuss. This is very different from many diagnostic assessments that focus on trying to categorize people.

It is essential to start an informal treatment plan during the very first session even before developing a formal treatment plan. At the most pragmatic level it is important to check for immediate threats or barriers to the participant’s (a) return for the next session, (b) personal safety, and (c) short-term sobriety. After the assessment is completed (or at the end of the first session), you should review the available information and discuss with the participant their plans immediately after leaving the assessment, between now and the next session, and for coming to the next session. Some participants may require admission to one of the ASAM levels of detoxification before they can 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 (the M1c items on the GAIN-I) or threats to personal safety (particularly item E9 on the GAIN). Next, make sure that the participant has thought through a plan for coming back for the next session (e.g., how he will get there). Finally, it is often desirable to provide some level of intervention or make sure the participant 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 participant and a wraparound coordinator, vocational services coordinator, case manager, or other staff member. For example, if the participant is concerned about being unable to keep the next few appointments because of unmet child-care needs, meet with the participant and the case manager together immediately (if possible) to assist the participant in finding a suitable solution to this problem. It is particularly important to cover this issue for new participants when the assessment is being done in their first or second session.

**Conceptualization of Core Problems.** As part of the GRRS (or other clinical summary) the severity of problems should have been summarized. While useful for diagnosis or placement, translating this into explicit treatment plans often requires further details or understanding. For those areas were there is a current or past problem, clinical staff review the relevant sections of
the GRRS, ICP and GAIN. The GRRS will identify the core problem and give a general
description. The ICP gives more explicit statements, scale scores, and detailed answers to narrow
down clinical issues. It also includes code in [brackets] that identifies the specific questions on the
GAIN that were the basis for the information if the clinician wants to go back to the individual
items on the GAIN. This information is designed to help clinicians conceptualize a give problem
three dimensions:

1. **Recency** – has this problem occurred and, if so, when did it last occur? Things that
   happened in the past week, month 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).
Thus the goal of the GAIN review 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 or referrals. In the multiple dimensions of the individual’s life,
this tells you about where a problem is and what it is probably related to. You can use this to
demonstrate your understanding to the client, but will then want to work with them to get more
details. For instance, you might identify that there is substance use and some illegal activity by
others in the client’s home, which is in public housing. Such an environment is hostile to recovery
and puts the family at further risk of eviction or homelessness. Further probing might identify that
the activity by others in the home is by a current significant other, spouse, parent, or other person,
and you may be able to identify potential interventions (e.g., a woman or child being victimized,
who might be eligible to go into a shelter or other form of protection).

**Feedback and Targeting of Problems.** If you went through a series of tests at the doctor’s
office or hospital, you want feedback on the results, how to interpret them, and information on
what your options are (including pros, cons, and the clinician’s recommendations). We therefore
recommend that the first clinical session after the assessment be dedicated to conducting a face-
to-face review of the core problems identified in the assessment with your participant in order to:
• identify and correct errors, misperceptions, and miscodes regarding answers to specific questions.
• allow the participant to clarify and expand upon the information recorded in the standardized assessment.
• provide the participant with a concise overview of his problems in eight important areas of functioning.
• provide a format for comparing and discussing the severity of problems as viewed by the participant and you.
• provide a logical starting point for developing an individualized treatment plan with active participant involvement.

Begin the session by telling the participant that you would like to review the findings from the standardized interview completed in the previous session because you expect this review to help develop a plan for addressing the problems in his life related to drug use. We recommend you review all modules of the assessment completely, including modules in which the participant and you agree few or no problems exist. We believe that a complete review often provides the participant with a clear “snapshot” of his 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 participant’s attention on the information to be covered in that module. Briefly review the participant’s response to each section of the assessment modules, including the participant’s and your ratings of the problem severity in each area. Encourage the participant 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 strive 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 participant. Our experience indicates that most GAIN reviews should be completed within a single session.

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

As an alternative to reviewing the full instrument, many clinicians prefer to use a shorter and more narrative report like the GRRS (see appendix F). Another, more focused report that is often used

**Prioritizing General Areas for Treatment Planning.** The next step is to prioritize the general areas of potential needs and identify specific areas on which to work. Exhibit 7-1 shows both the participant and counselor ratings on one of the GAIN profiles. Both participants and counselors were asked to rate the extent to which a participant needed help in each area; the last line is the sum across areas. In summarizing both the participant’s rating and your own, it is important to acknowledge your areas of agreement and disagreement (e.g., risk behaviors and mental health in the example). While the counselor should not dwell on or be sidetracked by areas of disagreement, acknowledging such areas helps establish the appropriate level of rapport. In other words, be supportive but honest.

**Exhibit 7-1. Treatment Planning Worksheet**

<table>
<thead>
<tr>
<th>Item</th>
<th>Participant (O)</th>
<th>Staff( )</th>
<th>Do Not</th>
<th>Getting Need</th>
<th>Help Already</th>
<th>3+ mos.</th>
<th>in 0 to 3 mos.</th>
<th>Need Help</th>
<th>Need Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>B9, B10 Tx Arrangement</td>
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<td>1</td>
<td>2</td>
<td>3</td>
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<td>0</td>
<td>1</td>
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<td>1</td>
<td>2</td>
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<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>

When using the Full version of the GAIN, participants who request help in the next three months (or now) will be asked to identify what kind of help they want using a list of common requests and an open-ended “other” statement. Below is a list of the types of services they are explicitly asked about and that, where appropriate, will be listed in the ICP.

**Access to Care**

- Making transportation arrangements [B9a1]
- Making child care arrangements [B9a2]
- Scheduling around work, school, or family responsibilities [B9a3]
- Paying for treatment [B9a4]
- Language, religious, ethnic or cultural issues [B9a5]
- Clothing [B9a6]
• Food [B9a7]
• Other issues that need to be addressed for participant to be able to come to treatment [B9a99v]

Substance Abuse Treatment
• Alcohol or drug use [S10a1]
• Family’s alcohol or drug use [S10a2]
• Situation at home, work or school [S10a3]
• Self-help and support groups [S10a4]
• Detoxification [S10a5]
• Getting treatment [S10a6]
• Getting methadone (methadose), Antabuse, or other medication (disulfiram, LAAM) for alcohol or other drug withdrawal or cravings [S10a7]
• Anything else related to alcohol or drug use [S10a99v]

Physical Health Treatment
• Getting dental treatment [P13a1]
• Pregnancy or family planning [P13a2]
• Testing, counseling, or education on hepatitis, TB, HIV, or STDs [P13a3]
• Help with sexual or fertility problems [P13a4]
• Getting health care treatment [P13a5]
• Coping with current medical problems [P13a6]
• Paying for health care treatment [P13a7]
• Physical handicap or physical therapy [P13a8]
• Anything else related to participant’s health situation [P13a99v]

Risk and Protective Behaviors
• Changing participant’s pattern of needle use [R7a1]
• Changing participant’s pattern of sexual behavior [R7a2]
• Getting information about health or prevention [R7a3]
• Diet, exercise, or relaxation programs [R7a4]
• Quitting or cutting back on smoking [R7a5]
• Anything else related to risk behaviors [R7a99v]

Mental Health
• How participant has been feeling emotionally [M6a1]
• How participant’s mind or body seems to be working [M6a2]
• How participant controls his mind or behavior [M6a3]
• Concerns about suicide [M6a4]
• Memories that disturb participant [M6a5]
• Getting medication to help control themselves [M6a6]
• Anything else related to participant’s emotional or mental situation [M6a99v]
Environment
- Housing [E16a1]
- Children the participant lives with or sees regularly [E16a2]
- People with whom participant lives, works, goes to school, or socializes [E16a3]
- How participant spends free time and gets social support [E16a4]
- People participant has been avoiding, arguing, or fighting with [E16a5]
- People who have or might attack or abuse participant physically, sexually, or emotionally [E16a6]
- How participant handles arguments [E16a7]
- Anything else related to environment or social situation or coping [E16a99v]

Legal Situation
- Civil justice proceedings [L10a1]
- Being involved in illegal activities [L10a2]
- Criminal justice proceedings [L10a3]
- Making arrangements with a probation officer, parole officer, or other officer of the court [L10a4]
- Child custody case [L10a5]
- Anything else related to participant’s legal situation [L10a99v]

Vocational Situation
- Going to training or school [V12a1]
- Getting a school loan or getting out of default on a school loan [V12a2]
- Getting a (better) job [V12a3]
- Getting or keeping public or private benefits [V12a4]
- Financial situation [V12a5]
- Gambling [V12a6]
- Identification (Social Security card) [V12a7]
- Childcare while in work or school [V12a8]
- Anything else related to school, work, or financial situation [V12a99v]

Following these is a list identifying issues typically required in a treatment plan by agency, accreditation, or state or federal regulations (see below) that includes red flags usually indicating the need for specific services or higher levels of care.

- Coordinate care with existing substance abuse treatment providers [S7f = 1]
- Monitor substance abuse medication compliance [S7c = 1]
- Consider more intensive treatment [(S9c-u, number of 3s > 9) or (S9n-u, number of 3s > 5) and S7f = 1]
- Refer for immediate treatment [(S9n-u, number of 3s > 2) and S7f = 0]
- Refer for treatment or early intervention [(S7f = 0 and S9c-u, number of 3s > 0)]
- Review need for continuing care [S7f = 1 and S9n-u, number of 3s > 0]
• Review need for detoxification or withdrawal services \[(\text{sum of } S3c1-99 > 12), \text{ or } (\text{Max } S2a-r = 6), \text{ or } (90-S2s1a > 45) \text{ or } (S3a = 1 \text{ and \ sum of } S3c1-99 > 0) \text{ or } (S3c9 \text{ or } S3c10 = 1)\]
• Coordinate care with physical health provider \([P11k = 1]\)
• Monitor physical health medication compliance \([P11d = 1]\)
• Refer for follow-up or additional care related to health problems \([P3, P3a-k, \text{ sum of answers } > 6] \text{ or } [P9a > 12] \text{ or } [\text{sum of } R1a-j > 1] \text{ or } [\text{sum of } R2a-n > 2]\]
• Coordinate care with mental health provider \([M5j = 1]\)
• Monitor mental health medication compliance \([M5d = 1]\)
• Refer for follow-up or additional care related to internal mental distress problems \([\text{max of } M1e, M2 = 6] \text{ or } [\text{sum of } M1a1-M1d12, M2a-p, > 23] \text{ or } [M1f > 44] \text{ or } [\text{max of } M1g, M2q > 12]\]
• Follow-up on homicidal/suicidal risk in past year \([2+ Sx \text{ in } M1c]\)
• Monitor homicidal/suicidal risk in past year \([1+ Sx \text{ in } M1c]\)
• Refer for follow-up or additional care related to behavior problems \([M3 = 6] \text{ or } [M3a1-18, M3b1-15, \text{ sum of answers } > 18] \text{ or } [M3c > 44]\]
• Follow-up on self-mutilation \([M4z4 > 0]\)
• Review history of self-mutilation and monitor \([M4z1-3 > 0]\)
• Refer to intervention related to readiness to change \([B4a-h, \text{ sum of answers } > 3] \text{ or } [S8a-d, \text{ sum of answers } > 2] \text{ or } [S8e-j, \text{ sum of answers } < 3]\)
• Refer to interventions related to relapse prevention \([S8k \text{ reversed}, S8m-q, \text{ sum of answers } < 3] \text{ or } [S8s-w, \text{ sum of answers } < 3]\)
• Refer to residential treatment or interventions related to reducing recovery environment risk \([E5a-g, E6a-g, E7a-g, \text{ sum of answers } > 39] \text{ or } [E7a-g, \text{ sum of answers } > 11] \text{ or } [4+ \text{ on } E9a-r \text{ (GV1)}]\)
• Review need for reporting child maltreatment \([1+ \text{ on } E9a-q] \text{ and } [E9e18 = 1]\)
• Follow-up on high levels of traumatic victimization \([4+ \text{ on } E9a-r \text{ (GV1)}]\)
• Follow-up on recent victimization \([E9t > 2] \text{ or } [E9u > 1]\)
• Follow-up on current concerns about being victimized again in the near future \([\text{any } 1 \text{ in } E9n-r]\)
• Coordinate care with DCFS/CPS \([B2b = 7] \text{ or } [E4a4 = 1]\)
• Coordinate care with probation officer \([L7_4 = 1]\)
• Coordinate care with parole officer \([L7_7 = 1]\)
• Coordinate care with criminal justice system \([1+ \text{ in } L7_1 \text{ to } 99]\)
• Follow-up on illegal activity \([L3a1-99, \text{ sum of answers } > 4] \text{ or } [L3d > 12] \text{ or } [L3e > 1]\)
• Coordinate schedule with school \([V3 > 2]\)
• Coordinate schedule with work \([V6 > 2]\)

Reviewing the above lists from the ICP can also be very useful in completing the treatment recommendations sections in the GRRS. While the general recommendations that are already there are useful, adding in specific things that the client has asked for or clearly needs will make the report more useful. It will also mean more to the client when you review it with them.
8. Training, Certification, and Clinical Supervision

Training, certification, and clinical supervision are three critical elements for the successful use of the GAIN whether for treatment or a research study. Our national training model consists of four days of training with the purpose of training staff members to return to their agency or site and become Local Trainers (see chapter 1, section 1.3 for details) who can then train others at their site to administer the GAIN. Local Trainers have the role of training staff at their site, both initially and ongoing to deal with staff turnover. This chapter deals with the practical issues involved with this work. The first section (8.1) is a how-to list for holding that first staff training, while the next section (8.2) describes effective methods for training new staff due to turnover. Section 8.3 describes our certification process, including a list of certification levels available from the GAIN Coordinating Center (GCC; see chapter 1 for description). Section 8.4 includes information on how to reach each level of certification. Section 8.5 contains required documentation for certification. Improving one’s clinical use of the GAIN through clinical supervision is discussed in section 8.6. While the certification process described in section 8.3 focuses on the collection of reliable and valid data using the GAIN, clinical interpretation of information collected using the GAIN as discussed in section 8.6 requires the integration of other information and should always be done by someone with formal clinical training (e.g., counseling, psychology, social work).

8.1 Holding a Major Initial Training

Conducting an effective training requires a lot of forethought and action. Initial trainings are typically large group trainings that cover a wide scope of information. This section contains a series of action lists for holding a major initial training. The information is broken down by time: items to do before, during, and after the training.

Before the Training. Prior to holding an initial training, a series of decisions and arrangements need to be made and materials need to be created. Decisions related to the training structure, materials, and logistics are listed below.

- **Decide on scope of training (research, clinical, or both)** – The GAIN instruments were designed to integrate research and clinical assessments for substance abuse treatment. They can and have been used effectively for research projects, in clinical settings, and for both simultaneously. When planning a training, knowing where the instruments will be used and for what purposes will help define the scope of the training.

- **Choose a form of the GAIN (I, M90, GAIN-Q, GCI, GCF)** – Depending on the purpose of the training, one of several forms of the GAIN instruments could be used. The GAIN-I is the most comprehensive and is used for intake assessments; the GAIN-M90 is used for follow-up, and items cover behaviors during the previous 90 days; the GAIN-Quick is a general assessment used to identify various life problems; and the GCI and GCF are for an adolescent participant’s parent or caregiver, an adult participant’s spouse or partner, or other people who have in-depth knowledge of the participant’s behavior. The GCI is an
initial collateral assessment and the GCF is a follow-up or monitoring collateral assessment.

- **Choose a version of the GAIN** – There are different versions within each form of the GAIN. Originally, versions were tracked by date (e.g., 1296 meant December 1996), but we now use a three-digit numbering system (e.g., 5.6.0). The first digit refers to the version and identifies a group of instruments that are almost identical. The second digit indicates a change (addition, deletion, or modification) of the questions or responses has been made that impacts data entry, scoring, or interpretation. This is generally limited to a small number of items and has little impact on the overall form. The third digit indicates that minor edits (such as fixing typos) have been corrected.

- **Finalize instrument design (e.g., delete or add items to the GAIN version)** – Depending on the needs of a particular research or clinical site, the item set on the chosen GAIN instrument may be over- or underinclusive of the desired item set. It is not unusual for research or clinical groups using a GAIN to tailor it to their needs, either by adding or deleting items. One way to delete items is to manually cross them off the instrument and inform interviewers to skip those items. Additional scales could be added to the GAIN by stapling them to the end or just adding separate assessment packages. Common measures added to the assessment package include service contact logs, family environment scales, and measures of adolescent or adult psychological and social functioning. We do not recommend making changes to the GAIN documents themselves because the number of multiple versions with the same version number can quickly get out of hand.

- **Identify training topics (administration and QA, interpretation, data entry)** – It is necessary to identify the set of training topics to be covered in the training. A training focused on clinical interpretation may not be interesting for research staff not associated with treatment, and those who are collecting data for clinical purposes may not be interested in using the data entry software or training on rigorous quality assurance standards.

- **Anticipate group size** – The size of the group determines the size of the facilities, the room configuration to be used, and amount of materials needed.

- **Identify trainers (total number, roles)** – The number of trainers needed is driven by the scope of the training. If the training covers a wide scope or if simultaneous sessions will be run, multiple trainers will be needed. When identifying roles of trainers, be sure to match trainers with their expertise.

- **Identify training dates and times** – Blocking out the dates and times for the training is necessary before a training location can be named. If the training is being held in anticipation of a large, funded multisite project, decisions about dates and times will be heavily influenced by the funding cycle. Sites may need time to procure funding and hire staff prior to training staff members.

- **Identify training location** – If the research or clinical site hosting the training does not have adequate facilities to hold a major training it would be necessary to look into conferencing locations such as hotels and conference centers. Conference locations typically are booked well in advance, so allow enough lead time in your planning to secure necessary space.
• **Decide on catering** – Decide whether meals and snacks will be provided as part of the training or whether participants will be on their own.

• **Decide whether continuing education units (CEUs) will be offered** – Certified GAIN Local Trainers may wish to apply for CEUs for trainees prior to hosting the training. The procedure for registering with the state agency overseeing CEUs varies from state to state, but in general one would need to submit evidence of the educational value of the training.

• **Create an agenda (including scheduled breaks)** – Once the scope, topics, instrument package, trainers, time and date, location, and availability of catering have been decided, the training agenda can be created. Be sure to schedule breaks throughout the training days: a minimum of one break in the morning, lunch, and one break in the afternoon. The GAIN training CD includes an example of an agenda for a large, multisite initial training with a wide scope for researchers and clinicians.

There are also numerous logistical details to attend to once basic decisions have been made:

• **Set up registration and payment protocols** – Decide what the training will cost, what it will include and not include, and how a participant will register and pay for the training. Develop the appropriate forms to gather necessary registration information that can be tracked in a simple database. Check with your parent organization about payment protocol. Also have a cancellation procedure in place.

• **Identify trainees (total number, roles)** – Gather enough identifying information on the registration form to generate a list of participants and include this list in the training materials. This is helpful to participants after the training if they want to contact a fellow participant. We suggest the participant list include participants’ names, roles or professional titles, organizations or projects, addresses, e-mail addresses, phone and fax numbers.

• **Arrange for CEUs (if applicable)** – If you have decided to register for CEUs, keep in mind that the application process can take a number of weeks and may need to be repeated for each training. The GAIN training CD includes an example of a CEU application that has been used for national training.

• **Advertise training** – If using e-mail or the U.S. mail, attach a copy of your agenda. Even when working with a captive audience (e.g., clinical staff members in a program or research assistants on a study), it is important to keep people informed about the logistics and what is expected of them (e.g., the need to bring computers).

• **Arrange for training location** – Working out the details with a conference center or hotel can take time and will require signing a contract. Be aware of contract details regarding services provided or not provided, payment, and cancellation policies. If training is conducted on-site, try to find a location or situation where the participants (and trainers) will not be regularly interrupted or paged.

• **Arrange for catering (lunches, snacks)** – If the training includes meals and snacks, gather menus from catering services or the conference center or hotel. Keep in mind that conference centers and hotels often prohibit food from the outside being brought in.
• **Arrange for equipment** – E.g., overhead projectors, LCDs, screens, laptops, tape recorders and cassettes or digital recorders, extension cords, video equipment, microphones, overhead pens, etc. Conference centers and hotels may be able to supply equipment, and some may have stipulations requiring that no outside equipment be brought in. Think about your equipment needs ahead of time and make necessary arrangements.

• **Arrange lodging and, if necessary, transportation for participants** – Large or local trainings held in a hotel bypass the need for transportation. However, if the training is held at a distance from participants’ lodging, look into transportation issues. Providing a logistics summary to participants as part of the registration packet is useful. This summary should include basic information such as training dates, times, location, lodging and travel information (including available shuttle services, directions to the facility from airports and train stations, and driving directions), and contact information for pertinent staff. Additional information given may include CEU availability, training attire, training rules and courtesies (e.g., turning off mobile phones/pagers during training), and if it would benefit participants to bring laptops or other electronic equipment.

• **Outline notebook materials needed (with deadlines)** – If you are creating your own training materials, create an outline of materials with deadlines and assign specific materials to staff members/trainers. All original materials should be completed at least a week before the training to allow time for duplication and notebook assembly.

Training materials take time to create and duplicate. Below are necessary materials for conducting a GAIN training:

• **Study-specific guidelines document** – Study-specific guidelines (see appendix A for an example) hold information used to complete the cover page of the GAIN. This document provides the range of values to use for each identifying field on the cover page and contact information and roles of key research and clinical staff members using the GAIN.

• **Evaluation forms** – Create an evaluation form keeping the following questions in mind. What do you want to know from the participants? What is the best way to ask questions that will provide the answers you are seeking? Generally, an evaluation form for training should ask questions on the quality of the logistics, materials, training sessions and trainers. Keep in mind that if you are offering CEU credits, CEU agencies may require you to collect and forward evaluation information.

• **Certificates of completion** – Consider developing a means to track participant training attendance hours. Make certificates of completion based on their qualifying hours and send to the trainees after the training. For trainees who wish to claim their CEUs, the CEU agency may require a copy of the certificate as proof of attendance.

• **Other materials** – Think ahead and plan for additional training materials you may need such as handouts, overheads, slides, cassette tapes or memory cards, CDs, and videotapes.

• **Notebooks** - Allow plenty of time for creating new materials and for copying the notebooks for the trainees and trainers, plus a few extras. There are a number of options for obtaining GAIN notebooks for your training:
• Paper copies of the GAIN notebooks can be purchased from Chestnut Health Systems for $50 per copy for the GAIN-I manual and $25 for the GAIN-Q manual.

• The text of the GAIN notebooks can be downloaded free from the Chestnut Health Systems website (see specific versions of the GAIN at http://www.chestnut.org/LI/gain/index.html#Instruments.)

• Notebook materials obtained at a Chestnut-conducted GAIN training may be copied. Copies of all the notebook materials, training handouts and other materials are included on the CD that accompanies this manual.

During the Training. Almost everyone has attended a training that was boring or unhelpful. This section discusses some tips to make the most of your training and keep your participants interested.

• **Teach by demonstration** – We use a round-robin approach during GAIN trainings. That is, the trainer has a sample script of a GAIN assessment and pretends to be the participant, and the trainees take turns being the assessment administrator. This keeps the trainees active and their attention focused, since they know that their turn will be coming. We also incorporate quality assurance feedback (as discussed in chapter 4) throughout the round robin sessions.

• **Use prerecorded examples** – Prerecord a sample assessment administration based on an actual case and play it during the training as part of the quality assurance presentation, asking participants to offer quality assurance feedback on the taped administration. This is a good way to help them put what they are learning into practice and to see administration from another point of view. Basing your example on an actual case and using a script is helpful because it keeps the administration session more realistic. It is difficult to create a case without many inconsistent responses, especially on the fly. When creating made-up cases, resist the temptation to create an impossibly difficult case – a conglomeration of every worst-case scenario encountered.

• **Incorporate practice sessions** – In addition to the round robin sessions, schedule time for participants to pair up and practice administering the GAIN to each other. During this time the trainer can circulate and give feedback to the trainees as they practice. Holding practice sessions for quality assurance (as in the audio-recorded session described in the previous bullet), scoring and interpretation, and data entry are also helpful to trainees.

• **Vary the agenda** – Try to switch back and forth between demonstrating, talking, and doing practice exercises. It is often easier for trainees to absorb information about the assessment process if they first see a demonstration.

• **Stick to the agenda** – To keep trainees’ attention and energy up, stay on topic during sessions and start and end sessions on time, especially around a break or lunch.

• **Review “next steps” homework assignments before trainees leave** – If trainees are required to audio-record assessments for A-QA review or have any paperwork to complete after the training has ended, be sure to remind them of it. Give them a handout to take with them explaining their next steps.
• **Ask trainees to complete an evaluation form** – Ask the trainees to evaluate their training experience. Collect completed evaluation forms before trainees leave the training so their training experience will be fresh in their minds and you can be assured of getting completed evaluation forms.

**After the Training.** After all is said and done, there are still a few more things to say and do.

• **Hold a debriefing meeting for all training staff members** – Take time to bring real closure to your training by reviewing your experience. Solicit impressions of the training process from all staff members and review completed evaluation forms and any notes taken during the training.

• **Make decisions about adaptations for future trainings** – Using the information gained in the debriefing meeting, decide on any adaptations for future trainings. Designate who will be responsible for revisions.

• **Distribute certificates of training completion to participants** – Make certificates of completion based on their qualifying hours and send to the trainees after the training.

• **Submit required post-training information to state CEU agency (if offered)** – Although the organization providing the training submits required information such as attendance lists to the state CEU agency, trainees are responsible for claiming their own CEUs. Trainees would need to check on requirements for claiming CEUs earned in another state as reciprocal agreements exist between some states.

• **Provide ongoing supervision for certification** – If your staff members are providing ongoing supervision (e.g., A-QA feedback) for certification, set up a protocol for managing the receipt of audio recordings, feedback distribution, and certification tracking. You may need to send periodic reminders to trainees to send in audio-recorded submissions. Upon completion of certification for administration, send certificates of completion to successful trainees.

### 8.2 Training for Turnover

This section contains a series of guidelines for conducting a small training for turnover, which typically involves targeting one or a few individuals and can usually be tailored more specifically to the staff members’ roles. Although there is some overlap in process between a smaller and larger training, preparations are far more focused. All the major decisions have been made and it is mostly a matter of getting the new staff members up to speed on administration, interpretation, and data entry.

In a one-on-one or small group training, the main ingredients are logistics (such as setting a training setting and time), materials, equipment, and trainers. The training curriculum (e.g., notebooks and handouts) and methods (e.g., teaching by example, taped examples, and practice sessions) are identical to those used in a larger training, though with smaller trainings there is the advantage of increased one-on-one time with the trainers and experienced staff members. Some of the common activities of one-on-one or small group trainings are:
• **Start with an orientation session** – This is done to review the materials and set expectations about the training. It may involve a review of the quality assurance criteria so trainees are aware of the features of a quality assessment administration.

• **Role play an interview** – This is done to help walk the person through the assessment, highlight frequently asked questions, and provide some practice.

• **Review frequently asked questions** – Ask trainees to review the FAQs on their own. Provide an opportunity to go over any FAQs the trainees do not understand.

• **Have trainees shadow an experienced interviewer administering the GAIN** – The trainee observes an experienced interviewer administering the GAIN and practices using the quality assurance form to help understand how each criteria is met. This should be followed by an opportunity for the trainee to debrief the interviewer on why or how they did things and on when and why they may have deviated from the planned protocol.

• **Proctor an administration** – Here, the trainee administers the GAIN to several participants while being observed by an experienced interviewer. The experienced interviewer is there to review the administration using the quality assurance criteria and can step in if there is a need to. This session should be followed by a debriefing session with the experienced interviewer. Note that the nature of this observed administration should be disclosed up front so the participant understands what is going on.

• **Audio-record an administration** – For logistical reasons it may be desirable or necessary to have early administrations recorded and reviewed at a later time.

• **Provide group feedback** – When a small group of people are trained it may be useful to do some group debriefings in which trainees share with one other what they have learned. This can also be done as part of a staff meeting if trainees are in various stages of training.

Post-training supervision and certification processes are identical to those used following larger trainings. Keep in mind that arrangements for CEUs, if offered, will most likely have to be made ahead of time for each training. Regardless of whether you are holding a large or small affair, the key to a successful, effective training is planning.

### 8.3 Global Appraisal of Individual Needs (GAIN) Certification

The Global Appraisal of Individual Needs (GAIN) is a family of semistructured assessments designed to meet both clinical needs for a preliminary biopsychosocial assessment and research needs for a standardized measure of problem severity, service utilization and outcomes. Appropriate administration requires balancing rigid rules of standardized tests that are designed to maximize reliability with the more flexible approaches used in clinical interviews that are designed to maximize validity. Like all measures, the information gathered will be more reliable and valid if the person administering the assessment understands how to appropriately balance these competing styles. Thus, training is the starting point, but we view ongoing quality assurance as the primary process through which all GAIN interviewers and trainers are pushed to their best. As they master each level, we recognize their achievements through a certification process.
Certification Levels. Below is a list of the levels of GAIN certification, at whom they are targeted, and what they require. Our train-the-trainer model is designed assuming that the GAIN Coordinating Center (GCC; see chapter 1, section 1.4 for description) will provide initial training and support with the goal of each agency or research site moving toward “detaching” from the GCC and providing their own ongoing training and support.

In order to achieve this goal, we have found it most effective to use the A-QA model described in chapter 4 of the manual and to “guide” trainees and their sites through an effective, multistep certification process. In this process, individuals who will be in charge of training and supervising research or clinical staff attend training and attain Coursework certification (level 2 below); work toward and achieve Administration certification (level 1 below); conduct a local training of line staff who will be administering the GAIN, conduct reviews of the local line staff as both a means of certifying interviewers at the site (level 1 below) and simultaneously working toward Local Trainer certification (level 4 below).

Usually at least two staff members from each agency work toward Local Trainer level for two important reasons: to have backup so that all the burden does not fall on one staff member and for the agency to be prepared for possible staff turnover. Once the designated staff members have reached Local Trainer certification, the site no longer relies on the GCC for A-QA reviews and regular guidance and support, but may call from time to time with specific questions or to request updated materials. Details on how to reach each level of certification can be found below. Note that all certificates are issued by the GCC.

1.) GAIN Site Interviewer Certification – This level of certification is for people who have been trained by a certified Local or National Trainer to administer the GAIN at a training other than one sponsored by the GAIN Coordinating Center. Certifications are issued by the GCC based on the recommendation of the certified Trainer and a review of a final written feedback form of Administration QA feedback. A certified Site Interviewer may not go on to Local Trainer certification without attending a subsequent GCC-sponsored national training and achieving Administration certification.

2.) GAIN Coursework Certification – This is the most general level of certification and the first step toward all other certifications.
   - Prerequisites
     - None
   - Requisites
     - Actively participating in and completing at least 90% of training hours at a GCC-sponsored GAIN training (either a four-day national train-the-trainer event in Bloomington-Normal, Illinois or a full on-site 3.5 day GCC-sponsored training).
     - A signed GAIN usage agreement.

3.) GAIN Administration Certification – This level of certification enables a paraprofessional or clinician to administer the GAIN. Note: a supervisor should continue to review the Administrator’s interviews over time to guard against any deterioration in the quality of the administration.
4.) **GAIN Local Trainer Certification** – This level of certification is available for those who will be responsible for leading local GAIN trainings at their own agency. These trainings are for staff members at the Local Trainer’s site and are covered under the same GAIN license as the Local Trainer. The Local Trainer performs quality assurance reviews on trained interviewers and recommends them to the GCC for Site Interviewer certification. In most cases people who wish to become GAIN Local Trainers must attend a GCC training. A certified National Trainer who is also a certified GAIN National QA Reviewer can, on a limited basis and with permission from the GCC, train GAIN Local Trainers. Most Local Trainers are trained at GCC-sponsored GAIN trainings and work directly with the GCC to attain this level of certification.

- **Prerequisites**
  - GAIN Coursework certification.
- **Requisites**
  - Ratings of sufficient or excellent by a GCC A-QA reviewer on all areas of the feedback form based on reviews of audio-recorded administrations.

5.) **GAIN National Trainer Certification** – This level of certification is available on an invitation-only basis for people who will train nationally and be eligible for paid consultant training work with GCC on national and on-site trainings. Certified National Trainers can train others as Site Interviewers outside their own agency or project with proper communication with the GCC. National Trainers can train Administrators and Local Trainers if they are collaborating with the GCC in a GAIN train-the-trainer event. Additionally, certified National Trainers may train a limited number of Administrators and Local Trainers if they also achieve National QA Reviewer certification (see below) and have written permission from the GCC to do so. Requirements for certification:

- **Prerequisites**
  - GAIN Administration certification.
- **Requisites**
  - A signed GAIN Local Trainer’s Agreement.
  - Pass Stage One and Stage Two of the Local Trainer process by writing feedback for GAIN interviewers and submitting the audio-recorded interview and feedback to the GCC until mastery level is reached.
  - Successful participation at a week-long GAIN Trainers Institute and successful participation in national GAIN trainings (usually one or two) until mastery of all GAIN training material is demonstrated.
  - Successful completion of a general competency exam and exams in areas of specialization (e.g. clinical, GAIN-Q, GAIN ABS user).
✓ Submission of participant evaluations of each regional non-GCC sponsored training conducted.
✓ Paid participation in at least one national or onsite training with GCC each year (or videotaped submission of training with GCC permission).

Specialty Certification

**GAIN National QA Reviewer Certification** – This level of certification is available to people who wish to review audio-recorded submissions for the GAIN Coordinating Center on a consultant basis. It is available on an invitation-only basis. More information on this level of certification is available by e-mailing the GAIN research projects manager at GAINInfo@chestnut.org.

### 8.4 How to Get Certified

The purpose of this section is to provide specific information on how to reach each level of certification and to answer some frequently asked questions about the process. It is important to start by reviewing the steps an agency or research site typically takes to get started once making the decision to use the GAIN. Generally a clinical director, principal investigator, or project director or coordinator will:

- **First**: call the GAIN Projects Manager or e-mail GAINInfo@chestnut.org to find out the requirements and options for training.
- **Third**: decide whether to send appropriate staff to the next national GAIN training, to host a single, on-site training, pursue becoming a regional training center, or a combination of these options (more information on this process can be found in section 1.4 of this manual).
- **Fourth**: decide which staff members are most appropriate to fit the role of Local Trainer: who will likely be training and supervising the agency or site staff who will be administering the GAIN?

Once these initial decisions have been made (see chapter 9 for a list of common implementation questions to answer when deciding to use the GAIN), the training is conducted and coursework certification (level 1) is awarded to trainees who meet the criteria described above. After training, the next step for trainees is to begin working on administration certification. This process is described in the following section (see also attachment 8-1 at the end of this chapter for a summary of how to reach each certification level).

**How to get Administration certification.** As described in detail in chapter 4, we use a process in which the trainee first practices administrations, then audiotapes actual administrations and submits them for A-QA review. After review, the trainee receives detailed written feedback with a recommendation of what to do next. The process continues until the trainee receives a rating of
Sufficient or better on all four major sections of the feedback form with a recommendation to certify. Before leaving a GCC-sponsored GAIN training, you will receive a handout specifying your next steps in the A-QA process, including the name and contact information of the designated GCC A-QA reviewer who will be your main point of contact for submitting tapes and asking questions, deadlines for submissions and a summary of what to do next. Following is a detailed description for proceeding through this process starting with the moment you leave training.

**What do I do first?** Practice at least twice and read through the GAIN aloud to increase your familiarity with it. This will help you get certified with fewer taped submissions.

**How do I send in a tape?** After practicing, try to use a real participant, but if one is not available you may use a mock assessment for your first attempt. This mock interview should be done with someone who uses a premade case, such as one of the cases included on the training CD. The person pretending to be the participant should purposely throw in some of the common errors listed in chapter 4 of the manual, but the case should not be made overly difficult. For the assessment itself:

- Be sure you have permission to tape the assessment if using a real participant. An example of an audiotape consent form can be found on the training CD accompanying this manual.
- Tape the entire assessment from beginning to end.
- You may use standard or mini-cassettes, but standard is preferred.
- Tape the assessment at regular speed.
- Keep the recorder close to the participant.
- Use pen, not pencil, on the assessment.

After you have finished the assessment:

- Make a copy of the assessment and, if you would like a copy of the tape, make a copy of the tape. **Send the a copy to the GCC, not the actual assessment**—neither the tape nor the assessment will be returned to you.
- Label the tape with the following information:
  - Participant’s ID number (but not his full name).
  - Interviewer’s name.
  - Date the assessment was recorded.
  - A number to call in case the tape is lost in the mail (e.g., “If found, call 1-800-XXX-XXXX”).
- Prepare a short cover letter that states:
  - The name of the interviewer.
  - To whom the feedback should be sent and that person’s e-mail address (we prefer to send all feedback via e-mail).
• That you are submitting the tape for review for administration certification.
• Whether the administration was conducted with a real participant or if a mock case was used.
• Any additional information that would help us in reviewing the tape (one example would be including a comment such as, “Participant scored high on cognitive impairment check but felt OK to do the assessment, but about halfway through started having greater difficulty understanding and following along”).

• Send the tape, the copy of the assessment, and the cover letter to the designated GCC A-QA reviewer listed on the A-QA Process Handout you received as part of training. Please send only the assessment copy and the tape, not any consent forms.
• All tapes will be sent to the same address: QA Tape Reviews, Chestnut Health Systems, 448 Wylie Drive, Normal IL 61761.
• Be sure to use a box or heavy padded envelope to ensure that the tape remains in the package until it reaches Chestnut.
• Double-check that no actual participant names are present on the assessment or tape. On the taping itself, it is okay to call the participant by their first name only.

• We suggest sending the tapes overnight or 2-day mail (see “Deadlines” section below for information regarding why this is preferable).
• E-mail GAINSupport@chestnut.org to alert the A-QA team that you sent a tape and include information on when it should be arriving. Again, during training you will receive information on who to send the e-mail to. Taking this extra step to send the e-mail helps us be on the lookout for the tape and notify you right away if we have not received it in a reasonable amount of time.

I sent a tape. Now what happens?

• The designated GCC A-QA reviewer will send you an e-mail message when the tape arrives at Chestnut confirming its receipt and stating a date by which you will receive feedback.
• You can keep practicing, but do not send any more tapes until you receive your feedback.
• A thorough review is conducted and feedback will be sent to the e-mail address indicated in the cover letter. The e-mail will include some summary information of our overall impressions of the assessment, and what you should do next.
• We typically are able to send you feedback within one week of the first full day after we receive your tape.
• Very few trainees have ever been certified based on only one taped submission, so it is likely that your first set of feedback will be rated “pending” with a recommendation that you:
  • Review the feedback carefully.
  • Contact your designated GCC A-QA reviewer or A-QA supervisor with questions about the review.
  • Practice problem areas.
  • Tape another administration to submit.
• This process is repeated until certification is achieved. It usually takes two to four tries to reach certification. Sometimes there may be one problem area that seems to be giving a trainee trouble, in which case additional technical assistance in the form of phone review and practice with the GCC A-QA team may be recommended before the trainee can submit another tape. This is done to help ensure the trainee will become certified on their next attempt.

**When can I train my staff?** Once Administration certification (level 2 above) is reached, you may conduct a site staff training. In fact, in order to work toward Local Trainer certification, you will need to conduct such a training.

**How do I become a Local Trainer?** Becoming a Local Trainer is desirable because a Local Trainer can train site staff and recommend them for Site Interviewer certification.

• The first step is to conduct a local training of site staff who will be conducting GAIN interviews.

• Have your trainees use the same process of taping their assessments, but instead of sending them to Chestnut, you will review them.

• Before reviewing a tape, make a copy of the assessment so that you will have a “clean” copy to send us after conducting your review.

• Review the trainee’s administration using the same criteria found in chapter 4 and that the GCC used to review your administrations.

• You will use the GCC feedback form to conduct these reviews until you become certified as a Local Trainer. This form is located in chapter 4 of this manual and a usable Word version of the form is located on the CD that accompanies this manual. Once you are certified, you can use any method you choose for initial or ongoing QA (e.g., in-person review with oral feedback or any other method you choose).

• After conducting your review and preparing feedback, you will be sending the tape, a copy of the assessment, and a cover letter to the designated GCC A-QA reviewer. You will also e-mail your feedback to the GCC A-QA reviewer.

• The GCC will conduct a blind review of the assessment and will then compare your feedback with the GCC A-QA reviewer’s feedback in order to prepare written suggestions and recommendations. You will be contacted to schedule a time to conduct a phone review to walk through the comparison and feedback. You will also be e-mailed the feedback our A-QA reviewer did, for comparison, and our written feedback and recommendations.

**What do you look for in the reviews?** We are concerned with both the ability of the reviewer to prepare detailed, easily understood feedback that catches most of the issues and includes positive feedback, with the ability of the reviewer to appropriately rate each section on the feedback form. We also look for the ability of the reviewer to make an overall decision of pending or certified (hopefully one that matches the decision from our blind review). Remember, once certified, a Local Trainer is able to recommend his or her staff for certification.
Two stages of reviews to reach Local Trainer certification. There are two stages involved in the Local Trainer process.

- **For stage one**, send a submission by a trainee you feel is not ready to be certified so we can rate your ability to give specific, behavioral feedback, catch issues, rate each section on the feedback form, and rate the overall quality of the assessment. It often takes two attempts to pass this stage.

- **For stage two** (after passing stage one), send a submission on a trainee you believe is ready for certification. The agreement on knowledge of mastery level required for certification is key in this stage.

What are the possible outcomes from a Local Trainer submission? Both in stage one and stage two, a decision will accompany your feedback letting your know if you:

- **Did not pass** – Must review feedback and resubmit for whichever stage you are working on.

- **Tentatively passed** – Feedback is good and ratings were in agreement but more detail could have been given in a couple of feedback areas. Must rewrite feedback for same submission and e-mail revised feedback only. Does not need to resubmit another tape for the level being worked on.

- **Passed** – Ready to either move on to stage two (if in stage one) or become certified as a Local Trainer (if in stage two).

What happens when I get certified? You will receive a certificate showing your new status as a certified Local Trainer as well as a Site Interviewer certificate for your trainee whose tape was used to pass Stage Two. In addition, this information will be updated in our list of certified trainers. In order to determine whether you are on a list of certified individuals, e-mail GAINSsupport@chestnut.org.

Do I need to submit more tapes to certify other Site Interviewers? No. In order to certify Site Interviewers after you have reached Local Trainer certification, e-mail the feedback form only (do not send tape or assessment) for only the interview meeting certification requirements (do not send prior reviews) to GAINSsupport@chestnut.org with an e-mail message recommending the person for certification. You will receive a response within 24 hours. Please note:

- You need to use our feedback form for these requests but are not required to use our form for any other reviews you conduct.

- We thank you for sending these requests, since they help us keep our records updated.

- Please also inform us if a certified staff member leaves the agency or project so we can update our records. This can also be done by e-mailing GAINSsupport@chestnut.org.

Deadlines for completing the certification process. We have found that trainees who wait for months to submit a tape to us often have a much more difficult time reaching certification. Based
on our experiences from reviewing hundreds of tapes, we have adopted a deadline schedule that begins at the end of training:

- **Deadline to submit first tape:** 2 weeks after last day of training
- **Deadline to reach administration certification:** 3 months after last day of training
- **Deadline to reach Local Trainer certification:** 6 months after last day of training

If you face difficulties reaching the first two deadlines, contact us right away and explain your situation (GAINSupport@chestnut.org; for confidential situations, ask to speak to the GAIN Research Projects Manager). Once you have gone past the 6-month deadline, you must attend another national training to be able to continue your certification process.

### 8.5 Documentation of Certification

The names of certified National Trainers are posted at [http://www.chestnut.org/LI/gain/GAIN%20Training/index.html](http://www.chestnut.org/LI/gain/GAIN%20Training/index.html). Any certified Local or National GAIN trainer can submit documentation for review for appropriate certification for persons whom he or she has trained. Please e-mail GAINSupport@chestnut.org for more information.

Names and signed GAIN usage agreements (exhibit 8.1) should be submitted to:

Joan Unsicker  
Chestnut Health Systems  
448 Wylie Drive  
Normal IL 61761  
E-mail: junsicker@chestnut.org

Requests for certificates at levels 3 and 4 will be accepted only from certified National Trainers. Completed certificates will be returned to the Local or National Trainer requesting them and issued only to individuals or staff members from an agency with a current GAIN license agreement. A copy of this license agreement is in appendix G. A list of agencies with GAIN licensees is also posted on the GAIN website. Contact GAINSupport@chestnut.org for further information.

**Continuing Education Credits.** GAIN training is approved for continuing education unit (CEU) credits by the Illinois Alcohol & Other Drug Abuse Professional Certification Association (IAODAPCA) for the following Categories: Counselor I or II, Assessor I or II, Mentally Ill Substance Abusers (MISA) I or II or Gambling II. Contact Joan Unsicker at Chestnut Health Systems regarding information on CEUs. If you want to apply for CEUs from another agency, an example of one of our applications is included on the CD.
Exhibit 8-1. GAIN Usage Agreement
(last updated June 2007)

By signing below I am agreeing to:

- use the GAIN only if I (or my agency) have a valid GAIN license agreement.
- represent the GAIN only as a tool for research or program evaluation and, if used clinically, as one of several sources of information that should be combined with clinical judgment in making diagnosis, placement and other clinical decisions.
- not train others to use the GAIN until I have been certified, or not otherwise misrepresent my certification level to others.

Name: ______________________________________________________________
Agency: ______________________________________________________________
Address: ______________________________________________________________
____________/________/________
Phone: ______________________________________________________________
Fax: ______________________________________________________________
E-mail: ______________________________________________________________

Grant Program (if applicable): ________________________________________________
Grant # (if applicable): _____________________________________________________
Sponsor/Funder (if applicable): _________________________________________________
GAIN License #: ____________________________________________________________

/________/________
Trainee Signature Date (MM/DD/YYYY)

Print Trainee’s name

/________/________
GAIN Certified Trainer Date (MM/DD/YYYY)

Print Trainer’s name

**Trainer, please initial all that apply:**
___ GAIN Coursework Certificate
___ GAIN Administration Certification
Exhibit 8-2. GAIN Local Trainer’s Agreement
(last updated October 2008)

By signing below I am agreeing to:

• conduct training only within my own licensed agency or a collaborating agency on my research project that is listed on my GAIN license;
• conduct quality assurance reviews on local trainees and assist them in moving toward Site Interviewer certification;
• submit a qualifying A-QA review to the national A-QA supervisor when recommending a Site Interviewer for certification and keep the national A-QA supervisor informed when certified staff leave the agency;
• represent the GAIN only as a tool for research or program evaluation and, if used clinically, as one of several sources of information that should be combined with clinical judgment in making diagnosis, placement and other clinical decisions;
• not misrepresent certification levels for myself or others;
• identify to Chestnut Health Systems anyone whose certification should be revoked for violating this agreement or because they are not meeting satisfactory ratings in quality assurance reviews (after attempts to correct them).

Name: ______________________________________________________________
Agency: ______________________________________________________________
Address: ______________________________________________________________

____________________________________________________________
Phone:  ______________________________________________________________
Fax:  ______________________________________________________________
E-mail: ______________________________________________________________
Licensee: ______________________________________________________________

___________________________________________  _____/____/________
GAIN Local Trainer’s Signature     Date (MM/DD/YYYY)

___________________________________________
Print GAIN Local Trainer’s Name

___________________________________________  _____/____/________
GCC A-QA Supervisor’s Signature     Date (MM/DD/YYYY)

___________________________________________
Print A-QA Supervisor’s Name
Exhibit 8-3. GAIN National Trainer’s Agreement  
(last updated June 2007)

By signing below I am agreeing to:

• Only conduct training for agencies with a **valid GAIN license agreement** and identify to Chestnut Health Systems GCC any agency using the GAIN without proper licensure.

• **Contact GAIN Coordinating Center (GCC) at GAINInfo@chestnut.org at least 4 weeks prior to contracting to provide training services and provide them with:**
  ✓ Agenda for the training and training date
  ✓ Agency and GAIN license number
  ✓ Names of trainees
  ✓ How quality assurance will be conducted
  ✓ A copy of the signed “GCC Services and Disclosure”

• Complete a “GCC Services and Disclosure” form with the client for every non-GCC GAIN training (with the exception of local trainings);

• Request from GAINInfo@chestnut.org updated GAIN materials and information prior to conducting training;

• Maintain a trainee to trainer ratio of 6:1 at every training (12:1 at GAIN-Quick Trainings);

• Not misrepresent certification levels for myself or others;

• Notify Chestnut Health Systems of anyone whose certification should be revoked due to violation of this agreement;

• Inform GAIN training participants that they are eligible for GAIN site interviewer certification only;

• Train others using the National Training, Quality Assurance (QA) model, and materials unless permission is received from the GCC to use alternate materials;

• Conduct at least one GAIN training per year as a GCC representative and receive feedback, or with GCC permission, submit a videotape of a full GAIN training conducted and receive feedback.

**Failure to comply with these requirements will result in revocation of your GAIN National Trainer Certification**

Name: ______________________________________________________________

Agency: ______________________________________________________________

Address: ______________________________________________________________

Phone: ________________________________________________________________

Fax: __________________________________________________________________

E-mail: ________________________________________________________________

Licensee: ______________________________________________________________

___________________________________________ _____/____/________
Name: ________________________________________________________________

National Trainer Candidate’s Signature Date (MM/DD/YYYY)

_________________________ /____/____
Print National Trainer Candidate’s Name

_________________________ /____/____
GCC Research Projects Manager’s Signature Date (MM/DD/YYYY)

_________________________ _______________________________
Print GCC Research Projects Manager’s Name
<table>
<thead>
<tr>
<th>To move from level...</th>
<th>You are required to...</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 2-Coursework         | • Provide evidence of a GAIN Coursework certificate.  
|                      | • Pass an Administration QA review.  
|                      | • Practice administering the GAIN.  
|                      | • Send the tape and a hard copy of a paper-administered GAIN to A-QA Team, Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761.  
|                      | • You will receive feedback from the A-QA review within one week of tape receipt.  
|                      | • The process continues until all sections of the feedback form are rated sufficient or better. | See chapter 7 in the GAIN manual on QA for important details about sending tapes and assessments through the mail. |
| 3-Administration      | • Provide evidence of a GAIN Administration certificate.  
|                      | • Submit a taped administration of a trained Site Interviewer to A-QA Team, Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761.  
|                      | • You will receive feedback within one week of tape receipt.  
|                      | • The process continues until all areas of the feedback form are rated sufficient or better. | There are two stages to the Local Trainer process. The first stage involves submitting a taped assessment and receiving feedback on a trainee who is not ready to be certified. The second stage involves submitting a taped assessment and receiving feedback on a trainee who is ready to be certified. See section 8.4 of the GAIN manual. |
| 4-Local Trainer       | • Provide evidence of a GAIN Local Trainer’s Agreement.  
|                      | • Submit taped assessments of trained Site Interviewers.  
|                      | • Conduct A-QA reviews on taped assessments to A-QA Team, Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761, where a blind review of the same assessment will be conducted.  
|                      | • You will be contacted by a Chestnut A-QA reviewer to set a time for a phone review of your application within two weeks of tape and feedback receipt.  
|                      | • The process continues until both stage one and stage two are passed. | National Trainers are similar to Local Trainers but can train Administrators and Local Trainers across multiple agencies in a region. |
| 5-National Trainer    | • Available by invitation and application only. Contact GAIN Info (GAINInfo@chestnut.org) for additional information.  
|                      | • Provide evidence of a GAIN National Trainer’s Agreement.  
|                      | • Approval of an application by senior certified National Trainers.  
|                      | • Successful completion of a general competency exam and exams in each specialization area of interest (e.g. clinical, GAIN Q, GAIN ABS user).  
|                      | • Submission of participant evaluations of each regional non-GCC training conducted.  
|                      | • Annual submission of videotaped training (of one full training) for comments and feedback to maintain certification or sometimes participation in a GCC-sponsored training. | National Trainers are similar to Local Trainers but can train Administrators and Local Trainers across multiple agencies in a region. 

There are two stages to the Local Trainer process. The first stage involves submitting a taped assessment and receiving feedback on a trainee who is not ready to be certified. The second stage involves submitting a taped assessment and receiving feedback on a trainee who is ready to be certified. See section 8.4 of the GAIN manual.
8.6 Clinical Supervision

Beyond quality assurance and individual supervision, clinical coordinators and directors can play a pivotal role in getting the most out of using the GAIN. It starts with setting up the expectation that assessment is an important component of high quality care. Would you want surgery done by a doctor who did not do a careful diagnosis, make adequate preparations, take necessary safety guards, and provide adequate follow through? Would you want to ride on an airplane where the pilot did not conduct systems or safety checks? While many counselors can quickly get to an issue, they may not be as good at consistently identifying the multiple overlapping problems that commonly occur. While standardized assessment suggests that 50% to 80% of people entering substance abuse treatment have multiple co-occurring psychiatric problems, treatment records suggest that clinicians regularly identify only about 3% to 10% (Kessler et al., 2001; Regier et al., 1990; Robins & Regier, 1991; Womack et al., in press). If counseling is to be effective, it is important to identify these other problems and understand how they are related to substance use and each other, both for program planning and because it is what the participants expect from us (Frank & Frank, 1991).

The next step is to avoid the trap of treating assessment as paperwork to be checked off a to-do list. To accomplish this, clinical supervisors must encourage staff members to actively use the results of the assessment in the diagnosis, placement recommendations, and treatment plans. As, or perhaps more important, the results should be regularly discussed as part of staff meetings, individual case reviews, and quality improvement meetings. For instance, clinical supervisors can require staff members to bring the assessment to staff meetings so everyone can ask follow-up questions (which even junior staff members should be able to answer since it is a standardized assessment). They can talk about whether or not to exclude someone from a general group session because of a high number of symptoms related to conduct disorder or violence (which are associated with negative effects on the other group members). They might develop a protocol of individual counseling or special groups for participants with high scores on the GAIN’s general victimization scale (who typically have a whole cluster of internal distress problems and often require residential treatment or a change in their environment in order to sustain recovery).

One advantage of standardized assessment is that it allows a group of clinicians to work more effectively with one other or take advantage of the findings of other groups. The clinical supervisor can develop decision rules for when cases should be referred to senior staff or specialty staff members (e.g., nurses, psychiatrists, vocational specialists) based on what is available in their system. Specialty programs (e.g., a program from pregnant or postpartum women, a methadone program or an adolescent residential program) that draw from a large catchment area may work with other agencies to do an initial assessment using the GAIN or the GAIN-Quick. For rural areas, this may allow an assessment to be done by another program and used for the initial placement/admission decision without requiring the person to travel several hours multiple times. For student assistance, employee assistance, juvenile justice, or criminal justice programs, it may allow a staff member to identify whether it would be better to refer a person to a substance abuse provider, a mental health provider or even to provide a brief intervention on site. Because the assessments are standardized, they also reduce the number of times participants are asked the same information over and over. Since assessments take a considerable amount of time and resources, these efficiencies are appreciated by both the program staff and participant.
Some other practices that supervisors can encourage to further hone their staff members’ ability to interpret and use the GAIN include:

- Have staff members present difficult or special cases in staff meetings and brainstorm about how to handle such cases.
- Have new staff members review an intake assessment for a participant admitted several months prior, recommend a course of treatment and speculate about the participant’s response. This is a particularly useful training tool since the participant’s treatment result is actually known.
- Have staff members review and report to the group on an article using the GAIN with a related population, then discuss its implication for your program.
- Have staff members develop specific procedures (e.g., motivational interviewing) or curricula (e.g., a group on dependence or victimization) that use information from the GAIN (pooled across people) as a starting point.
- Have staff members use the GAIN scales to talk about caseload severity and distribution.
- Have staff members identify specific types of problems that are occurring for which there is a gap in the current service system (discussed further in the next chapter).

Since many staff members are involved in professional training or continuing education, there are often opportunities for them to use the data and report to their colleagues.

Since April 2003 it has been necessary for clinical supervisors to develop explicit policies regarding access to GAIN data. The GAIN includes personal health information and, thus, comes under the Health Insurance Portability and Accountability Act of 1996. Therefore, there needs to be an organizational policy regarding who has access to both the hard and electronic copies of the GAIN. The GAIN’s computer applications are written in ABS (Hodgkins & Dennis, 2002), which is HIPAA compliant and allows you to specify access in terms of both roles (e.g., supervisor, a clinical team) and individual staff member ID numbers. It also is capable of tracking who accesses the records, exporting password-protected copies of the data or report (used for transferring a case or making a referral) and exporting the data (with or without confidential information). Clinical supervisors will have to define the clinical team or role-based access or procedures for allowing specific individuals to access a record. Generally speaking, the supervisory role is also one that allows them to have access to all cases or grant access to other staff members.

When first implementing the GAIN with existing staff it is important to win over a couple of senior counselors to whom the other staff look up and will follow and bring them into the planning and implementing process. A quick way to win over senior staff is to suggest they use the GAIN with an existing case that has reached a clinical “plateau.” Assuming the initial or primary problem was addressed, the plateau is likely due to a problem that was originally missed or one that arose after the initial assessment was done. Since the senior staff likely has been working the case for some time, they are vested in it and will be impressed if the planning and implementing process results in a breakthrough. Asking a long-standing participant to help staff members practice a new assessment provides a positive opportunity for the participant to “turn the tables” and may result in a treatment breakthrough for staff.

Another way to get senior staff members vested in the assessment is to have them debrief the participant by interpreting the results. Despite the large amount of time invested in assessment, it
is relatively rare for participants to be told what it all means. Debriefing the participant forces the staff member out of a skeptic mode and helps them focus on integrating the information into a clinical impression and use skills like motivational interviewing (discussed further in chapter 7).

Both senior and junior staff may initially raise concerns about how the GAIN will impact the establishment of early clinical rapport. The two most common concerns are about the need for more open ended discussion and about the invasiveness of some questions. While a few minutes of rapport building is often beneficial, the working or therapeutic alliance (the goal of this process) is actually equal to or slightly better after doing a standardized assessment and providing some insightful feedback. Given that the median participant stays in treatment for only 4 sessions, we cannot afford to spend 1-2 whole sessions in an unstructured rapport-building process. Moreover, this is also counterproductive and frustrating for the participants: can you imagine going to a doctor for a specific problem and having them spend the first or two visits just getting to know you?

The second concern staff members often raise is that participants will be uncomfortable talking about sexual activity or past victimization. This is actually the staff members saying that they are uncomfortable with it since certified staff members easily and routinely collect this information without any problems. Moreover, it is often critical information for understanding the participant’s situation.

Some staff members will also shy away from collecting information related to suicide risk, victimization, or current pregnancy (with current substance use) because they do not know what to do about it or are afraid of invoking reporting requirements. This is particularly true in research studies where staff members may have less clinical training or be under institutional review boards with a “don’t ask, don’t tell” policy. The unfortunate reality is that these problems are common among people entering substance abuse treatment and staff members using the GAIN will be increasingly identifying these situations. It is, therefore, important for clinical supervisors and programs to have clear procedures for handling such incidents.

It is important to recognize that some participants will have problems estimating when something happened, be cognitively impaired or may simply lie. Clinical staff members often view the calendaring exercise as unnecessary, but research suggests that failure to correctly anchor the time points is the major source of inconsistency and unreliability in assessments (Cottler et al., 1994). Similarly, staff members often complain about using the cognitive impairment check, but about 10% of the participants have problems that are likely to impact the validity of the assessment. In some cases the problems are so severe the GAIN must be postponed or alternative methods such as collateral reports must be relied on to collect the information.

Finally, this is a population with a high rate of personality disorders and a subset of people who blatantly lie about their substance use, illegal activity and other behaviors. Therefore, it is important to look for inconsistencies (e.g., a large number of arrests with no self-reported illegal activity) and combine information collected using the GAIN assessment with other information (e.g., urine tests, collateral reports, referrals). As a clinical supervisor, your enthusiasm for using the GAIN has to be tempered with efforts to get staff members to address these issues.
In this chapter we will briefly review the GAIN’s integrated and progressive approach to assessment (section 9.1), how it is related to key facets of program evaluation (section 9.2), and specific issues in implementing the GAIN (section 9.3). The latter includes a list of specific tools we provide to help use the GAIN for program evaluation.

9.1  An Integrated and Progressive Approach to Assessment

As noted in chapter 1, the GAIN was designed to integrate research and clinical assessment in order to create an efficient process that maximizes both reliability and validity (see Dennis, 1998). It is less a single measure than a related set of measurement batteries that are designed to be part of a progressive approach to assessment. This approach includes:

- **Identifying who needs to be fully assessed** – The focus here is on relative brevity and simplicity of administration. This can be attained with a GAIN-Quick or another comparable measure (see Dennis, 2002 for a list of other measures).

- **Identifying participants for targeted referral** – The goal of assessing for targeted referral is to determine who needs crisis or brief intervention (e.g., by SAP, doctor) versus more detailed assessment and specialized treatment/referral. Decision rules about where to send a participant may be more complex (e.g., substance abuse, mental health, both). For this kind of screening, the assessment is more likely to use the GAIN-Q and possibly supplement it to support a brief intervention.

- **Comprehensive biopsychosocial** – The GAIN proper is used to identify common problems and how they are interrelated among people who are highly likely to be admitted to treatment. It requires more skill in administration and even more in interpretation.

- **Specialized assessment** – The biopsychosocial may identify areas where additional assessment by a specialist (e.g., psychiatrist, school counselor) may be needed to rule out a diagnosis or develop a treatment plan or individual education plan. The GAIN is designed to facilitate referral to this next level by using DSM-IV and collecting questions that specialists need to know.

- **Program-level assessment** – The combination of screeners, the GAIN and other data can be combined to provide an important tool for program management, evaluation and development. Specifically it can be used to identify unmet needs and provide feedback on impact of new approaches.

- **Evaluation research** – The same data can be used to support local program evaluations or research studies and combined into a cross-site database for comparison with other programs to examine less common subgroups and answer methodological questions.

In terms of evaluation research, the GAIN incorporates several methods checks, has been mapped onto numerous major epidemiological databases, and contains a number of items to support benefit cost analysis of substance abuse treatment. In addition to conducting methodological work on the GAIN, we also encourage people to compare it with other measures,
records and clinical judgment. User-friendly reports to help clinicians and participants interpret the results have been developed and are available for use.

9.2 Relationship of the GAIN to Program Evaluation in General

**Stakeholders.** In most program evaluations and treatment service research studies, there are multiple audiences, each with different needs, interests, priorities and timelines. It is essential to consult with all potential stakeholders and end users of research from the earliest planning stages. In fact, explicitly identifying the mutual self-interests of the various collaborators in the research endeavor is crucial to its success. To the extent that these often disparate needs and issues can be integrated, the project will be easier to implement and the resulting report more useful. In contrast, failure to consider the input of research partners will likely lead to roadblocks, if not outright subversion. Many evaluators consult with program or agency leadership, but often leave out other key groups such as the program’s line staff members and participants or other closely related agencies (e.g., major referral sources). These groups can be involved via interviews, advisory board meetings, surveys, focus groups, participant observation, or full ethnographic studies (Dennis, Fetterman, & Sechrest, 1994). The GAIN helps address these issues by supporting multiple definitions and collecting information that is needed for different common stakeholder subgroups.

**Timelines.** Decision makers often require preliminary feedback on study results to guide their planning, particularly when the research is intended to explicitly inform practice or policy. Evaluators can often design the study to produce information that would be useful if provided in a timely manner, but may be of little or no use if provided years later. Examples include a needs assessment component, preliminary study data to support a funding request, preliminary evidence suggesting that an experiment is very harmful (or more beneficial than expected), the results of an individual’s clinical assessment, or input on a staffing problem. Local evaluations can be particularly informative by providing quarterly management reports summarizing participant demographics, clinical characteristics and outcomes for the current period and to date. Where feasible, it is also desirable to compare performance against large contemporary datasets (see Guess & Tuchfeld, 1979 for one of the best examples of the U.S. government facilitating this comparison). The GAIN is set up to provide immediate feedback for clinicians and rapid cleaning/feedback at the program level for planners. Because the data is pooled across sites, it can also provide access to a wide range of comparison groups and facilitate dissemination of findings.

**Logistical constraints.** Unlike general clinical research, most program evaluations and treatment services research studies deal with ongoing entities and active operations. Therefore, formative evaluations can be useful to understand and improve the treatment program. Furthermore, although a summative evaluation on a particular procedure or service may be meaningful, it is often less useful to do this on an entire modality, program, or agency. For example, although early drug treatment evaluations focused on the effectiveness of the main treatment modalities such as outpatient, methadone, short-term residential, long-term residential, subsequent analyses have found considerable variation within modalities that severely limits the usefulness and generalizability of the original findings (Condelli & Hubbard, 1994). In fact, with the movement toward providing a continuum of care along which participants move, it is becoming more and more difficult to statistically separate the effect of a specific modality from total treatment
Questions. While every research study has its own specific questions, the list below mentions some of the most common questions (Dennis, Fetterman, & Sechrest, 1994):

- Who is being served?
- Who is not being served?
- What are the major participant subgroups?
- What services did they receive?
- What needed services did they not receive?
- To what extent are services being targeted?
- Are some service protocols more effective than others?
- Are some service protocols more cost-effective or benefit-cost efficient than others?

It perhaps overstates the obvious to note that the specific research question being asked determines the design of the study needed to answer it. Yet this simple equation is frequently neglected. Current literature often seems to overlook the fact that randomized designs, commonly viewed as the pinnacle method of basic clinical research, can actually only answer questions dealing with relative effectiveness and cost-effectiveness and are not very powerful in answering other types of questions. Failure to address the other questions with appropriate designs has often called into question the validity of field experiments (Dennis, 1990; 1994). Many existing measures fail to document the clinical severity of the population or services provided; others focus more on lifetime epidemiology and are not set up well to measure change over time or economic costs and benefits. The GAIN attempts to include questions to answer each of these questions in a balanced approach.

Other Evaluation Issues and Strategies. For a broader program evaluation, it may also be useful to review the recommendations Dennis, Perl, Huebner, and McLellan (2000) offered for improving the state-of-the-art of substance abuse treatment evaluation:

1. Identifying in advance all stakeholders and issues (reviewed above).
2. Developing conceptual models of intervention and context.
3. Identifying the population to whom the conclusions will be generalized.
4. Matching the research design to the question.
5. Conducting randomized experiments only when appropriate and necessary.
7. Prioritizing analysis plans and increasing design sensitivity.
8. Combining qualitative and quantitative methods.
9. Identifying the four basic types of measures needed.
10. Identifying and using standardized measures.
11. Carefully balancing measurement selection and modification.
12. Developing and evaluating modified and new measures when necessary.
13. Identifying and tracking major clinical subgroups.
14. Measuring and analyzing the actual pattern of services received.
15. Incorporating implementation checks into the design.
16. Incorporating baseline measures into the intervention.
17. Monitoring implementation and dosage as a form of quality assurance.
18. Developing procedures early to facilitate tracking and follow-up of study participants.
19. Using more appropriate representations of the actual experiment.
20. Using appropriate and sensitive standard deviation terms.
21. Partialing out variance due to design or known sources prior to estimating experimental effect sizes.
22. Using dimensional, interval and ratio measures to increase sensitivity to change.
23. Using path or structural equation models.
24. Integrating qualitative and quantitative analysis into reporting.
25. Using quasi-experiments, economic or organizational studies to answer other likely policy questions.

The GAIN was explicitly designed to support many of these approaches. The list of articles using the GAIN (at http://www.chestnut.org/li/gain) identifies several examples of it being used with different populations and analytic methods.

9.3 Planning to Implement and Use the GAIN

Exhibit 9-1 contains a list of common questions that need to be addressed when using the GAIN for clinical practice or research and is meant as a starting point, not an exhaustive list. But, these are issues better addressed sooner rather than later. In many cases Chestnut staff members work with a group of grantees (within a multi-site study) as a data-coordinating center to clean the data, generate management reports, create analytic files, and support cross-site analysis. Individual licensees typically manage their own site’s data and analyses. We do have a policy of sharing our instruments, manuals, and syntax for minimal or no cost (with licensed users). In addition, the GCC can manage an individual licensee’s data and analysis needs if arranged in advance (usually contractually). Please contact GAINInfo@chestnut.org if you are interested in these services.

Some of the specific tools available on the attached CD and our website (http://www.chestnut.org/li/gain) to support local program evaluation or treatment research are:

- Copies of the instruments (including an archive of prior versions).
- A crosswalk identifying what the items are used for and a core set for a shorter version.
- Maintained cross walks of data collected by version and site across over 100 projects to facilitate later cross-site or methodological analyses.
- Information on the HIPAA-compliant GAIN ABS online system for managing local versions of the instrument, generating individual level reports, transferring records and exporting (de-identified) data.
- SPSS syntax for cleaning data and creating scale scores for analysis and reporting.
- Crosswalks to existing standards (e.g., ASAM, DSM, GPRA, JCAHO, TEDS).
- Individual level reports to support specific interventions (e.g., Sampl & Kadden’s 2001 MET/CBT5), motivational interviewing, interpretation and referrals/recommendations in general.
- Detailed psychometric norms by age and level of care.
- An electronic encyclopedia (more than 1,000 pages) describing calculated scales and variables used for analysis or clinical reports. Information is provided about each scale’s
and variable’s measurement type, description, calculation, interpretative ranges, and related references. (See Appendix H for a full listing of the scales and variables.).

Moreover, we continually add to our website and will continue to expand this list. It is particularly useful to check on the scales and variables file as it is being updated quarterly to include the most recent publications and changes to any syntax to address problems that have been identified by other users.

**Exhibit 9-1. Common Implementation Questions**

**Design**

1. Which instruments will you be using (e.g., GQ, GAIN-I, TxsI, M90, GCI, GCF, others)?
2. How will you be using the information (e.g., diagnosis, placement, treatment planning, outcome monitoring, program development/evaluation, research)?
3. From where will you recruit people?
4. What is the process to get the participant from identification to admission?
5. Do you need a screener or process of determining initial eligibility?
6. How will you implement and document random assignment or placement decisions that need to be made?
7. What safeguards are in place to protect the integrity of any randomization or quasi-experimental assignment decisions?
8. How will you document initial working alliance and the services provided?
9. When will you do follow-up (e.g., at 3, 6, 9, 12 months either post-intake or post-discharge). Will it be done in person or by telephone?
10. What will be your follow-up protocol (e.g., releases, locators, verification, reminders, trackers, monitoring, follow-up log)?

**Clinical**

11. What policies will you follow related to suicide risk or imminent danger to others, infectious diseases, victimization, and substance use during pregnancy?
12. Who will initially get and have access to the intake results? Are there implications for releases or business partnerships under HIPAA?
13. Who will initially get and have access to any follow-up data?
14. Who will have ongoing access to the records (based on role or ID) and who will monitor this process?
15. Have you identified critical issues or populations to be tracked for management reports (e.g., intake case flow, clinical characteristics, retention data, leading outcomes like urine tests or school or employment attendance)?
16. What steps will you take to get staff members to integrate the assessment into their actual practice?

**Training and Supervision**

17. What do you need in your study specific appendix (e.g., cross-site ID, local site ID, staff ID, time periods, instruments to be completed)?
18. Who will be responsible for training, supervising and certifying the staff members administering the GAINs?
19. How will you initially train people?
20. How will you train new people due to turnover?
21. Will you be granting continuing education credits for staff members?
22. What process of quality assurance (e.g., tapes, direct observation) and certification will be used locally?
23. Who will be the backup person when the trainer/supervisor is unavailable or in the event that she leaves?
24. How will you proactively identify and address staff members’ concerns during the initial implementation phase?

**Statistical**
25. Who will be responsible for doing additional local reports or analyses?
26. Who will be involved in the data management or just receiving (de-identified) data from which to work?
27. Do the people responsible for #25 and #26 have SPSS or other software to support statistical analysis?
28. Who will provide syntax and information to help data managers use the data?

**Logistical**
29. Where will you do the assessments at intake and follow-up? Will they be private and secure? Will you have multiple remote locations?
30. Who will administer and (if applicable) score and interpret the GAIN? Will it be a few people or everyone?
31. Will you administer the GAIN online with GAIN ABS or use the paper version and data-enter responses after the fact?
32. Do the people involved with #31 have adequate equipment to do this?
33. Where will the hard and electronic data be stored?
34. Who will be responsible for installing and updating software?
35. Who will be responsible for managing the local database (and corresponding with data coordinating center where applicable)?
36. Do you have to accommodate people with special language, cultural or other needs?
37. Do you have to accommodate collaterals or children while doing the assessment?
38. Do you need any special releases for treatment or follow-up?
10. References


