GAIN-Q3 3.2

Administration, Clinical Interpretation, and Brief Intervention

July 2013

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Acknowledgments

The development of this manual was supported by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract 270-07-0191, using data provided by the following grantees: TI13190, TI13308, TI13309, TI13313, TI13323, TI13344, TI13345, TI13354, TI13356, TI14090, TI14214, TI14254, TI14261, TI14271, TI14272, TI14283, TI14315, TI15415, TI15421, TI15433, TI15438, TI15446, TI15447, TI15458, TI15461, TI15466, TI15467, TI15475, TI15478, TI15481, TI15485, TI15489, TI15524, TI15527, TI15562, TI15586, TI15670, TI15674, TI15677, TI15678, TI16386, TI16400, TI16904, TI16915, TI16928, TI16939, TI16961, TI16992, TI17046, TI17070, TI17071, TI17119, TI17434, TI17446, TI17475, TI17476, TI17484, TI17486, TI17490, TI17517, TI17523, TI17530, TI17534, TI17535, TI17538, TI17589, TI17604, TI17605, TI17646, TI17648, TI17673, TI17702, TI17719, TI17724, TI17728, TI17742, TI17751, TI17761, TI17763, TI17769, TI17775, TI17779, TI17786, TI17788, TI17812, TI17817, TI17821, TI17825, TI17831, TI17847, TI17864, TI18406, TI18587, TI18671, TI18723, TI18735, TI18849, TI19313, TI19323, TI19942, TI20084, TI20085, TI20017, TI20759, TI20798, TI20806, TI20827, TI20828, TI20847, TI20849, TI20852, TI20925, TI20938, TI20941, TI20946, TI21551, TI21580, TI21585, TI21595, TI21597, TI21624, TI21632, TI21639, TI21682, TI21688, TI21705, TI21714, TI21748, TI21774, TI21788, TI21815, TI21874, TI21883, TI21890, TI21892, TI21948, 655371, 655372, 655373, and 655374. Data was also provided by the following state, county, system (e.g. Department of Public Health) or individual human service agencies: Auburn Youth Resources, Center for Human Services, Therapeutic Health Services, Community Psychiatric Clinic, Consejo Counseling & Referral Service, Friends of Youth, Kent Youth & Family Services, NAVOS, Rather Child Center, Seattle Counseling Service, United Indians of All Tribes Foundation, Valley Cities Counseling & Consultation, Washington Asian Pacific Islander Families Against Substance Abuse, Youth Eastside Services, Renton Area Youth and Family Services, Sound Mental Health, Asian Counseling and Referral Service, Pioneer Human Services, Snoqualmie Tribe/Raging River Recovery Center, North Shore Youth and Family Services, Integrative Counseling Services, Avita Community Partners, CETPA, Cobb Co./Douglas Community Services Board, Highland Rivers CSB, New Horizons CSB, Pathways CSB, Behavioral Health Services of South Georgia, Gateway BHS, Gwinnett Rockdale Newton, D7 Treatment Program, Mountain States Chemical Dependency and Counseling, Riverside Recovery, Twin Falls County Treatment and Recovery Clinic, Addictions Rehabilitation Association, Lifestyle Changes Counseling, MK Place - Bannock Youth Foundation, Personal Development, Port of Hope Centers, Road to Recovery, Family Recovery Center Foundation, Positive Connections, Pro Active Advantage LLC, Salmon Mental Health Clinic, Upper Valley Resource & Counseling Center, Walker Center, Alliance Family Services North Inc., Foundation Services Group Inc., Human Dynamics & Diagnostics, Padron Counseling Services, Restored Paths, Solutions for Life, A to Z Family Services, Brannon & Brannon

Psychological Services, Preferred Child and Family Services, Idaho Youth Ranch, Ada County Drug Court, Preston Counseling, Pacific Rim Consulting, Ascent Behavioral Health Services, Integrity Wellness Group, Bell Chemical Dependency and Counseling, Community Services Counseling, West Marriage and Family Counseling, Emmett Family Services, Ada County Juvenile Court Services, Renewal Services of Idaho, CLUB Inc., Nez Perce County Court Services, Weeks and Vietri Counseling, New Journeys Inc., Family Services Center, Mountain Lake Counseling and Support Services, Valley View Recovery, ChangePoint, Lighthouse For Recovery, Riverside Recovery – Orofino, Idaho Department of Juvenile Corrections, Rathdrum Counseling Center, OATS Family Center, Chestnut Health Systems Adolescent Unit, Lifeworks Northwest, Mental Health and Recovery Center of Clinton County (Cincinnati),Operation PAR Inc., Project Metamorphosis, Stewart Marchman Act (SMA) Behavioral Healthcare, Spectrum Youth and Family Services Inc., Perception Programs Inc., Rushford Center, Hartford Youth Project, and Seattle Reclaiming Futures. The opinions are those of the authors and do not reflect official positions of the federal or states' governments.

Opinions expressed herein are those of the authors and do not reflect official positions of the government. The authors would like to thank Leah R. Cleeland, Cherié C. Dew, Rodney R. Funk, Pamela C. Ihnes, Kathryn C. Modisette, Matthew G. Orndorff, Sarah Pate, Emily Ryburn, Jen Salzman, April S. Thomas, and Laine Twanow for their work on this manual and the GAIN-Q3 instrument and motivational-interviewing protocol.

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Suggested APA citation:

Titus, J. C., Feeney, T., Smith, D. C., Rivers, T. L., Kelly, L. L., & Dennis, M. D. (2013). *GAIN-Q3 3.2: Administration, clinical interpretation, and brief intervention*. Normal, IL: Chestnut Health Systems. Retrieved from http://gaincc.org/GAINQ3

Contents

1. Introduction to the GAIN-Q3

1.1 GAIN-Q3 Overview

The Global Appraisal of Individual Needs–Q3 (GAIN-Q3, or Q3) is a multipurpose assessment used to accurately and efficiently identify a wide range of life problems among adolescents and adults in both clinical and general populations. As a clinical tool, the Q3 is designed for use by personnel in diverse settings, including employee assistance programs, student assistance programs, health clinics, juvenile and criminal justice programs, child welfare programs, and mental health and substance abuse treatment programs. The overall purpose of the Q3 is to efficiently and accurately assign people entering or being screened for services into one of three groups: 1) those who do not appear to have problems in need of attention, 2) those who appear to have mild problems that can be addressed in a brief intervention, and 3) those whose results indicate the need for referral for a more detailed assessment or specialized treatment. For participants whose results indicate mild problems, the Q3 system provides the means to conduct a brief intervention based on the principles of motivational interviewing.

The GAIN-Q3 Follow-Up (in two versions, Standard and Lite) can be administered quarterly after the initial assessment to monitor the participant's response to treatment, clinical status, and service utilization. The Q3 Follow-Up can also monitor outcomes at a group, program, agency, or regional level.

The Q3 can be administered with pen and a paper copy or with GAIN ABS (Assessment Building System), the GAIN's online administration and reporting system. For assessments that are completed using a paper version of the instrument, GAIN ABS can be used in data-entry mode to enter and store the information collected during the assessment. Interviewers can administer the assessment in person or via telephone, an online voice-communication program such as Skype, or with the help of an interpreter for deaf and hard-of-hearing participants.

The Q3 is one of the main instruments in the GAIN family of assessments, which includes the GAIN Initial (GAIN-I), a comprehensive biopsychosocial assessment, and the GAIN Short Screener (GAIN-SS), a 5-minute screener. The GAIN Monitoring 90 Days (GAIN-M90) is a comprehensive follow-up assessment used with the GAIN-I. All are available in Spanish and other languages.

1.2 GAIN-Q3 Content

At the heart of the Q3 are nine separate screeners (two in the Mental Health section, one in all others). Each screener is four to ten items long and provides an estimate of the level of severity of problems in each life area, or domain, represented.

Q3 section	Q3 screener name
School Problems	School Problems Screener (SPScr)
Work Problems	Work Problems Screener (WPScr)
Physical Health	Health Problems Screener (HPScr)
Sources of Stress	Sources of Stress Screener (SSScr)
Risk Behaviors for Infectious Diseases	Risk Behaviors Screener (RBScr)
Mental Health	Internalizing Disorders Screener (IDScr)
	Externalizing Disorders Screener (EDScr)
Substance Use	Substance Disorders Screener (SDScr)
Crime and Violence	Crime and Violence Screener (CVScr)

The screening items in each Q3 section measure problem recency (the most recent or last time the participant experienced a particular problem) and can be calculated for past month, past 90 day, past 12 month, and lifetime behaviors. For example, item SP1a on the School Problems Screener (SPScr) asks, "When was the last time you came in late or left early from school or training?" Participants answer by choosing the response that corresponds to the last time they engaged in that behavior: past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never. All the screeners are scored to indicate low, moderate, or high-severity problems depending on the number and recency of reported behaviors.

The set of nine screeners composes the most basic form of the Q3. Adding successively more items to this base creates additional forms of the Q3. In total, there are three forms of the initial Q3 assessment:

Q3-Lite. The most basic form of the assessment, the Q3-Lite is a comprehensive screening tool consisting of the nine screeners described above, which measure the recency of the participant's behaviors and provides an estimate of the severity and breadth of problems in each area represented. Information collected using the Q3-Lite can also be used to compute a measure of the participant's quality of life. The Q3-Lite takes about 20 minutes to administer.

Q3-Standard. This form of the Q3 consists of the nine screeners plus additional items (the median number per section is six) that record information on the frequency of the participant's service utilization and behaviors during the preceding 90 days. For example, item WP1e1 asks, "During the past 90 days, on how many days were you absent from work for a full day?" Participants report their best estimate of the number of days they engaged in that behavior. In addition, information collected using the Q3-Standard can be used to compute indices on the participant's prevalence of problems during the preceding 90 days and

their quarterly cost to society. The Q3-Standard also includes a six-item measure on current life satisfaction. The average time to administer the Q3-Standard is 35 minutes.

Q3-MI (Motivational Interview). This form of the Q3 includes the nine screeners, the past-90-day items, and the measure of life satisfaction as in the Q3-Standard, as well as reasons and readiness items to facilitate a motivational-interviewing (MI) session or other brief intervention. For any life area that screens as problematic (or for any problematic area that a site chooses ahead of time to address), Q3 interviewers have the option of collecting information on the participant's reasons and readiness to change their behaviors. "Reasons" items are statements that explain why someone would choose to reduce or eliminate problematic behaviors. For example, in the Risk Behaviors for Infectious Diseases section, one of the offered reasons for changing health risk behaviors is "because you don't want to get HIV or some other serious illness." The participant answers each yes-no reasons item and is given the opportunity to offer their main or most important reason for wanting to change their risk behaviors. The "readiness" items ask the participant how ready they are right now to change their problematic behaviors. These responses are reported on a scale from 0% (for not ready at all) to 100% (for completely ready). This information is then used during the Q3 brief intervention, which can be conducted either during the assessment session or at a later meeting.

The Q3-MI can be administered in two ways:

- The interviewer can administer the entire Q3-MI and conduct the motivational intervention all in one session. This approach is most useful when working with high-risk participants whom you want to motivate to enter the treatment process. The entire assessment is conducted at once, saving time in the long run and increasing reliability. However, this approach takes the longest of all the Q3 administration options.
- The interviewer can administer the Q3-Standard portion of items on the Q3-MI (that is, all but the reasons and readiness items). At a second session, the pertinent Q3-MI items on reasons and readiness to change are administered and the motivational intervention is conducted. The benefit of this approach is a short initial session. A limitation of this approach is that some participants may drop out before the second session when the motivational interview items are administered. In addition, the participant's situation may have changed between sessions, leading to reduced reliability for the reasons and readiness items.

The time required to conduct the screening and brief intervention varies depending on the number of life areas the participant reports as problematic, but on average the Q3-MI assessment by itself takes about 45 minutes to administer. If the motivational intervention is conducted during the same session as the Q3-MI, the entire process takes about 60 to 75 minutes.

1.3 GAIN-Q3 Life Impact Measures

Information collected with the various forms of the Q3 can be used to calculate a set of four indices called the Life Impact Measures. These measures provide a unique lens on the costs associated with a person's life problems and the benefits associated with improving their life situation. The four measures are the Quality of Life Index (QOLI), the Problem Prevalence Index (PPI), the Quarterly Cost to Society Index (QCS), and the Life Satisfaction Index (LSI). As mentioned above, the measures are calculated from information pulled from each of the main sections of the Q3, with the exception of the Life Satisfaction Index, which is a standalone section at the end of the Q3-Standard and the Q3-MI. All four measures are computable when using the Q3-Standard and the Q3-MI, while only the Quality of Life Index can be measured when using the Q3-Lite.

The **Quality of Life Index (QOLI)** is based on the past-year results from each of the 9 problem screeners. As the number of problems in each life area increases, the score of the Quality of Life Index decreases. This measure can be computed using data from the Q3-Lite, Q3-Standard, or Q3-MI.

Both the **Problem Prevalence Index (PPI)** and the **Quarterly Cost to Society Index (QCS)** are available with the Q3-Standard and Q3-MI. The Problem Prevalence Index is drawn from 23 items across all sections of the Q3. The index is the percent of days during the preceding 90 that the participant experienced problems across all life areas. The Quarterly Cost to Society Index provides an estimate of the monetary value of services that the participant received during the previous 90 days. Each of the 19 services mentioned in the Q3 (emergency room visits, jail time, mental health services, etc.) is assigned a unit cost to society. The total value of the services reported by the participant is an estimate of the costs to society. These two measures can be computed using data from the Q3-Standard and Q3-MI. However, because these are past-90-day measures, if the participant does not report pertinent behaviors during the past 90 days, the scores cannot be computed.

The **Life Satisfaction Index (LSI)** measures a participant's current general satisfaction across multiple areas of life: sexual or marital relationships, family relationships, general level of happiness, place of residence, how life is going so far, and school and work situations. This standalone measure is included in the Q3-Standard and Q3-MI.

The values of the Life Impact Measures will vary according to the complexity of problems that a participant has in their life. As the complexity of life problems increases, measures of problem prevalence and quarterly cost to society should increase, and as complexity decreases, quality of life and life satisfaction should increase.

1.4 GAIN-Q3 Clinical Reports

Once the participant's responses are entered in GAIN ABS, the system processes the infor-

mation and generates a series of reports for use in diagnosis and treatment planning. The following reports are available:

The **GAIN-Q3 Recommendation and Referral Summary (Q3RRS)** is the Q3's main clinically descriptive treatment planning report. It is a narrative summary of a Q3 assessment with recommendations for treatment planning based on the participant's self-reported information. The content of Q3RRS depends on the form of the Q3 administered, with the Q3-MI providing the most information.

The Q3RRS is designed to approximate a biopsychosocial summary of the interview to aid in understanding the participant's current status and plan for treatment, if deemed necessary. This summary includes the participant's basic demographics and background information (including priority population membership, which includes participants who typically require expedited intake or specialized services), their reason for referral to screening or treatment, and the details of the evaluation process. For each section of the Q3, the Q3RRS lists the participant's problems, service utilization, and reasons for wanting to change their behaviors, followed by placement and treatment planning recommendations. The Q3RRS also interprets the participant's scores in the four Life Impact Measures and concludes with a summary of the participant's current status in each of the Q3's main life areas and recommendations for further action where warranted.

The Q3RRS is fully editable in GAIN ABS, allowing users to modify or delete the generated suggestions. Prompts are provided to enter additional information, and users can incorporate notes and information from other sources into the final report. Because the Q3RRS takes the form of a narrative, with a minimum of technical language or schematics, it is easy to read and share among treatment staff and others. The Q3RRS requires about 20 to 30 minutes of editing on average, as opposed to the hours required to create a traditional narrative report from scratch.

The **Q3 Individual Clinical Profile (Q3ICP)** is a report listing the items that factor into a participant's Q3 scale scores, to be used by the primary therapist or staff person handling a case. The Q3ICP lists much of the same information as the Q3RRS but in visual form, showing the cut-points for low, moderate, and high problem severity or service utilization. The Q3ICP notes priority population information and presenting concerns, including referral source. It also lists the interviewer's validity concerns, such as staff suspicions of possible denial or misrepresentation. Unlike the Q3RRS, the Q3ICP should be used only by people trained on interpretation of the Q3; it is not designed to be edited or read by others or by the participant.

The **Q3 Personalized Feedback Report (Q3PFR)** is a summary of the participant's reported problems along with their reasons for wanting to change. For each main section of the GAIN-Q3, the Q3PFR reviews the participant's problems, notes their problem severity and percent readiness to change behavior, and creates an outline for a motivational interviewing session. This report can be used to support motivational interviewing or brief interven-

tion (MI, MET, or CHOICE model). The Q3PFR is designed for use with the Q3-MI. While it can be generated from the Lite or Standard, the results will contain sections of missing information that have to be collected from the participant in a subsequent session or during motivational interviewing. See Chapter 6 for extensive information about the Q3PFR.

The **Validity Report** can be run at any point during the interview to identify inconsistencies in the participant's self-reported information for clarification during or immediately after the interview. For example, if a participant states for item SU1a that they last used alcohol or other drugs weekly or more often within the past month, but then in later items they report no use in the preceding 90 days, the validity report would flag the relevant items and explain the inconsistency or possible inconsistency. Identification of validity errors helps increase the overall strength of the participant's self-report and helps ensure proper treatment planning.

1.5 GAIN-Q3 Data Management Services

To ensure the long-term sustainability of the Q3, the GAIN Coordinating Center offers data management services. Each month the GCC's Data Team will process your agency's Q3 data to determine whether there are any data anomalies or missing data that need to be addressed. The GCC will work with an assigned staff member at your agency to resolve these issues and to ensure that you have the most accurate data set possible. This process also allows your agency to identify training needs: For example, if data cleaning reveals that interviewers consistently make the same error at one point in the assessment, it suggests the need for additional training in that area. In addition, the GCC provides quarterly Site Profiles reports, which provide a breakdown of your agency's population in more than 50 categories. For more information on data management services, please contact gaininfo@chestnut.org.

1.6 Organization of the Manual

The next chapter provides background and guidelines for semistructured assessments and for administration of the GAIN-Q3.

Chapter 3 is an item-by-item walkthrough of the Q3 instrument. It explains the administration nuances of each item and item set, answers many commonly asked questions, and suggests ways to avoid common problems and inconsistencies.

Chapter 4 explains the GAIN Coordinating Center's model of training and administration quality assurance (A-QA), an essential component for maximizing reliability and validity.

Chapter 5 explains the use of the GAIN-Q3's clinical reports, focusing primarily on the Q3 Recommendation and Referral Summary and the Q3 Individual Clinical Profile.

Chapter 6 details the use of the Q3 Personalized Feedback Report in motivational interviewing and introduces the CHOICE (Compassionate Helpers Openly Inviting Client Empowerment) model of delivering MI-consistent feedback to clients.

Appendixes and references round out the manual.

1.7 Getting Started

For more information on the GAIN-Q3, including use, licensing, and GAIN ABS, please contact the GAIN Coordinating Center:

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2. GAIN-Q3 Administration Guidelines

2.1 Semistructured Interviewing and the 10 + 1 Guidelines

The GAIN-Q3 is designed to collect reliable, valid information during interviews. This ensures that accurate information is collected for use in the treatment planning process and for analysis by evaluators and other researchers. In this context, reliable and valid information have specific meanings:

> Reliability is consistency across measurement. The participant would give the same response to the question regardless of who asks it.

> Validity is the extent to which something is factually true. A valid response is an accurate response, given in the appropriate format.

Traditionally, different types of assessments were better at achieving either reliability or validity but not both. A highly structured assessment, such as a standardized test, delivers good reliability because of its scripted format: Every participant is asked the same question the same way every time. On the other hand, a less-structured assessment, such as a clinical interview, delivers good validity because the interview can ask clarifying follow-up questions to hone in on the most accurate response.

However, each approach has limitations as well. Highly reliable assessments come at the expense of validity: A participant may misunderstand an item on a standardized test, and there may be no means for clarifying if the participant has a question or gives a response that doesn't make sense. Likewise, an assessment with good validity may lack reliability because of the deviation in administration from one interviewer to the next, or even because the same questions were not asked from interview to interview.

Because both reliability and validity are important, the substance abuse treatment field has come to value flexible assessments. The GAIN-Q3 is a medium-structured assessment, also known as a semistructured assessment. This approach offers the best of both worlds: It is structured to allow the interviewer to collect concrete information, but it also allows the flexibility to explain and clarify items and collect verbatim responses from the participant.

Mastering the basic skills required for semistructured interviewing is relatively simple. The following are guidelines for conducting a semistructured interview, adapted from Dennis and colleagues (1995).

1. **Ask items exactly as worded.** It's important to ask each item exactly as it's printed, since changing any wording can change the meaning of the item and cause the participant to respond differently. For example, item MH2h1 asks, "During the past 90 days, how many times have you had to go to an emergency room for mental, emotional, behavioral, or psychological problems? But if the interviewer does not read the item as printed and instead asks only, "During the past 90 days, how many times have you had to go to an emergency room?" it changes the intent of the item.

2. **Ask items in the exact order as printed.** Items in the GAIN follow a logical progression. Not following the order in the GAIN-Q3 could cause unnecessary items to be administered, or it could confuse the participant. If you forget to administer an item, it's important to go back and administer it, even if it's out of order.

3. **Ask every item unless there is a skip instruction.** Be sure to ask every item unless there's a skip instruction to follow. For example, item PH1f asks, "When was the last time you saw a doctor or nurse about a health problem or took prescribed medication for one?" If the participant responds with a time frame within the preceding 90 days, the interviewer moves to items asking about the frequency (how often something has occurred) of services that the participant received during those 90 days. But if the last time the participant saw a doctor or took prescribed medication was more than 90 days before the interview, then it makes no sense to ask about how often the participant received services in the past 90 days.

4. **Read each item completely.** Reading each item completely ensures that nothing is left out that the participant may report. For example, the question "During the past 90 days, on how many days did you get drunk at all?" is very different than the wording actually used for item SU3b, "On how many days did you get drunk at all *or were you high for most of the day*?" (emphasis added). One way that this might happen is if the participant interrupts the interviewer and tries to answer the question before it has been read all the way through. If this occurs, the interviewer should politely remind the participant that the whole item needs to be asked, then readminister the item.

5. **Read introductory and transitional statements.** Introductory and transitional statements let the participant know what will be asked and how to respond. An example of an introductory statement is, "The next question is about your use of alcohol and other drugs. Alcohol includes beer, wine, whiskey, gin, scotch, tequila, rum or mixed drinks. 'Other drugs' include marijuana; other street drugs like crack, heroin, PCP, and poppers; inhalants like glue or gasoline; and any nonmedical use of prescription-type drugs. Please do not include any prescription drugs you use or used under the direction of a doctor." Introductory and transitional statements also include the response scales before most item sets, such as "Please respond to each of the next statements using yes or no."

6. **Read the items at an appropriate tempo.** The interviewer may be extremely familiar with the assessment, but in most interviews it's the participant's first time hearing the

questions. Be sure not to read the items too quickly or too slowly. Use a pace appropriate to the participant's needs.

7. **Repeat misunderstood items.** The hallmark of GAIN administration is the philosophy of "standardization of understanding." It's vital that the participant understands the question being asked in order to provide the most accurate response. If a participant does not understand an item, be sure to repeat it, and offer additional explanation to help the participant give the most accurate response. For example, for item SP1e1 in the School Problems section (During the past 90 days, on how many days were you absent from school or training for a full day?), suppose the participant isn't sure what counts as an absence. The interviewer consults the GAIN-Q3 walkthrough (in the next chapter) and explains that an absence is any day that the participant should have been in school but wasn't. The participant can then offer an accurate response.

8. **Listen to responses (keeping in mind possible inconsistencies with previous responses).** By listening to the participant's story, you will be able to recognize when something they report doesn't make sense with the rest of their story, and you will be able to clarify that response with the participant. Say that for item PH1f in the Physical Health section (When was the last time you saw a doctor or nurse about a health problem or took prescribed medication for one?) the participant answers, "2 to 3 months ago." But when asked follow-up questions about how many times in the past 90 days they saw a doctor or took prescribed medication, they answer zero. If the interviewer isn't listening closely to the participant, they may not recognize that these responses are inconsistent. In addition, a participant's story is important to them. Although you are listening to identify inconsistent responses, be sure to pay attention to everything else the participant has to say; this will help create trust and rapport.

9. **When needed, use neutral probes.** If a participant provides a vague or inconsistent response, the interviewer should use neutral probes (without suggesting an answer) to help shape the responses into ones that can be coded. There are several 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?"
- 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.

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.

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?" is one of the interviewer's possible responses. Note that the interviewer is clarifying by offering several options (yes *or* no) rather than proposing only one option (yes). Do not lead the participant with, "So do you want to go with yes?" or worse, don't assume that the participant meant yes and circle that response without asking for clarification.

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 unbiased and suppressing value judgments or the natural instinct to help (aside from the semistructured clarifying guidelines outlined here). Facial expressions can easily reveal reactions to a response. Interviewers should avoid giving any cues to the participant about whether they approve or disapprove of a response or other statement. Keep in mind that many participants are 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. Remain an unbiased recorder of the information that the participant offers.

The "+1" guideline. The most important guideline is to use common sense:

- Get to know the GAIN
- Be aware of participant fatigue and inattentiveness
- Be humane
- Avoid being confrontational
- Be culturally sensitive

2.2 Understanding GAIN-Q3 Items

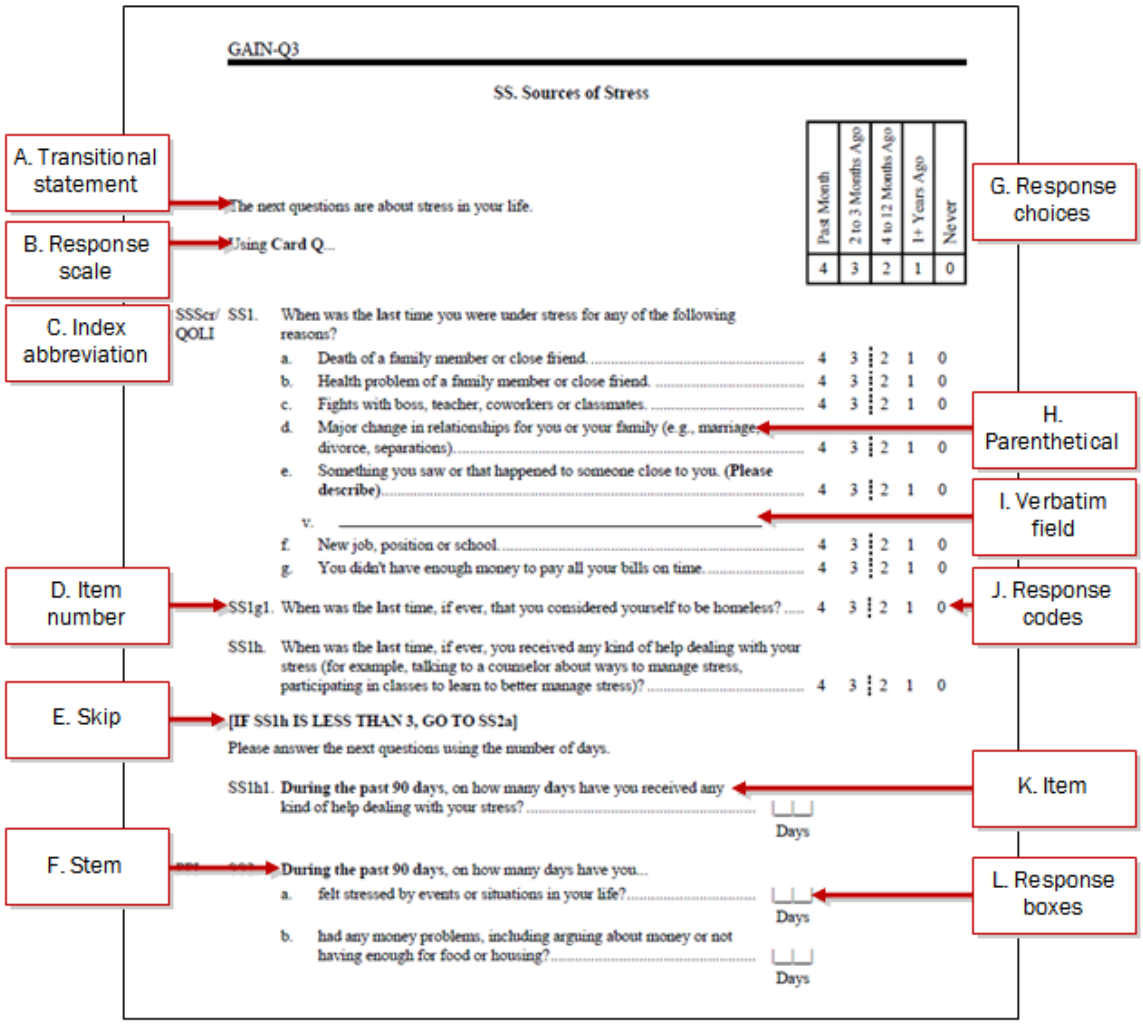
Each section of the GAIN-Q3 is made up of a few simple components (Figure 2.1).

A. Transitional statement – information for the participant that introduces a series of items and shifts the focus from one set of items to another.

B. Response scale – instructions on how to answer a question or series of questions, such as "Using card Q."

C. Index abbreviation – letters in the margin of the GAIN-Q3 used to identify the items that make up an index, scale, or measure. In the example above, SSScr/QOLI stand for the Sources of Stress Screener and the Quality of Life Index. These abbreviations are not part of the item numbers.

Figure 2.1 The main components of the GAIN-Q3 (paper version)



D. Item number – the letters and numbers that uniquely identify each item in the GAIN. On this page the item numbers start with SS1a and continue through SS1h1 before switching to SS2a–b at the bottom of the page. See below for details on item numbering conventions.

E. Skip – an instruction that, if the participant's response to an item meets certain criteria, directs the interviewer to advance past some items or item sets. The participant's response to the item with the skip eliminates the need to ask follow-up items. In Figure 2.1 the user is instructed to skip to item SS2a if the participant has not received help dealing with their stress in the preceding 90 days (item SS1h). The skip allows the interview to bypass the item on the number of days the participant has received help for their stress in the past 90 days, which doesn't make sense to ask if the participant has already stated that they haven't received help in that time frame.

F. Stem – a phrase that starts each item in a particular series of questions, such as "During the past 90 days, on how many days did you…"

G. Response choices – a fixed set of responses from which the participant answers a question. In Figure 2.1 the response choices are "past month," "2 to 3 months ago," "4 to 12 months ago," "1+ years ago," and "never."

H. Parenthetical – phrases within items or instructions that are read to the participant only if clarification or additional information is necessary. Parenthetical material often offers examples for the participant and isn't meant to be read word for word (such as the examples of relationship changes in item SS1d).

I. Verbatim field – lines on the paper copy of the GAIN-Q3 on which a participant's free response to an open-ended question is recorded. The three lines on the paper version do not correspond to the number of responses; the participant can give one response or several. Lengthy responses that don't fit on the lines can continue in the margin or on another sheet of paper. (GAIN ABS has no lines in its verbatim fields but otherwise functions the same.)

J. Response codes – numeric codes that correspond to the response choices, used when entering the participant's responses into GAIN ABS. In this example the range of response codes, from card Q, is 0 through 4.

K. Item – a single question or other query in the GAIN assessment (also referred to as a question). Items on this page include the individual items in SS1a–g, SS1g1, SS1h, SS1h1, and SS2a–b.

L. Response boxes – spaces in which a participant's numeric responses are recorded. Numbers entered in response boxes should be flush to the right (e.g., see Figure 2.10 on p. 24). Some response boxes appear in staff use boxes, which are documented only by the interviewer or other staff member.

2.3 Naming Conventions

Most Q3 item numbers begin with the first letter or an abbreviation of a section name:

- **B**ackground Information (**B**)
- **S**chool **P**roblems (**SP**)
- **W**ork **P**roblems (**WP**)
- **P**hysical **H**ealth (**PH**)
- **S**ources of **S**tress (**SS**)
- **R**isk **B**ehaviors for Infectious Disease (**RB**)
- **M**ental **H**ealth (**MH**)
- **S**ubstance **U**se (**SU**)
- **C**rime and **V**iolence (**CV**)
- **L**ife **S**atisfaction (**LS**)
- **E**nd items (**Z**)
- **A**dministrative information (**XADM**)

The next character in the item number is a numeral. For instance, item B1 ("What is your gender?") is the first item in the Background section. Subitems are usually denoted by letters: B2a, B2b, etc. Subitems of subitems continue in alternating letter-number format: PH1f1, Ph1f2, and so on.

The letters *i*, *o*, and *l* are always skipped in item numbering to avoid confusion with the numbers 1 and 0. For example, the items in the Substance Use section include items SU4a–h, SU4j–k, SU4m–n, and SU4p–s; there is no SU4i, SU4l, or SU4o.

2.4 Q3 Item Types

There are five main types of questions in the Q3: select one, give a number, mentioned, clarify and code, and verbatim.

Select one. The most common and straightforward type of question asks the participant to choose one answer from several possibilities. This type includes yes-no items, items that utilize the response cards, and items for which the interviewer reads a set of response choices. The participant answers these questions using one of the set choices, and the interviewer clarifies any ambiguities or inconsistencies.

Give a number. Some items ask the participant for the frequency with which they've done something. Usually these questions take the form of "During the past 90 days [or other time frame], how many times [or days, nights, etc.] did you…?" and the participant gives the most accurate response. Responses to numeric questions must be given in whole numbers, not fractions or decimals. If a participant gives a fraction of a whole number, explain that you can record only whole numbers and ask them to choose which number they feel comes closest to an accurate response. If the participant cannot choose a whole number (which is rare), always round up to the next whole number. The same principle applies to dates: If the participant can't choose between two time frames, round to the most recent.

Figure 2.2 Give a number

MH3. **During the past 90 days**, on how many **days**...

a. were you bothered by any nerve, mental or psychological problems? ..... |__|__| **[IF 0, GO TO MH3c]**
Days

b. did these problems keep you from meeting your responsibilities at work, school or home, or make you feel like you could not go on?... |__|__|
Days

c. have you been disturbed by memories of things from the past that you did, saw or had happen to you? ..... |__|__|
Days

d. have you had any problems paying attention, controlling your behavior, or broken rules you were supposed to follow? ..... |__|__|
Days

Mentioned. Mentioned items ask the participant to give as many pertinent responses as they can. For example, the interviewer reads item B3a, "Which races, ethnicities, nationalities, or tribes best describe you?" The participant then offers the appropriate responses (see Figure 2.3), and the interviewer codes yes for the corresponding responses in B3a1–99. The interviewer follows up by asking "Any others?" until the participant has nothing else to report, at which point the interviewer codes no for the unmentioned responses. (Each item must be coded as either yes or no; no items in a mentioned list should ever be left unmarked.)

The interviewer does not typically read each response in a mentioned list to the participant unless the participant has trouble understanding the item or needs an example of the kind of response they should offer.

Figure 2.3 Mentioned item

B13. What kinds of diplomas, degrees, work-related certificates or licenses have you received? (Any others?)

		MENTIONED	
		Yes	No
1.	High school diploma	(1)	0
2.	Passed GED (general equivalency diploma)	1	(0)
3.	Adult Basic Education (ABE) certificate	1	(0)
4.	Junior college or associate's degree	(1)	0
5.	Bachelor's degree	(1)	0
6.	Advanced college degree (master's or doctorate)	1	(0)
7.	Vocational or trade certificate	1	(0)
8.	Trade license apprenticeship	1	(0)
9.	Commercial driver's license	(1)	0
99.	Other degrees or licenses **(Please describe)**	1	(0)

v. _____

Clarify and code. Some item sets can be administered as clarify-and-code items, which are sort of a cross between mentioned and select-one items. That is, the interviewer asks the question, the participant answers, and the interviewer codes the most accurate item answer from a list of options, clarifying if necessary. The interviewer can also read the response choices if doing so helps the participant give an accurate answer. An example is item B2b, "Who currently has legal custody of you?" Suppose the interviewer asks the question and the participant responds, "My mom." The interviewer then clarifies by asking, "Does she share custody with anyone else?" The participant answers, "No, just her," so the interviewer codes 3 (One parent). Like mentioned items, the interviewer could read the entire list of possible responses if necessary; but to save time and allow for a more natural interactive flow, the interviewer should first ask the question and allow the participant to respond freely.

Figure 2.4 Clarify-and-code item

B15. What is your **current** marital status?

(Clarify and code)

Married	1
Remarried	2
Living with someone as married	3
Married but living apart	4
Divorced	5
Legally separated	6
Widowed	7
Never married and not living as married	8

Verbatim. Participants respond to verbatim items in their own words rather than from a predetermined set of responses (e.g., response cards) or by using yes or no. Verbatim items always have a "v." just before the line and are often marked "Please describe." If the participant's response to a verbatim item is too long to enter word for word, the interviewer can summarize, but they should confirm the wording of the summary with the participant by reading it back to them and confirming that it adequately records their statement.

Figure 2.5 Verbatim items

A4b. What is the name of the person who referred you to come here?

v. _____

A4c. What is this person's relationship to you?

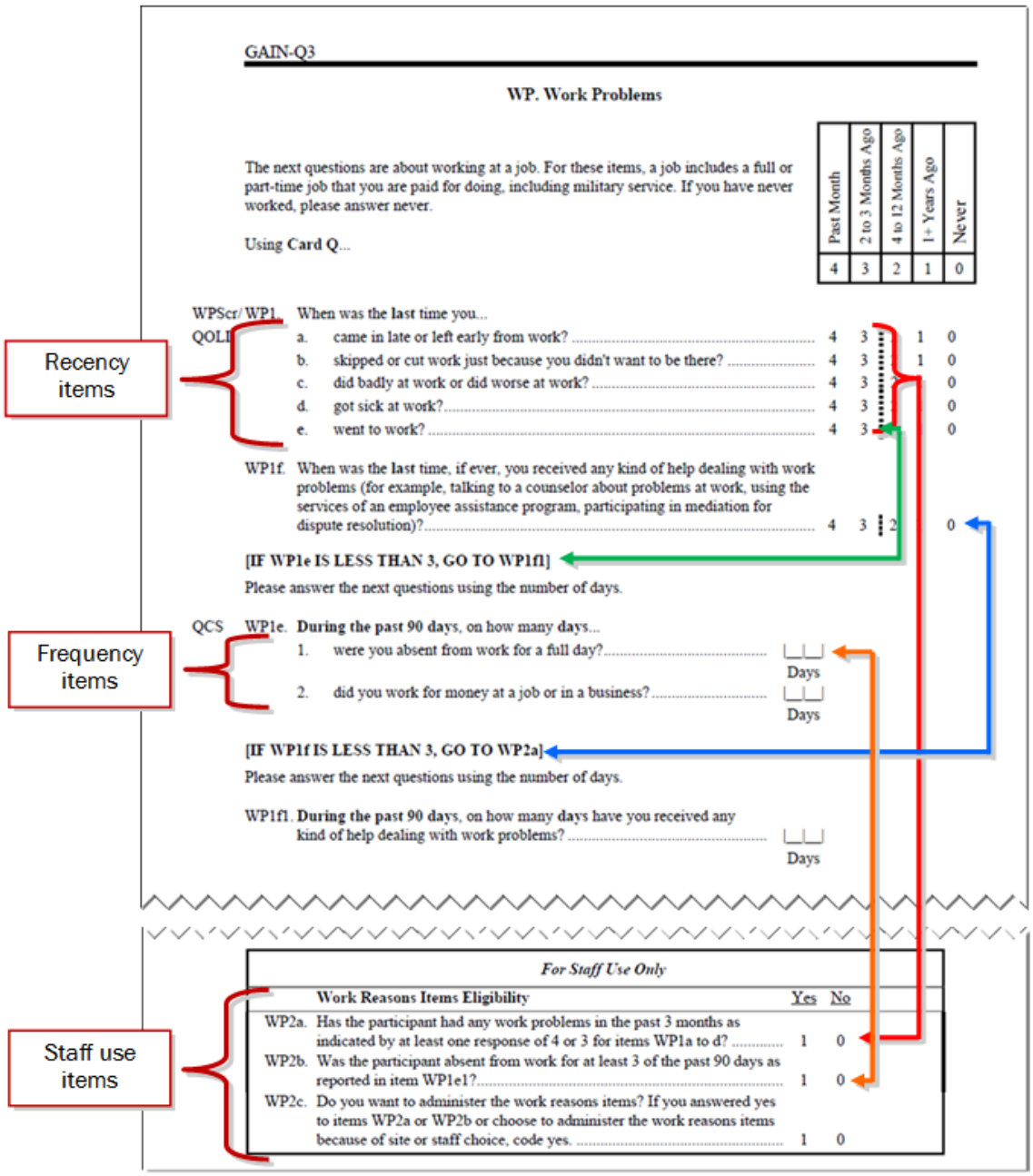
v. _____

2.5 Structure within Sections

The eight main screening sections of the GAIN-Q3 are organized in a standard pattern. First, in all versions of the Q3, a transitional statement introduces the subject matter of each section. For example, the transitional statement preceding the Mental Health section begins, "The next questions are about common psychological, behavioral, and emotional problems." Next, items ask about the recency of various problems and the participant's behaviors in that domain, or life area. Each section's screener is made up of these recency items. (Recency refers to *the last time* the participant had a particular problem.) If the participant has experienced any problems or received any services in the preceding 90 days, the Q3-Standard and the Q3-MI go on to ask about the frequency of those problems during that time period. Finally, in the Q3-MI, the participant is asked about their reasons for making changes in their current behavior and their readiness to do so.

Figure 2.6 demonstrates this pattern using the Work Problems section of the Q3-MI as an example. The participant's response to item WP1e (When was the last time you went to work?) determines the first skip: If the participant hasn't worked in the preceding 90 days, then it makes no sense to ask questions related to the number of days worked in the same time frame, so those items are skipped (the green line in the figure demonstrates the relationship). The second skip (as shown by the blue line) comes from the participant's response to item WP1f (When was the last time, if ever, you received any kind of help dealing with work problems?) and follows the

Figure 2.6 Basic Q3 structure



same logic as the first skip: It would be illogical to ask the participant for the number of days in the past 90 that they received help for their work problems if they just reported receiving no help in the past 90 days. (The Q3-Lite contains only the recency items, not the subsequent frequency items.)

The items in the staff-use-only box (used only on the Q3-MI) refer back to the recency and frequency items. The first item, WP2a, corresponds to items WP1a–d (the Work Problems Screener), as shown by the red line in Figure 2.6. If the participant answered either "past month" or "2 to 3 months ago" for any of those items (the responses to the left of the dotted line), then the interviewer should code yes for item WP2a. The participant's responses to the left of the dotted lines also provide an easy way to determine their current problems (defined in the GAIN-Q3 as occurring within the past 90 days) in each section, which are used in services planning (see Chapter 5) and when conducting a motivational interview (see Chapter 6). The second staff use item relates to a specific item, in this case item WP1e1 (orange line): If the participant reported 3 or more days of absence from work in the preceding 90 days, then the interviewer should code yes for item WP2b. The third staff use item, WP2c, should be coded yes a) if either of the preceding items WP2a or WP2b was marked yes or b) if there are other circumstances where the reasons and readiness items should be administered, such as site protocol or interviewer preference.

The last items in each main section of the Q3-MI are the reasons items (You want to make changes in your behavior because…) and a readiness item, which asks the participant to report on a scale of 0 to 100 how ready they are to change their behavior in that area. These items are used when conducting a motivational interview following the assessment (see Chapter 6).

The Background, Life Satisfaction, and administrative sections do not have recency, frequency, or reasons or willingness items, but they do feature the same general item types as the other sections, such as mentioned or clarify-and-code items, and the basic administration guidelines are the same.

2.6 Preparing for the Interview

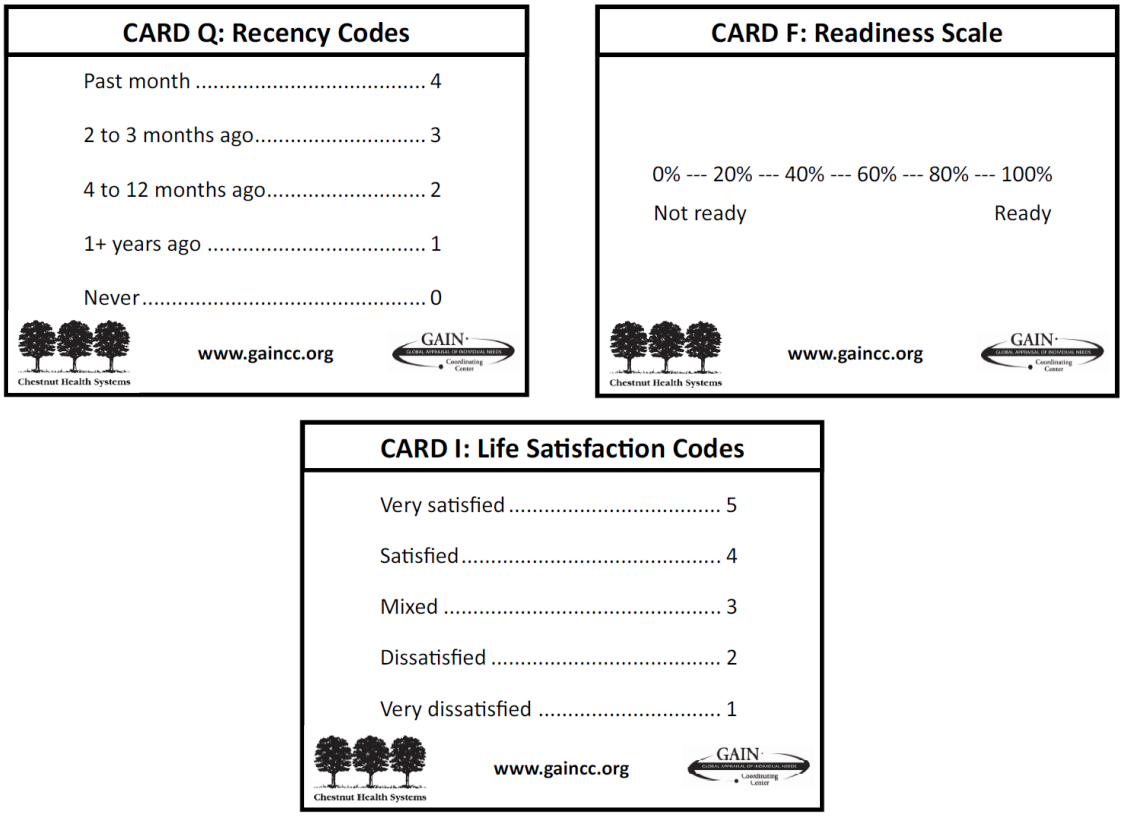
Several items are required for a GAIN-Q3 interview:

- At least one paper copy of the Q3 instrument to be administered. Even if the interview will be conducted with a computer, we strongly recommend keeping paper copies of the Q3 on hand in case of technical problems: If a computer fails during an assessment, the interviewer can continue with a hard copy.
- If using GAIN ABS, a laptop or desktop computer with internet connectivity and a fully charged battery or access to a power source.
- At least one copy of an up-to-date 2-year calendar (available from http://gaincc.org/_data/files/Posting_Publications/GAIN_Calendar.pdf). These calendars are used to

anchor the time frames used throughout the GAIN-Q3 and help orient the participant during the interview. See p. 36 for more information.

- Additional paper for notes or scratch paper.
- Pens. Do not use pencils or erasable-ink pens. Standard pens are considered secure for documentation purposes, while pencils and erasable-ink pens are not. Black or blue ink is preferable, though other colors are acceptable if site protocol allows. Felt-tip pens are often permitted in controlled environments where ballpoint and other hard-tip pens are not.
- A set of GAIN response cards. During the interview, the participant uses these cards to answer item sets with predetermined response options, which helps reduce administration time. The cards can be purchased from Chestnut Health Systems (http://chestnut.org/LI/bookstore/index.html) or copied from Appendix C. Users who print their own cards may wish to laminate them for durability. The GAIN-Q3 uses only three of the cards (supplemental measures may require other cards, as do other GAIN instruments):

Figure 2.7 Standard GAIN-Q3 response cards



- **Card Q** offers standardized time frames for the recency of certain behaviors. Response options on Card Q are past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never. Card Q is used with every version of the GAIN-Q3.
- **Card F** contains a range (from 0 to 100) that corresponds to how ready the participant feels they are to make changes in their behaviors in each section of the Q3. Card F is used only with the Q3-MI.

- **Card I** offers satisfaction-related response choices, including very satisfied, satisfied, mixed, dissatisfied, or very dissatisfied. Card I is used only in the Life Satisfaction section (see p. 83), which appears in the Q3-Standard and the Q3-MI.

The interview should be conducted in a place free of distractions and interruptions. Ideally, no other people should be within earshot of the interview. A desk or table and a couple of chairs are ideal, though not always available, especially at field interviews. A watch or clock is useful for recording the start and end times of the interview and breaks. If available, use a sound masker or white-noise machine to help ensure privacy (music or sound from a television can also work, though both can be distracting).

It's also recommended that the participant have access to juice, soda, coffee, or other refreshments; a bathroom; and a place to take smoke breaks. Whether a site can provide all of these depends on its facilities and resources (e.g., participants in controlled environments may need staff supervision while taking a break). Participant comfort often facilitates a more productive interview.

Depending on site protocol, the location and circumstances of the interview can vary widely. Many agencies conduct only on-site interviews, but others allow for field interviews, which can include the participant's home, school, or workplace; a jail, prison, detention center, or other correctional setting; a public-aid office; a restaurant or other third-party location; or even interviews via telephone. Field interviews are often a matter of necessity; participants often have busy or erratic schedules, so interviewers must conduct the interview wherever possible (this is especially true for follow-up interviews, when the participant is usually free in the community and can be difficult to track down). Computers may not be permitted in some of these locations, which is another reason that interviewers should be adept in Q3 administration with the paper version. Many experienced field interviewers carry blank hard copies of the Q3 assessments with them in their car or briefcase in case they run across a participant they've been looking to interview.

Interviewers in the field should always follow agency procedures to ensure their safety and that of their participant.

2.7 Optional Use of the GAIN's Cognitive Impairment Screener

Sometimes you may suspect that a participant is experiencing some degree of cognitive impairment. Such impairment may be the result of current intoxication or temporary or permanent mental problems. You may know that the participant is impaired before you start the interview, or it may become apparent as you proceed. If the participant is too distraught, distracted, intoxicated, or otherwise impaired, it may make sense to postpone the interview, since they must be able to place themselves in space and time in order for their responses to be valid.

Prior to administering the GAIN-Q3, it is important to verify that the participant possesses the necessary cognitive and literacy skills to complete the assessment, and doing so is required by the Joint Commission (2012). Unfortunately, impairment is often a matter of degree, and it is not always clear when someone is too impaired to go through the interview process. For these situations, interviewers have the option of using the GAIN's Cognitive Impairment Screener (Dennis, White, Titus, & Unsicker, 2005), shown in Figure 2.8 and available in Appendix B. This check is a modified version of the 10-item Short Blessed Scale of Cognitive Impairment (Katzman, Brown, Fuld, Peck, Schechter, & Schimmel, 1983), which has been used extensively in research on substance abuse, homelessness, head injury, Alzheimer's, and other forms of cognitive impairment. Administration time varies but usually takes no more than a minute or two.

Figure 2.8 GAIN Cognitive Impairment Scale

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

ERROR SCORES

a. What year is it now?
(Select 4 for any error)..... 0 4

b. What month is it now?
(Select 3 for any error)..... 0 3

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

c. About what time is it?
(Select 3 for any error)..... 0 3

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

e. Please say the days of the week in reverse order.
[Sat, Fri, Thurs, Wed, Tues, Mon, Sun]
(Select 2 for one error, 4 for two or more errors) 0 2 4

f. Please repeat the phrase I asked you to repeat before.
[John/ Brown/ 42/ Mark Street/ Detroit]
(Select 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 participant 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.)

To administer the check, ask each question and then circle the code for the number of errors. Note that each error does not equal one point: For example, missing one number when counting backwards equals 2 points, while missing the month or the time equals 3 points and missing the year equals 4 points.

As the number of errors go up, it will likely be increasingly difficult to get reliable and valid answers from the client. In general, about 5% of a substance abuse treatment population will score 10 or higher, at which point you should consider other options. If the client's main problem is intoxication, distress, or another issue that appears to be transitory, it is probably better to reschedule the interview, if possible. If you decide to proceed with the interview in spite of a high score, you should do the following:

- Administer the GAIN-Q3 to the participant (rather than opt for self-administration; see section 2.11 on p. 28)
- Assume that the interview will be more difficult or take longer
- Be careful to avoid overinterpreting the responses
- Note the client's problems when reporting the results

In general, if a person cannot remember any of the recall test (the John Brown phrase, item e), the interview will be problematic, and alternative means of assessment should be considered (such as relying on collateral reports or a psychiatric referral). You will need to consult with your supervisor to determine whether to reschedule, assess in another way, or proceed with the understanding that the Q3's clinical reports may be inaccurate.

During follow-up or a subsequent admission, it is not uncommon for some higher-functioning people to recall the entire check, including the John Brown phrase, from memory. Usually this can be interpreted as a sign that there are few (if any) recall problems.

2.8 GAIN-Q3 Documentation Guidelines

The ability to properly record the participant's responses is a fundamental skill for GAIN interviewers. Clear documentation ensures that Q3 information is correctly entered into GAIN ABS and that the generated reports are accurate. Unclear documentation may affect the clinical process, including diagnosis and treatment planning. Therefore, keep these keys in mind when documenting participant responses, information in staff use boxes, and staff notes:

Use pen, preferably blue or black ink. Do not use pencil or thick markers that impair readability.

Circle responses clearly. On the paper version, make circles neat and lined up in an easy-to-read column. Avoid making the circles so large, staggered, or off-center that they overlap onto other response choices, making it difficult to tell which is the intended response.

Figure 2.9 Circling responses

PH4.	You want to make changes in your health-related behaviors because...	Yes	No
a.	you will feel better.	(1)	0
b.	you will stop worrying about your health.	1	(0)
c.	you will be able to participate in more activities.	(1)	0
d.	you will get more done.	(1)	0
e.	you won't be in pain.	1	(0)
f.	other people will stop bothering you about your health.	1	(0)

Enter numbers clearly. Numbers should be legible to anyone else who data-enters or interprets the GAIN. All numbers should be written flush right in the response boxes to avoid ambiguity and the possibility of data-entry error.

Dates should be entered in mm/dd/yyyy format, complete with zeroes in the first position of a month or date consisting of only a single digit (e.g., 03/06/2013 for March 6, 2013). All times should be entered in standard time, not military, and the correct AM or PM should also be entered.

Figure 2.10 Entering numbers and dates

Site ID [XSITE]: |8|6|3|1|1|1|
Staff ID [XSID]: |_|_|3|5|3|8|
Part. ID [XPID]: |_|_|_|2|1|0|
Observation [XOBS]: |_|0|
Edit Staff ID [XEDSID]: |_|_|_|_|_|_|
Data Entry Staff ID [XDESID]: |_|_|_|_|_|_|

Local Site ID [XSITEa]: |_|_|_|_|_|_|
Staff Initials [XSIN]: |D|R|I|
Last Name [XPNAM]: ____
First Name: Jake M.I.: ___
v. ____
Edit Date [XEDDT]: |_|_| / |_|_| / 20 |_|_|
Key Date [XDEDT]: |_|_| / |_|_| / 20 |_|_|

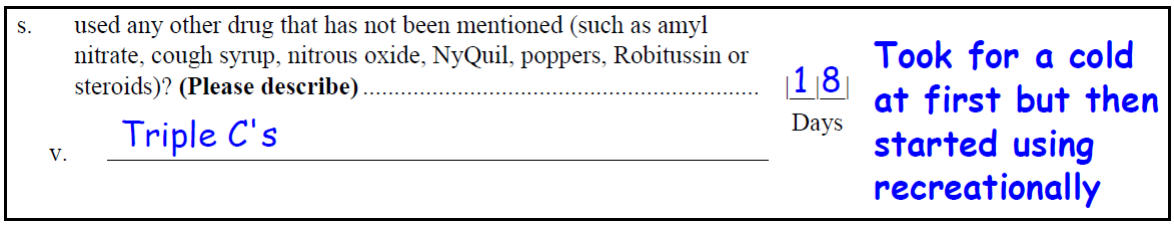
For Staff Use Only

A1. Administrative Information
A1a. Time: |0|2| : |5|3| HH:MM A1b. |PM| (AM/PM)
A1c. Today's Date [XOBSDT]: |1|1| / |2|0| / 20 |1|2| (MM/DD/YYYY)

Write verbatim responses and staff notes clearly. Documented verbatim responses should be easily legible to anyone reading a paper copy of the GAIN. Take your time when writing responses to ensure legibility; do not rush to record a response if there's a chance that the information will be misinterpreted later. As mentioned earlier, try to record the statement as true to the participant's own words as possible. A participant's verbatim response can be lengthy, but it is acceptable to summarize their statement as long as you review the summary with the participant.

Interviewers use staff notes during the interview to record information that isn't covered by the items but that will be helpful to anyone interpreting the case. For example, a participant could report abusing cough medicine but then mention in an aside that they originally took it as directed. This could be significant for the participant's treatment planning, so the interviewer can make a staff note to ensure that the information is recorded as part of the case. Staff notes can also be used to explain apparent inconsistencies: For instance, a participant might state for item MH1d that they recently had significant problems with becoming very distressed and upset when something reminded them of the past, but then for item MH3c they report zero times in the past 90 days that they were disturbed by memories of things from the past that they did, saw, or had happen to them. When the interviewer asks about this apparent discrepancy, the participant might state that they were disturbed by something from the past that they did not actually witness, such as the death of a loved one. In this case, the interviewer could make a staff note to give a plausible explanation for what might otherwise appear to be an inconsistency.

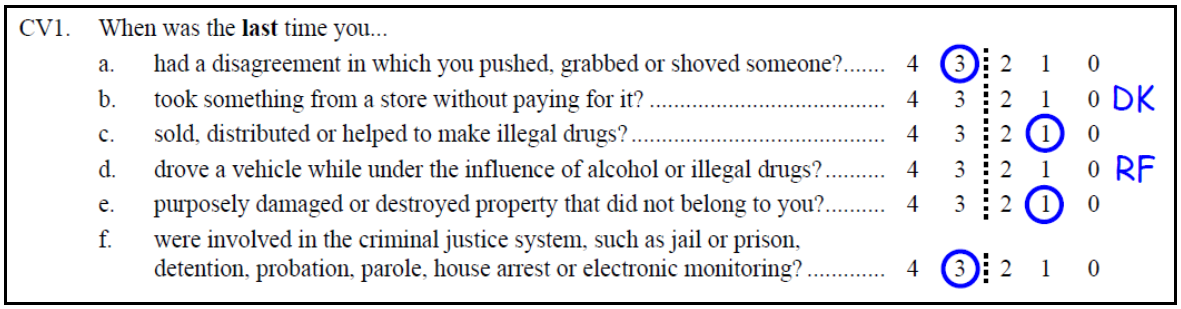
Figure 2.11 Recording verbatim responses and staff notes



Don't know. If a participant doesn't know how to answer an item even after the interviewer attempts clarification, write DK in the margin to the right of the item. A DK can be changed at any point to a regular response if the participant remembers what the response should be.

Refusal. If the participant refuses to answer a question, write RF in the margin to the right of the item.

Figure 2.12 Recording don't-know and refused responses

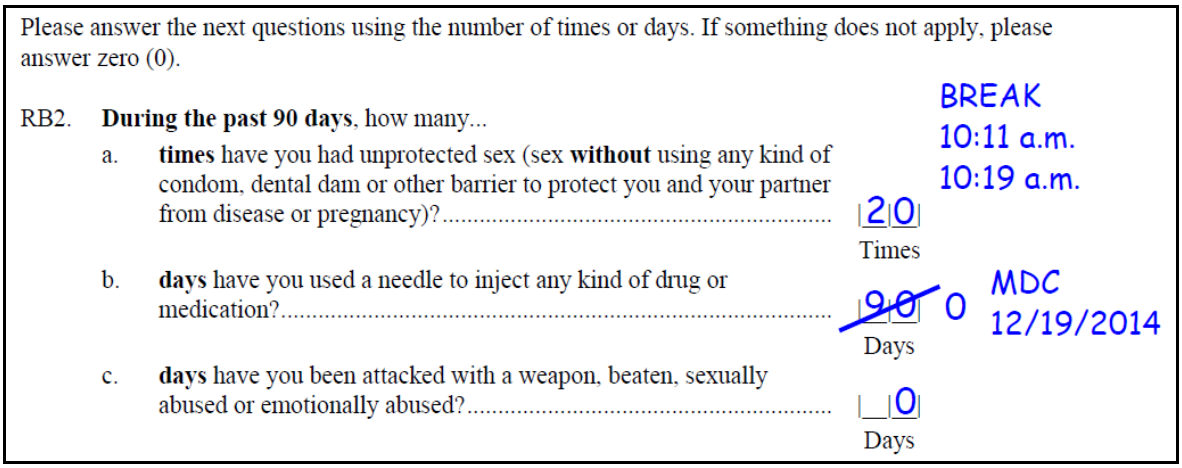


Corrections. When corrections need to be made to responses already written on the GAIN (such as if the participant changes their answer or if the interviewer accidentally enters something incorrectly), the interviewer should neatly cross out the first answer, write the new one, and initial and date the change for authentication. If the original answer was written on a

verbatim line or in response boxes, write the new response as close to the first as possible while maintaining legibility.

Breaks should be documented in the margin of the assessment at the point where the break is taken. All break time is subtracted from the overall time of administration to get the total time to complete the assessment (see p. 84 for more information). A break taken while administering a Q3 assessment with GAIN ABS should be recorded on scratch paper.

Figure 2.13 Making corrections and recording breaks



2.9 The Interview Process

The basic administration procedure is the same for all versions of the GAIN-Q3 instrument. Before beginning the Q3 interview, the interviewer should have response cards, a 2-year calendar, pens, and scratch paper. If the assessment is being done with GAIN ABS, the computer should have internet connectivity and access to a power source or a charged battery. At least one paper copy of the instrument should be available as backup in case of technical failure.

The interviewer prepares for the interview by recording some basic information on the cover page of the paper assessment or in GAIN ABS. (Some of these fields are entered automatically in GAIN ABS, but you should confirm that they are correct before beginning the interview.) Optional fields that an agency or program does not use are left blank. This can be done at the start of the interview but can also be done a short time beforehand. If site protocol includes the Cognitive Impairment Screener, the best time to administer is at this point, before the interview begins.

Next, the interviewer reads the introduction, which explains the purpose, format, and length of the interview as well as confidentiality restrictions and exceptions. If the participant has no questions, the interviewer moves on to time frame anchoring. This establishes a date on the

calendar for the 90-day time frame used in the Q3 and provides the participant with a salient point of reference during the interview. (See p. 36 for time frame anchoring guidelines.)

During the interview, the interviewer reads the instructions and items to the participant in order, following skips when directed to avoid administering unnecessary items. The interviewer records the participant's responses and clarifies ambiguous responses when necessary. The interviewer also answers participant questions or provides other information. If a break is taken, the interviewer records (either in the margin of the paper copy or in the notes field of GAIN ABS) the time that the break starts and ends.

At the end of the interview, the interviewer reviews the completed assessment to ensure that all required items have been asked and that there are no unresolved clarification issues. This check should be done before the participant leaves so that any outstanding issues can be resolved immediately. At that point, the interview is concluded.

If the interview was conducted on paper, the participant's responses are then data-entered into GAIN ABS, either by the interviewer or another staff person. Finally, the information gathered from the participant is used to generate the various reports in GAIN ABS.

2.10 Concluding the Interview and Conducting a Field Review

At the end of the interview and before the client leaves the interview setting, review the client's responses to ensure that all required items have been completed and that there are no unresolved clarification issues or inconsistencies. The review should also confirm that all responses were entered neatly and legibly. This review ensures accurate information, which results in more accurate clinical reports and more accurate data for analysis. A field review also allows the interviewer to correct any errors that may affect their quality assurance feedback and summary ratings (see Chapter 4).

The review can take several minutes, depending on the circumstances of the interview, so this can be a good opportunity for the participant to take a break (be sure to let them know that they may have to answer a small number of additional questions to help clarify any missing or unclear responses). Scan the pages to make sure that no required items were skipped and that all responses are legible. Flag any questionable responses to resolve them with the participant when they return from their break. GAIN ABS has the ability to print a validity report that shows all inconsistencies and possible inconsistencies, but you should give the rest of the assessment a quick scan to ensure that no other issues require clarification. Once you have completed the field review, thank the participant and let them know their next steps.

Below is a checklist of some important items to review. In addition, consult the GAIN-Q3 walkthrough (chapter 3) for more information on specific items.

- All required fields on the cover page should be documented: site ID, staff ID and initials, participant ID, and observation, plus any site-specific fields.

- The time and date should be documented.
- The verbatim response to item A4a (In a few words, can you tell me why you are here today? What is your main reason for coming to treatment?) should match the corresponding code in items A4a1–99.
- All staff use boxes should be documented according to site protocol.
- All corrections should be made by crossing out the original response, documenting the new response, and initialing and dating the change.
- All mentioned items must be documented completely: Either yes or no must be coded for every item.
- All dates must be documented in mm/dd/yyyy format.
- All 99 (Other) items should be accompanied by verbatim responses.
- All numeric responses should be within the limit for each item (for example, items that ask for the number of days that something happened in the preceding 90 days cannot be more than 90)
- All breaks should be recorded with the start and end times of each break documented at the point in the interview where they occurred.
- The end time and time to complete (minus all time spent on breaks) should be recorded in items Z1–Z1d at the end of the interview. If the interview took place over more than one day, the information should be recorded in items XADMh1–1d, and items Z1–Z1d should be documented only for the first day of administration.
- Make sure that the participant's response to item Z2 (Are there any other special issues we need to know about to help you? Do you have any additional comments or questions?) is documented, even if the response is no.
- Depending on your site's protocol, confidential items may need to be removed before sending the assessment or data to a quality assurance reviewer, data manager, evaluator, or other end user. In general, if a verbatim response gives a specific name, location, or other private information, it should be removed to ensure confidentiality.

2.11 Self-Administration of the GAIN-Q3

The GAIN Coordinating Center discourages self-administration of the GAIN-Q3 and most GAIN instruments (with the exception of the GAIN Short Screener). Self-administration can be an efficient and reliable option in some cases, but it often results in decreased validity and missing data. Some participants may do more guessing when answering questions by themselves, or they may not understand an item and fill in a random response instead of asking for help (regardless of whether a proctor instructed them to ask questions if they needed help). The field review following a self-administered GAIN-Q3 must be thorough to check for missing responses and errors, so the staff time that self-administration saves on the front end is often spent cleaning up afterwards. And if the GAIN-Q3-MI is self-administered on paper, a proctor or other staff member must still review the assessment and administer the appropriate reasons and readiness items because the participant can't do them on their own. In short, a self-administered GAIN-Q3 is often a poor substitute for an interviewer-administered assessment.

If considering self-administration, first administer the Cognitive Impairment Screener (see p. 21) to ensure that the participant has sufficient mental functioning to complete the GAIN-Q3 on their own. Next, fill in the administrative information on the first page (including the start time) and read the introduction to the participant. In addition, establish the anchors with the participant before the interview, taking time to mark the calendar and explain how the time frames are used.

Next, do the following:

- Demonstrate how to mark responses
- Demonstrate how to mark refusals, don't-know responses, and breaks
- Explain how to follow skips
- Explain how to use the cards
- Explain the purpose of the staff use boxes. A participant who is self-administering a GAIN-Q3-MI on paper should be instructed to skip from the eligibility items to the next section and leave the staff use box and the reasons and readiness items for staffers to administer. In GAIN ABS, a participant can self-administer a GAIN-Q3-Standard, and the staffer can then change the template to the Q3-MI and administer the appropriate reasons and readiness items.
- Stress that the participant should answer every applicable question
- Ask the participant whether they have any questions, and encourage them to ask questions during the interview or to flag any items that they have questions about
- Reiterate that someone will be available to answer questions and that the participant will be able to take a break if needed

Appendix D on p. 187 has instructions for the participant on how to self-administer the assessment (also available as a PDF at http://gaincc.org/gainq3).

While the participant is taking the assessment, check in periodically to answer any questions and to watch for signs of frustration, distress, or fatigue.

After the participant completes the assessment, be sure to conduct a thorough field review (see section 2.10 above). Reviews of self-administered assessments must be especially thorough because participants aren't as familiar with the instrument as the interviewer.

3. GAIN-Q3 walkthrough

The GAIN-Q3 walkthrough is an item-by-item description of the GAIN-Q3 instrument, covering every item in all three versions of the Q3. The walkthrough explains the administration nuances of each item and item set, answers many commonly asked questions, and suggests ways to avoid common problems and inconsistencies. Scale and index names, abbreviations, and component items appear alongside corresponding item sets for quick reference. Given its length and depth of information, the walkthrough is not intended to be memorized start to finish; instead, it is a reference to consult when questions arise about instructions or item sets.

Included in this walkthrough are the most common inconsistencies that can occur during GAIN-Q3 administration. Interviewers can use this walkthrough to cross-check items that they feel may be problematic, during either the interview or a field review. Given the complexity of many participants' situations, not every potential inconsistency is included, but the ones given here should help prevent the majority of inconsistent responses.

Remember that "within the past 90 days" (used throughout the Q3 items and in this walkthrough) includes both "past month" and "2 to 3 months ago" responses.

All references to page numbers designate pages within this walkthrough, not in the paper versions of the GAIN-Q3.

3.1 Cover Page and Administration (B)

COVER PAGE

The cover page should be completed before the interview (or, if pressed for time at the beginning, immediately after the interview) to record identifying information about the assessment. The interviewer or other staff member completes these items; they are not administered to the participant. The cover page also helps confirm that the correct version of the GAIN-Q3 is being used: In GAIN ABS the version number (GVER) appears on the assessment header page, while on the paper copy the version number appears with the title on the cover page and in the footer of every page.

Figure 3.1 GAIN-Q3 cover page items (paper version)

Site ID [XSITE]:..... |__|__|__|__|__|__|
Staff ID [XSID]: ..... |__|__|__|__|__|__|
Part. ID [XPID]: ..... |__|__|__|__|__|__|
Observation [XOBS]: ..... |__|__|
Edit Staff ID [XEDSID]: ..... |__|__|__|__|__|__|
Data Entry Staff ID [XDESID]: ..... |__|__|__|__|__|__|

Local Site ID [XSITEa]:..... |__|__|__|__|__|__|
Staff Initials [XSIN]: ..... |__|__|__|
Last Name [XPNAM]: .... _____
First Name: _____ M.I.: ___
v. _____
Edit Date [XEDDT]: ..... |__|__| / |__|__| / 20 |__|__|
Key Date [XDEDT]: ..... |__|__| / |__|__| / 20 |__|__|

For Staff Use Only

A1. Administrative Information
A1a. Time: .....|__|__| : |__|__| HH:MM.....A1b. |__|__| (AM/PM)
A1c. Today's Date [XOBSDT]: ..... |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

At the top of the cover page is a series of identification fields. There are five required items:

- Site ID (XSITE)
- Staff ID (XSID)
- Staff initials (XSIN)
- Participant ID (XPID)
- Observation wave (XOBS)

The remaining fields are completed at each site's discretion.

In cases where an interview is started by one person but finished by another, or when an interview starts at one location but moves to a different location, the cover page items record the initial interviewer and site. (The concluding interviewer and site are recorded in the administrative section at the end of the assessment.)

IDs on all GAIN instruments are usually six-digit numbers assigned according to site protocol. IDs in GAIN ABS can accept any alphanumeric character, but to simplify data management we strongly recommend that IDs be limited to the numbers 0 through 9 and not include any leading zeros, letters, or special characters. IDs on the GAIN should also be kept consistent over time: Interviewers should use their unique ID on every GAIN assessment they administer, and participants should generally keep the same ID throughout a treatment episode and follow-ups or as part of a research project. GAIN ABS is able to track participants over multiple admissions and treatment episodes, so consistent assignment of participant IDs facilitates easy searching and identification. Individual sites or studies may deviate from the recommended protocol depending on their requirements.

Site ID (XSITE)

- Record your site or research project's ID number (up to six digits long). Site IDs are identical to a site's grant number. Independent sites without grant numbers may choose their own site ID or it may be assigned by a statewide or regional GAIN coordinator.

Local site ID (XSITEa)

- **Optional.** This field can be used for a secondary site ID, such as to distinguish between multiple facilities within the same agency, to identify research project cases or other reporting systems, or for other purposes to be determined by a statewide or regional system. If there is no need to distinguish between sites or studies, the local site name should be left blank.
- The GAIN ABS team can set up an agency's local site names and IDs to appear in a drop-down menu if needed; contact abssupport@chestnut.org for more information.

Staff ID (XSID)

- Record the ID (up to six digits) of the person who will be administering the GAIN. Each staff member's GAIN ID should remain the same for the duration of their interviewing career. A staff ID should never be reissued, even if the original staff member has left an agency, and each staff member should use a unique staff ID.

Staff initials (XSIN)

- Record the initials of the person who administers the assessment. Every interviewer should always use the same initials. We recommend using three initials to avoid confusion with GAIN or site-specific codes (for example, "DK" for "don't know" could be confused for a staff member whose initials happen to be DK). However, if two or more staff members have the same initials, one must be changed to prevent duplication. (For example, one of the staff members can change a middle initial to an X.)

Participant ID (XPID)

- Record the participant's ID number (up to six digits).
- Participant IDs should remain the same throughout a participant's treatment career to ensure proper record keeping across episodes of care. The ID assigned to a participant's intake GAIN-Q3 should be used on their quarterly Q3 Follow-Up, and the same ID should be used if the participant is ever readmitted to treatment, even if they are assessed with a different GAIN instrument (such as the GAIN-I).

Participant's last name, first name, middle initial (XPNAM)

- **Optional.** Record the participant's last name, first name, and middle initial if required by your agency. This is the only place on the GAIN-Q3 where the participant's full name should be recorded; use initials, an ID number, or the abbreviation "Px" (participant) everywhere else on the assessment. Participants' names are protected information under HIPAA confidentiality guidelines, so if a hard copy of the assessment containing a participant's full name or other identifying information must leave a site (such as when a participant is re-

ferred to another agency), the participant's name should be removed from the assessment with a black permanent marker.

Observation (XOBS)

- Often, studies or programs that use the GAIN-Q3 conduct assessments in multiple waves. The observation wave records the number of each wave and usually designates the number of months since the participant's initial assessment. On the participant's first GAIN-Q3, the observation wave will always be zero because it is an intake assessment. For the participant's first Q3 Follow-Up, which usually takes place 3 months after the initial assessment, the observation wave would be 3; for a 6-month follow-up, XOBS would be 6; and so on. GAIN ABS allows only multiples of 3 for this field.

Observation verbatim (XOBSv)

- The observation verbatim is used to identify site-specific randomization groups, distinguish between research participants, or denote any other group identifiers. For example, if a participant is part of a follow-up research project whose protocol differs from other participants in the same observation wave, a clinical supervisor could have this field marked "RESEARCH" for all applicable participants. (Contact your project coordinator for more information.) The observation verbatim field should not simply repeat the number entered in the observation (XOBS) field.

The remaining fields on the cover page are completed after the interview. Each remaining ID field must have its corresponding date field completed.

Edit staff ID (XEDSID) and edit date (XEDDT)

- Record the staff ID (up to 6 digits) of the person who completed the field edit and the date on which they do.

Data entry staff ID (XDESID) and key date (XDEDT)

- Record the staff ID (up to 6 digits) of the person who data-enters the GAIN-Q3 (if the interview was conducted on paper and transferred to GAIN ABS) and the date.

The identifying information is followed by time and date information. None of these items are administered to the participant.

Figure 3.2 Time and date information

For Staff Use Only
A1. Administrative Information
A1a. Time: .....|__|__| : |__|__| HH:MM.....A1b. |__|__| (AM/PM)
A1c. Today's Date [XOBSDT]: ..... |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

A1a Start time

- Record the time that the interview begins. All times must be standard, not military.

A1b Start time AM/PM

- Record AM or PM. On the paper version, write "AM" or "PM" in the proper field; do not circle the letters.

A1c Today's Date (XOBSDT)

- This is the date on which the interview begins.
- As with all dates on GAIN assessments, the date of the interview is recorded in mm/dd/yyyy format.

The next step in the interview is to explain the purpose of the GAIN-Q3 to the participant.

INTRODUCTION

Research suggests that the validity of clients' responses is improved if they understand the interview process and know how their information will be used (Boruch, Dennis, & Cecil, 1996). Read all five parts of the introduction to the participant: purpose, format, length, privacy, and confidentiality. It is best to read the introduction verbatim to avoid missing important details, but it can be paraphrased if site protocol differs in some details. In either case, all parts of the introduction should be explained:

- **Purpose.** Explain to the participant why their information is being collected and how it will be used.
- **Format.** Explain to the participant what will be asked of them.
- **Length.** Make sure that the participant understands how long the interview will take. The introduction states that the GAIN-Q3 will take 20 to 45 minutes to complete (the time depends on the version administered and the severity of the participant's life problems). You can adjust the number of minutes in the introduction if you feel that the interview will take more or less time.
- **Privacy and confidentiality.** These two concepts are related but have distinct applications. Privacy relates to a person (e.g., providing an environment where the participant can't be overheard while the GAIN is being administered), while confidentiality relates to information about a person (e.g., making sure the participant's information as entered into GAIN ABS is encrypted and password protected). Together, privacy and confidentiality ensure that a participant's involvement with the GAIN-Q3 as well as the information gathered is limited to a set number of people whom the participant has granted permission. To this end, the participant must be informed of their rights under HIPAA and local regulations. It is also important to notify the participant of any situations in which privacy or confidentiality would be broken. Many participants are concerned about privacy and confidentiality (especially pertaining to family and legal-system notification), so be prepared to explain their rights and what the information they report on the GAIN-Q3 will and will not be used for. Read the parenthetical statement regarding the certificate of confidentiality only if one has

actually been obtained prior to the interview. Also include any other situations outside those mentioned on the GAIN-Q3 that your agency may be required to report, such as elder abuse.

If your site or research project has any additional introductory remarks, read them with the rest of the introduction. After the introduction, ask the participant whether they have any questions before continuing with the administrative section.

Time frame anchoring

The next part of the GAIN-Q3 establishes the 90-day time frame used throughout the interview. The time frame is important to define clearly because the biggest impediment to reliability in a self-reported assessment is confusion about the time period covered by the questions (Cottler, Robins, & Hezler, 1989; Gaskell, Wright, & O'Muircheartaigh, 2000; Sudman & Bradburn, 1973). To help address this problem, the GAIN-Q3 uses memory anchors to help the participant keep the time frames straight in their mind. (Anchors are based on Sobell and Sobell's Timeline Follow-Back technique (1992).)

To establish the anchor, first print a 2-year calendar from the GAIN website (http://gaincc.org/_data/files/Posting_Publications/GAIN_Calendar.pdf) and circle the current date. In the example in Figure 3.3, the date is December 11, 2014. Next, count back 13 weeks to approximately 90 days before the current date (September 11, 2014 in the example). Circle this earlier date, referred to as the 90-day target date. The target date is the start date of the 90-day time frame used in the interview, and the date of the interview marks the end date.

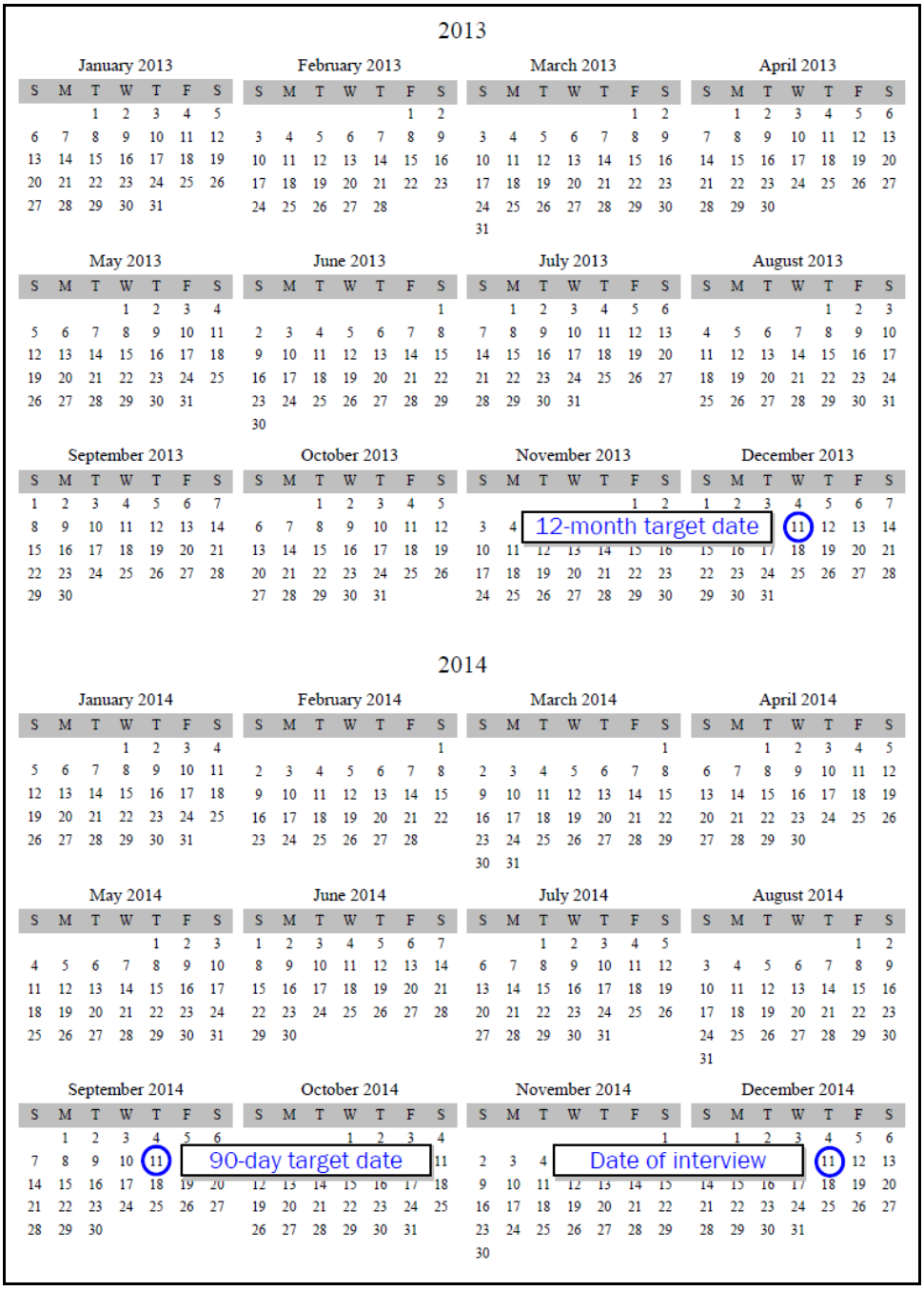
Then ask the participant, "Do you recall anything that was going on about [state the target date]?" If the participant has trouble remembering anything on or within a few days of that date, offer suggestions such as, "Do you remember any birthdays, holidays, or other big events that happened around that date? Did anything change with where you were living, who you were with, or at treatment, work, school, or jail?"

After the participant comes up with an anchor, enter it in the verbatim field, then read the instruction, "When we talk about things happening to you during the past 90 days, we are talking about things that have happened since about [repeat the anchor]." This statement is important because it explains the purpose of the anchors to the participant.

Some guidelines:

- If there is time beforehand, it can be helpful to circle the date of the interview and the 90-day anchor date to eliminate the chance for error when counting back on the calendar during the interview.
- If the participant is unable to come up with an anchoring event that took place exactly on the target date, it is acceptable to use an event that took place within 7 days of the date. However, when using this date as the anchor, you must reference it with respect to how many days it falls from the target date. For example, if the participant's 90-day target date was

Figure 3.3 Documented 2-year calendar



June 15 but the only event the participant could think of, a concert, took place on June 10, you would read the anchor as, "about 90 days ago, or five days after the concert."

- The anchor must be an event on or within 7 days of the target date. Sometimes interviewers will accidentally read the anchoring instructions as, "Do you recall anything that was going on during those 90 days?" and accept an event that happened nowhere near the target date, which defeats the purpose of the anchors.

- The anchors that the participant comes up with should be positive or neutral events because they will be referred to throughout the assessment. Repeatedly mentioning negative events, such as "since the time you were arrested" or "since your cousin passed away," can stress or upset the participant and damage rapport.
- Occasionally participants will not be able to offer an event that is both specific and positive or neutral, especially participants who were in a controlled environment such as jail on the target date. Continually probing for an event after the participant has tried but failed to think of an anchor could frustrate them. In this situation, it is acceptable to use the target date itself as the anchor: "During the past 90 days, or since September 11, 2014…"
- The anchor should be a specific event. Something too broad, such as "I was in school," covers a broad range of time and cannot anchor the time frames as effectively as a more distinct event.
- If time allows before the interview, come up with some events that happened on or near the 90-day target date to use as anchor suggestions in case the participant is unable to think of any. If the interview takes place at the end of February, for instance, you can come up with some events from late November for the 90-day anchor: For example, "Thanksgiving was 90 days ago—did you do anything for Thanksgiving?"
- If working with foreign participants, keep in mind that some holidays fall on different dates than in the U.S. For instance, Thanksgiving in the United States is celebrated on the fourth Thursday in November but on the second Monday in October in Canada. Make a staff note or report the participant's country of origin in item XADMj (see p. 88).
- The participant's anchor is considered confidential information if it reveals potentially identifying information, and it is protected under HIPAA guidelines.

A3a1 90-day anchor

- The participant's 90-day anchor should be documented verbatim.
- The 90-day anchor is protected information under HIPAA confidentiality guidelines and should be removed with a black marker from any hard copies of the GAIN that leave an agency. If the participant gives a full name as part of the anchor, use only the first name.

Additional administration instructions

If the GAIN-Q3 is being interviewer-administered, the additional administration instructions must be read to the participant. Like the introduction, these instructions are best read to the participant word for word, but if you paraphrase, be sure to cover all the major points:

- The participant should keep the calendar handy for referencing the different time frames.
- The participant should answer the questions in the GAIN-Q3 as accurately as possible.
- The participant can say that they do not know the answer to a question, or they can refuse to answer any item.
- Give the participant the response cards and explain how they are used. Using the response cards reduces administration time because they help the participant quickly answer certain

item sets using standardized responses. The cards also give restless participants something to hold during the interview.

- Be sure to ask the participant whether they have any questions before you begin. A good way to conclude the additional instructions is to remind the participant that they can ask for a break at any time and tell them the location of restrooms, snack machines, and other conveniences.

A4a	**In a few words, can you tell me why you are here today? (What is your main reason for coming to treatment?)**

A4a1–99	**Reasons for coming to treatment**
A4a1	Drug availability (difficulties obtaining drugs or "good" drugs)
A4a2	Financial (can't afford to stay on drugs, lost an income source)
A4a3	General personal motive (habit out of control, tired, want to change, improve lifestyle, save self)
A4a4	Health reasons (too ill to continue; drugs or related diseases are hurting or threatening own health, unborn baby, to live)
A4a5	Pressure from family (parent, spouse, partner)
A4a6	Parenting issues (get or keep custody or become a better parent)
A4a7	Pressure from criminal justice system (court mandate, probation officer, parole officer, attorney, etc.)
A4a8	Pressure from Department of Child and Family Services (DCFS)
A4a9	Pressure from schoolteacher, minister, coach, etc.
A4a10	Desire for services (want housing or other benefit)
A4a11	School or job (to get, keep, or improve situation)
A4a99	Other
A4a99v	*Other reason for coming to treatment verbatim*

- Item A4a is a clarify-and-code item. Ask the question and code the response that most closely fits the participant's answer, and clarify by confirming the choice with the participant. Do not read all the responses unless the participant needs help answering, when you can read a few examples to help prompt them.
- The participant should give only one response to item A4a. Unlike most other verbatim items, do not ask "any others?" until the participant has nothing left to report; simply code their initial response. If the participant gives multiple responses, document them all but ask which is their main reason for coming to treatment, then record that main response in a staff note or highlight it on the paper copy and code the most closely corresponding item in A4a1–99. If the participant is unable to decide between two or more reasons, record them all and code item A4a99 (Other).
- If the participant gives a vague answer to item A4a that does not seem to fit any of the A4a1–99 categories, such as "I'm an alcoholic," then clarify the response (e.g., "Would you say it's a general personal motive or for health reasons or something else?"). In addition, the participant's answer to item A4a can sometimes fall under two or more of the A4a1–99 categories, in which case you should clarify for a more precise response.
- Users in countries other than the U.S. may change the mention of the Department of Children and Family Services in item A4a8 to the name of an equivalent government agency.

- The participant's verbatim response to item A4av1 is protected information under HIPAA guidelines and should be removed with a black marker from any hard copies of the GAIN that leave an agency.

A4b **What is the name of the person who referred you to come here?**
A4bv *Person referring participant to treatment verbatim*

- The participant's verbatim response to item A4bv is protected information under HIPAA guidelines and should be removed with a black marker from any hard copies of the GAIN that leave an agency.
- If the participant gives a full name, record only the first name in the verbatim field and clarify for that person's relationship to the participant.

A4c **What is this person's relationship to you?**
A4cv *Relationship verbatim*

- The participant's verbatim response to item A4c is protected information under HIPAA guidelines and should be removed with a black marker from any hard copies of the GAIN that leave an agency.

A4d **Referral code [of person or agency referring participant to treatment]**

- Document the code that most closely fits the participant's response to item A4c (do not administer item A4d to the participant).

Figure 3.4 Item A4d referral codes

Individuals		Agencies	
1 Self	10 Judge	21 Alcohol/Drug abuse program	41 State alcohol/drug abuse program
2 Mother	11 Teacher	22 Behavioral health provider	42 State mental health program
3 Father	12 Supervisor at work	23 Other health care provider	43 State DCFS or welfare program
4 Brother	13 Social Worker	24 Outreach, Advocacy or	44 State health department
5 Sister	14 Lawyer	Prevention program	49 Other State Agency
6 Grandparent	15 Probation Officer	25 School	50 Out of State CJ program
7 Aunt	16 Parole Officer	26 Employer	59 Other out of State agency
8 Uncle	17 Public Aid Worker	27 Social Service Agency	99 Other (please describe in A4c)
9 Other family	18 Priest/Minister	28 Criminal Justice Agency	
	19 Other individual	30 TASC or diversion program	
		39 Other Agency	

- The list of referral codes is separated into people and agencies. Note that item 19 specifies other people, while item 99 should include only institutions, such as other agencies or other referral situations.
- Select the code that provides the best information to anyone interpreting the GAIN-Q3, and use staff notes to record further information that will help clarify potentially unclear codes. For instance, a participant who reports being referred to treatment by an aftercare worker could be referring to a social worker (13), a worker in an alcohol or drug abuse program (21), a behavioral health provider (22), another health care provider (23), or many other choices, depending on whether the counselor works for the school directly or is

contracted through a social work agency or behavioral-health care provider. Clarify the response with the participant, select the most relevant code, and make a staff note with additional notes, if necessary.

- Because parents are split into separate items for the participant's mother and father, if the participant says that both parents referred them to treatment, the interviewer should clarify for which parent had the most influence in the decision, then code either 2 (Mother) or 3 (Father) as appropriate and record in the verbatim field (item A4cv) that both parents had a role. If the participant says that both parents had equal influence, code 99 and record "Both parents" in the verbatim field.
- If the participant reports that a friend referred them to treatment, code item 19 (Other individual).

3.2 Background Information (B)

B1 What is your gender?

B1_1	Male
B1_2	Female
B1_4	Transgender (male to female)
B1_5	Transgender (female to male)
B1_99	Other
B1_99v	*Other gender verbatim*

- Always ask for the participant's gender. Some participants may look like one gender but identify as another, or they may be having gender-identity issues and would like to give a response that might not seem obvious.
- Note: The B1 response choices intentionally skip B1_3.

B1d About how tall are you in feet and inches?
B1e About how much do you weigh without shoes?

Body Mass Index (BMI): B1d–e

B2 What is your date of birth?

- Record the date in mm/dd/yyyy format.

B2a How old are you today?

- Record the participant's age in years. Younger participants may report their age plus a half, as in "twelve and a half," in which case, record the age without the half.

B2b1–99 Who currently has legal custody of you?

B2b1	Parents living together
B2b2	Parents who are separated but share custody
B2b3	One parent (even if living with stepparent)
B2b4	Other family members
B2b5	Legally emancipated minor living on your own
B2b6	Runaway/on own (without legal emancipation)
B2b7	County/state (foster home or protective services)
B2b8	Juvenile or correctional institution

B2b99 Other
B2bv *Person who has legal custody of participant verbatim*

- Item B2b1–99 is a clarify-and-code item. Ask the question and code the response that most closely fits the participant's answer, and clarify by confirming the choice with the participant. Do not read all the responses unless the participant needs help answering, when you can read a few examples to help prompt them.
- The intent of item B2b is to record who has legal guardianship of an adolescent participant. This means the person who makes decisions on behalf of the participant, not just the person who has physical or legal custody of the participant. (Also be aware that the definitions of legal custody and legal guardianship may differ from state to state, and some states may use different terminology; check local statutes.) Some young participants may not understand the difference between legal custody and legal guardianship, or they may feel uncomfortable discussing their situation. Record the participant's response, clarifying if necessary, but also take collateral information into account when reviewing the case and use any additional specific information available.
- If the participant answers with "my mom" or "my dad," clarify for whether the participant's parents are separated but share custody (item B2b2), whether their legal custodian is a single parent (item B2b3), or whether some other situation applies.
- Similarly, if the participant responds, "my parents," be sure to check whether their parents live together (item B2b1), are separated but share custody (item B2b2), or are in some other situation. If a biological parent plus a stepparent have custody, check to see whether both have the legal right to make the participant's decisions, which would be coded as 1, "Parents living together." If only one parent has the legal right to make the participant's decisions, code 3, "A single parent." If the participant is not sure, code 99, "Some other situation," and enter an explanation in the verbatim field.
- Divorced parents should be coded under "Parents who are separated but share custody" (item B2b2).
- The participant's verbatim response to item B2bv is protected information under HIPAA guidelines and should be removed with a black marker from any hard copies of the GAIN that leave an agency. If the participant gives a full name, record only the first name in the verbatim field and clarify for that person's relationship to the participant.

B3a1–99 Which races, ethnicities, nationalities, or tribes best describe you?
B3a1 Alaskan Native (Please record tribe in B3av1)
B3a2 Asian
B3a3 African American/Black
B3a4 Caucasian/White
B3a5 Hispanic, Latino, or Chicano
B3a5a Puerto Rican
B3a5b Mexican
B3a5c Cuban
B3a5e Dominican
B3a5f Other Central American
B3a5g Other South American
B3a5z Other (Please describe in B3av1)

B3a6	Native American (Please record tribe in B3av1)
B3a7	Native Hawaiian
B3a8	Pacific Islander
B3a99	Some other group (Please describe in B3av1)
B3av1	*Other group verbatim*

- Item B3a is a mentioned item. To properly code item B3a, ask the question and enter the participant's response in the verbatim field, then ask, "Any others?" until the participant reports nothing else. Then code yes for the appropriate mentioned items in B3a1–99 and no for all others. (In other words, the participant's response should be recorded in both the verbatim field and the B3a1–99 mentioned items, and everything recorded in the verbatim field should have a corresponding item coded.) If the participant has trouble answering at first, read a few examples to help prompt them.
- Ask the question and record all the participant's responses, following up with "Any others?" after each response until the participant has nothing left to report. Then code yes for the corresponding mentioned items and no for the others. If the participant has trouble answering at first, read a few examples to help prompt them.
- Record the participant's exact statement in the verbatim field. For example, if the participant says, "I'm white," record "white," not "Caucasian." How the participant self-describes is important to record for the assessment and treatment process.
- If the participant uses "multiracial" or a similar term, document that in the verbatim field, but go on to clarify for specific ethnographic groups.
- The race categories on the GAIN-Q3 are drawn from the U.S. Office of Management and Budget's minimum race categories, which are the options that must be included if asking any questions about race (in other words, a survey can include other options but must include the minimum categories). The OMB does not include Indian and Arabic, among others, as separate races. If the participant reports either of these races or another race not listed, code yes for item B3a99 (Some other group) and enter the race in the B3av verbatim field.
- Although nationalities, ethnicities, and tribes are mentioned in the wording of item B3a, the intent is to record the participant's race. If necessary, explain the differences between race, ethnicity, nationality, and tribe:
  - **Race:** A group of people distinguished by genetically inherited physical characteristics, such as skin color and facial features. Examples include African American or black, Asian, Caucasian or white, and Native American or Alaskan Native.
  - **Ethnicity:** A group of people distinguished by a predominantly cultural heritage. Examples include Creole, Hausa, Hispanic, Latino, and Yamato.
  - **Nationality:** Descriptive of people born into or allegiant to a specific nation or country. Examples include Canadian, Chilean, German, Mexican, and Nigerian.
  - **Tribe:** An indigenous group with common ancestry and in many countries with status as an independent nation. Examples include Cherokee, Cree, Inca, Inuit, Iroquois, Navajo, Ojibwe, Sioux, and Tapirape.
  - If the participant reports a nationality, record it in the verbatim field, but clarify for a race. Only if the participant reports a nationality and cannot or will not give a race should you code B3a99 (Some other group) to correspond to the nationality. If the par-

ticipant refuses to specify a race but appears to be a particular race, you can mention it in a staff note.

- If the participant reports a Central or South American group, code yes for both the general "Hispanic, Latino, or Chicano" item (B3a5) and the correct group from items B3a5a–g. If the participant reports that they are Hispanic, code yes for item B3a5 but clarify for a more specific group in items B3a5a–g. If the group the participant reports does not appear in items B3a5a–g, code yes for item B3a5z (Other Hispanic, Latino, or Chicano) and record the specific group in the B3av verbatim field. (Note: The B3a5 response choices intentionally skip B3a5d.)
- If the participant reports any Native American tribes, ask for the name of the tribes and record the response in the B3av1 verbatim field.
- In general, people from or descended from mainland Asia, Japan, and the Philippines are coded under B3a2 (Asian). People from Asian island communities (Fiji, Micronesia, Polynesia, Samoa, Tonga, among others) are coded under B3a8 (Pacific Islander). People from South Asian countries (including the Indian subcontinent) and the Middle East are coded under item B3a99 (Some other group).
- There are several important reasons for collecting ethnographic information in a biopsychosocial assessment such as the GAIN-Q3. The primary reason is to document how the participant self-identifies. A person's ethnographic identity can identify possible strengths, barriers to treatment, or historical issues; the information collected can help researchers better understand issues within or between different ethnographic groups; and the information is used in federal, state, local, and tribal reporting systems. See issue 9 of the GCC *Insider* newsletter (http://www.gaincc.org/insider) for further information.

B12 What is the last grade or year that you completed in school?

- Record the last grade that the participant actually completed, not the grade that they are currently in or the grade they were in when they left school.
- Do not code educational equivalencies such as a General Educational Development (GED) certification or an honorary degree.
- Freshman through senior years of high school should be coded as 9 through 12, while freshman through senior years of college should be coded as 13 through 16 (a fifth year and beyond of college should be coded as 16). An associate's degree is equivalent to sophomore year of college, or 14. Code 17 for graduate school.
- Code only formal schooling and equivalent years of homeschooling.
- Code years in vocational or trade schools only if the institution is accredited. In most cases you won't need to clarify the participant's response; however, it may be an issue only if they state that they earned a degree through certain for-profit online schools or other dubious sources.

B13 What kinds of diplomas, degrees, work-related certificates, or licenses have you received?

B13_1	High school diploma
B13_2	Passed GED (general equivalency diploma)
B13_3	Adult Basic Education (ABE) certificate
B13_4	Junior college or associate's degree

B13_5	Bachelor's degree
B13_6	Advanced college degree (master's or doctorate)
B13_7	Vocational or trade certificate
B13_8	Trade license apprenticeship
B13_9	Commercial driver's license
B13_99	Other degrees or licenses
B13_99v	*Other degrees or licenses verbatim*

- Item B13 is a mentioned item. Ask the question and enter the participant's response in the verbatim field, then ask, "Any others?" until the participant reports nothing else. Then code yes for the appropriate mentioned items in B13_1–99 and no for all others. (In other words, the participant's response should be recorded in both the verbatim field and the B13_1–99 mentioned items, and everything recorded in the verbatim field should have a corresponding item coded.) If the participant has trouble answering at first, read a few examples to help prompt them.
- Item B13 includes only vocational and educational degrees, such as work-related certifications and various college degrees. Standard driver's licenses, private pilot's licenses, and sporting licenses do not count, although commercial driver's and commercial pilot's licenses do (recorded in item B13_9). Minor recognitions such as honor roll certificates or certificates for completing programs such as drug court should not be included.
- A license required by an individual to do business, such as a real estate license or a car dealer's license, should be included in item B13_7 (the specific license can be recorded in a staff note, if desired.) Most "other" degrees, licenses, or certifications will likely be recorded in item B13_7 (Vocational or trade certificate).
- Personal licenses and certifications, such as a marriage license, do not count for item B13. A clergy or religious license can be recorded in item B13_7 (Vocational or trade certificate) if used for vocational purposes. If not, record it in item B13_99 (Other degrees or licenses).
- Skills-based certifications, such as CPR certification, do not count unless used for vocational purposes (e.g., as part of a nursing job), which would be coded under B13_7. GAIN certification would also be included under B13_7.
- Item B13 includes all degrees and licenses received in the participant's lifetime, so expired licenses and certificates should be included.
- Do not include middle school or junior high diplomas or any other schooling before high school, but do include high school and all college degrees. If a participant has an advanced college degree (item V2_6), include their bachelor's degree (item V2_5), high school diploma (item V2_1) or equivalent, and any others.

B14 **Which of the following best describes your sexual orientation?**

B14_1	Nonsexual or asexual
B14_2	Heterosexual or straight
B14_3	Homosexual, gay, or lesbian
B14_5	Bisexual
B14_6	Questioning or curious
B14_7	Not sure
B14_99	Other
B14_99v	*Other sexual orientation verbatim*

- The GAIN-Q3 asks about sexual orientation for a number of reasons. First, people from gay, lesbian, bisexual, transgender, and questioning (GLBTQ) populations are more likely to have a history of victimization than those from non-GLBTQ populations, and they are more likely to report substance abuse problems. Sexual orientation thus connotes important information about past and present experiences that are related to trauma or comorbid conditions. Knowing a participant's sexual orientation can help to place them with providers that specialize in treatment for GLBTQ populations. Some GLBTQ participants may prefer to work with providers who belong to the same community. Finally, sexual orientation is important demographic information to collect when describing a research sample and helps ascertain and address the needs of sexual minority populations, many of which have historically been underserved or misunderstood.
- Read all the choices even if the participant interrupts with a response because a later choice might better describe their sexual orientation.
- Note: The B14 response choices intentionally skip B14_4.

B15 **What is your current marital status?**

B15_1	Married
B15_2	Remarried
B15_3	Living with someone as married
B15_4	Married but living apart
B15_5	Divorced
B15_6	Legally separated
B15_7	Widowed
B15_8	Never married and not living as married.

- Item B15 is a clarify-and-code item. Ask the question and code the response that most closely fits the participant's answer, and clarify by confirming the choice with the participant. Do not read all the responses unless the participant needs help answering, when you can read a few examples to help prompt them.
- Participants who live with their significant other but are unmarried should code 3 (Living with someone as married). Common-law marriages can also be coded as 3.
- Participants who are dating or in a committed relationship but who have never been married and who don't live with their significant other should code 8 (Never married and not living as married).
- If the participant reports that they are single, clarify to determine which description best fits their situation (in other words, do not automatically code 8, "Never married and not living as married").

The next items cover the participant's military service (if applicable). A participant who has been in the military will usually know the details of their rank, status, and discharge. The details below are provided to ensure proper reporting.

B16 **Have you ever been in the armed forces of the United States or another country?**

B16_0	No, never served in any armed forces
B16_1	Yes, served in the United States armed forces
B16_1v	*Branch verbatim*

B16_99 Yes, served in the armed forces or military of another country
B16_99v *Country verbatim*

- A participant on delayed entry, or DEP (Delayed Entry Program or Delayed Enlistment Program), has not officially served in the armed forces, so their response to this item should be no.

B16a Were you ever in a combat zone?
B16av *Where verbatim*

- A combat zone is designated by executive order of the president. Peacekeeping operations such as those that occurred in Somalia (1992–1994) and Bosnia (1995–2004) are also considered combat zones.

B16b What was your highest rank in the military?
B16bv *Highest-rank verbatim*

- Rank names between the branches differ for enlisted and officers. When asking the participant this item, be sure to record the branch of the military and their grade (e.g., E-3) for uniform coding. See Table 3.1 (p. 48) for a comprehensive list of military ranks and grades.

B16c Are you currently on active duty in the armed forces, including in a reserve or guard?

B16c_1 What is your current military status?
B16c_1_1 On active duty in the armed forces (not including activated Guard or reserve)
B16c_1_2 In a guard or other reserve component that drills regularly
B16c_1_3 In the Individual Ready Reserve (Inactive Ready Reserve, Nonaffiliated Reserve Sections)
B16c_1_4 Other
B16c_1_4v *Other military status verbatim*

- Item B16c_1 is a mentioned item. Ask the question and record all the participant's responses, following up with "Any others?" after each response until the participant has nothing left to report. Then code yes for the corresponding mentioned items and no for the others. If the participant has trouble answering at first, read a few examples to help prompt them.
- If the participant is a member of a foreign military, the interviewer should attempt to clarify and match their current military status into one of these categories. If an equivalent description does not exist, the interviewer should code B16c_1_4 (Other) and describe the discharge or current military status in the B16c_1 verbatim field.
- If the participant is in the National Guard but is not on active duty, code only B16c_1_2 (In a guard or other reserve component that drills regularly). If the participant is in the active guard or is currently serving on active duty in the guard (typically part-time but has been called up to active service), code B16c_1_1 (On active duty in the armed forces) and make a note stating that the participant is in the guard but has been called up to active duty. It is important to distinguish between federal reserve troops and National Guard troops (who operate at the state level) because there are often differences in the types of benefits each component is eligible for.

Table 3.1 Enlisted ranks and grades

	Army	Air Force	Navy	Marines	Coast Guard
E-1	Private	Airman Basic	Seaman Recruit	Private	Seaman Recruit
E-2	Private	Airman	Seaman Apprentice	Private First Class	Seaman Apprentice; Fireman Apprentice; Airman Apprentice
E-3	Private First Class	Airman First Class	Seaman	Lance Corporal	Seaman; Fireman; Airman
E-4	Corporal/ Specialist	Senior Airman	Petty Officer Third Class	Corporal	Petty Officer Third Class
E-5	Sergeant	Staff Sergeant	Petty Officer Second Class	Sergeant	Petty Officer Second Class
E-6	Staff Sergeant	Technical Sergeant	Petty Officer First Class	Staff Sergeant	Petty Officer First Class
E-7	Sergeant First Class	Master Sergeant	Chief Petty Officer	Gunnery Sergeant	Chief Petty Officer
E-8	Master Sergeant	Senior Master Sergeant	Senior Chief Petty Officer	Master Sergeant	Senior Chief Petty Officer
E-9	Sergeant Major	Chief Master Sergeant	Master Chief Petty Officer	Master Gunnery Sergeant / Sergeant Major	Master Chief Petty Officer
O-1	Second Lieutenant	Second Lieutenant	Ensign	Second Lieutenant	Ensign
O-2	First Lieutenant	First Lieutenant	Lieutenant Junior Grade	First Lieutenant	Lieutenant Junior Grade
O-3	Captain	Captain	Lieutenant	Captain	Lieutenant
O-4	Major	Major	Lieutenant Commander	Major	Lieutenant Commander
O-5	Lieutenant Colonel	Lieutenant Colonel	Commander	Lieutenant Colonel	Commander
O-6	Colonel	Colonel	Captain	Colonel	Captain
O-7	Brigadier General	Brigadier General	Rear Admiral (lower half)	Brigadier General	Rear Admiral (lower half)
O-8	Major General	Major General	Rear Admiral (upper half)	Major General	Rear Admiral (upper half)
O-9	Lieutenant General	Lieutenant General	Vice Admiral	Lieutenant General	Vice Admiral
O-10	General	General	Admiral Chief of Naval Operations	General	Admiral Chief of Naval Operations
W-1	Warrant Officer	N/A	N/A	Warrant Officer	N/A
W-2	Chief Warrant Officer 2	N/A	Chief Warrant Officer 2	Chief Warrant Officer 2	Chief Warrant Officer 2
W-3	Chief Warrant Officer 3	N/A	Chief Warrant Officer 3	Chief Warrant Officer 3	Chief Warrant Officer 3
W-4	Chief Warrant Officer 4	N/A	Chief Warrant Officer 4	Chief Warrant Officer 4	Chief Warrant Officer 4
W-5	Chief Warrant Officer 5	N/A	Chief Warrant Officer 5	Chief Warrant Officer 5	N/A

B16c_2 Have you ever been discharged from the military?

B16c_2a What is your discharge status?

B16c_2a1 Retired/honorably discharged
B16c_2a2 Honorably discharged (not retired)
B16c_2a3 Generally discharged or entry-level separation
B16c_2a4 Other than honorably discharged
B16c_2a5 Bad conduct or other administrative discharge or dismissal
B16c_2a6 Dishonorably discharged or dismissal after court martial
B16c_2a99 Other
B16c_2av *Other discharge status verbatim*

- If the participant has completed two different service terms and received different discharge ratings for each, the interviewer should code the lowest discharge status and include a margin note explaining that the participant also received a higher status from a previous service term. For example, if a participant served on active duty in the Army for 4 years and received an honorable discharge, but then re-entered for a second enlistment and received a bad-conduct discharge, the interviewer should code item B16c_2a5 (Bad conduct or other administrative discharge or dismissal) and include a staff note about the participant's honorable discharge on their first enlistment. Eligibility of benefits for veterans varies by state based on this situation, and the lowest ranking will often takes precedence when determining benefits.
- If the participant was a member of a foreign military, the interviewer should attempt to clarify and match their discharge type into one of these categories. If an equivalent description does not exist, the interviewer should code B16c_2a99 (Other) and describe the discharge or current military status in the B16c_2a verbatim field.
- If the participant reports that they are honorably discharged, be sure to ask whether they are currently in any kind of reserve, including Individual Ready Reserve, selected (federal) reserve, National Guard, or something else. For example, a participant can be honorably discharged from active duty (as reported on their DD-214, the form issued when a person leaves the military) but be assigned to the Individual Ready Reserve until their total military service obligation is fulfilled. In this case, the interviewer would code both B16c_1_3 (Individual Ready Reserve) and B16c_2a2 (Honorably discharged).
  - Note that the participant's DD-214 is usually required by veterans' organizations in order to enroll in or receive services or benefits and will usually be on file at veterans' facilities. In programs other than veterans' organizations, an interviewer or clinician will be unlikely to have access to the DD-214 unless the participant provides it.
- "Retired from the military" (item B16c_2a1) includes only those who have completed at least 20 years of service and are either collecting military pensions and benefits from active or reserve duty or will be eligible when they reach the age of 60. A person who serves a regular enlistment for less than 20 years can be honorably discharged, but they have not "retired" from the military.
- "Honorable discharge" (item B16c_2a2) is given when a service member completes their tour of duty and meets or exceeds the required standards of duty performance and personal conduct.

- "Generally discharged or entry-level separation" (item B16c_2a3) is reserved for service members who leave the service under honorable conditions, but their conduct and performance of duty was not commendable enough to receive an honorable discharge. Entry-level separations, or uncharacterized discharge, are given to those who separate prior to completing 180 days of military service or when discharge action was initiated prior to 180 days of service. This type of discharge is considered neither good nor bad.
- "Other than honorably discharged" (item B16c_2a4) is the most severe form of administrative discharge. This type of discharge represents a serious departure from expected conduct and performance and is typically given to service members who have been convicted in a civilian court or certain civil hearings when warranted. Recipients of this discharge type are prohibited from re-enlisting into any component of the armed forces (including the reserves) and are normally barred from joining the Army National Guard or Air National Guard except under rare circumstances that require exception-to-policy waivers.
- "Bad conduct or other administrative discharge or dismissal" (item B16c_2a5) is a punitive discharge that can be given only by a court martial as punishment to an enlisted service member. A recipient of this discharge is ineligible for nearly all veteran's benefits with the exception of disability compensation.
- "Dishonorably discharged or dismissal after court martial" (item B16c_2a6) can be handed down only to an enlisted member by a general court-martial for what the military considers the most severe type of unacceptable conduct. All veteran's benefits are lost with this type of discharge. Several states regard this form of discharge as a felony conviction, and therefore certain civil rights may be revoked. Individuals with this discharge type are also prohibited from owning firearms.
- Every existing level of discharge is included in the B16c_2a response choices. Item B16c_2a99 (Other military status or type of discharge) should be coded only in extremely rare circumstances that aren't covered by any other choice.

B16d	**Was your discharge related to any physical, mental, alcohol, drug, or other problems? (Clarify and select all that apply)**
B16d1	Physical
B16d2	Medical
B16d3	Mental
B16d4	Alcohol
B16d5	Drug
B16d99	Other problem
B16d99v	*Other discharge-related problem verbatim*

- Item B16d is a mentioned item. Ask the question and record all the participant's responses, following up with "Any others?" after each response until the participant has nothing left to report. Then code yes for the corresponding mentioned items and no for the others. If the participant has trouble answering at first, read a few examples to help prompt them.
- A physical problem (item B16d1) is generally the result of an injury, while a medical problem (item B16d2) is generally the result of a disease or a pathophysiological process.
- Check for a possible inconsistency if a veteran reports that their discharge was related to a problem listed in this item but also reports that they were honorably discharged (item

B16c6). Sometimes a veteran might receive an honorable discharge for an exemplary service record despite developing physical or mental health problems, or if they developed physical or mental health problems as a consequence of battle.

B17 **Are you currently pregnant?**

3.3 School Problems (SP)

Many of the items in the Vocational section refer to "school or training." For the purposes of the GAIN, training consists of any type of vocational training, including on-the-job training, at-school programs such as shop or home economics, attendance at institutes of technology or polytechnic, and others.

Schoolwork performed at home should be counted only if it represents a norm for the student: for example, if they are homeschooled, if they are chronically ill and complete most or all of their work at home under the direction of a school-appointed private tutor, or if they are earning a degree online. Likewise, schoolwork in a controlled environment, such as a jail or prison, should be counted. Routine homework or work sent home on a sick day should not count for the School Problems items. Note that occupational work performed at home is treated differently than schoolwork performed at home (see the introduction to the Work Problems section on p. 54 for details).

SP1a–e	**When was the last time you...? [*Card Q*]**	School Problems Screener (SPScr): SP1a–d
SP1a	came in late or left early from school or training?	
SP1b	skipped or cut school or training just because you didn't want to be there?	
SP1c	got bad grades or had your grades drop at school or training?	
SP1d	got sick at school or training?	Quality of Life Index (QOLI): See p. 88
SP1e	went to any kind of school or training?	

- Responses to the left of the dotted line (representing time frames within the past 90 days) determine whether to administer the motivational-interviewing items in the Q3-MI (see SP2a–c below).
- Item SP1d (Got sick at school or training) includes coming down with any sort of illness, such as a cold or flu, or getting physically ill for any reason (including food poisoning). The illness can result from legitimate sickness or from the effects of current intoxication or a hangover. It also includes getting hurt or injured.

SP1f **When was the last time, if ever, you received any kind of help dealing with school problems (for example, talking to a school counselor about problems at school, working with a tutor, attending a social skills group at school)?**

- Item SP1f refers only to professional help. Advice or other assistance from friends, family, and other sources of social support, while potentially beneficial, does not count for these items. Self-administered "help" using alcohol or other drugs does not count.

SP1e1–2 **During the past 90 days, on how many days...?**
SP1e1 were you absent from school or training for a full day?
SP1e2 did you go to any kind of school or training?

Quarterly Costs to Society (QCS): See p. 88

- Item SP1e1 includes days on which the participant should have been at school but was not. This does not include days off for vacations, holidays, and other officially approved absences. A good way to determine whether an absence is excused is to have the participant consider whether an absence got them into trouble (or would have gotten them in trouble if discovered) or if trouble caused them to miss school (such as if the participant was suspended). An excused absence should not get a participant in trouble. Thus, days off for suspensions, whether in-school or out of school, should be counted as unexcused absences because of what they reveal about the participant's behavioral patterns. However, a student who has dropped out of school or been expelled is not considered still in school.
- For item SP1e2, if a participant went to school or training Monday through Friday every day during the preceding 90 days, their correct response should be 64, not 90. (This number is derived by taking 90 days and subtracting 26, which is the number of weekend days in 13 weeks.) However, the participant should take into account all other holidays, vacations, and other days off as well as days skipped. There are few, if any, 90-day periods during the year when participants will not have at least one day off for holidays or vacations, so responses of less than 64 are to be expected.
- The participant could have attended school or training on more than 64 days if they also attended on weekends. If the participant reports more than 64 days, clarify to see whether they legitimately attended on Saturdays or Sundays as well as Monday through Friday. However, doing homework or training work at home over the weekend does not count for these items. These items measure the participant's involvement at school or training, so work performed at home represents a different environment.
- If the GAIN-Q3 is administered at the end of summer or another long vacation, you can expect the responses to item SP1e2 to be very low. However, just as there are few periods when a participant will have been in school for all 64 of the preceding 90 days, vacations are rarely so long that a participant will not have been in class or training for at least a few days in the preceding 90 (even summer vacation is often less than 90 days). If the participant reports zero days in school or another abnormally low number, clarify to see when the participant's summer vacation began. (To account for extended vacations and other time off, the GAIN-Q3 measures the percentage of days that the participant was required to be in school versus actual attendance.)
- In addition, days missed because of illness are usually excused absences but should still be included as days missed because of what they indicate about a participant's overall physical health and what they can reveal about other areas of the participant's life, including substance use and mental health patterns. Days off for bereavement should also be counted as days missed because of what they can reveal about a participant's stress levels.
- If the participant reports attending any kind of school or training within the past 90 days (item SP1e), then the number of days in the past 90 on which they attended school or training (item SP1e2) must be greater than zero.

SP1f1 **During the past 90 days, on how many days have you received any kind of help dealing with school problems?**

- Item SP1f1 refers only to professional help. Advice or other assistance from friends, family, and other sources of social support, while potentially beneficial, does not count for these items. Self-administered "help" using alcohol or other drugs does not count.
- If the participant reported receiving help with school or training problems within the past 90 days (item SP1f), then the number of days in the past 90 on which they received help for school or training problems (item SP1f1) must be greater than zero.

SP2a–c **School reasons items eligibility**

SP2a	Has the participant had any school problems in the past three months as indicated by at least one response of 4 or 3 for items SP1a to SP1d?
SP2b	Was the participant absent from school for at least 3 of the past 90 days as reported in item SP1e1?
SP2c	Do you want to administer the school reasons items? If you answered yes to items SP2a or SP2b or choose to administer the school reasons items because of site or staff choice, code yes.

- **Q3-MI staff use only.** This set of items determines the client's eligibility for answering the motivational items. If your program does not administer the motivational items, do not code items SP2a–c.
- Some programs administer the motivational items even if the participant answers no to both SP2a and SP2b. If this is true for your program, code yes for SP2c before continuing with the rest of the section.

SP3a–f **You want to make changes in your behavior at school or training because...**

School Problems Reasons for Change (SPRFC): SP3a–f

SP3a	you will do better in school or training
SP3b	you will get better grades
SP3c	you won't get into trouble
SP3d	you won't get expelled
SP3e	other people will stop bothering you about your school or training problems
SP3f	you can get your diploma and thus a better paying job than if you did not have a diploma

SP4 **What is your main or most important reason for wanting to make changes right now in your behavior at school or training?**

- If the participant gives multiple reasons, document them all but ask which one is their main reason, then record their response in a staff note or highlight it on the paper copy. If the participant can't decide between multiple responses, document them all and make a staff note explaining the situation.

SP5 **How ready are you right now to make changes in your behavior at school or training? [*Card F*]**

- The participant can report any whole number between 0 and 100, not just the multiples of 20 listed on card F.

3.4 Work Problems (WP)

The job-related information reported in the Work Problems section of the GAIN-Q3 applies only to legitimate jobs (including military service), not to illicit work. Examples of illicit work include drug dealing, hustling, pimping or sex trading, and other criminal activities that result in financial gain for the participant. Illicit work should not count for any job-related items in the Vocational section. Off-the-books jobs that pay cash but do not involve engagement in illegal activities should be counted as legitimate work because the circumstances of the payment may be technically illegal, but the work itself is not. Such cash jobs include under-the-table jobs such as waiting tables and common adolescent jobs such as paper routes and babysitting.

In contrast to schoolwork performed at home, work performed at home should be counted, even on sick days, for the Work Problems items as long as the work from home was approved by the participant's supervisors and the participant completed their normal workload. A paid job in a controlled environment such as a jail or prison should also be counted for items in the Vocational section.

WP1a–e **When was the last time you...? [*Card Q*]**

- WP1a came in late or left early from work?
- WP1b skipped or cut work just because you didn't want to be there?
- WP1c did badly at work or did worse at work?
- WP1d got sick at work?
- WP1e went to work?

Work Problems Screener (WPScr): WP1a–d

Quality of Life Index (QOLI): See p. 88

- Responses to the left of the dotted line (representing time frames within the past 90 days) determine whether to administer the motivational-interviewing items in the Q3-MI (see WP2a–c below).
- Item WP1d (Got sick at work) includes coming down with any sort of illness, such as a cold or flu, or getting physically ill for any reason (including food poisoning). The illness can result from legitimate sickness or from the effects of current intoxication or a hangover. It also includes getting hurt or injured.

WP1f **When was the last time, if ever, you received any kind of help dealing with work problems (for example, talking to a counselor about problems at work, using the services of an employee assistance program, participating in mediation for dispute resolution)?**

- Item WP1f1 refers only to professional help. Advice or other assistance from friends, family, and other sources of social support, while potentially beneficial, does not count for these items. Self-administered "help" using alcohol or other drugs does not count.

WP1e1–2 **During the past 90 days, on how many days...?**

- WP1e1 were you absent from work for a full day?
- WP1e2 did you work for money at a job or in a business?

- The guidelines in the School Problems section on how to calculate full-time school or training in the preceding 90 days also apply to items WP1e1–2:

- 5 days per week in 90 days to equal 64 days.
- If the participant reports more than 64 days, clarify to see whether they worked on Saturdays or Sundays as well as Monday through Friday.
- The participant should take into account all other holidays, vacations, and other days off, as well as days absent for any reason.

See p. 52 for more information.

- If the participant reports working within the past 90 days (item WP1e), then the number of days in the past 90 on which they worked for money at a job or in a business (item WP1e2) must be greater than zero.

WP1f1 **During the past 90 days, on how many days have you received any kind of help dealing with work problems?**

- Item WP1f1 refers only to professional help. Advice or other assistance from friends, family, and other sources of social support, while potentially beneficial, does not count for these items. Self-administered "help" using alcohol or other drugs does not count.
- If the participant reported receiving help with work problems within the past 90 days (item WP1f), then the number of days in the past 90 on which they received help for work problems (item WP1f1) must be greater than zero.

WP2a–c **Work reasons items eligibility**

WP2a	Has the participant had any work problems in the last 3 months as indicated by at least one response of 4 or 3 for items WP1a to WP1d?
WP2b	Was the participant absent from work for at least 3 of the past 90 days as reported in item WP1e1?
WP2c	Do you want to administer the work reasons items? If you answered yes to items WP2a or WP2b or choose to administer the work reasons items because of site or staff choice, code yes.

- **Q3-MI staff use only.** This set of items determines the client's eligibility for answering the motivational items. If your program does not administer the motivational items, do not code items WP2a–c.
- Some programs administer the motivational items even if the participant answers no to both WP2a and WP2b. If this is true for your program, code yes for WP2c before continuing with the rest of the section.

Work Problems Reasons for Change (WPRFC): WP3a–f

WP3a–f **You want to make changes in your behavior at work because...**

WP3a	you will get more work done
WP3b	you will get better evaluations
WP3c	you won't get into trouble
WP3d	you won't get fired
WP3e	other people will stop bothering you about your work problems
WP3f	you can continue providing for yourself (and your family)

WP4 **What is your main or most important reason for wanting to make changes right now in your behavior at work?**

- If the participant gives multiple reasons, document them all but ask which one is their main reason, then record their response in a staff note or highlight it on the paper copy. If the participant can't decide between multiple responses, document them all and make a staff note explaining the situation.

WP5 **How ready are you right now to make changes in your behavior at work? [*Card F*]**

- The participant can report any whole number between 0 and 100, not just the multiples of 20 listed on card F.

3.5 Physical Health (PH)

The GAIN-Q3's Physical Health section includes all aspects of the participant's physical condition, including information current and past health problems and interactions with the health care system. The Physical Health section can also include treatment for the physical health components of substance use or mental health problems: For example, a participant who is physically injured as the result of a mental illness episode can report details of the treatment for the physical injury in the Physical Health section. (Subsequent mental health–related hospitalization or counseling for the same episode would be included in the Mental Health section.)

PH1a–f	**When was the last time you...? [*Card Q*]**	Health Problems Screener (HPScr): PH1a–e
PH1a	gained 10 or more pounds when you were not trying to?	
PH1b	lost 10 or more pounds when you were not trying to?	
PH1c	were worried about your health?	
PH1d	had a lot of physical pain or discomfort?	
PH1e	had health problems that kept you from meeting your responsibilities at school, work, or home?	Quality of Life Index (QOLI): See p. 88
PH1f	saw a doctor or nurse about a health problem or took prescribed medication for one?	

- Weight gain that accompanies pregnancy should not count for item PH1a. If a female participant says that she's gained weight because of a pregnancy (or lost weight after having a baby), code no and explain the situation in a staff note. Weight gain that accompanies normal adolescent growth spurts should not count, either.
- A participant can both gain and lose 10 or more pounds when not trying to (items PH1a and PH1b), so positive responses within the same time frames are not necessarily inconsistent.
- For item PH1e, examples of responsibilities at work include arriving on time, completing required work, adequately performing assigned work tasks, and staying for the entire scheduled work day. Examples of responsibilities at school include arriving on time, paying attention, participating in class, getting in-school work done, and staying for the entire scheduled school day. Responsibilities at home can vary by age level: For adolescents, responsibilities

might include completing homework or assigned household tasks or chores or watching younger siblings. For adults, examples include completing household tasks, caring for children, paying bills on time, or preparing meals.

- If the participant answers "never" to item PH1f, clarify by asking whether they have ever been sick or stayed home from school or work because of a cold. Many participants initially answer "never" to this item, perhaps under the assumption that it refers to serious medical problems. Seeing a doctor or taking medication for something as simple as a cold counts. It is unlikely that a participant will have gone their whole lives without ever being affected by a health or medical problem. Also include treatment the last time a female participant saw a doctor or nurse for pregnancy or childbirth.
- If the participant takes prescribed medication for a health problem only when needed (such as an inhaler for asthma) but has no other current or ongoing health issues, the proper response to item PH1f should be the most recent time they took the medication.
- School nurses and other onsite licensed health professionals (such as a doctor at a large business's onsite infirmary) should be counted for item PH1f.
- A pregnant participant should not include prenatal vitamins for item PH1f but should include other medications related to their pregnancy.
- Responses to the left of the dotted line (representing time frames within the past 90 days) determine whether to administer the motivational-interviewing items in the Q3-MI (see PH3a–c below).

PH1e1 **During the past 90 days, on how many days did you have an injury where any part of your body was hurt?**

PH1f1–5 **During the past 90 days, how many…?**

Quarterly Costs to Society (QCS): See p. 88

PH1f1	times have you had to go to the emergency room for a health problem?
PH1f2	nights total did you spend in the hospital for a health problem?
PH1f3	times did you see a doctor or nurse in an office or outpatient clinic for a health problem?
PH1f4	times did you have an outpatient surgical procedure for a health problem?
PH1f5	days did you take prescribed medication for a health problem?

- For items PH1f1–5, the participant should count a single medical event in every applicable category. For instance, if the participant went to the emergency room but was then admitted to a hospital for treatment and stayed for several days, the nights in the hospital would be recorded in item PH1f2 and the emergency room would be recorded in PH1f1. You can make a staff note to report any notable or unusual situations.
- Outpatient surgical procedures (item PH1f4) are minor surgeries for which a patient is not hospitalized but is able to return home afterwards. Examples of outpatient surgery include receiving stitches, having warts or other growths removed, dental surgery, vasectomies, needle biopsies, and other invasive but relatively minor procedures.

- For item PH1f5 (Days did you take prescribed medication for a health problem?), a pregnant participant should not include prenatal vitamins but should include other medications related to their pregnancy.
- If the participant reported last seeing a doctor or a nurse about a health problem or taking prescribed medication within the past 90 days (item PH1f), then the number reported for at least one of the items in PH1f1–5 must be greater than zero.

PH2a–c	During the past 90 days, on how many days...?	Problem Prevalence Index (PPI): See p. 88
PH2a	have you been bothered by any health or medical problems?	
PH2b	have health problems kept you from meeting your responsibilities at school, work, or home?	
PH2c	have you smoked or used any kind of tobacco?	Quarterly Costs to Society (QCS): See p. 88
PH2d	have you exercised for at least 20 minutes per day?	

- If the participant answers "never" to this item, clarify by asking whether they have ever been sick or stayed home from school or work because of a cold. Many participants initially answer "never" to item PH2a, perhaps under the assumption that the item refers to serious medical problems. Others seem to think of the word in primarily psychological terms, so their response to the question of being "bothered" by physical health concerns is, truthfully, never. Other participants seem to equate "bothered" with weakness. However, the item's intent is to measure the number of days the participant feels the effects of any illness, such as colds or other minor medical issues, in addition to more serious concerns. It is unlikely that a participant will have gone their whole lives without ever being affected by a health or medical problem.
- If the participant reports past-90-day health problems earlier in the section but then answers zero for item PH2a, clarify by asking whether they've been sick or had other health problems during that 90-day period. If a participant suffers from a chronic or asymptomatic illness but has not been bothered by that problem in the past 90 days, make a staff note explaining the participant's situation.
- All of the participant's physical health problems should be considered in the responses to items PH2a and PH2b, including those caused by substance use and mental health problems.
- If the participant reported last having a lot of physical pain or discomfort within the past 90 days (item PH1d) or had health problems that kept them from meeting their responsibilities at work, school or home (item PH1e), then the number of days they were bothered by any health or medical problems (item PH2a) must be greater than zero.
- For item PH2b, see item PH1e on p. 56 for examples of responsibilities.
- If the participant reports being kept from meeting responsibilities at school, work, or home because of health problems during the past 90 days (item PH2b), then the last time they had health problems that kept them from meeting their responsibilities at work, school or home (item PH1e) must be within the past 90 days.
- Item PH2c includes only tobacco products, not marijuana or other smokable illicit drugs. Such tobacco products can include cigarettes, cigars, chewing tobacco, pipes, and hookahs.

PH3a–c **Health reasons items eligibility**

- PH3a Has the participant had any health problems in the last 3 months as indicated by at least one response of 4 or 3 for items PH1a to PH1e?
- PH3b Did the participant report any health problems for at least 3 of the past 90 days in items PH2a to PH2c?
- PH3c Do you want to administer the health reasons items? If you answered yes to items PH3a or PH3b or choose to administer the health reasons items because of site or staff choice, code yes.

- **Q3-MI staff use only.** This set of items determines the client's eligibility for answering the motivational items. If your program does not administer the motivational items, do not code items PH3a–c.
- Some programs administer the motivational items even if the participant answers no to both PH3a and PH3b. If this is true for your program, code yes for PH3c before continuing with the rest of the section.

PH4a–f **You want to make changes in your health-related behaviors because...**

Physical Health Reasons for Change (PHRFC): PH4a–f

- PH4a you will feel better
- PH4b you will stop worrying about your health
- PH4c you will be able to participate in more activities
- PH4d you will get more done
- PH4e you won't be in pain
- PH4f other people will stop bothering you about your health

PH5 **What is your main or most important reason for wanting to make changes right now in your health-related behaviors?**

- If the participant gives multiple reasons, document them all but ask which one is their main reason, then record their response in a staff note or highlight it on the paper copy. If the participant can't decide between multiple responses, document them all and make a staff note explaining the situation.

PH6 **How ready are you right now to make changes in your health-related behaviors? [*Card F*]**

- The participant can report any whole number between 0 and 100, not just the multiples of 20 listed on card F.

3.6 Sources of Stress (SS)

SS1a–g **When was the last time you were under stress for any of the following reasons? [*Card Q*]**

Sources of Stress Screener (SSScr): SS1a–g1

Quality of Life Index (QOLI): See p. 88

- SS1a Death of a family member or close friend
- SS1b Health problem of a family member or close friend
- SS1c Fights with boss, teacher, coworkers, or classmates
- SS1d Major change in relationships for you or your family (e.g., marriage, divorce, separations)

SS1e Something you saw or that happened to someone close to you
SS1ev *Something seen or happened verbatim*
SS1f New job, position, or school
SS1g You didn't have enough money to pay all your bills on time

SS1g1 When was the last time, if ever, that you considered yourself to be homeless?

Sources of Stress Screener (SSScr): SS1a–g1

- Item SS1d (Major change in relationships) includes all personal relationships, not just marriages or other long-term committed relationships. Breakups between unmarried or adolescent couples, for example, can be significant sources of stress.
- For item SS1e (Something you saw or that happened to someone close to you), the participant should not repeat anything already reported in items SS1a–d. If the participant does report a distinct event for item SS1e, record what happened in the SS1e verbatim field.
- Responses to the left of the dotted line (representing time frames within the past 90 days) determine whether to administer the motivational-interviewing items in the Q3-MI (see SS3a–c below).

SS1h When was the last time, if ever, you received any kind of help dealing with your stress (for example, talking to a counselor about ways to manage stress, participating in classes to learn to better manage stress)? (*Card Q*)

SS1h1 During the past 90 days, on how many days have you received any kind of help dealing with your stress?

- Items SS1h and SS1h1 refer only to professional help. Advice or other assistance from friends, family, and other sources of social support, while potentially beneficial, does not count for these items. Self-administered "help" using alcohol or other drugs does not count.

SS2a–b During the past 90 days, on how many days have you…?
SS2a felt stressed by events or situations in your life?
SS2b had any money problems, including arguing about money or not having enough for food or housing?

Problem Prevalence Index (PPI): See p. 88

- If the participant reported being under stress within the past 90 days for any of the items in SS1a–g, then the number of days on which they felt stressed by events or situations in their life (item SS2a) must be greater than zero.
- If the participant reports not having enough money within the past 90 days (item SS1g), then the number of days they had money problems (item SS2b) must be greater than zero.

SS3a–c Stress reasons items eligibility
SS3a Has the participant had any stress problems in the past 3 months as indicated by at least one response of 4 or 3 for items SS1a to SS1g1?
SS3b Did the participant report stress problems for at least 3 of the past 90 days in items SS2a or SS2b?

SS3c Do you want to administer the stress reasons items? If you answered yes to items SS3a or SS3b or choose to administer the stress reasons items because of site or staff choice, code yes.

- **Q3-MI staff use only.** This set of items determines the client's eligibility for answering the motivational items. If your program does not administer the motivational items, do not code items SS3a–c.
- Some programs administer the motivational items even if the participant answers no to both SS3a and SS3b. If this is true for your program, code yes for SS3c before continuing with the rest of the section.

SS4a–f **You want to make changes in how you deal with stress because...**

Stress Reasons for Change (SSRFC): SS4a–f

- SS4a you will feel better or more relaxed
- SS4b you will learn how to deal with your problems in a healthy way
- SS4c you won't feel so anxious all the time
- SS4d you won't be so irritable
- SS4e you will sleep better
- SS4f you will get more done

SS5 **What is your main or most important reason for wanting to make changes right now in how you deal with stress?**

- If the participant gives multiple reasons, document them all but ask which one is their main reason, then record their response in a staff note or highlight it on the paper copy. If the participant can't decide between multiple responses, document them all and make a staff note explaining the situation.

SS6 **How ready are you right now to make changes in how you deal with stress? [*Card F*]**

- The participant can report any whole number between 0 and 100, not just the multiples of 20 listed on card F.

3.7 Risk Behaviors for Infectious Diseases (RB)

RB1a–k **When was the last time you...? [*Card Q*]**

Risk Behaviors Screener (RBScr): RB1a–RB1m2

Quality of Life Index (QOLI): See p. 88

- RB1a had two or more different sex partners during the same time period?
- RB1b had sex without using any kind of condom, dental dam, or other barrier to protect you and your partner from diseases or pregnancy?
- RB1c had sex while you or your partner was high on alcohol or other drugs?
- RB1d used a needle to inject drugs like heroin, cocaine, or amphetamines?
- RB1g were attacked with a weapon, including a gun, knife, stick, bottle, or other weapon?

RB1h	were physically abused, where someone hurt you by striking or beating you to the point that you had bruises, cuts, or broken bones?
RB1j	were sexually abused, where someone pressured or forced you to participate in sexual acts against your will, including your regular sex partner, a family member, or a friend?
RB1k	were emotionally abused, where someone did or said things to make you feel very bad about yourself or your life?
RB1m1	were abused several times or over a long period of time?
RB1m2	were afraid for your life or that you might be seriously injured by the abuse?

- Item RB1a (Two or more different sex partners during the same time period) means whether the participant had more than one ongoing or short-term sexual relationship during the preceding 12 months, such as going back and forth between different sex partners or having one-night stands. It does not necessarily mean two or more partners during the same act, as in threesomes or other group sex, but it should if the partner has engaged in such activities.
- Only physical-barrier methods of contraception and disease control should be counted for item RB1b (Sex without using any kind of condom, dental dam, or other barrier to protect you and your partner from diseases or pregnancy). Birth control methods that do not use barriers, such as pills, Depo-Provera or Norplant injections, contraceptive patches, intrauterine devices, or cervical caps (all of which allow contact between partners), should not count.
- Item RB1d (Used a needle to inject drugs like heroin, cocaine, or amphetamines) refers only to illicit drugs, not prescribed medications such as insulin.
- If the participant reports current abuse or current threat of abuse when answering item RB1k (or any other item), follow agency procedures to address the situation. In addition, make a staff note explaining the situation and the subsequent actions taken.
- Responses to the left of the dotted line (representing time frames within the past 90 days) determine whether to administer the motivational-interviewing items in the Q3-MI (see RB3a–c below).
- Note: The RB1 items intentionally skip RB1e and RB1f.

RB1n **When was the last time, if ever, you received any kind of help to reduce your risk behaviors (for example, participating in a needle exchange program, being instructed in safe sex practices, moving to a shelter for domestic violence victims)? [*Card Q*]**

RB1n1 **During the past 90 days, on how many days did you receive any kind of intervention to reduce your risk behaviors?**

- Items RB1n and RB1n1 refer only to professional help. Advice or other assistance from friends, family, and other sources of social support, while potentially beneficial, does not count for these items. Self-administered "help" using alcohol or other drugs does not count.
- The intervention mentioned in item RB1n1 refers to prevention services or other help. Some participants may think of interventions as a confrontation with a person in an effort to make them seek professional help for a problem (also known as the Johnson model of

intervention, after Dr. Vernon Johnson). While this type of intervention can be included in the response, the item's intent is to record the last time the participant received any kind of help or other service, including counseling or preventive services related to safe sex and relationships, safety planning to avoid domestic violence or other interpersonal violence, personal safety, needle use or needle-exchange programs, and others related to reducing risk behaviors. (However, substance abuse treatment by itself would not count here; instead it should be recorded in the Substance Use section.)

- If the participant reported receiving an intervention to reduce their risk behaviors within the past 90 days (item RB1n), then the number of days on which they received any kind of help or intervention to reduce their risk behaviors (item RB1n1) must be greater than zero.

RB2a–c	During the past 90 days, how many...?
RB2a	times have you had unprotected sex (sex without using any kind of condom, dental dam, or other barrier to protect you and your partner from diseases or pregnancy)?
RB2b	days have you used a needle to inject any kind of drug or medication?
RB2c	days have you been attacked with a weapon, beaten, sexually abused, or emotionally abused?
RB2d	days have you gone without eating or thrown up much of what you did eat?

Problem Prevalence Index (PPI): See p. 88

- The participant cannot report having had sex in the preceding 90 days without a barrier method of contraception (itemsRB1a–c) but then report zero for item RB2a.
  - If the participant reported having sex without protection within the past 90 days (item RB1b), then the number of days on which they had unprotected sex (item RB2a) must be greater than zero.
  - Item RB2b (used a needle to inject any kind of drug or medication) includes self-injection of prescribed medications such as insulin as well as illicit substances. The participant should not include injections given by a doctor, nurse, or other licensed health professional because of the safe and sterile conditions in which such shots are usually administered. (Because the item RB2b includes prescribed medications such as insulin, it is consistent if the participant reports past-90-day needle use for RB2b but reports no such use for item RB1d, "used a needle to inject drugs like heroin, cocaine, or amphetamines.")
  - If the participant reported using a needle to inject drugs within the past 90 days (item RB1d), then the number of days on which they used a needle to inject any kind of drug or medication (item RB2b) must be greater than zero.
  - As with item RB1k (and any other item), if the participant reports current abuse or current threat of abuse when answering item RB2c, follow agency procedures to address the situation. In addition, make a staff note explaining the situation and the subsequent actions taken.
  - If the participant reported experiencing any of the problems described in items RB1g–k within the past 90 days, then the number of days on which they were attacked with a

weapon, beaten, sexually abused, or emotionally abused (item RB2c) must be greater than zero.

- The response to item RB2d (gone without eating or thrown up much of what you did eat) should include all times the participant went without eating or threw up, including because of illnesses like the flu or food poisoning or because of self-induced vomiting.
- Item RB2d is concerned primarily with illness and self-harming disorders. If a participant reports fasting for religious or cultural reasons, record the number of days but also explain the situation in a staff note. A religious or cultural fast can still be a risk behavior but is much different in intent than self-harming behavior or illness.

RB3a–c **Risk behaviors reasons items eligibility**

RB3a	Did the participant report risk behavior problems in the past 3 months as indicated by at least one response of 4 or 3 for items RB1a to RB1k?
RB3b	Did the participant report risk behavior problems for at least 3 of the past 90 days in items RB2a to RB2c?
RB3c	Do you want to administer the risk behavior reasons items? If you answered yes to items RB3a or RB3b or choose to administer the risk behavior reasons items because of site or staff choice, code yes.

- **Q3-MI staff use only.** This set of items determines the client's eligibility for answering the motivational items. If your program does not administer the motivational items, do not code items RB3a–c.
- Some programs administer the motivational items even if the participant answers no to both RB3a and RB3b. If this is true for your program, code yes for RB3c before continuing with the rest of the section.

RB4a–f **You want to make changes in your risk behaviors because...**

Risk Behaviors Reasons for Change (RBRFC): RB4a–f

RB4a	you don't want to get HIV or some other serious illness
RB4b	you don't want to put yourself in a situation where you could be hurt
RB4c	you don't want your behaviors to negatively impact your family, friends, or kids
RB4d	you don't want to be responsible for spreading disease
RB4e	you don't want to die before your time
RB4f	engaging in risk behaviors makes you look bad

RB5 **What is your main or most important reason for wanting to make changes right now in your risk behaviors?**

- If the participant gives multiple reasons, document them all but ask which one is their main reason, then record their response in a staff note or highlight it on the paper copy. If the participant can't decide between multiple responses, document them all and make a staff note explaining the situation.

RB6 **How ready are you right now to make changes in your risk behaviors? [*Card F*]**

- The participant can report any whole number between 0 and 100, not just the multiples of 20 listed on card F.

3.8 Mental Health (MH)

For items MH1a–f, clarification issues may arise over the word "significant." In the context of the Mental Health section, a significant problem is one that lasts for two or more weeks, that keeps coming back, that keeps the participant from meeting their responsibilities, *or* that makes the participant feel like they cannot go on. (The participant does not have to experience all four conditions for the problem to count as significant.)

MH1a–f	**When was the last time you had significant problems with...? [*Card Q*]**	Internalizing Disorders Screener (IDScr6): MH1a–f
MH1a	feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	
MH1b	sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	Quality of Life Index (QOLI): See p. 88
MH1c	feeling very anxious, nervous, tense, fearful, scared, panicked, or like something bad was going to happen?	
MH1d	becoming very distressed and upset when something reminded you of the past?	
MH1e	thinking about ending your life or committing suicide?	
MH1f	seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	

- The type of sleep trouble referred to in item MH1b does not include such normal activities as naps, catching up on sleep after a few busy days, or infrequent difficulty falling asleep because of caffeine or excitement. The item refers to severe problems, such as chronic insomnia or an inability to stay awake.
- Responses to the left of the dotted line (representing time frames within the past 90 days) determine whether to administer the motivational-interviewing items in the Q3-MI (see MH4a–c below).

MH2a–g	**When was the last time you did the following things two or more times? [*Card Q*]**	Externalizing Disorders Screener (EDScr6): MH2a–g
MH2a	Lied or conned to get things you wanted or to avoid having to do something	
MH2b	Had a hard time paying attention at school, work, or home	
MH2c	Had a hard time listening to instructions at school, work, or home	Quality of Life Index (QOLI): See p. 88
MH2d	Had a hard time waiting for your turn	
MH2e	Were a bully or threatened other people	
MH2f	Started physical fights with other people	
MH2g	Tried to win back your gambling losses by going back another day	

- Item MH2g (Tried to win back your gambling losses by going back another day) includes nearly any type of wager, legal or illegal, where exchanges of money, drugs, sex, or other things take place: betting on sports, playing the lottery (including scratch-off tickets or Lotto), casino games, bingo, slots, dice, card games for money (including poker), internet gambling, video

casino games such as video bingo or video poker (though only if payouts are given), and other games of chance.

- Responses to the left of the dotted line (representing time frames within the past 90 days) determine whether to administer the motivational-interviewing items in the Q3-MI (see MH4a–c below).

MH2h **When was the last time, if ever, you were treated for a mental, emotional, behavioral, or psychological problem by a mental health specialist or in an emergency room, hospital, or outpatient mental health facility, or with prescribed medication? [*Card Q*]**

MH2h1–4 **During the past 90 days, how many…?**

Quarterly Costs to Society (QCS): See p. 88

MH2h1	times have you had to go to an emergency room for mental, emotional, behavioral, or psychological problems?
MH2h2	nights total did you spend in the hospital for mental, emotional, behavioral, or psychological problems?
MH2h3	times did you see a mental health doctor in an office or outpatient clinic for mental, emotional, behavioral, or psychological problems?
MH2h4	times did you take prescribed medication for mental, emotional, behavioral, or psychological problems?

- Item MH2h3 specifically mentions a doctor, but the participant should include all licensed mental health specialists they saw in the preceding 90 days. If necessary, make a staff note stating that the treatment was with a counselor or other licensed specialist rather than a doctor.
- Item MH2h4 includes only medication prescribed to the participant. The participant should not report taking medication prescribed to someone else, the use of which should instead be reported in the Substance Use section. If necessary, make a staff note to explain the details of the participant's situation.
    - If the participant reported being treated for mental, emotional, behavioral, or psychological problems within the past 90 days (item MH2h), then the number reported for at least one of the items in MH2h1–4 must be greater than zero.

MH3a–d **During the past 90 days, on how many days…?**

Problem Prevalence Index (PPI): See p. 88

MH3a	were you bothered by any nerve, mental, or psychological problems?
MH3b	did these problems keep you from meeting your responsibilities at work, school, or home or make you feel like you could not go on?
MH3c	have you been disturbed by memories of things from the past that you did, saw, or had happen to you?
MH3d	have you had any problems paying attention, controlling your behavior, or breaking rules you were supposed to follow?

- The participant should not answer zero for item MH3a if they reported any past-90-day problems in items MH1a–f.

- As with item PH2a (see p. 58), some participants have a different conception of the word "bothered" than others, so if the participant reports past-90-day mental health problems in items MH1a–f but then answers zero for item MH3a, clarify by asking, "On how many days in the past 90 did you experience the problems you reported earlier?"
  - For item MH3b, see item PH1e on p. 56 for examples of responsibilities.
  - If the participant reported having significant problems in the past 90 days with becoming distressed and upset when something reminded them of the past (item MH1d), then the number of times they were disturbed by memories of things from the past that they did, saw, or had happen to them (item MH3c) must be greater than zero. (Technically, this may not be inconsistent in all cases: For instance, the participant may say for item MH1d that they were disturbed by something from the past that they did not witness, such as the death of a loved one, but then legitimately answer zero for item MH3c. If this is the case, make a staff note explaining the situation.)
  - If the participant reported a time frame within the past 90 days for any of the items in MH2a–g, then the number of days on which they had any problems paying attention, controlling their behavior, or breaking rules they were supposed to follow (item MH3d) must be greater than zero.

MH4a–c	Mental health reasons items eligibility
MH4a	Has the participant had any mental health problems in the past 3 months as indicated by at least one response of 4 or 3 for items MH1a–f or MH2a–g?
MH4b	Did the participant report mental health problems for at least 3 of the past 90 days in items MH3a to MH3d?
MH4c	Do you want to administer the mental health reasons items? If you answered yes to items MH4a or MH4b or choose to administer the mental health reasons items because of site or staff choice, code yes.

- **Q3-MI staff use only.** This set of items determines the client's eligibility for answering the motivational items. If your program does not administer the motivational items, do not code items MH4a–c.
- Some programs administer the motivational items even if the participant answers no to both MH4a and MH4b. If this is true for your program, code yes for MH4c before continuing with the rest of the section.

MH5a–k	You want to make changes in your mental health–related behaviors because...
MH5a	you will feel better
MH5b	you will get more things done
MH5c	you will be able to move forward in your life
MH5d	you will be able to concentrate better
MH5e	your energy will improve
MH5f	you will be able to think more clearly
MH5g	you don't want your problems to negatively impact your family, friends, or kids
MH5h	your family, friends, or kids want you to get help with your problems

Mental Health Reasons for Change (MHRFC): MH5a–k

MH5j you want to avoid having problems with other people
MH5k you don't want to get in trouble

MH6 What is your main or most important reason for wanting to make changes right now in your mental health–related behaviors?

- If the participant gives multiple reasons, document them all but ask which one is their main reason, then record their response in a staff note or highlight it on the paper copy. If the participant can't decide between multiple responses, document them all and make a staff note explaining the situation.

MH7 How ready are you right now to make changes in your mental health–related behaviors? [*Card F*]

- The participant can report any whole number between 0 and 100, not just the multiples of 20 listed on card F.

3.9 Substance Use (SU)

Tobacco use, including smoking and chewing, should not be counted in the Substance Use section because nicotine use and dependence are not sufficient for admission to drug treatment programs. All tobacco use is covered in the Physical Health section (see p. 58), and tobacco use appears in the physical health section of the Q3RRS.

Some substances, called polydrugs, are combinations of two or more drugs that fall under different SU4 categories, such as speedballs (a mix of heroin and cocaine) or marijuana laced with opium. Every substance in a polydrug is recorded separately in the SU4 items; see below for details. Additionally, sometimes one substance may be cut, or bulked up, with other substances. Some of these cutting agents may be inert filler, but others may be drugs that should be coded as appropriate in the SU4 items, if known (e.g., the participant knows that they used heroin that had been cut with a sedative).

Prescription drugs should be included in the Substance Use section only when a participant abuses their own prescription (e.g., taking more than prescribed) or if they use someone else's prescribed drugs. If the participant reports problems with a drug that they use as prescribed by a health professional for physical or mental health problems, make a staff note explaining the situation (which will be helpful for treatment planning and coordinating care with current doctors and others), but do not code the drug in the Substance Use section.

Another exception is medical marijuana, which should be included in the Substance Use section regardless of whether it was prescribed legally (just as alcohol is included regardless of whether the participant is underage or old enough to use it legally). Whenever recording medical marijuana use, include a staff note with the details of the prescription and note whether the participant exceeded the prescribed amount (just as you would with any other prescribed medication). Over-the-counter medications should also be included if the participant used them for recreational purposes.

SU1a–f	When was the last time ...? [*Card Q*]	Substance Disorders Screener (SDScr6): SU1a–e
SU1a	you used alcohol or other drugs weekly or more often?	
SU1b	you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	
SU1c	you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	Quality of Life Index (QOLI): See p. 88
SU1d	your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	
SU1e	you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	
SU1f	you received treatment, counseling, medication, case management, or aftercare for your use of alcohol or any other drug? Please do not include any emergency room visits, detoxification, self-help, or recovery programs.	

- The "recovering" mentioned in item SU1b refers to enduring the aftereffects of using substances, like suffering from a hangover.
- Only withdrawal symptoms that result from a lack of use should be counted for item SU1e. Withdrawal symptoms should not be confused with some physical effects of substance use and substance-induced disorders, such as shaking after ingesting stimulants or throwing up while experiencing a hangover. In addition, do not count seizures or other effects that may have occurred because of an overdose.
- Responses to the left of the dotted line (representing time frames within the past 90 days) determine whether to administer the motivational-interviewing items in the Q3-MI (see SU6a–e on p. 78).

SU1f2–5	During the past 90 days, how many...?	Quarterly Costs to Society (QCS): See p. 88
SU1f2	nights were you in a halfway house, residential, inpatient, or recovery program for your alcohol or other drug use problems?	
SU1f3	days were you in an intensive outpatient or day program for your alcohol or other drug use problems?	
SU1f4	times did you go to a regular (1–8 hours per week) outpatient program for your alcohol or other drug use problems?	
SU1f5	days did you take medication like methadone or Antabuse to help with withdrawal or cravings?	
SU1f99	Days did you go to any other kind of treatment program or work with some other kind of case manager for your alcohol or other drug use problems?	
SU1f99v	*Other kind of treatment verbatim*	

- The participant cannot report past-90-day treatment, counseling, medication, case management, or aftercare for item SU1f but then report zero for all items in SU1f2–5.

- The treatment mentioned in items SU1f2–5 does *not* include detox (see below) or programs that do not require diagnosis or licensure, such as 12-step or self-help group meetings such as Alcoholics Anonymous, prevention or early-intervention programs, church groups, or stays in sanctuaries or recovery homes. Treatment for use of cigarettes or tobacco is not included, either.
- Item SU1f5 includes only medications prescribed specifically to alleviate withdrawal or cravings. It does not include use of medications prescribed for other purposes, nor does it include the use of alcohol or other drugs to lessen the effects of withdrawal or cravings.
    - If the participant last received treatment, counseling, medication, case management, or aftercare for their use of alcohol or any other drug within the past 90 days (item SU1f), then the number reported for at least one of the items in SU1f1–99 must be greater than zero.
- Note: The SU1f items intentionally skip SU1f1.

SU2a–d	During the past 90 days, how many...?	Quarterly Costs to Society (QCS): See p. 88
SU2a	days have you been in a detoxification program to help you through withdrawal?	
SU2b	days have you attended one or more self-help group meetings for your alcohol or other drug use?	
SU2c	times have you been given a breathalyzer or urine test to check for your alcohol or other drug use?	
SU2d	times did you go to an emergency room for your alcohol or other drug use problems?	

- Detoxification programs (item SU2a) are places with professional help and often medication to help you through severe withdrawal. Typically they are part of or affiliated with a larger agency or hospital.
- Self-help groups (item SU2b) are groups of people who meet to provide social support, mutual aid, and guidance. Twelve-step programs are often considered self-help groups. While typically part of a large association, they are generally not run by professionals.
- Item SU2c (Breathalyzer or urine test to check for your alcohol or other drug use) mentions only breath and urine tests, but the response should include all other biological drug tests, such as hair, saliva, sweat, and blood tests.
- Count all tests from any source, whether scheduled or random: substance abuse treatment, justice system, school programs, employment, job screening, traffic stops, and any other.

SU3a	During the past 90 days...?	Substance Frequency Scale (SFS8pq): SU3a–c, SU4a–c, SU4e–s Problem Prevalence Index (PPI): See p. 88
SU3a	on how many days did you go without using alcohol, marijuana, or other drugs?	
SU3b	on how many days did you get drunk at all or were you high for most of the day?	
SU3c	on how many days did alcohol or other drug use problems keep you from meeting your responsibilities at work, school, or home?	

- See the comments for items SU4a–s (starting on p. 73) for details on properly coding item SU3a and SU3b.
- For item SU3c, examples of responsibilities at work include arriving on time, completing required work, adequately performing assigned work tasks, and staying for the entire scheduled work day. Examples of responsibilities at school include arriving on time, paying attention, participating in class, getting in-school work done, and staying for the entire scheduled school day. Responsibilities at home can vary by age level: For adolescents, responsibilities might include completing homework or assigned household tasks or chores or watching younger siblings. For adults, examples include completing household tasks, caring for children, paying bills on time, or preparing meals.

SU4a–s	During the past 90 days, on how many days have you...?
SU4a	used any kind of alcohol?
SU4b	gotten drunk or had 5 or more drinks?
SU4c	used marijuana, hashish, blunts, or other forms of THC?
SU4d	used cocaine, opioids, methamphetamine, or any other drug, including a prescription medication that was not prescribed to you, or one that you took more of than you were supposed to?
SU4e	used crack, smoked rock or freebase?
SU4f	used other forms of cocaine?
SU4g	used inhalants or huffed?
SU4h	used heroin or heroin mixed with other drugs?
SU4j	used nonprescription or street methadone?
SU4k	used painkillers, opiates, or other analgesics?
SU4m	used PCP or angel dust?
SU4n	used acid, LSD, ketamine, special K, mushrooms, or other hallucinogens?
SU4p	used antianxiety drugs or tranquilizers?
SU4qa	used methamphetamines, crystal, ice, glass, or other forms of methedrine?
SU4qb	used speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants?
SU4r	used downers, sleeping pills, barbiturates, or other sedatives?
SU4s	used any other drug that has not been mentioned?
SU4sv	*Other drug verbatim*

Substance Frequency Scale (SFS8pq): SU3a–c, SU4a–c, SU4e–s

Problem Prevalence Index (PPI): See p. 88

- Code zero if the participant has not used a substance within the past 90 days (do not leave blank spaces).
    - The examples in parentheses following each question do not have to be read unless the participant needs additional clarification. For instance, if the participant does not know what counts as an antianxiety drug or tranquilizer, you can read some or all the parenthetical examples. However, item SU4s (Any other drug) is an exception: Many participants do not initially think to report some substances that haven't been explicitly named in the questions, so reading the parenthetical can help jog their memory. For instance, a participant who has abused cough syrup may not think to mention it because it is not named in any of the items. (See below for more on item SU4s.)

  - The number of days that the participant reported getting drunk or having 5 or more drinks (item SU4b) cannot be greater than the number of days of alcohol use (item SU4a).
  - Items SU4e–s (measuring days of use of individual substances) is a subset of item SU4d (Used cocaine, opioids, methamphetamine, etc.). The participant cannot report a larger number for any individual item in SU4e–s than they report for item SU4d.
  - Items SU4qa and SU4qb separate methamphetamine and other stimulants (including other types of amphetamine). If the participant reports using speed or other common slang terms for stimulants, clarify to be sure which specific substance they mean, since different participants may use the same term to refer to different substances. Abuse of caffeine, such as consuming an entire box of caffeine tablets at once, or abuse of diet pills, Mini Thins, ephedrine, and similar substances should be recorded in item SU4s (Other).
- On the GAIN-Q3, MDMA (ecstasy) is coded under SU4qb (Speed, uppers, amphetamines, ecstasy, MDMA, or other stimulants). Some sources consider MDMA a hallucinogen—for example, the National Institute on Drug Abuse states that its chemical makeup is similar to mescaline as well as methamphetamine—but the GAIN-Q3 codes it as a stimulant because it appears as one in common urine tests. Also note that "liquid ecstasy" (GHB) is actually a sedative (coded as item SU4r); if the participant reports using ecstasy, clarify for which kind, MDMA or GHB.
  - Polydrugs should be coded under all applicable categories. For example, the number of days using marijuana laced with opium would be coded under both item SU4c (Marijuana, hashish, blunts, or other forms of THC) and item SU4k (Painkillers, opiates, or other analgesics). A speedball would be recorded under item SU4h (Heroin or heroin mixed with other drugs) and either item SU4e (Crack, rock, or freebase) or SU4f (Other forms of cocaine) depending on whether it was injected or smoked. Also make a staff note specifying all the substances in the polydrug.
- Substances that do not fit the categories in items SU4a–r are recorded in item SU4s (Any other drug). If for SU4s the participant reports a substance that should be reported in items SU4a–r, go back and clarify the applicable item, then readminister item SU4s to ensure that the participant has reported every substance.
  - Some of the more frequently reported substances that should be coded for item SU4s include cough remedies like NyQuil, Coricidin ("triple C's"), or Robitussin, many of which contain dextromethorphan, also known as DXM; lean, a drink that contains cough suppressant with promethazine (and sometimes codeine, which would be reported in item SU4k); poppers or amyl nitrite, a stimulant; nitrous oxide whippets, or laughing gas, a dissociative anesthetic; Dramamine (dimenhydrinate); and Tylenol PM and other sleep aids.
  - Synthetic cannabinoid "incense blends," such as Spice and K2, and synthetic stimulant "bath salts" should also be coded under SU4s.
  - If the participant reports more than one substance for item SU4s, record the name of the most frequently used substance and the number of days, then record the names

and number of days of all other SU4s substances in a staff note. If two or more SU4s substances were used on the same number of days, record both and state in the verbatim field or a staff note that both were used on the same number of days.

- Tobacco use should not be recorded for item SU4s nor anywhere else in the Substance Use section. Tobacco use is recorded only in the Physical Health section (see p. 58).
- The total number of days that the participant reported using individual drugs other than alcohol and marijuana (items SU4e–s) cannot be less than the overall days of other drug use (item SU4d).

ITEMS SU4A–S AND ITEM SU3A

- Be careful to check item SU3a against the days of individual substance use reported in items SU4a–s (see p. 71). There are two easy rules to help you establish the range of consistent responses from the participant:
  - The *minimum* number of days on which the participant could have used is equal to the largest number in items SU4a–s. This presumes that the participant used all reported substances on the same days.
  - The *maximum* number of days on which the participant could have used is equal to the total number of days of use in items SU4a–s. This presumes that the participant never used more than one substance on the same day (which may not be accurate but which can be assumed for the purposes of establishing the range of use).

Therefore, to be consistent the participant's response must fall within the minimum and maximum days of use as established by these rules. Below are the participant's responses to items SU4a–d.

Figure 3.5

SU4. **During the past 90 days**, on how many **days** have you...

a.	used any kind of alcohol (beer, gin, rum, scotch, tequila, whiskey, wine or mixed drinks)?	|1|5| Days	**[IF 0, GO TO SU4c]**
b.	gotten drunk or had 5 or more drinks?	|_|0| Days	
c.	used marijuana, hashish, blunts or other forms of THC (herb, reefer, weed)?	|6|0| Days	
d.	used cocaine, opioids, methamphetamine or **any other drug**, including a prescription medication that was **not** prescribed to you, or one that you took more of than you were supposed to?	|_|0| Days	**[IF 0, GO TO SU5]**

The participant used alcohol on 15 days (item SU4a), marijuana on 30 days (item SU4c), and no other substances (item SU4d). This gives us the following minimum and maximum days of use:

- Minimum days of use: 60 (equal to days of marijuana use, the largest single number, which presumes that all substances were used on the same days)
- Maximum days of use: 75 (equal to days of alcohol + marijuana use, which presumes that each substance was used on different days)

The corresponding days of nonuse can be determined by subtracting the minimum and maximum days of use from 90 days overall:

- Minimum days of nonuse: 90 days overall minus 75 maximum days of use = 15
- Maximum days of nonuse: 90 days overall minus 60 minimum days of use = 30

Therefore, for item SU3a the range of consistent responses is between 15 and 30.

Here are two examples of instances when the participant's responses are inconsistent given the numbers shown in Figure 3.5 above. In the first the participant reports too many days for item SU3a:

Figure 3.6

SU3. **During the past 90 days**...

a. on how many **days** did you go **without using any** alcohol, marijuana or other drugs? ..... |5|2| Days **[IF 90, GO TO SU5]**

The participant reports going 52 days out of the preceding 90 without using alcohol or other drugs. However, because the maximum days of nonuse as shown in Figure 3.5 is 30, this means that the participant is attempting to report 112 days of activity in a 90-day period (52 days of nonuse + 60 days minimum use). You would need to explain the situation to the participant and clarify the responses for consistency.

In the next example the participant reports too few days:

Figure 3.7

SU3. **During the past 90 days**...

a. on how many **days** did you go **without using any** alcohol, marijuana or other drugs? ..... |_|0| Days **[IF 90, GO TO SU5]**

The participant reports going without alcohol, marijuana, or other drugs on zero days, meaning that they used substances on every day of the preceding 90. But their total days of substance use from figure Figure 3.5 add up to a maximum of 75 days, leaving 15 days unaccounted for. Again, to address this inconsistency you would have to explain the situation to the participant and clarify the responses.

Remember that these numbers represent only the potential minimum and maximum days of use. It is possible, even probable, that the participant used multiple substances on some days and only one substance on others. The minimum days of nonuse and maximum days of use serve as the ends of the range of consistent responses.

Be aware that for item SU3a, some participants mistakenly report the most days *in a row* without using. Item SU3 records the *total* number of days that the participant went without using in the 90-day timeframe.

Items SU4a–s and item SU3b

- Item SU3b measures the days on which the participant used a significant quantity of alcohol or other drugs. This item puzzles some interviewers at first because it equates getting drunk *at all* during the day with getting and staying high for *most* of the day, which seems like an imbalance (e.g., it seems to equate having a few drinks and getting tipsy at the end of the day with a day-long cocaine binge). However, the intent is to record the number of days on which the participant used alcohol or other drugs heavily, not light usage like a couple drinks or a single use of marijuana. Therefore, the response to item SU3b should combine two numbers: 1) the number of days drunk and 2) the number of days high for most of the day. If the participant reports a number for item SU3b that conflicts with their responses in items SU4a–s (such as reporting more days of use for a single substance than they report as a total for item SU3b), explain that item SU3b asks about the number of days drunk at all *plus* days the number of days high for most of the day, then clarify the appropriate items.
- For consistency, check the participant's response to item SU3b against their responses to items SU4a–s. There are several things to keep in mind:
  - Because item SU3b asks about the number of days drunk at all, the response to item SU3b should not be less than the number reported for item SU4b (During the past 90 days, on how many days have you gotten drunk or had 5 or more drinks?).
  - A participant may report a smaller number for item SU3b than they do for items SU4c–s, but when clarifying, they may reveal that they were not high for most of the day. For example, the participant may report 10 days of marijuana use (item SU4c) but 0 for item SU3b. When asked, they report that they used marijuana only once per day on those 10 days. Therefore, the items are consistent.
  - The participant can't report a larger number for item SU3b than their maximum days of use for the preceding 90 days (as demonstrated with regard to item SU3a above).

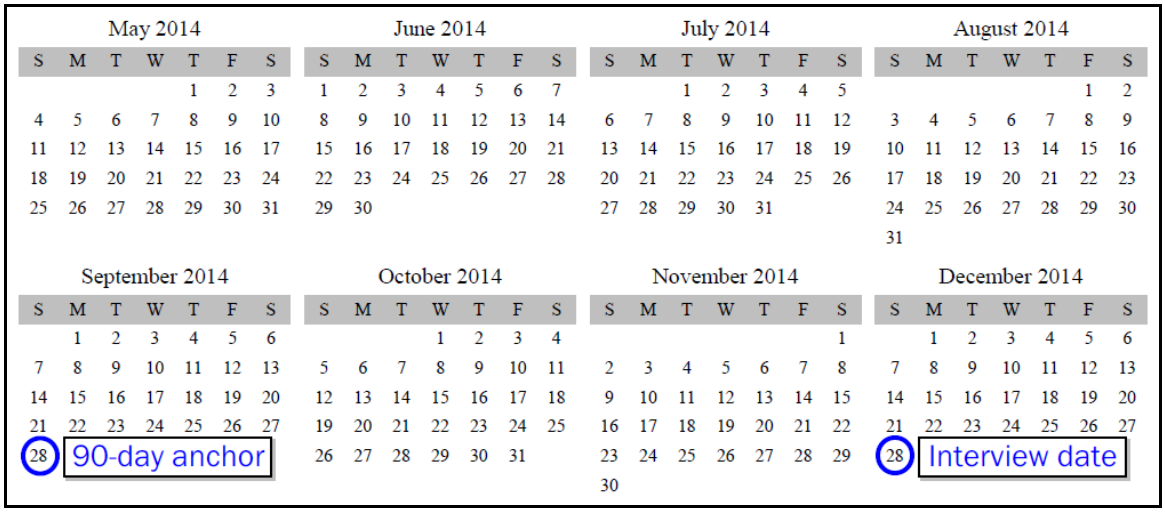
SU5 **During the past 90 days, on how many days have you been in a jail, hospital, or other place where you could not use alcohol, marijuana, or other drugs?**

- If the participant spent more than 12 days in a controlled environment during the preceding 90 days, then you must establish a new anchor and administer items SU5a–c. At 13 or more days in a controlled environment, usual patterns of behavior are disrupted and cannot be reported reliably. Even if a participant in a controlled environment is able to use substances (see below), they are unlikely to engage in their usual patterns of use, and they may use something other than their preferred substances because they are unable to obtain anything else. Therefore, to get a picture of their typical use, the GAIN-Q3 asks about the participant's most recent time in the community.

  If the participant answers 13 or more for item SU5, you must first establish a new 90-day time frame when the participant was outside a controlled environment and in the community and able to engage in their typical patterns of use. As when establishing the 90-day anchor at the beginning of the interview, use the calendar with the participant to find the most recent 90-day period in which they spent 12 or fewer days in a controlled environment.

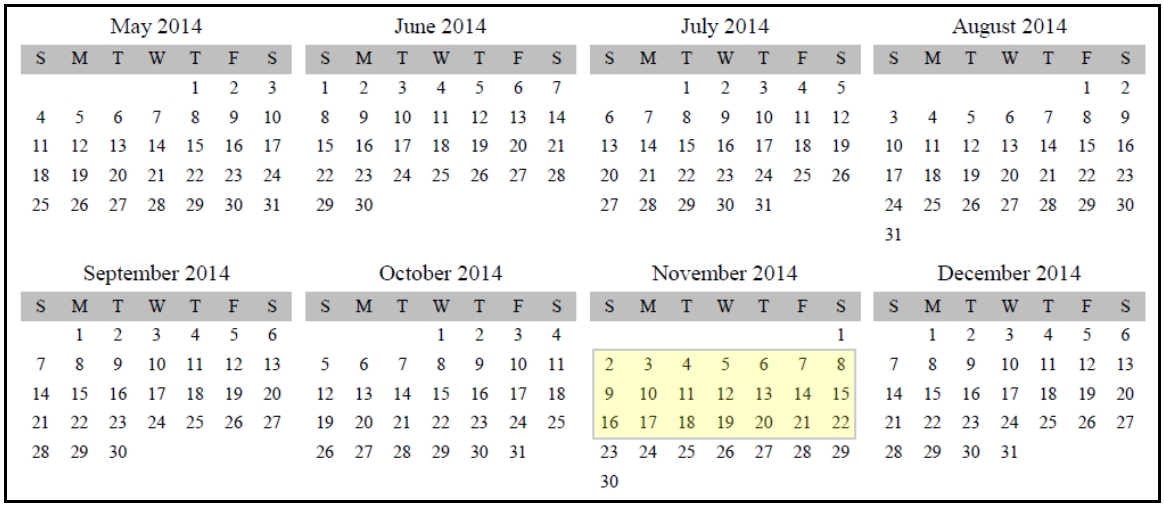
  Start by determining the date on which the participant began their most recent stay in a controlled environment, then count back 13 weeks to establish a 90-day time frame. In the following example (Figure 3.8), the interview date is December 28 and the 90-day anchor date is September 28. For item SU5 the participant states that they were in a controlled environment for 21 days, so the interviewer turns to the calendar to establish a new time frame.

Figure 3.8



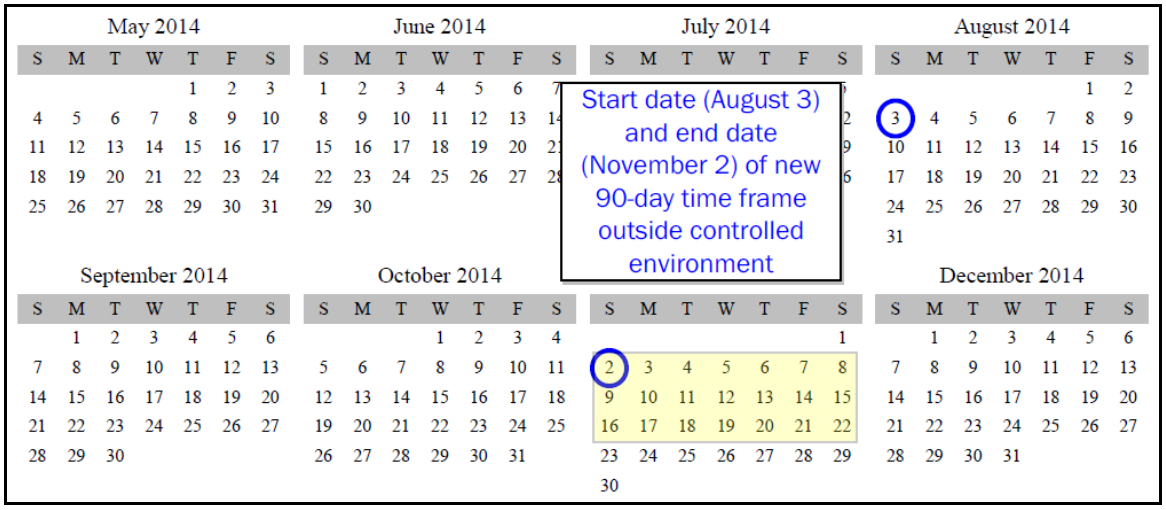
The interviewer asks the participant when they were in the controlled environment. The participant states that they entered on November 2 and were released on November 22 (Figure 3.9).

Figure 3.9



Similar to establishing the original 90-day anchor, the interviewer counts back 13 weeks from the day the participant entered the controlled environment to establish a new 90-day time frame. In this case, the new time frame in the community starts on August 3.

Figure 3.10



Ask the participant whether they had been in a controlled environment for more than 12 days at any point during this new 90-day time frame. If not, the new time frame will be used for items SU5a–c. (In other words, the participant can be in a controlled environment for 12 or fewer days without having to establish a new time frame.) If, on the other hand, the participant has more than 12 days in a controlled environment in the new 90-day time frame, repeat the steps above to determine another new 90-day time frame. Continue until you have a 90-day period during which the participant was in a controlled environment for 12 or fewer days.

Finally, establish a new anchor for the new 90-day time frame, using the same procedure as when establishing the 90-day anchor at the start of the interview. Explain that the new time frame covers the period starting from their anchor and ending 90 days later. This new anchor and time frame is used only with items SU5a–c. (The anchor is protected information under HIPAA guidelines and should be removed with a black marker from any hard copies of the GAIN that leave an agency. If the participant gives a full name as part of the anchor, use only the first name.)

Sometimes it can be difficult to establish a block of 90 days in the community because a participant may have been in and out of controlled environments several times in the recent past, and it may have been some time since they were in the community for 90 consecutive days. Be prepared to go back as long as necessary, even several years, to get 90 consecutive days when the participant was in controlled environments for 12 or fewer days in a 90-day time frame. The only exception is if going back to the most recent 90-day period outside a controlled environment means going back to a point before the participant started using substances. A young participant, for example, may have begun using at the same time they began periods of incarceration or residing in other controlled environments, in which case their most recent 90-day period in the community would have been a time before they used substances at all. In this case, and only in this case, should an interviewer put together the largest and most recent blocks of time to total 90 days or to use a 90-day period with the least amount of time in a controlled environment.

- Sometimes participants are able to use substances in controlled environments. If the participant raises this issue, clarify by asking, "On how many days during the past 90 have you been someplace where you were *not supposed to* use alcohol, marijuana, or other drugs? Or how many days were you someplace where you weren't supposed to be able to use?"

SU5a–c **In those 90 days in the community...?**

SU5a	on how many days did you go without using any alcohol, marijuana, or other drugs?
SU5b	on how many days did you get drunk at all or were you high for most of the day?
SU5c	on how many days did alcohol or other drug use problems keep you from meeting your responsibilities at work, school, or home?

- See items SU3b and SU3c for guidelines on administering items SU5b and SU5c.
- After administering item SU5c, tell the participant that you will be returning to their original 90-day anchor for the rest of the interview.

SU6a–e Substance use reasons items eligibility

SU6a	Has the participant had any substance use problems in the past month as indicated by at least one response of 4 or 3 for items SU1a to SU1e?
SU6b1	Did the participant report substance use problems interfering with their responsibilities for 1 or more of the past 90 days in item SU3c?
SU6c1	Did the participant report getting drunk or having 5+ drinks on 3 or more of the past 90 days in item SU4b?
SU6d1	Did the participant report using any illicit drugs for 1 or more of the past 90 days in items SU4c to SU4s?

SU6e1 Did the participant report substance use problems for 1 or more of the 90 days prior to being in a controlled environment in item SU5?

SU6f Do you want to administer the substance use reasons items? If you answered yes to items SU6a to SU6e1 or choose to administer the substance use reasons items because of site or staff choice, code yes.

- **Q3-MI staff use only.** This set of items determines the client's eligibility for answering the motivational items. If your program does not administer the motivational items, do not code items SP6a–f.
- Some programs administer the motivational items even if the participant answers no to items SU61–e1. If this is true for your program, code yes for SU6f before continuing with the rest of the section.
- If the participant has not been in a controlled environment in the preceding 90 days, code no for item SU6e1.

SU7a–j **You want to make changes in your behavior related to your use of alcohol or other drugs because...**

Substance Use Reasons for Change (SURFC): SU7a–j

SU7a	you don't like the way it makes you feel
SU7b	you want to get your life on a better path
SU7c	alcohol or other drugs are hurting your body
SU7d	you are under legal pressure to quit (e.g., probation, drug testing, parole)
SU7e	your family, friends, or kids want you to quit
SU7f	you want to keep your children
SU7g	you don't want to get into trouble at work
SU7h	you don't want to get into trouble with the law
SU7j	it costs too much money

SU8 **What is your main or most important reason for wanting to make changes right now in your behavior related to your use of alcohol or other drugs?**

- If the participant gives multiple reasons, document them all but ask which one is their main reason, then record their response in a staff note or highlight it on the paper copy. If the participant can't decide between multiple responses, document them all and make a staff note explaining the situation.

SU9 **How ready are you right now to make changes in your behavior related to your use of alcohol and other drugs? [*Card F*]**

- The participant can report any whole number between 0 and 100, not just the multiples of 20 listed on card F.

3.10 Crime and Violence (CV)

CV1a–f **When was the last time you...? [*Card Q*]**

Crime and Violence Screener (CVScr): CV1a–e

CV1a	had a disagreement in which you pushed, grabbed, or shoved someone?
CV1b	took something from a store without paying for it?
CV1c	sold, distributed, or helped to make illegal drugs?

CV1d	drove a vehicle while under the influence of alcohol or illegal drugs?	Quality of Life Index (QOLI): See p. 88
CV1e	purposely damaged or destroyed property that did not belong to you?	
CV1f	were involved in the criminal justice system, such as jail or prison, detention, probation, parole, house arrest, or electronic monitoring?	

- "Purposely damaged or destroyed property that did not belong to you" (item CV1e) refers to vandalism, the deliberate wrecking of someone else's belongings, or any other purposeful damaging or sabotage of another person's possessions. The item is not intended to record the sort of damage or destruction that may accompany work in the armed forces (such as shelling during combat), police or fire protection (such as breaking down a person's door), or other related professions, though the participant can include these actions if they feel strongly about it.
- For item CV1f, some participants involved in the criminal justice system at the time of the interview do not answer "past month" (the time frame best reflecting current involvement), perhaps thinking that the question refers to their most recent sentencing. For example, a participant on probation at the time of the interview may give the time frame for when they were put on probation, overlooking the fact that they are on probation at the time of the interview. If later items (especially items CV2a–e) reveal that the participant is currently engaged in the criminal justice system but did not report that involvement in items CV1a–f, be sure to return to CV1a–f and resolve the inconsistency.
- Responses to the left of the dotted line (representing time frames within the past 90 days) determine whether to administer the motivational-interviewing items in the Q3-MI (see CV5a–c below).

CV2a–e	**During the past 90 days, on how many days have you been...?**	Quarterly Costs to Society (QCS): See p. 88
CV2a	on probation?	
CV2b	on parole?	
CV2c1	in juvenile detention?	
CV2c2	in jail or prison?	
CV2d	on house arrest?	
CV2e	on electronic monitoring?	

- The participant may report past-90-day involvement in the criminal justice system (item CV1f) but answer zero for all the items in CV2a–e. If the participant's involvement is not included in CV2a–e, record it in a staff note. Some examples include awaiting charges, a trial, or sentencing; out on bail or released on own recognizance; on treatment release, work release, or school release; or assigned to a sentencing alternative or treatment program such as TASC (Treatment Alternatives for Safe Communities).
- A participant cannot usually be on probation and in jail or prison at the same time (going to jail is a violation of probation). If a participant reports overlapping jail and probation within the preceding 90 days, such as 30 days in jail and 90 days on probation, clarify to ensure that the participant understands their legal situation.

- Underage participants will occasionally report both juvenile detention (item CV2c1) and jail or prison (item CV2c2). Most are likely to have been only in juvenile detention, so if a participant reports both, clarify the items to confirm the information.

CV3 **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?**

Problem Prevalence Index (PPI): See p. 88

CV4 **During the past 90 days, on how many days were you involved in any activities that you thought might get you into trouble or be against the law, besides drug use?**

Problem Prevalence Index (PPI): See p. 88

- The wording of item CV4 specifically mentions the last time the participant did something that they *thought* might get them in trouble or be against the law. One purpose of item CV4 is to record the participant's perception of their own problems (which can sometimes point to denial or other problems). The participant may not believe that a particular action is illegal, or they may recognize that an action is illegal but don't recognize the extent of their engagement with that activity. If the participant's other responses in the Crime and Violence section appear to conflict with their response to item CV4, attempt to clarify the inconsistencies, but if the participant does not see the items as inconsistent, make a staff note explaining the situation.
- Activities that can be counted for item CV4 include virtually anything illegal, including those described in items CV1a–f. The participant should not include use of alcohol or other drugs, but they should include more substantial substance-related crimes, such as dealing or trafficking. Include any alcohol or drug-related activity more serious than simple purchase, possession, or use (such as driving under the influence).
- Cigarette use by adolescents should not be included for item CV4; however, selling cigarettes to adolescents is a low-level form of dealing and should be reported.

CV4a1–3 **On how many of these days were you involved in these activities (you thought might get you into trouble or be against the law)...?**

Problem Prevalence Index (PPI): See p. 88

CV4a1	in order to support yourself financially?
CV4a2	in order to obtain alcohol or other drugs?
CV4a3	while you were high or drunk?

- Items CV4a1–3 is a subset of item CV4. The participant should not report a greater number of days for any of the items in CV4a1–3 than for item CV4.
- Participants may have engaged in illegal behaviors for multiple reasons and while simultaneously high or drunk, so they may report the same incident for all three items in CV4a1–3.

CV4b **During the past 90 days, how many times have you been arrested and charged with breaking a law? (Please do not count minor traffic violations)**

Quarterly Costs to Society (QCS): See p. 88

- Both an arrest and a charge are required for item CV4b. If a participant is held in jail but released without being charged, or is ticketed without being arrested, it should not count.

Some participants, especially adolescents, may be unsure about whether they have been both arrested and charged, so the best indication is if the participant was a) detained by law enforcement officials and b) told to appear in court on a specific date. To be arrested and charged with a crime, a number of events usually happen: The police would read the participant their rights, they might be handcuffed, they would be taken to the station for fingerprints, their photo would be taken, and they would be given a date to appear in court.

- Examples of minor traffic violations are moving violations (which include such things as crossing lines, illegal turns, wrong way on a one-way street, failing to stop or signal, speeding, etc.), parking violations, expired driver's license or violation of driver's license restrictions, expired plates or registration, disobeying signals or rules of the road, and noise or horn violations. More serious violations, which often result in arrest, include DUI or DWI, driving with a suspended license, motor vehicle assault or homicide, reckless driving, and open-container and other substance-related violations and should not be counted for item CV4b.

CV5a–c **Crime and violence reasons items eligibility**

CV5a	Has the participant had any crime or violence problems in the past 3 months as indicated by at least one response of 4 or 3 for items CV1a to CV1e?
CV5b	Did the participant report crime or violence problems for 1 or more of the past 90 days for item CV4?
CV5c	Do you want to administer the crime or violence reasons items? If you answered yes to items CV5a or CV5b or choose to administer the crime and violence reasons items because of site or staff choice, code yes.

- **Q3-MI staff use only.** This set of items determines the client's eligibility for answering the motivational items. If your program does not administer the motivational items, do not code items CV5a–c.
- Some programs administer the motivational items even if the participant answers no to both CV5a and CV5b. If this is true for your program, code yes for CV5c before continuing with the rest of the section.

CV6a–d **You want to make changes in your criminal or violent behavior because...**

Crime and Violence Reasons for Change (CVRFC): CV6a–d

CV6a	you don't want to get into trouble with the law (e.g., go to jail or detention, be on probation)
CV6b	your family or friends want you to stop
CV6c	you want to get your life on a better path
CV6d	crime and violent behavior are wrong

CV7 **What is your main or most important reason for wanting to make changes right now in your criminal or violent behavior?**

- If the participant gives multiple reasons, document them all but ask which one is their main reason, then record their response in a staff note or highlight it on the paper copy. If the participant can't decide between multiple responses, document them all and make a staff note explaining the situation.

CV8 **How ready are you right now to make changes in your criminal or violent behavior? [*Card F*]**

- The participant can report any whole number between 0 and 100, not just the multiples of 20 listed on card F.

3.11 Life Satisfaction (LS)

LS1g–n **Currently, how satisfied are you with...? [*Card I*]** Life Satisfaction Index (LSI): LS1g–n

LS1g	the level of physical intimacy (sexual activity) in your relationships?
LS1h	your family relationships?
LS1j	your general level of happiness?
LS1k	where you are living?
LS1m	how your life is going so far?
LS1n	your school or work situation?

- Note: The LS1 items intentionally skip LS1a–f.

3.12 End (Z)

After finishing the last items, thank the participant for their time and fill out the information in the staff use box (see Figure 3.12) on your own (do not administer them to the participant) before moving to item Z2.

If the interview was administered over more than one day, only the first day's time to complete is recorded in item Z1–Z1d; see item XADMh1 (p. 87) for information on recording information for the rest of the interview. Start and end times for additional days of administration, as well as the dates, should be recorded in staff notes during the assessment.

Z1 **What time is it now?**

- Record the time that the assessment was completed in standard time, not military.
- For interviews that take place over more than one day, record the end time of the first day of the interview and record the details of the rest of the interview in item XADMh1 (see p. 87).

Z1b **Is it AM or PM?**

- Enter AM or PM. On the paper version, write "AM" or "PM" in the proper field; do not circle the letters.

Z1c **How many breaks did you take today?**

- Enter the total number of breaks taken during the interview.
- For interviews lasting more than one day, enter the number of breaks taken on only the first day of the interview.

Z1d Not counting breaks, how long did it take you to finish this today?

- To calculate the time to complete, start by determining how much time was spent on the interview from beginning to end, then subtract the time spent on breaks. The start time is found in items A1a–b at the beginning of the assessment.

Figure 3.11 Start time example

For Staff Use Only
A1. Administrative Information
A1a. Time: .....|1|2| : |0|3| HH:MM..... A1b. |P|M| (AM/PM)
A1c. Today's Date [XOBSDT]: ..... |0|7| / |2|2| / 20 |1|2| (MM/DD/YYYY)
A1d. Reference Date if Different [XRFDT]: ..... |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

Figure 3.12 End time example

Z. End

Thank you! That is all of the questions we have for you at this time.

(Please enter the current time in Z1. If you went straight through, we will figure out how many minutes you took. If you took any breaks, please make sure that you record about how many minutes total it took you to do the assessment without including the time for the breaks. If continuing interview on another day, record the time for the first day in Z1d and record the total time in XADMh1a-d.)

Z1. What time is it now? ..... \|0\|2\| : \|1\|9\| Time (HH:MM)

b. Is it AM or PM ..... \|PM\| AM/PM

c. How many breaks did you take today?..... \|__\|2\| Breaks — 11 minutes total

d. Not counting breaks, how long did it take you to finish this? ..... \|1\|2\|5\| Minutes

  - In the example above, the interview starts at 12:03 p.m. and ends at 2:19 p.m. (136 minutes).
  - Two breaks were taken, totaling 11 minutes.
  - The total break time is subtracted from the overall assessment time to arrive at a final time to complete: 136 – 11 = 125 minutes.
- The time to complete cannot be determined without the start time (items A1a and A1b), the end time (items Z1 and Z1b), and the start and stop times of all breaks.
- For multiday interviews, record only the time spent on the first day of the interview. The total time for the entire interview is recorded in item XADMh1c.

After completing item Z1d, administer item Z2 to the participant.

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?**

- Item Z2 is often one of the first places a clinician or evaluator will look for information about the participant. Be sure to administer this item to the participant and record any additional information they have to offer.
- After the participant answers item Z2, their part of the interview is complete. Complete the XADM section on your own.

3.13 Administrative ratings (XADM)

In the administrative-ratings section of the GAIN-Q3, the interviewer answers several questions about the interview. These items should be completed as soon as possible after the interview. This information is used to fulfill reporting requirements when GAIN data is used in papers and presentations, and it can also be used to compare characteristics of assessments in research studies.

For multiday interviews, code items XADMa–g based on the first day of the interview only. If circumstances change between one session and the next (for example, if the participant is cooperative on one day but not the second), make a staff note in XADMj explaining the change.

XADMa1 **How were the questions administered?**

a	Self-administered
b	Orally administered by staff
c	Orally administered by others
z	Other
zv	*Other administration verbatim*

- Mark yes or no for each response choice, similar to a mentioned item, to record how the assessment was administered: by the participant on their own, orally administered by staff, orally administered by others, or some other way.

XADMa2 **What was the mode of administration?**

a	Done with pen and paper
b	Done on computer
c	Done on telephone
z	Other
zv	*Other mode of administration verbatim*

- Mark yes or no for each response choice, similar to a mentioned item, to record how the interview was conducted: with pen and paper, on a computer with GAIN ABS, by telephone, or some other way.
- More than one response may be marked as yes: For example, an interview can be conducted over the phone (item 2c) and the responses recorded with pen and paper (item 2a).

XADMb **What was the primary language in which it was conducted?**

1 English using the English GAIN
2 Spanish using the English GAIN
3 Spanish using the Spanish VGNI
99 Other combinations/languages
99v *Other combinations/languages verbatim*

XADMc **Were there any indications that the client might have learning disabilities that would interfere with his or her ability to respond to or participate in treatment or, in general, indications of developmental disabilities?**

0 No/none
1 Minimal
2 Moderate
3 Major

XADMe **Was there any evidence of the following observed participant behaviors?**

1 Depressed or withdrawn
2 Violent or hostile
3 Anxious or nervous
4 Bored or impatient
5 Intoxicated or high
6 In withdrawal
7 Distracted
8 Cooperative

- Mark yes or no for each behavior, similar to a mentioned item. More than one yes can be marked if the participant exhibited more than one behavior.
- A participant's culture may affect the way they interact with the interviewer. For instance, some people may never meet the interviewer's eyes not because they are depressed or nervous but because direct eye contact with authority figures is considered impolite in their culture. If you feel that a participant's behavior may be culturally related, code yes for the appropriate behaviors but make a staff note explaining the situation.
- Note that the first seven behaviors are negative while item 8, "cooperative," is positive. If the participant was cooperative and exhibited no other negative behaviors, be sure to mark yes for item 8 (some interviewers accidentally mark no for all).
- It is possible that the participant may not have exhibited any negative behaviors but was not particularly cooperative either, in which case all eight items can be marked no.

XADMg **What was the participant's location during the assessment?**

1 Treatment unit
2 Specialized intake unit
3 Correctional setting
4 School
5 Employment or work setting
6 Home
7 Probation or parole office
8 Welfare or child protection agency
11 Research office or setting

99 Other location
99v *Other location verbatim*

- Note: The XADMg response choices intentionally skip 9 and 10.

XADMg1–5 Were there any problems providing a quiet, private environment?

1 Noise or other frequent distractions
2 Divided attention or frequent interruptions
3 Other people present or within earshot
4 Police, guards, social workers, or other officials present
5 Speaker or telephone monitoring

- Mark yes or no for each circumstance that might have had an effect on the interview, similar to a mentioned item.
- If a 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. The issues described in the XADMg items are a concern only 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.

XADMh1 Was administration done over multiple days?

- If the interview was conducted over more than one day, code yes and enter the details of the remaining time on task in items XADMh1a–d (after having recorded the first day's details in the Z items). Otherwise code no and skip to item XADMj.

XADMh1a What is the final revision date?

- Code the date on which the interview was completed.

XADMh1b What is the total number of breaks across all sessions and days?

- The number reported for item XADMh1b should include all breaks reported in item Z1c, all breaks taken during the second day of the interview, and an additional break for the time between days. For instance, if half the interview is administered on one day and half on the next, and one break is taken on each day, the correct number for item XADMh1b would be 3 (one break on each day and one break between days). The number reported for item XADMh1b should always be at least one more than the number reported for item Z1c to account for the break between days.

XADMh1c What is the total number of minutes spent doing the interview across all sessions and days?

- Record the total number of minutes spent administering the GAIN across all days. As with item Z1d, do not include time taken for breaks. As an example, start with Figure 3.12 on p. 84 and say that the interview resumed and concluded on the following day, lasting for an additional 60 minutes, with one 5-minute break.
  - The final revision date would be 07/23/2012.
  - The total number of breaks would be 4: two on the first day, one between days, and one on the second day.

- The total number of minutes would be the total time on the first day plus the total time on the second day. In this case, the second day took 55 minutes (60 minutes minus a 5-minute break), so adding that time to the time to complete on the first day means that the total number of minutes to complete is 180.

XADMh1d What is the staff ID of the person finishing the interview?

- The person who completes the interview should record their ID in item XADMh1d, whether it was the person who began the interview on the first day or a new interviewer.

XADMj Do you have any additional comments about the administration of the assessment or things that should be considered in interpreting this assessment? Be sure to document any critical collateral information that you think should be considered during interpretation (or cross-reference where it is documented).

- Item XADMj is often the first place that clinicians and evaluators look for extra information on the interview, so record any information that should be considered in interpreting or data-entering the assessment. This includes circumstances such as parents or other authority figures listening in on the interview, which can affect the participant's responses; details of the participant's behaviors during the interview; and many others. On the paper version of the GAIN-Q3 only two lines are given on the page for this field, but you can use the margins or another sheet to make additional notes.

3.14 Across sections

Some of the indices and other measures in the GAIN-Q3 comprise items from across sections:

Problem Prevalence Index (PPI): PH2a–c, SS2b, RB2b–c, MH3a–d, CV3, CV4, CV4a1–3, SU3a–c, SU4b, SU4c, SU4e–s (34 items)

Quality of Life Index (QOLI): all nine screeners (SP1a–d, WP1a–d, PH1a–e, SS1a–1g1, RB1a–m2, MH1a–f, MH2a–g, SU1a–e, and CV1a–e)

Quarterly Costs to Society Index (QCS): SP1e1, PH1f1–3, PH2a, Mh2h1–3, MH3a, SU1f2–4, SU2a, SU2d, CV2a–c2, CV4b (19 items)

4. GAIN-Q3 Administration Quality Assurance

4.1 Benefits of Training and Certification

The most effective GAIN-Q3 user is one who has been trained and certified in Q3 administration. There are substantial advantages associated with this process:

- Training enables an interviewer to optimize the benefits of a semistructured assessment and efficiently collect valid, reliable information.
- GAIN training and certification have been demonstrated to reduce GAIN-I administration time by 31% (White, 2006), and similar time savings are expected for the GAIN-Q3. This reduction in time spent administering the assessment saves staff resources and helps maintain rapport with the participant.
- GAIN-certified interviewers collect higher quality data than uncertified interviewers, with the best data collected from more rigorously trained and certified interviewers with greater experience (Titus et al., 2011).
- Every trainee from a GAIN Coordinating Center–sanctioned training (a training held by the GAIN Coordinating Center or by GCC-approved trainers) is assigned their own GAIN Administration Quality Assurance Team contact during the certification processes. The A-QA Team e-mail support line (gainsupport@chestnut.org) is also available to assist GAIN-Q3 users with administration and certification questions.

4.2 GAIN-Q3 Administration Quality Assurance

The heart of the certification process is Q3 administration quality assurance, or A-QA. Quality assurance is a training process that uses set standards, practice, and feedback to reinforce concepts and develop skills learned during training. It is difficult to learn every aspect of administration in depth during an initial training, especially outside a real-world interviewing environment. The Q3 certification process serves as the first application of the skills learned during training.

After their training, a GAIN-Q3 trainee continues to study GAIN administration and conducts interviews that are audio-recorded for evaluation by an A-QA Team reviewer. The reviewer offers specific feedback on the trainee's administration, enabling the trainee to hone their skills on subsequent interviews. Once the trainee demonstrates the ability to administer the Q3 effectively to a real participant and receives satisfactory ratings from the A-QA reviewers (see section 4.4 on p. 93), they are certified in GAIN-Q3 interviewing.

Note: Certification can be granted only on an interview with a real participant, or one whose responses to the GAIN-Q3 are based on their own real-life experiences. A real participant allows the interviewer to demonstrate the ability to use real time lines and anchors, individualize the assessment (such as by making cultural adaptations), establish rapport, and clarify actual responses. Suitable real participants include clients entering or currently engaged in substance abuse treatment or related services, friends or acquaintances currently or previously involved in treatment, or friends or acquaintances with some substance use issues in their past, among other possibilities.

4.3 GAIN Certification Levels

The train-the-trainer model of Q3 training encompasses several levels of certification: Coursework, Administration, Local Trainer, and Site Interviewer. Depending on their role at a site, a staff person may need only the basic certifications (Administration or Site Interviewer) or they may be required to progress to the Local Trainer level. Coursework, Administration, and Local Trainer trainees are required to attend a GCC-sanctioned training to achieve certification, whereas a Site Interviewer is trained and recommended for certification by a certified Local Trainer.

GAIN-Q3 Coursework. This is the most basic level of certification. Coursework certification is earned after attending at least 90% of a GCC-sanctioned GAIN training (either a national training in Bloomington-Normal, IL or a full on-site training) or by completing the GAIN-Q3 distance-learning course and clinical webinar.

GAIN-Q3 Administration. Administrators are often the primary interviewers at a site, administering the assessments and performing assigned administrative tasks. Administration certification is achievable by anyone for whom the GCC provides quality assurance services. The prerequisite for Administration certification is GAIN-Q3 Coursework certification.

The Administration certification process follows a standard procedure:

1. The trainee audio-records themselves administering the GAIN-Q3. (Interviews should be recorded with digital recorders.)
2. The trainee's first interview can be with a mock participant, such as a fellow staff member or a friend. As mentioned above, certification can be granted only on an interview with a real participant.
3. The trainee sends the audio recording and either a) a digitally scanned copy of the paper assessment or a mailed photocopy or b) the full assessment report from GAIN ABS to the A-QA Team for review. Digital recordings and PDF files of the assessment are uploaded to the A-QA Team's secure submission-posting site, gainsubmission.org, while photocopies of assessments are mailed (contact the A-QA Team at gainsupport@chestnut.org for uploading information and mailing addresses).
4. An A-QA reviewer listens to the recording while following along with the trainee's documented Q3 (either on paper or the full assessment report from GAIN ABS). The

reviewer takes notes to evaluate the trainee's skills at applying Q3 administration guidelines during an interview. These skills include explaining the instructions to the participant, documenting the participant's responses, clarifying unclear responses and ambiguities, and engaging the participant in the interview. (Local Trainers will follow this same process when training their own trainees.)

5. The A-QA reviewer then writes an evaluation using a standard feedback form (see Figure 4.2 on p. 95). The form is divided into four main areas of administration: Documentation, Instructions, Items, and Engagement. Each area may be rated as Excellent, Sufficient, Minor Problems, or Problems.
6. The A-QA Team returns the feedback to the trainee along with assigned next steps toward certification. These steps may include a phone review, where a trainee discusses their feedback with a A-QA Team member; mock administration of portions of the assessment with a A-QA Team member (also over the phone); or additional training activities, depending on the trainee's needs.
7. The trainee continues to record interviews and complete training with the A-QA Team until their skills reach the level of certification. To achieve certification, the trainee must achieve summary ratings of sufficient or excellent in all four areas of administration on the same interview.

Certified GAIN-Q3 Administrators are eligible to proceed to GAIN-Q3 Local Trainer certification.

GAIN-Q3 Local Trainer. This level of certification is for staff members who are responsible for the training of GAIN-Q3 users at their agency. GAIN Administration certification is a prerequisite for Local Trainer certification. Local Trainers can perform a number of duties:

- Plan and conduct GAIN-Q3 interviewer training for site staff.
- Perform A-QA functions for trainees at their site.
- Recommend trainees to the GCC for Site Interviewer certification (see below for more on Site Interviewers).
- Monitor Site Interviewer performance via quality assurance and supervision.
- Assist with the basic operation of GAIN ABS.
- Act as the communication link between their site and the GCC, ensuring that the site's Q3 instruments and supporting materials are up to date.
- Keep site staff aware of updated instruments or procedures.

In addition, Local Trainers can also administer interviews and perform other Administrator-level duties.

There are two stages of the Local Trainer certification process:

- **Stage one:** The Local Trainer candidate reviews a submission from a trainee who is not yet ready for certification (the trainee's feedback has any rating below sufficient). This allows A-QA staff the opportunity to assess the Local Trainer candidate's ability to ac-

curately identify key administration skills, provide coaching and reinforcement, and rate each area of administration on the feedback form.

- **Stage two:** The Local Trainer candidate reviews a submission from a trainee who meets certification requirements (the trainee's feedback has ratings of either sufficient or excellent in all categories either at the initial review or after a short consultation with the reviewer). This allows A-QA staff the opportunity to assess the candidate's ability to maintain the GCC's standards for certification.

To illustrate the process for becoming a Local Trainer, let's follow the case of a certified GAIN Administrator named Greg. Greg's agency is hiring more staff for conducting interviews, and Greg will be in charge of training and supervising them. Therefore, Greg will need to complete the Local Trainer process under the guidance of GAIN Coordinating Center staff. Greg's Local Trainer certification process begins when he conducts a GAIN-Q3 Site Interviewer training for the new staff members at his agency. The new staff members (now officially Site Interviewer trainees) practice the GAIN and audio-record interviews, similar to the GAIN Administration certification process, while Greg evaluates their interviews in a process similar to the one used by the A-QA Team. Let's take the case of a Site Interviewer trainee named Andrea.

1. Andrea audio-records an interview on the paper version of the GAIN. She gives the recording and a copy of her paper assessment to Greg (similar to how Administration trainees send submissions to the A-QA Team).
2. Before Greg reviews the trainee's submission, he makes at least two copies of the paper assessment: one for him to use while reviewing Andrea's interview and the other to send to the A-QA Team (the second copy can be a digital scan). If the interview had been conducted with GAIN ABS, Andrea would need to submit the full assessment report to Greg by either saving a PDF copy or printing it out.
3. Greg listens to the recording of Andrea's interview while following along on the paper copy or full assessment report, then writes feedback using the A-QA Team's criteria and feedback form (see section 4.4 below).
4. After completing the review and feedback, Greg sends his written feedback, the audio recording of Andrea's interview, and a copy of her original paper assessment or full assessment report to the A-QA Team. This can be done digitally via the A-QA Team's secure submission-posting site, GAINSubmission.org, or via postal service. Local Trainer candidates should ask their A-QA Team lead for details on sending GAIN-Q3 submissions.
5. An A-QA reviewer at the GCC then conducts a blind review (without consulting Greg's feedback) of Andrea's original interview and writes A-QA feedback.
6. After this review, a second A-QA reviewer compares Greg's feedback to the feedback written by the first A-QA reviewer. The second reviewer evaluates Greg's ability to write detailed, instructive feedback and writes a comparison report.
7. The A-QA Team returns the comparison report to Greg with his next steps toward certification. These steps can include a phone review, rewrites of the feedback, or various training activities. When Greg demonstrates sufficient skill at providing feedback, he

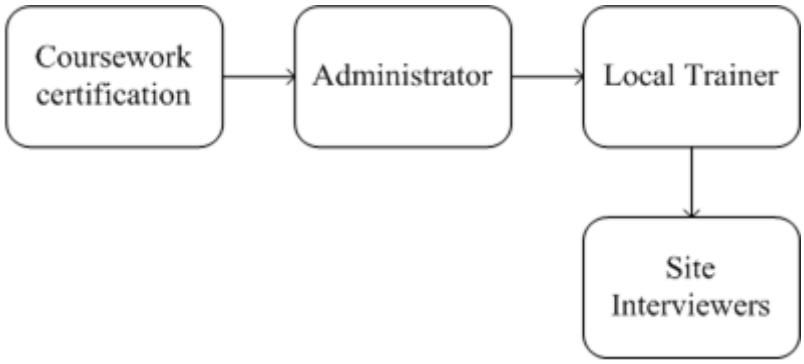
may either advance to the second stage of the process or be certified as a GAIN Local Trainer.

Local Trainer candidates may contact their assigned A-QA Team contact for assistance at any point during their certification process. (The A-QA Team does not have direct contact with the Local Trainer candidate's trainees. It is the Local Trainer candidate's responsibility to pass along any information to their trainees they may have received in their comparison report or through other contact with the A-QA Team.)

Note that Local Trainers can train and certify only to the Site Interviewer level unless the GCC provides their trainees' quality assurance services.

GAIN Site Interviewers are trained by certified Local Trainers and recommended to the GCC for certification. Site Interviewers learn the same skills and perform virtually the same functions as Administrators, but they have been trained and certified by a site's Local Trainer, not by the GCC. Unlike Administrators, Site Interviewers do not progress to Local Trainer certification unless they attend a GCC-sanctioned training and pass the requirements for Administration certification. The GCC issues Site Interviewer certification to a trainee based on the recommendation of a Local Trainer (either already certified or as part of stage two of their certification process) and a review of the trainee's feedback.

Figure 4.1 GAIN-Q3 certification levels



4.4 Understanding Q3 A-QA Feedback

Q3 trainees will typically receive several sets of written Q3 A-QA feedback during the certification process. The A-QA Team provides specific, behavioral feedback to reinforce best practices and provide additional training in targeted areas.

Written feedback provides trainees with a reference to use when preparing for subsequent Q3 interviews. Each set of feedback includes both positive comments to reinforce the trainee's skills and corrective comments to suggest areas for improvement. This review of interviewing skills and provision of written feedback helps ensure that every Q3 interviewer is following the

same guidelines and principles to achieve reliable information for diagnosis, treatment planning, and evaluation.

The GAIN-Q3 A-QA feedback form. The feedback form mirrors the administration features of the GAIN-Q3 and is intended for use with all versions of the instrument.

The feedback form has headings for each of the four main areas of administration: Documentation (for interviews conducted with the paper version) or Data Entry (for interviews conducted with GAIN ABS), Instructions, Items, and Engagement. Under each main area are subheadings for specific criteria.

For each subheading, there will be at least one comment related to how well the interviewer demonstrated a Q3 administration skill. A comment will usually summarize a situation from the interview and will include pertinent item numbers and dialogue. If applicable, the reviewer will offer suggestions for how to improve administration skills in future interviews.

At the end of each of the four main areas of administration, the reviewer assigns a summary rating. As mentioned earlier, possible summary ratings include Excellent, Sufficient, Minor Problems, and Problems.

A rating of Excellent means that the interviewer went above and beyond to enhance the quality of the interview, such as demonstrating great engagement skills or including staff notes to improve the interpretation of the information collected. A rating of Sufficient indicates that the interviewer correctly demonstrated GAIN-Q3 administration skills and collected valid, reliable information with few errors. A rating of Minor Problems indicates small technical errors that are easily cleared up with more practice, such as not following some skip instructions or missing a small number of inconsistencies. A rating of Problems indicates that the trainee requires more training for issues such as not knowing how to establish the anchor, or that there is a substantial amount of missing or incorrect information. Below are the definitions of the rating scales used to assess interviewers' skills in each of the four administration areas:

Figure 4.2 GAIN-Q3 Administration Quality Assurance Feedback Form (paper version)

Identifiers			
Site ID (XSITE):		Reviewer site:	
Staff name:		Reviewer name:	
Staff ID (XSID):		Reviewer ID:	
Date of assessment (XOBSDT):		Date of review:	
Participant ID (XPID):		Assessment:	

Documentation

- Cover page and staff use boxes
- Documentation of anchors (90-day anchor and SU5)
- Time to complete
- Administration ratings
- Documentation of participant responses

Summary rating:

Instructions

- Introduction (purpose, format, length, privacy and confidentiality)
- Establishing time frames and anchors (90-day anchor and SU5)
- Additional administration instructions
- 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 following of word order
- Appropriate use of stems and anchor
- 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:

Documentation

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

Excellent: The 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

Excellent: The interviewer repeats items and time frames, defines terms, or demonstrates other skills 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 changes in meaning, item wording, or time frames; unclear clarification; missed opportunities to clarify responses
Problems: Repeated difficulties that result in missing information or problems with validity

Engagement

Excellent: The interviewer engages participant and manages the interview well, increasing validity and making the interview less burdensome for the participant
Sufficient: The interviewer engages the participant and facilitates 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 the participant; ignoring the participant's questions or emotional state

Figure 4.3 Sample page of GAIN-Q3 feedback (paper version)

Q3 Administration Quality Assurance
Feedback Form

Identifiers			
Site ID (XSITE):	500	Reviewer site:	500
Staff name:	Jen S.	Reviewer name:	Megan M.
Staff ID (XSID):	4572	Reviewer ID:	4839
Date of assessment (XOBSDT):	10/12/2012	Date of review:	10/15/2012
Participant ID (XPID):	25661	Assessment:	GAIN-Q3 3.1.2 Standard

Documentation

- Cover page and staff use boxes
  - The cover page and staff use box were completed correctly, **with the following exceptions:**
    - The observation [XOBS] was not documented but should have been recorded as 0.
- Documentation of anchors (90-day anchor and SU5)
  - The 90-day anchor was documented correctly. Nice work!
- Time to complete
  - There were breaks in the recording on pp. 8, 12, and 20. The start and stop times of each break should have been documented in the margin of the assessment.
  - The total time to complete (Item Z1d on p. 24) could not be accurately determined because there were undocumented breaks.
- Administration ratings
  - All the administration ratings on pp. 25-26 were correctly completed.
- Documentation of participant responses
  - Responses were documented legibly 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.
  - Changes to the assessment were made correctly by crossing out the original response, documenting a new response, and initialing and dating the change (e.g., item PH1f5 on p. 11).
  - The interviewer did a great job of documenting "15/Probation Officer" for item A4d on p. 3, based on the participant's response of "my probation officer" to item A4c on the same page.
  - For item B12 on p. 6 (What is the last grade or year that you completed in school?), the interviewer did a great job of documenting "16" based on the participant's response of "Bachelor's degree."

Summary rating: Sufficient

Instructions

- Introduction
  - All parts of the introduction on p. 1 were covered. Good!

Receiving a rating of Problems in any area of administration indicates that a trainee must continue to practice and complete another GAIN-Q3 interview for A-QA review. A trainee who receives a rating of Minor Problems in only one area may be certified if they can demonstrate competency during a phone review with the A-QA Team.

The "other" section at the end of the feedback form is used to record anything worth bringing to the trainee's attention but that doesn't fit in the four main areas of administration, such as

noting pages missing from the submitted copy of the Q3 assessment or comments about the audibility of the interview.

The interviewer's certification status is listed at the end of the feedback form. Certification status is either pending (any summary ratings are below Sufficient) or certified. Once a trainee receives ratings of Sufficient or Excellent in all four Q3 administration areas of the same interview, the interviewer will be certified as a GAIN-Q3 Administrator.

4.5 Training and Certification Support

There are numerous resources available for Q3 trainees as they progress through the certification process that will improve Q3 administration skills and decrease the number of A-QA submissions needed to reach certification. Contact the A-QA Team at gainsupport@chestnut.org for phone reviews, training activities, and assistance on all matters related to Q3 training and certification.

5. Interpretation and Utility of the GAIN-Q3 Reports

Tommi L. Rivers

5.1 Introduction

The purpose of this chapter is to provide information on the interpretive capabilities of the GAIN-Q3 and to outline the function and intent of the reports generated by GAIN ABS. As a brief assessment with screeners, the GAIN-Q3 collects information sufficient to identify a wide range of key problem areas among adolescents and adults in both clinical and general populations. As stated in the first chapter, the overall aim of the GAIN-Q3 and the Q3 reports is to efficiently and accurately triage participants entering or being screened for services into three groups:

- Those who do not appear to have problems in need of attention
- Those who appear to have mild or moderate problems that can be addressed in a brief intervention
- Those whose results indicate the need for a more detailed assessment or specialized treatment or other services as appropriate

The GAIN-Q3 identifies problems across a broad range of life areas. The next section discusses the interpretative design of specific types of GAIN-Q3 items and how these items can lend to triaging participants into the three groups outlined above.

5.2 Interpretation of GAIN-Q3 Information

The interpretation of the information gathered by the GAIN-Q3 depends on three primary concepts: recency, prevalence, and breadth.

- **Recency** is the last or most recent time that something has happened. In general, the more recent an event is, the greater the significance; for treatment planning the GAIN-Q3 focuses on past-90-day behaviors and service utilization.
- **Breadth** is the scope of the participant's problems or service utilization. A more widespread presentation of clinical symptoms or services is of greater significance than problems or services in a smaller number of areas.

- **Prevalence** is how often or how frequently something has occurred. Greater prevalence of either problem behaviors or service utilization is more significant than lower prevalence.

Each main section of the GAIN-Q3 begins with screeners on the recency of behaviors and service utilization. These screening items are designed to quickly determine the last time, if ever, that a problem occurred. Generally, current problems (defined as having occurred within the preceding 90 days) play a greater role in treatment or service planning than problems that occurred at a more distant time. For example, the recency items from the Work Problems section are shown in the figure below.

Figure 5.1 Work Problems recency items

WP. Work Problems

The next questions are about working at a job. For these items, a job includes a full or part-time job that you are paid for doing, including military service. If you have never worked, please answer never.

Using **Card Q**...

			Past Month	2 to 3 Months Ago	4 to 12 Months Ago	1+ Years Ago	Never
			4	3	2	1	0
WPScr/ WP1. QOLI	When was the **last** time you...						
	a.	came in late or left early from work?	4	3	2	1	0
	b.	skipped or cut work just because you didn't want to be there?	4	3	2	1	0
	c.	did badly at work or did worse at work?	4	3	2	1	0
	d.	got sick at work?	4	3	2	1	0
	e.	went to work?	4	3	2	1	0

If a participant reported experiencing work problems within the past 90 days (giving a response of "past month" (4) or "2 to 3 months ago" (3), the time frames to the left of the dotted line), it would suggest a need to initiate services to address these problems. Because the recency items identify whether a problem currently exists (i.e. within the preceding 90 days) in a given life area, they are the first items to appear in every section of the GAIN-Q3. Recency items will also indicate whether (and if so, how recently) a participant has received any kind of assistance or help with problems in any given area. For example, the recency item related to receiving assistance for work-related problems is shown below:

Figure 5.2 Work Problems recency-of-services item

WP1f.	When was the **last** time, if ever, you received any kind of help dealing with work problems (for example, talking to a counselor about problems at work, using the services of an employee assistance program, participating in mediation for dispute resolution)?	4	3	2	1	0

From an interpretive standpoint, knowledge of the most recent time a participant received help in a problem area can be crucial for planning treatment, services, or a referral (in this chapter we will usually group these together under the phrase "service planning"). Consider the difference between the following two scenarios. Participant A reported four work-related problems within the past 90 days but also reported never receiving any kind of help dealing with work problems. The likely response from staff members assessing this participant would be to recommend work-related services to help address the problems reported. Thus, the absence of services in an area identified as problematic would generally necessitate service planning for that area. Conversely, Participant B reported four work-related problems within the past 90 days but also reported receiving help dealing with work problems within the past month. In this case, the presence of services would negate the need to initiate new services for work-related problems. Instead a recommendation might be to coordinate care with any existing services to provide continued support for this participant.

The next type of item related to interpretation concerns breadth. While recency determines whether a problem is current, breadth relates to the scope of the participant's problems, or how widespread the participant's problems are. For instance, there is a significant clinical difference between a participant who reports one problem in one domain and another participant who reports four problems in the same area: The latter participant would appear to be in need of more intensive services than the first. A unique feature of the GAIN-Q3 is that it combines both recency and breadth in the same set of questions to reduce overall administration time and to maximize the quality of the information gathered. As seen in Figure 5.1 above, each item in WP1a–d covers a separate area of the participant's work life (breadth) in addition to the last time the participant experienced those problems (recency). By reviewing participant responses to only these four items, a staff person can determine whether a problem with the participant's work situation exists and how widespread or diverse the presentation of problems is.

The third interpretive concept, prevalence, is also captured in the GAIN-Q3 items. Prevalence is synonymous with frequency, or how often in the past 90 days a problem has caused distress in a particular area or how often a service has been utilized.

The Work Problems prevalence items shown in Figure 5.3 include the number of days on which the participant reported being absent, working at a job or in a business, and receiving help dealing with work problems. The more often a participant reports experiencing problems in the past 90 days, the greater the problem is likely to be and the greater the need for more intensive services to address those problems.

Taken together, recency, breadth, and prevalence can be examined for each section of the GAIN-Q3 to quickly yet comprehensively triage participants into groups based on a) no need for services; b) the need for brief intervention to address mild or moderate problems; or c) the need for more intensive services or a more detailed assessment. Further facilitating interpretation is the fact that because GAIN-Q3 questions are designed to encompass these interpretive concepts, the associated reports are organized to highlight problem areas.

Figure 5.3 Work Problems prevalence items

WP1e. **During the past 90 days**, on how many **days**...

1. were you absent from work for a full day? ..... |__|__| Days
2. did you work for money at a job or in a business? ..... |__|__| Days

[IF WP1f IS LESS THAN 3, GO TO WP2a]

Please answer the next questions using the number of days.

WP1f1. **During the past 90 days**, on how many **days** have you received any kind of help dealing with work problems? ..... |__|__| Days

5.3 Scope and Organization of the GAIN-Q3 Reports

There are four reports available from the GAIN-Q3: the Validity Report, the Q3 Individual Clinical Profile (Q3ICP), the Q3 Personalized Feedback Report (Q3PFR), and the Q3 Recommendation and Referral Summary (Q3RRS). The Q3PFR was designed specifically to be used with motivational interviewing and is covered in detail in chapter 6.

The GAIN-Q3 Validity Report contains a list of possible and definite validity issues, or inconsistencies, that arose during the administration of the interview. Inconsistencies occur when a participant's response to two or more items cannot be simultaneously true (see Chapter 3 for more information on inconsistencies). These must be reconciled to obtain the most accurate information possible for overall interpretation and for service planning.

Either after completing the GAIN-Q3 using the GAIN ABS system or after the participant's information has been data-entered, there are two reports that can be useful to determine a participant's problem severity across domains and the level of services necessitated by these problem areas: the GAIN-Q3 Recommendation and Referral Summary and the GAIN-Q3 Individual Clinical Profile.

The GAIN-Q3 Recommendation and Referral Summary (Q3RRS) is a text-based narrative designed to be edited by trained staff and shared with others across multiple service sectors (e.g., school systems, child protection workers, probation or parole offices, physician's offices) as well as third-party payers or lay people. This report can be customized by the participant's clinicians or other qualified staff members and individualized to the participant's needs.

The GAIN-Q3 Individual Clinical Profile (Q3ICP) is a more detailed report designed to help triage problems and help clinical staff quickly consider identified problem areas in light of reported current services in order to determine the participant's service needs. The report

contains detailed information specifying the rules by which self-reported information was used to generate statements regarding problem severity and service recommendations. It is generally not edited or shared beyond the participant's primary service providers.

Note that these reports are generated based on the information collected from the participant. As with all instruments based on a participant's self-reported information, the staff member interpreting the GAIN-Q3 reports (usually a clinician, which we refer to throughout this chapter) should always consider collateral sources of information that may help to further expand the understanding of the presenting problems. In addition, the scope of the information in the reports will vary depending upon the version of the GAIN-Q3 utilized. Thus, reports based on the Q3-MI will contain more information than reports based on the Q3-Standard, which in turn will contain more information than reports based on the Q3-Lite. More information about the differences between items included in each of these versions of the GAIN-Q3 can be found in chapter 1.

5.4 GAIN-Q3 Individual Clinical Profile (Q3ICP)

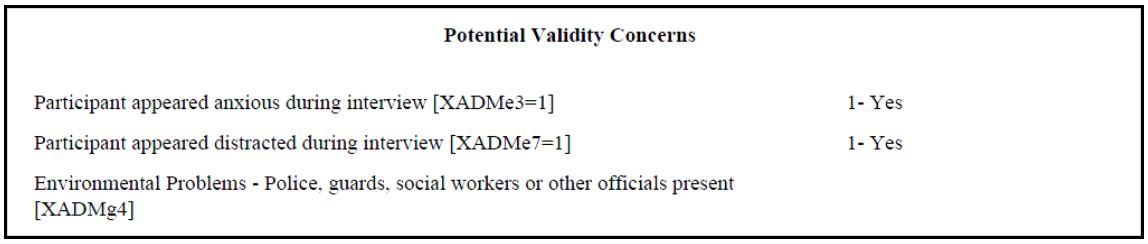
The Q3ICP is a technical report containing a summary of the participant's self-reported information on the assessment. It is organized by sections corresponding to the sections of the GAIN-Q3. The first section contains demographic information, including gender, age, race or ethnicity, highest level of education, marital status, and referral source. The next section contains information on priority populations, or groups who typically require expedited entry into treatment or services or who may require more specialized services. For example, in the Q3's Background Information section, if for item B16 the participant reports that they served in the United States armed forces, the priority population "Veteran of the U.S. armed forces [B16 = 1]" will print on the Q3ICP. The criteria used to generate a priority population statement will always be included in brackets after the statement on the Q3ICP. The priority population statements that will be automatically printed if certain criteria are met include the following:

- Veteran of the U.S. armed forces [B16 = 1]
- Pregnant [B17 = 1]
- Past-month homelessness [SS1g1 > 2]
- Involvement with the legal system [CV1f > 2]

The next section of the Q3ICP contains a list of potential validity concerns, or inconsistencies. As mentioned above, validity concerns are considered crucial to overall interpretation of the participant's self-reported information because they may indicate that the information gathered in the interview is not as accurate as possible. If the participant's responses contained validity concerns, clinicians could encounter difficulty interpreting the information to determine the most appropriate level of services necessary for the participant. The Q3ICP's validity concerns are generated from the administration ratings found in the XADM section of the GAIN-Q3 (see chapter 3). The interviewer uses these ratings to document possible validity issues, such as the presence of learning or developmental disabilities, evidence of certain observed participant

behaviors (such as depression or nervousness), the participant's location during the assessment, and whether there were any problems providing a quiet, private environment in which the interview could be conducted. Any of these factors could compromise the validity or accuracy of the responses given by the participant during the course of the interview. Consider the following example of the potential validity concerns from a sample Q3ICP report:

Figure 5.4 Q3ICP validity concerns



Potential Validity Concerns	
Participant appeared anxious during interview [XADMe3=1]	1- Yes
Participant appeared distracted during interview [XADMe7=1]	1- Yes
Environmental Problems - Police, guards, social workers or other officials present [XADMg4]	

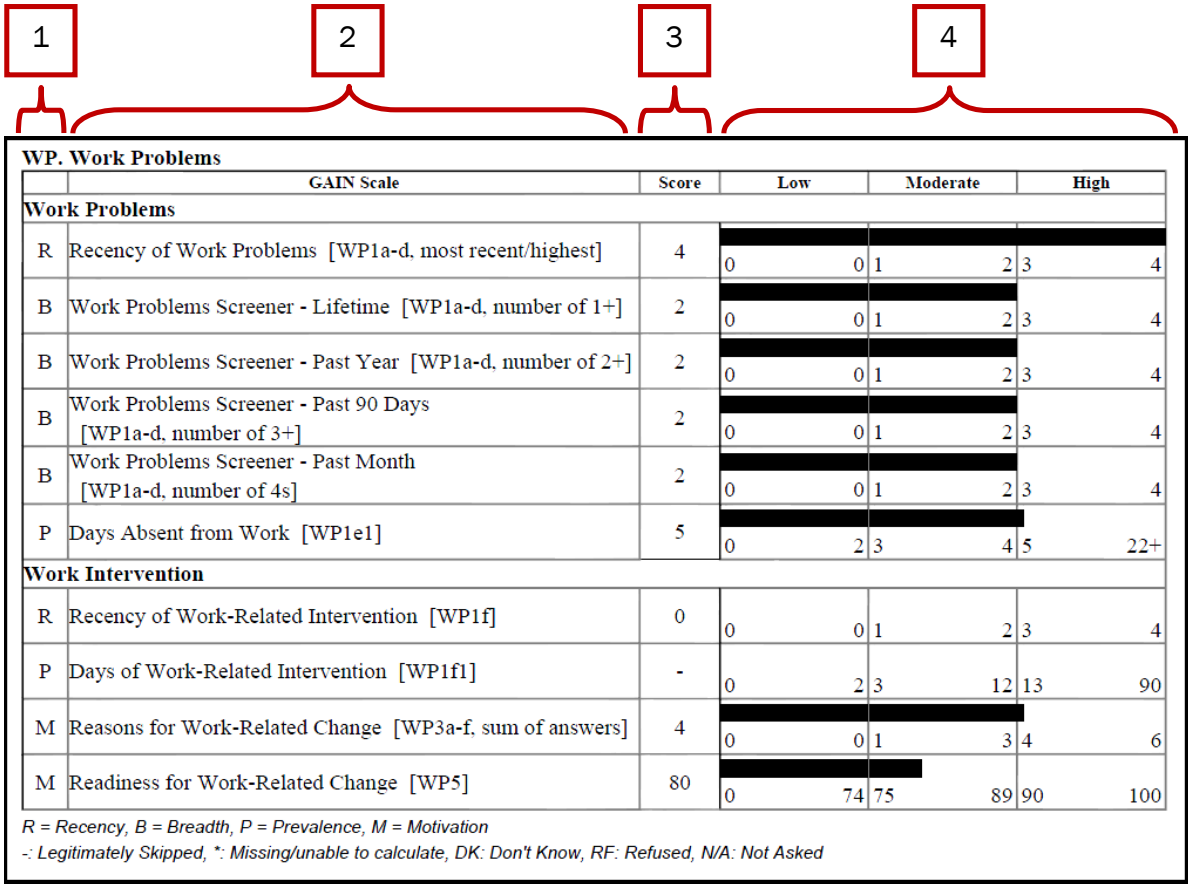
In this example, because the participant appeared anxious and distracted and because officials were present during the interview, the interpreter of the GAIN-Q3 information may have reason to suspect that the participant might have underreported problems in certain areas. These conditions can have a tangible impact on the accuracy of the information available for service planning. The importance of knowing whether there are potential validity concerns, and understanding their potential effects on interpretation and service planning, underscores the value of completing the administration ratings in the XADM section of the GAIN-Q3 immediately after the interview is concluded.

As shown on p. 25, the interviewer may also document staff notes throughout the administration of the GAIN-Q3 brief assessment. When these staff notes are keyed into the GAIN ABS, they will appear on the Q3ICP in the section after the potential validity concerns. They will be listed in the order in which they appeared in the GAIN-Q3 instrument. Staff notes can contain important information crucial to understanding the context of the participant's reported problems or services received; they can also provide information or insights on problem areas. Prior to evaluating the problem areas and issues summarized in the Q3ICP, the interpreter is encouraged to review the staff notes for context that may impact the interpretation of scores presented in the report.

Q3ICP Placement Profile Worksheet. The Q3ICP Placement Profile Worksheet (which makes up the bulk of the report) provides a graphical representation of the participant's self-report across all sections of the GAIN-Q3. The Placement Profile Worksheet is a summary table for each section of the GAIN-Q3 (School Problems, Work Problems, etc.). Each table contains scores on problem screeners and other measures related to recency, breadth, and prevalence to help the clinician interpreting the report to evaluate problem severity within a given life area. Some measures relate to problems, while others relate to services received for a particular problem area. If the Q3-MI is used, the Q3ICP will also include scores for motivational factors, such as reasons for change and readiness for change within each area.

Figure 5.5 illustrates one table from the Placement Profile Worksheet in a sample Q3ICP. For ease in understanding the layout of the table, the columns have been assigned numbers.

Figure 5.5 Placement Profile Worksheet example (Work Problems section)



WP. Work Problems

	GAIN Scale	Score	Low	Moderate	High
Work Problems					
R	Recency of Work Problems [WP1a-d, most recent/highest]	4	0 0	1 2	3 4
B	Work Problems Screener - Lifetime [WP1a-d, number of 1+]	2	0 0	1 2	3 4
B	Work Problems Screener - Past Year [WP1a-d, number of 2+]	2	0 0	1 2	3 4
B	Work Problems Screener - Past 90 Days [WP1a-d, number of 3+]	2	0 0	1 2	3 4
B	Work Problems Screener - Past Month [WP1a-d, number of 4s]	2	0 0	1 2	3 4
P	Days Absent from Work [WP1e1]	5	0 2	3 4	5 22+
Work Intervention					
R	Recency of Work-Related Intervention [WP1f]	0	0 0	1 2	3 4
P	Days of Work-Related Intervention [WP1f1]	-	0 2	3 12	13 90
M	Reasons for Work-Related Change [WP3a-f, sum of answers]	4	0 0	1 3	4 6
M	Readiness for Work-Related Change [WP5]	80	0 74	75 89	90 100

R = Recency, B = Breadth, P = Prevalence, M = Motivation
*-: Legitimately Skipped, *: Missing/unable to calculate, DK: Don't Know, RF: Refused, N/A: Not Asked*

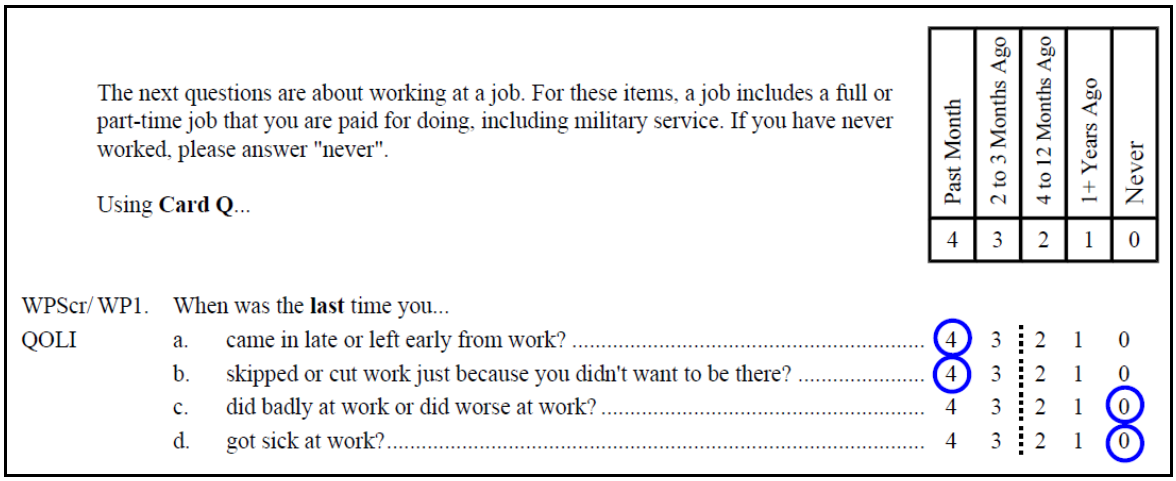
Column 1: Recency, Breadth, Prevalence, and Motivation Measures

Column 1 denotes whether the GAIN scale is a recency (marked as R), breadth (B), prevalence (P), or motivation (M) measure. Recall that these types of measures aid interpretation by helping clinicians quickly identify problem areas for prioritizing service needs. Recency, breadth, and prevalence were discussed earlier; motivation measures help clinicians identify the level of motivation to change as well as the number of specific reasons for wanting to change within an identified problem area. Again, the motivation measures are available only if the Q3-MI is used; otherwise these rows will be marked as "N/A" for "not asked."

Column 2: GAIN Scale

Column 2 provides the name of the GAIN-Q3 scale included within each section of the GAIN-Q3 along with a description of the specific items that were used to calculate the scale. For example, the first GAIN-Q3 scale in the figure above is Recency of Work Problems. In brackets, this is described as "WP1a–d, most recent/highest." This means that the score is determined by the most recent time frame reported in WP1a–d. The figure below illustrates the items used to generate the Recency of Work Problems measure.

Figure 5.6 Items in Recency of Work Problems measure



The next questions are about working at a job. For these items, a job includes a full or part-time job that you are paid for doing, including military service. If you have never worked, please answer "never".

Using **Card Q**...

			Past Month	2 to 3 Months Ago	4 to 12 Months Ago	1+ Years Ago	Never
			4	3	2	1	0
WPScr/ WP1. QOLI	When was the **last** time you...						
	a.	came in late or left early from work?	4	3	2	1	0
	b.	skipped or cut work just because you didn't want to be there?	4	3	2	1	0
	c.	did badly at work or did worse at work?	4	3	2	1	0
	d.	got sick at work?	4	3	2	1	0

In this example, the participant would score 4 on the Recency of Work Problems measure because they reported last experiencing work-related problems within the past month, which equals 4 according to the scoring logic.

Column 3: Score

The third column contains the score for the participant on each measure, calculated by the logic included in brackets next to each GAIN scale. Each score is based on either the response codes (as in the problem screeners, where 4 equals past month, 3 equals 2 to 3 months ago, etc.) or the number of days of reported problems. The clinician or other staff person interpreting the Q3ICP is advised to review the GAIN Scale column to determine what the score references:

- the number of problems reported
- the number of days that the participant experienced a particular problem
- the percent readiness to change in a problem area (motivation items)
- the number of reasons to change (motivation items)

In some situations, the Score column may not include a numeric score. For example, the Score column will print a dash (-) if there were any questions that were legitimately skipped during

the interview or an asterisk (*) for questions that were skipped but should have been asked. Additionally, if the participant responds that they don't know the answer to a question or they refuse to answer a question, the Score column would reflect that with a "DK" for "don't know" responses or an "RF" for any items that the participant refused to answer. If the Q3-MI is not used, the score column will display "N/A" (not asked) for the motivation items, since reasons for change and readiness for change questions are not asked in the Q3-Lite or Q3-Standard.

Column 4: Low, Moderate, and High Interpretive Cut-Points

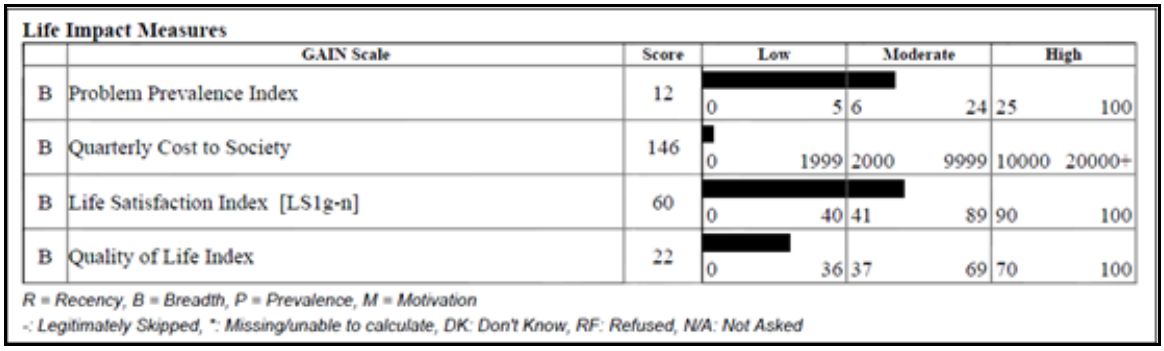
A unique feature of the Q3ICP is the use of interpretive cut-points to help clinicians and other staff members readily identify both problems and strengths across each section of the GAIN-Q3. The first half of the table within each section of the Q3ICP addresses problems in a given domain. The black bar in each row indicates clinical severity within that problem area, divided into low, moderate, and high cut-points. For example, in the figure above, the participant scored in the high range of the Recency of Work Problems the Days Absent from Work measures. Taken together, this indicates that addressing work problems would be a priority for treatment planning.

The second half of the table within each section (see Figure 5.5 above) addresses interventions, or services received, in a given domain. The black bar in each row indicates the extent to which the participant has received services for problems within that life area, again divided into low, moderate, and high cut-points. The Interventions subsection also includes measures of motivation, which provide clinicians and other staff members with an indication of how motivated the participant is to make positive changes in each area as well as the number of reasons for change that they reported. For example, in Figure 2.7 above, the participant did not report any service to help with work problems (as indicated by the score of 0 in the Recency of Work-Related Intervention measure). This would indicate that treatment planning should incorporate services related to helping the participant with work problems. In terms of motivation, in the Interventions subsection the participant scored in the high range of Reasons for Work-Related Change measure and in the moderate range of the Readiness for Work-Related Change measure. Taken together, these indicate that despite the absence of current services to address problems with work environment, the participant has a significant number of self-reported reasons for wanting to make changes related to work problems and is moderately motivated to make these changes.

Life Impact Measures

As discussed in Chapter 1, the GAIN-Q3's Life Impact Measures include the Problem Prevalence Index (PPI), Quarterly Cost to Society Index (QCS), Life Satisfaction Index (LSI), and the Quality of Life Index (QOLI). Together these measures provide a unique lens on the costs associated with life problems and the benefits associated with improving the participant's life situation. They appear in the Q3ICP as shown in Figure 5.7.

Figure 5.7 Q3ICP Life Impact Measures



Life Impact Measures

	GAIN Scale	Score	Low	Moderate	High
B	Problem Prevalence Index	12	0 5	6 24	25 100
B	Quarterly Cost to Society	146	0 1999	2000 9999	10000 20000+
B	Life Satisfaction Index [LS1g-n]	60	0 40	41 89	90 100
B	Quality of Life Index	22	0 36	37 69	70 100

R = Recency, B = Breadth, P = Prevalence, M = Motivation

*-: Legitimately Skipped, *: Missing/unable to calculate, DK: Don't Know, RF: Refused, N/A: Not Asked*

Descriptions of these cross-domain measures appear below the Life Impact Measures table on the Q3ICP. Interpretively, the values on the Life Impact Measures will vary according to the complexity inherent in a participant's life. Some general observations are that as the complexity of life problems increase, measures of problem prevalence and quarterly costs to society tend to also increase. As complexity of life problems decreases, the participant's overall quality of life and life satisfaction should increase.

Problem Prevalence Index (PPI)

The Problem Prevalence Index is derived from 23 items across all sections of the GAIN-Q3. The PPI is the percent of days during the preceding 90 that the participant reported experiencing problems across all life areas. Higher scores on this index indicate greater problem prevalence across multiple life domains and the need for more intensive initial services designed to target multiple life areas; lower scores indicate the opposite.

Quarterly Cost to Society (QCS)

The Quarterly Cost to Society Index provides an estimate of the monetary value of services that the participant reported receiving during the 90 days prior to the GAIN-Q3 interview. Each of the 19 services included in the Q3 (health care utilization, substance abuse treatment, criminal justice system intervention, mental health treatment, etc.) is assigned a unit cost to society. The total value of the services reported by the participant is an estimate of the costs to society. Higher scores on the QCS indicate that the participant has been utilizing more expensive types of services to address problems experienced. In terms of treatment planning, staff members should review the services received and their impact on the participant's reported problems. If appropriate, consider less intensive services that would provide less expensive options for continuing care for the participant.

Life Satisfaction Index (LSI)

The Life Satisfaction Index is calculated based on the participant's responses to the Life Satisfaction questions appearing on the Q3-Standard and Q3-MI, depicted in Figure 5.8.

Figure 5.8 GAIN-Q3 Life Satisfaction Index

LS. Life Satisfaction

The next questions are about how satisfied you feel with different parts of your life. After you hear each question, please tell me **how satisfied** you currently feel by using **Card I** and responding "very satisfied," "satisfied," "mixed," "dissatisfied," or "very dissatisfied."

		Very Satisfied	Satisfied	Mixed	Dissatisfied	Very Dissatisfied
		5	4	3	2	1
LS1.	**Currently**, how satisfied are you with...					
	g. your sexual or marital relationships?	5	4	3	2	1
	h. your family relationships?	5	4	3	2	1
	j. your general level of happiness?	5	4	3	2	1
	k. where you are living?	5	4	3	2	1
	m. how your life is going so far?	5	4	3	2	1
	n. your school or work situation?	5	4	3	2	1

Together, these items are used to create a measure of the participant's overall life satisfaction across multiple life areas. While the other three Life Impact Measures are created using items across multiple sections of the GAIN-Q3, the LSI is the only one that is calculated based on its own section in the instrument. Higher scores on the LSI indicate greater levels of satisfaction. With the use of the GAIN-Q3 Follow-Up, clinicians can measure changes in a participant's life satisfaction from initial assessment to discharge and beyond when follow-ups are administered at quarterly intervals.

Quality of Life Index (QOLI)

The Quality of Life Index is based on the past-year results from each of the GAIN-Q3's nine problem screeners. As participants report lower problem prevalence across the sections in the Q3, the score on the QOLI will increase. Thus, higher scores are desirable because they indicate lower problem prevalence. Use of the GAIN-Q3 Follow-Up enables clinicians and other staff members to measure improvements in a participant's overall quality of life over time.

5.5 Practical Application of the Q3ICP

The Q3ICP should be used as a practical tool to assist clinicians with quickly triaging participants based on their immediate need for treatment, services, or interventions. The Q3ICP can be generated immediately after entering the participant's information into GAIN ABS and should be used to facilitate service planning. Practical application of the GAIN scales and other information contained in the report can be used to "FIND" key pieces of information about the participant that can then be used to prioritize problem severity across all GAIN-Q3 assessment areas.

Basic Steps for Practical Application of the Q3ICP

F – Flag areas of significance
I – Identify the impact of services or interventions
N – Notice potentially conflicting information
D – Determine problem areas in need of services, treatment, referral, or additional assessment

Flag Areas of Significance. The first in the series of four FIND steps involves the clinician utilizing the concept of recency, breadth, and prevalence depicted in the GAIN Scales column on the Q3ICP. The first GAIN scale shown in the Q3ICP displays the recency of problems in each domain. This will be followed by breadth items, which measure the diversity of the symptoms (or the count of problems in each area). The clinician can review a section and identify at a glance the recency and breadth of a problem by viewing the bar graph. While it is possible that some participants will report problems in all nine life areas of the Q3, others will not. The interpretive task for the clinician working with the case is to quickly identify the areas where the participant has significant problems in order to prioritize treatment planning. Consider the example in Figure 5.9, in which the section presented is School Problems:

Figure 5.9 School Problems Screener section of Q3ICP

SP. School Problems

	GAIN Scale	Score	Low	Moderate	High
School Problems					
R	Recency of School Problems [SP1a-d, most recent/highest]	4	0 0	1 2	3 4
B	School Problems Screener - Lifetime [SP1a-d, number of 1+]	4	0 0	1 2	3 4
B	School Problems Screener - Past Year [SP1a-d, number of 2+]	4	0 0	1 2	3 4
B	School Problems Screener - Past 90 Days [SP1a-d, number of 3+]	3	0 0	1 2	3 4
B	School Problems Screener - Past Month [SP1a-d, number of 4s]	1	0 0	1 2	3 4
P	Days Absent from School [SP1e1]	4	0 2	3 4	5 22+

The clinician or other staff person reviewing the School Problems table can readily see that the participant scored in the high range of the Recency of School Problems measure and the School Problems Screeners, with three of the four reported problems having occurred within the past 90 days. It is clear from the figure above that school problems should be a priority area for the participant's service planning.

However, in Figure 5.10 below, the participant reported having experienced physical health problems within the past year, as evidenced by a score of 2 on the Recency of Physical Health Problems measure. Reviewing the description of the measure in brackets for the Health Problems Screener, we see that this particular screener considers participant responses to the six items in PH1a–f. The participant reported only one past-year physical health problem in this series, which falls just into the moderate range. In this case, though there is evidence of a

past-year problem, the participant did not report any issues within the past month, and thus, physical health problems would likely not be a priority for service planning.

Figure 5.10 Health Problems Screener section of Q3ICP

PH. Physical Health

	GAIN Scale	Score	Low	Moderate	High
Physical Health Problems					
R	Recency of Physical Health Problems [PH1a-e, most recent/highest]	2	0 0	1 2	3 4
B	Health Problems Screener - Lifetime [PH1a-e, number of 1+]	1	0 0	1 2	3 4
B	Health Problems Screener - Past Year [PH1a-e, number of 2+]	1	0 0	1 2	3 4
B	Health Problems Screener - Past 90 Days [PH1a-e, number of 3+]	0	0 0	1 2	3 4
B	Health Problems Screener - Past Month [PH1a-e, number of 4s]	0	0 0	1 2	3 4
P	Days of Physical Health Problems [PH2a-c, sum of answers, max 90]	0	0 2	3 12	13 90

Identify the Impact of Services and Interventions. The Q3ICP is organized with both problems and interventions in a life area summarized in the same table. This enables the clinician or other staff person interpreting the information to quickly determine whether a service or intervention is present in a problem area and whether those services have made an impact on any reported problems. In Figure 5.10 we examined a participant's Physical Health section to determine whether that was an area to prioritize in service planning. Below is the Physical Health section summary from the participant's Q3ICP, showing both physical health problems and interventions.

Figure 5.11 Physical Health section of the Q3ICP

PH. Physical Health

	GAIN Scale	Score	Low	Moderate	High
Physical Health Problems					
R	Recency of Physical Health Problems [PH1a-e, most recent/highest]	2	0 0	1 2	3 4
B	Health Problems Screener - Lifetime [PH1a-e, number of 1+]	1	0 0	1 2	3 4
B	Health Problems Screener - Past Year [PH1a-e, number of 2+]	1	0 0	1 2	3 4
B	Health Problems Screener - Past 90 Days [PH1a-e, number of 3+]	0	0 0	1 2	3 4
B	Health Problems Screener - Past Month [PH1a-e, number of 4s]	0	0 0	1 2	3 4
P	Days of Physical Health Problems [PH2a-c, sum of answers, max 90]	0	0 2	3 12	13 90
Physical Health Intervention					
R	Recency of Physical Health Treatment [PH1f]	2	0 0	1 2	3 4
P	Days of Physical Health Treatment [PH1f1-5, sum of answers, max 90]	-	0 0	1 12	13 90
M	Reasons for Physical Health-Related Change [PH4a-f, sum of answers]	-	0 0	1 3	4 6
M	Readiness for Physical Health-Related Change [PH6]	-	0 74	75 89	90 100

R = Recency, B = Breadth, P = Prevalence, M = Motivation

*-: Legitimately Skipped, *: Missing/unable to calculate, DK: Don't Know, RF: Refused, N/A: Not Asked*

We saw earlier (Figure 5.10) that this participant reported past-year physical health problems (top half of the table) but none within the past 90 days. From the Physical Health Intervention subsection (bottom half of the table), we see that the participant reported last receiving physical health treatment 4 to 12 months ago (recall from Chapter 2 that on card Q, "2" corresponds to "4 to 12 months ago," or what would be considered the past year). Using just the information available in this table, the clinician could deduce that the participant last experienced a physical health problem 4 to 12 months ago, received care (presumably for that problem) within the same time frame, and is experiencing no current (i.e., past-90-day) physical health problems. In other words, the participant received an intervention for the reported problem, and the intervention received was sufficient enough to reduce or alleviate the problem. In light of the fact that a prior intervention appears to have resolved the problem reported, the main service-planning recommendation might be simply to monitor the participant's physical health in order to ensure that the problem does not recur in the future.

Notice Potentially Conflicting Information. The GAIN-Q3, like all self-report assessments, is limited by the veracity of the information disclosed by the participant and is subject to possible underreporting or overreporting (intentionally or not) as well as deliberate misrepresentation. The Q3ICP can be used to help identify these areas quickly by reviewing GAIN scale scores across domains. Consider the following example from the Substance Use Problems section on the Q3ICP.

Figure 5.12 Substance Use section of the Q3ICP

SU. Substance Use

	GAIN Scale	Score	Low		Moderate		High	
Substance Use Problems								
R	Recency of Substance Use Problems [SU1a-e, most recent/ highest]	0	0	0	1	2	3	4
B	Substance Disorder Screener - Lifetime [SU1a-e, number of 1+]	0	0	0	1	2	3	5
B	Substance Disorder Screener - Past Year [SU1a-e, number of 2+]	0	0	0	1	2	3	5
B	Substance Disorder Screener - Past 90 Days [SU1a-e, number of 3+]	0	0	0	1	2	3	5
B	Substance Disorder Screener - Past Month [SU1a-e, number of 4s]	0	0	0	1	2	3	5
P	Days Drunk or High Most of the Day [SU3b]	15	0	1	1	12	13	90
P	Days of Use in the Past 90 Days [SU3b, 90 - SU3a, most/ highest]	30	0	0	1	44	45	90
P	Days of Substance Use 90 days prior to controlled environment [90-SU5a]	-	0	0	1	12	13	90

Though the participant reported using alcohol or other drugs on 30 of the past 90 days (second row from the bottom) and being drunk or high for most of the day on 15 of those days (third row from the bottom), this participant did not report any of the substance-related problems on either the Recency of Substance Use Problems measure or the Substance Disorder Screeners. It is possible to review the specific questions on the Substance Disorder Screener because the items are listed in brackets. The GAIN-Q3 items used to measure both Recency

of Substance Use Problems and the Substance Disorder Screener are items SU1a–e, shown in Figure 5.13 below.

Recall from the Substance Use section on the Q3ICP that the participant had reported using alcohol or other drugs on 30 of the past 90 days. The GAIN-Q3 measures problems using a 90-day time frame. Recall from Chapter 2 that 90 days equals approximately 13 weeks. Thus, if a participant reported using on 13 or more of the past 90 days, on average it would be considered using alcohol or other drugs weekly or more often. However, as shown above, this participant did not report having used alcohol or other drugs weekly or more often, which conflicts with the report of having used on 30 of the past 90 days. The clinician or other staff person responsible for interpreting this participant's self-reported information can surmise that the participant was either overreporting the number of days that they used alcohol or other drugs, underreporting their problems associated with substance use, or a combination of the two factors.

Figure 5.13 Q3 Substance Disorder Screener

SU. Substance Use

The next questions are about your use of alcohol and other drugs. Alcohol includes beer, wine, whiskey, gin, scotch, tequila, rum or mixed drinks. "Other drugs" include a) marijuana, b) other street drugs like crack, heroin, PCP, or poppers, c) inhalants like glue or gasoline and d) any **non-medical** use of prescription-type drugs. Please do not include any prescription drugs you used only as instructed by a doctor.

Using **Card Q**...

			Past Month	2 to 3 Months Ago	4 to 12 Months Ago	1+ Years Ago	Never
			4	3	2	1	0
SDScr/ QOLI	SU1.	When was the **last** time...					
	a.	you used alcohol or other drugs weekly or more often?	4	3	2	1	(0)
	b.	you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	(0)
	c.	you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	(0)
	d.	your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home or social events?	4	3	2	1	(0)
	e.	you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	(0)

Identifying such conflicts in self-reported information helps users more accurately plan for services. Using the example described above, with the conflict between the Substance Disorder Screener and the items on use during the past 90 days, the clinician cannot rely solely on the Substance Disorder Screener to determine problem severity. In this instance, the clinician should first try to clarify the items with the participant to see whether there's been some misunderstanding: "I might have made a mistake, but at first you reported never using alcohol or other drugs weekly or more often, and you also reported never spending a lot of time using

alcohol or other drugs. But then you said that you used on 30 of the past 90 days, and you were drunk or high for most of the day on 15 days. Do you see what I mean?" If the participant can't explain this inconsistency, the clinician might consider recommending a urine drug screen to confirm or rule out the presence of specific substances in the participant's system. Recall that the GAIN-Q3 can indicate the presence of a possible substance-related disorder, but it does not include the diagnostic criteria required for a substance abuse or substance dependence diagnosis as detailed in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV-TR). The validity-concerns section of the Q3ICP is a great help when clarifying validity concerns such as presented in the example above, as is the Validity Report.

Determine Areas in Need of Planning. Each of the preceding three steps in the practical application of the Q3ICP help to identify areas in need of treatment or service planning or more detailed assessment, as shown in the Substance Use section example above. In cases such as these, sometimes there is not enough information available, or the information that is available might lack the validity or accuracy necessary for service planning. When this occurs, a default recommendation can be to refer or recommend a more detailed assessment in a particular life area in order to determine the true nature and extent of the problem.

Using these basic FIND steps, the clinician or other staff person planning the participant's services can quickly identify primary problem areas, identify whether services or interventions are in place (or once were), identify validity concerns, and determine areas in need of treatment planning. The interpretation of the information presented in the Q3ICP, using the practical application of the FIND elements, should dovetail with use of the GAIN-Q3 Recommendation and Referral Summary (Q3RRS).

5.6 GAIN-Q3 Recommendation and Referral Summary (Q3RRS)

The GAIN-Q3 Recommendation and Referral Summary (Q3RRS) is a narrative of the participant's self-reported information. Because there are three different versions of the GAIN-Q3 (Lite, Standard, and MI), the Q3RRS will vary in content depending on the version of the instrument used, with the Q3-MI and Q3-Standard providing the most content. As mentioned previously, the GAIN-Q3 is a self-report instrument, so the narrative of the unedited Q3RRS is based only on that self-reported information. By synthesizing the participant's self-report with staff judgment and other collateral information, the final edited product can be a more effective tool for meeting the participant's identified needs. The Q3RRS is fully editable, and GAIN-Q3 users are strongly encouraged to edit the Q3RRS to individualize the report for each participant's unique presenting concerns and treatment and service needs. Editing should take at most 20 to 30 minutes.

The Q3RRS is similar in organization to the Q3ICP and follows the order of sections of the GAIN-Q3 itself. The GAIN-Q3 covers a wide range of life areas to cast a wide net when screening for potential problem areas. A benefit of gathering information across the Q3's nine sections is to provide staff members with sufficient information to efficiently individualize

service planning. In consideration of the variety of settings where the GAIN-Q3 may be utilized (employee assistance programs, student assistance programs, health clinics, juvenile and criminal justice programs, child welfare programs, mental and substance abuse treatment programs, among others), the Q3RRS was designed to be easily customized for specific service sectors or shared across sectors; it can be edited as required by agency, local, state, or federal reporting requirements.

Prompts. Each section of the Q3RRS contains one or more prompts, which are meant to provide the clinician or other staff member with general tips on how each section could be edited. For example, in the Presenting Information section, the first prompt instructs the clinician making the edits to "Expand on reason referred." The user can then insert additional information on why the participant was being referred to assessment.

Throughout each section of the Q3RRS, a common prompt will instruct the user to "Enter collateral information obtained about problems in relevant areas." As mentioned previously, because the GAIN-Q3 is a self-report instrument, additional sources of information should always be considered to provide a more robust understanding of the context surrounding the participant and their reported problems. Another type of prompt appears at the end of each assessment area (School Problems, Work Problems, etc.) in a section devoted to intervention placement and planning recommendations. Here the prompt instructs the user to "Review, delete, or edit according to specific needs and clinical indications." More information on intervention placement and planning recommendations is presented later in this chapter.

The last prompt in the Q3RRS pertains to summary recommendations. The Q3RRS will not generate a level-of-care placement recommendation. This is best left to trained clinicians and other staff members who have the proper experience and qualifications to make such recommendations. Instead, users are prompted to "Enter recommendations for placement or referral to specific local agencies, programs or people. Comment on any special barriers to placement and what might be done about them."

These prompts are the minimum suggestions for editing. In other words, the clinician or other staff person editing the Q3RRS has the ability to edit more or less than prompted depending on considerations such as agency or program requirements, among other factors. The Q3RRS is designed to be a tool to augment clinical judgment and staff knowledge, skills, and abilities, including education and experience, in order to support decision-making.

5.7 Service and Referral Planning with the Q3RRS

As discussed previously in this chapter, prioritizing problem severity is accomplished through consideration of recency, breadth, and prevalence. The goal of the Q3RRS is to apply these concepts across the nine assessment areas, thereby providing a mechanism by which problem areas can be flagged as having high clinical significance or importance in service planning.

Across each assessment area in the Q3RRS, the following information will be automatically generated:

- Problems
- Interventions
- Reasons and readiness to change (if using the Q3-MI)

Prioritizing Problem Severity and Service Need in the Q3RRS. To facilitate prioritizing areas for treatment planning, GAIN ABS uses a particular logic, summarized in the following Categories of Need and Placement grid, to create treatment planning statements. The two intersecting factors in this grid are problem recency and service/intervention history.

Table 5.1 Categories of Need and Placement grid

Service/Intervention History	Problem Recency: None	Past	Current/Recent: Moderate severity	Current/Recent: High severity
None	**1.** No problem	**2.** Past problem; no current service/ intervention	**3.** Moderate problems; no current service/ intervention	**4.** Severe problems; no current service/ intervention
Past	**0.** Not logical *Check for misunderstanding of problem or misrepresentation and recode.*	*Consider monitoring and relapse prevention.*	*Consider initial or low-invasive treatment.*	*Consider more intensive treatment or intervention strategies.*
Current		**5.** No current problems; current service/ intervention *Review for step-down or discharge.*	**6.** Moderate problems; current service/ intervention *Review need to continue or step up.*	**7.** Severe problems; current service/ intervention *Review need for more intensive or assertive treatment.*

In the GAIN-Q3, the participant provides information about both problem recency and service/intervention history, enabling the GAIN ABS system to automate placement in one of the categories illustrated above. This is done for every assessment area in the GAIN-Q3 within the Q3RRS. Based on these categories, GAIN ABS will automatically generate a list of intervention placement and planning recommendations depending on whether the participant has an identified problem, how severe that problem is, and whether the participant currently receives a service or intervention to address that problem.

In exploring each of these categories, the user will have an understanding of scenarios that would trigger placement in a particular category as well as the logic of specific items used to place a participant in one category over another. Based on collateral or other information, the clinician or other staff person editing the Q3RRS may elect to change these categories. Please note that changing a category within GAIN ABS will also change the list of default recommendations that are generated.

Category 0 is "not logical," meaning the information provided by the participant in a particular assessment area contains inconsistencies that need to be clarified before a determination of problem severity can be made. For example, if a participant reported recently receiving physical health treatment but also reported that they have never been bothered by a physical health problem, it would trigger category 0. In this scenario, category 0 should prompt the staff to seek additional information about the participant's physical health history to obtain more accurate information.

Unlike category 0, category 1, "no problem," is logical. For example, consider responses an adolescent might give in response to questions in the Work Problems section of the Q3. If the participant reports that they had never had a job and thus have never had any work-related problems nor received an intervention related to work-problems, then they would fall into category 1. This indicates that there is no problem in this area and that there is no history of interventions in this nonproblematic area.

In categories 2 through 7, the participant has reported a lifetime history of a problem. The problem recency categories are thus past problem, current moderate problem, or current severe problem. The primary difference between the top and bottom rows of the grid is that the top row indicates no current (i.e., past-90-day) service, while the bottom row indicates the presence of a current service. GAIN ABS will print customized treatment recommendations based on participant responses to specific items on the GAIN-Q3 as shown below. (Note that the clinician or other staff person editing the Q3RRS may elect to change the default category placement within GAIN ABS. Clinical judgment or judgment based on professional experience and knowledge should always overrule a default categorization.)

School Problems

Past Problem	• Any school problems lifetime [any SP1a–d > 0]
Moderate Problem	• Any school problems in the past 90 days [any SP1a–d > 2]; or • More than two absences in the past 90 days [SP1e1 > 2]
Severe Problem	• 3 or more school problems in the past 90 days [3 or more problems in SP1a–d > 2]; or • More than four absences in the past 90 days [SP1e1 > 4]
Lifetime Intervention History	• Any lifetime history of help with school [SP1f > 0]
Current Intervention	• Help with school during the past 90 days [SP1f > 2 *or* SP1f1 > 0]

Work Problems

Past Problem	• Any work problems lifetime [any WP1a–d > 0]
Moderate Problem	• Any work problems in the past 90 days [any WP1a–d > 2]; or • More than two absences in the past 90 days [WP1e1 > 2]
Severe Problem	• 3 or more work problems in the past 90 days [3 or more problems in WP1a–d > 2]; or • More than four absences in the past 90 days [WP1e1 > 4]
Lifetime Intervention History	• Any lifetime history of help with work [WP1f > 0]
Current Intervention	• Help with work during the past 90 days [WP1f > 2 *or* WP1f1 > 0]

Physical Health

Past Problem	• Any physical health problems lifetime [any PH1a–e > 0]
Moderate Problem	• Any physical health problems in the past 90 days [any PH1a–e > 2]; or • More than 2 days of physical health problems, functional impairment from physical health problems, or using tobacco in the past 90 days [sum of PH2a–c > 2]
Severe Problem	• 3 or more physical health problems in the past 90 days [3 or more problems in PH1a–e > 2]; or • More than 12 days of physical health problems, functional impairment from physical health problems, or tobacco use in the past 90 days [sum of PH2a–c > 12]
Lifetime Intervention History	• Any lifetime history of physical health care utilization [PH1f > 0]
Current Intervention	• Physical health care utilization in the past 90 days [PH1f > 2 *or* sum of PH1f1–5 > 0]

Sources of Stress

Past Problem	• Any stress problems lifetime [any SS1a–g > 0]
Moderate Problem	• Any stress problems in the past 90 days [any SS1a–g > 2]; or • More than 2 days of stress or financial problems in the past 90 days [sum of SS2a–b > 2]
Severe Problem	• 3 or more stress problems in the past 90 days [3 or more problems in SS1a–g > 2]; or • More than 12 days of stress or financial problems in the past 90 days [sum of SS2a–b > 12]

Lifetime Intervention History	• Any lifetime history of help with stress [SS1h > 0]
Current Intervention	• Help with stress in the past 90 days [SS1h > 2 *or* SS1h1 > 0]

Risk Behaviors

Past Problem	• Any risk behavior problems lifetime [any RB1a–m2 > 0]
Moderate Problem	• Any risk behavior problems in the past 90 days [any RB1a–m2 > 2]; or • More than 2 days of risk behaviors related to sex, needle use or victimization in the past 90 days [sum of RB2a–c > 2]
Severe Problem	• 3 or more risk behavior problems in the past 90 days [3 or more problems in RB1a–m2 > 2]; or • More than 12 days of risk behaviors related to sex, needle use or victimization in the past 90 days [sum of RB2a–c > 12]
Lifetime Intervention History	• Any lifetime history of risk behavior–related intervention [RB1n > 0]
Current Intervention	• Risk behavior–related intervention the past 90 days [RB1n > 2 *or* RB1n1 > 0]

Mental Health

Past Problem	• Any mental health or behavioral problems lifetime [any MH1a–f > 0 *or* MH2a–g > 0]
Moderate Problem	• Any mental or behavioral problems in the past 90 days [MH1a–f > 2 *or* MH2a–g > 2]; or • More than 2 days of mental or behavioral problems in the past 90 days [sum of MH3a–d > 2]
Severe Problem	• 3 or more mental or behavioral problems in the past 90 days [3 or more problems in MH1a–f > 2 *or* 3 or more problems in MH2a–g > 2]; or • More than 12 days of mental or behavioral problems in the past 90 days [sum of MH3a–d > 12]
Lifetime Intervention History	• Any lifetime utilization of mental health care [MH2h > 0]
Current Intervention	• Mental health care utilization in the past 90 days [MH2h > 2 *or* sum of MH2h1–4 > 0]

Substance Use

Past Problem	• Any substance use problems lifetime [any SU1a–e > 0 *or* SU5c > 0]
Moderate Problem	• Any substance use problems in the past 90 days [any SU1a–e > 2 *or* SU3c > 0]; or • More than 2 days of having 5+ alcoholic drinks or getting drunk [SU4b > 2]; or • Any days of substance use in the past 90 days [any SU4b–s > 0]
Severe Problem	• 3 or more substance use problems in the past 90 days [3 or more problems in SU1a–e > 2]; or • More than 12 days of substance use problems in the past 90 days [SU3c > 12]; or • More than 12 days of alcohol intoxication in the past 90 days [SU4b > 12]; or • More than 12 days of other drug use in the past 90 days [sum of SU4c–s > 12]
Lifetime Intervention History	• Any lifetime history of substance abuse treatment or related intervention [SU1f > 0]
Current Intervention	• Substance abuse treatment or related intervention in the past 90 days [SU1f > 2 *or* sum of SU2a–d > 0]

Crime and Violence

Past Problem	• Any crime/violence problems lifetime [any CV1a–e > 0]
Moderate Problem	• Any crime/violence problems in the past 90 days [any CV1a–e > 2]; or • More than 2 days of arguing or violence toward others in the past 90 days [CV3 > 2]; or • Any illegal activity in the past 90 days [sum of CV4a–c > 2]
Severe Problem	• 3 or more crime/violence problems in the past 90 days [3 or more problems in CV1a–e > 2]; or • More than 12 days of arguing/violence toward others in the past 90 days [CV3 > 12]; or • More than 12 days of illegal activity or functional impairment from crime/violence problems in the past 90 days [sum of CV4a1–a3 > 12]
Lifetime Intervention History	• Any lifetime history of criminal justice intervention [CV1f > 0]
Current Intervention	• Criminal justice intervention the past 90 days [CV1f > 2 *or* sum of CV2a–e > 0 *or* CV4b > 0]

Intervention Placement and Planning Recommendations

As stated previously, the category placement will be determined according to a specific set of criteria (described above), which will, in turn, be used to create a set of default intervention placement and planning recommendations designed to meet the needs of a participant who falls within a particular category.

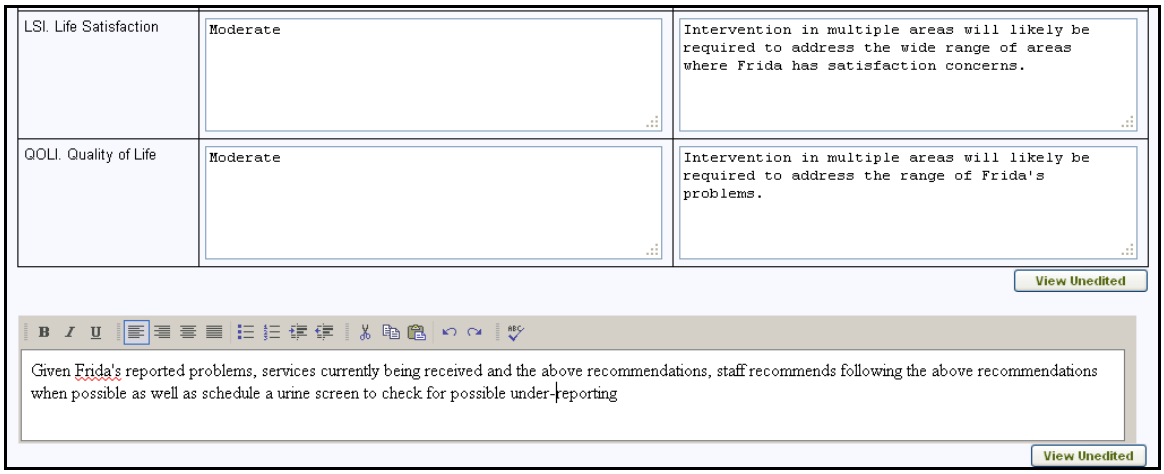
The intervention placement and planning recommendations generated should be reviewed, edited, and individualized. The clinician or other staff person has the capability to change, delete, or write new recommendations to meet the unique needs of each participant assessed. In this manner, the goal is to target the treatment or services/interventions recommended to the needs identified via the GAIN-Q3 assessment.

Summary Recommendations

The Summary Recommendations section contains a summary of any priority population issues (such as veteran status or involvement with the legal system) and recommendations to coordinate care across any systems of care with which the participant is currently involved. This section also features a summary table of the participant's status across all sections assessed in the GAIN-Q3. Though the clinician or staff person editing the Q3RRS has the capability to edit and individualize intervention placement and planning recommendations throughout the Q3RRS, in the Summary Recommendations section, the summary table provides only a synopsis of problem status and a summary of recommendations across all sections.

Following the summary table, the clinician or other staff person can enter specific placement recommendations as well as any specific overall summary recommendations related to programs, referrals, or interventions appropriate for the participant's identified needs.

Figure 5.14 Summary Recommendation example



6. Delivering Motivational Feedback Following GAIN-Q3 Administration: The CHOICE Model

Douglas C. Smith

Nothing so needs reforming as other people's habits.
—Mark Twain

6.1 Introduction

We all want our clients to be receptive to our ideas about how change should occur, what treatment is needed, and why it should be a top priority in their lives. However, ask any health services professional about how many of their clients "comply" with their advice, and you will probably hear that "compliance" is often low. Historically, this has been a major problem in the mental health and substance abuse treatment fields, with studies showing that as few as 12 to 15% of people in need of treatment actually pursue it (Grant, 1997). On the other hand, we know that effective services do exist and that substance abuse treatments are as effective as medical treatments for other chronic medical conditions (McClellan, Lewis, O'Brien, & Kleber, 2000). So what is one to do when armed with professional wisdom about an array of helpful treatments and faced with clients who are often reluctant to use them? Motivational interviewing (MI; Miller & Rollnick, 2002) is a client-centered way to address clients' ambivalence about making changes. It is supported in over 200 clinical trials as an effective treatment for substance abuse and other health-related behaviors (Miller & Rose, 2009). Although it is not a cure-all (Miller & Rollnick, 2009) or a trick to get people to magically enter treatment against their wills, it has excellent research support for situations when people are ambivalent about behavior change.

This chapter provides an overview of motivational interviewing and also details the specific protocol used to deliver MI-consistent feedback to clients who have completed the GAIN-Q3. We call this specific protocol the **CHOICE** (**C**ompassionate **H**elpers **O**penly **I**nviting **C**lient **E**mpowerment) **model**, which as you will see below is a handy mnemonic to remember the core philosophy of motivational interviewing. As the intervention can be used to discuss ambivalence about multiple target behaviors such as mental health, substance abuse, or physical health, the CHOICE model is appropriate for many settings. Depending on the setting and number of target behaviors addressed, it can be completed in roughly 20 to 40 minutes and can be done immediately following the administration of the Q3. Models using similar MI-consistent procedures following an initial assessment have been shown to increase

short-term retention in substance abuse treatment for both adults (Carroll et al., 2006) and adolescents (Smith, Hall, Arndt, & Jang, 2009).

In this chapter we will start out by defining motivational interviewing. Then, we will talk about the major components of MI, including adhering to the motivational interviewing spirit, using the counseling skills associated with MI, and eliciting and reinforcing client change talk. Finally, we conclude this chapter by showing how all these major components are used in the CHOICE model.

6.2 What Is Motivational Interviewing?

According to Miller and Rollnick (2002), motivational interviewing is a client-centered and directive counseling method for helping resolve ambivalence about behavior change. This definition is chock full of information on the core philosophy and clinical techniques of the model. So, let's spend a moment breaking it down.

First, it is client-centered because in motivational interviewing we a) respect the client's autonomy to choose how to proceed, b) listen closely to the client, c) work with the client to generate their goals rather than ours, and d) provide support and empathy to the client as much as possible. Being client-centered means much more than simply using a set of microcounseling skills like active listening and clinical summaries, and it also encompasses adhering to the general principles of MI, referred to as the **MI spirit**.

Second, this model is directive. Many professionals confuse MI with simple reflective listening. For this reason, we hear countless people who have been trained in motivational interviewing say, "I already use that," when in fact they are missing the directive element of the model. The directive element involves staying focused on a target behavior and generating **change talk**, which we briefly define here as statements that clients make about why they want to change or how they may go about it (see Section 5). In MI we use strategies that get clients to engage in change talk and reduce their discussion of why they want to stay the same. This is quite different from listening to anything the client will say and following their lead, or walking down every path that you feel could yield clinically relevant information whether it is related to the target behavior or not. In MI, the therapist takes an active role in keeping the conversation focused on the **target behavior**, which is defined as any behavior-change topic the client and therapist discuss. The target behavior could be broad like reducing substance use or very narrow like talking about going into a specific treatment for a mental health problem.

Finally, the technique is specifically designed to be used with people who are ambivalent about making changes in their health behaviors. Ambivalence is defined here as feeling two ways about behavior change. It is normal for clients to come to an assessment with ambivalence. It does not mean they are "resistant" or "difficult to treat"; when using MI, we try to avoid using these types of labels. When someone is ready to make changes or has already made a decision to change, we must move beyond focusing on "why it may be a good idea to change" to "what is the best way to make the changes." That is, and as you will see later, some MI skills may not

be needed as much for clients who are ready to change and need only to discuss the nitty-gritty of what to do next. MI is best suited for those who are ambivalent and typically culminates in a decision about what should be done, at which time other therapeutic techniques are typically integrated within an MI-consistent intervention.

So, to summarize, here are some key points to remember about motivational interviewing:

- Motivational interviewing involves adherence to the MI spirit, expert use of microcounseling skills, and generating client change talk. Thus, simply using microcounseling skills does not constitute MI.
- MI is directive in that the clinician takes an active role, staying focused on a target behavior.
- MI is best suited for people who are ambivalent about or not quite ready to make changes.

6.3 Who Let the Ghost Out: The MI Spirit

As mentioned above, motivational interviewing moves beyond simple microcounseling skills such as reflective listening, being empathic, and providing summary statements to clients. If you're building a model airplane, you need the pieces of the plane to snap together, but without the glue holding it together it's an incomplete and flimsy creation. In much the same way, one could think of microcounseling skills as just pieces without glue. The glue that holds the model together is referred to here as the **motivational interviewing spirit**, or MI spirit.

Three core components make up the MI spirit: respect for client autonomy, evocation, and collaboration. Let us briefly discuss each of these here.

Autonomy. What does one think of when they are told they have to respect a client's autonomy? For many practitioners it simply means abstaining from confronting a client. Traditionally, substance abuse treatment programs viewed client denial as an obstacle that must be met with a heavy dose of reality and would use a number of techniques to attempt to get the client to "see the light" and acknowledge the problem. Sometimes very demeaning techniques were used, which made clients feel humiliated. Nowadays "confrontation" is a dirty word, so everyone seems to say they are not confrontational with their clients. However, some very well-intentioned practitioners claiming to be nonconfrontational continue to express subtle things that are confrontational or that violate a client's autonomy. These behaviors often threaten positive feelings a client may have about the therapist or their trust in the therapy process, often referred to as rapport. For example, I have heard clinicians make subtly sarcastic comments to clients, such as "We'll save you a seat when you are ready" when they were not following the treatment plan closely. This type of communication seems to privilege the clinician's view on how change should proceed (usually by close adherence to clinician-endorsed goals) and fails to acknowledge or explore alternatives that may be more acceptable to the client. Although the counselor's perception was that this statement acknowledged client

autonomy, it seemed to do so in a manner that could be interpreted as confrontational by the client. Specific strategies are used in the CHOICE model to enhance the perception of autonomy by the client.

In the addictions field, we frequently hear clients adamantly saying that they "are here for themselves" and yet we don't believe it for one second because we've heard it so many times from so many clients who have ultimately decided not to change. Why do we hear this? Would a client say this if they felt they could truly say anything to their therapist? What would it be like for you if you could hear a client "genuinely" expressing their doubts about whether they can quit or whether they want to quit? In fact, one marker of good rapport with a client may be that a client will tell you the truth about doubts they harbor about making changes. Our goal as counselors, then, is to create an environment where that can happen, and one great way to do that is by respecting clients' autonomy to make decisions.

When we refer to respecting the client's autonomy, it means that whatever our clinical agenda or hopes for a client may be (e.g., get the client to accept a treatment plan, start taking a new medication, quit using drugs entirely, accept a disease-model view of their current problem), we communicate respect for our clients' decisions and enhance their perception of choice. Here are some ways we do this:

- Telling the client that they will have to choose.
- Using tentative language like "if you decide to change" to acknowledge the possibility that they may not change.
- If clients do not like your ideas, acknowledging that there are different ways to change, and asking them what may work better.
- Praising their ideas on how to change, even if they are not the ones we have used personally.
- Asking for the client's permission to make a suggestion or concern.
- After expressing a concern, eliciting the client's thoughts about what you just said.
- In situations where the client says they are not going to do something, we sometimes use an **amplified reflection** (also known as "coming alongside") by saying something like, "Maybe you're right, maybe now isn't the time to change and there is nothing at all to be gained here [entering treatment]." Interestingly, doing this sometimes prompts the client to argue the other side and talk about what may be gained from entering treatment.

In addition to doing these things to create a sense of autonomy, we also try to avoid certain behaviors. Specifically, we resist whatever natural impulses we have as therapists to give unsolicited advice, warn clients what may happen if they don't follow our advice, threaten clients with negative consequences for not changing, or otherwise try to fix the client (right now) in ways they do not want to be fixed. Miller and Rollnick (2002) refer to this as resisting the righting reflex. The following are examples of behaviors that are typically considered as threats to client autonomy:

- Trying to persuade the client why they should change or convincing them that something they experienced is a problem.
- Giving unsolicited advice about how to change a problem without first asking the client permission to make a suggestion.
- Confronting a client by openly disagreeing with them or making a negative, sarcastic, or otherwise demeaning statement about a choice they made.
- Telling clients that they have no choice in the matter because the legal system will require them to change.
- Without first asking the client for permission to share a concern, telling them that their ideas about change won't work.

To illustrate these ideas, let's consider two different responses to the same client statement.

Scenario 1:

> ***Client:*** *I love smoking weed. Don't you know it is safer than alcohol anyway and that this treatment is stupid because the powers that be have it all wrong about weed?*
>
> ***Therapist:*** *Actually, research is finding that there are a lot of problems people can experience after smoking weed, like amotivational syndrome, breathing problems, anxiety when they stop smoking, or problems with memory and learning. It is common for people just like you to be in denial when they are becoming addicted, because they just don't see how pot is affecting their life.*

Scenario 2:

> ***Client:*** *I love smoking weed. Don't you know it is safer than alcohol anyway and that this treatment is stupid because the powers that be have it all wrong about weed?*
>
> ***Therapist:*** *This legal trouble has been horrible for you, and you can't even imagine how your life would be better without smoking weed.*

What is happening here in these two different therapist responses? In the first, the therapist is lecturing and providing information to make sure that their point gets across. How might an ambivalent client respond to such a statement? Sometimes they respond by providing counterarguments. This brings us to a very important point. You as a helper can say things that actually provoke clients to argue with you. For this reason, there is an MI adage that "resistance is interpersonal" (Miller & Rollnick, 2002). Thus, MI therapists strive to avoid behaviors that prompt clients to argue for the status quo. When a client makes a statement in favor of not changing a behavior, we call it **sustain talk**. In MI we want to reduce the amount of sustain talk by clients and use techniques that make it more likely that clients will engage in change talk, or statements about the benefits of changing or actions needed to change. Using tactics like the one in Scenario 1 above can result in the client arguing the other side. To illustrate this further, imagine the client's most obvious counterargument to the therapist's statement above in Scenario 1: "I don't have any of those problems and I'm not in denial

about anything, so what am I even doing here?" This is an example of sustain talk, comments indicating that the client is ambivalent and will push back if the therapist argues to hard for them to change their behaviors.

Think for a moment about a time when a health professional was giving you information in a preachy, persuasive manner. Perhaps it was a dentist telling you about the importance of flossing your teeth or a physician advising you to watch your cholesterol. How did you react when the advice was something you already knew would probably be good for you but you were just not sure you wanted to or could change? Did you tune out because you were bored with the conversation? Or maybe you are feisty and told your provider that it just wasn't worth the effort. Fortunately there is an alternative to preaching and arguing with our clients about what changes they "should" make. In Scenario 2 the therapist resists the impulse to correct the client and instead uses a tool in motivational interviewing referred to as a **complex reflection,** or a restatement of what the client said that takes a bold guess about what the client meant. The first part of the statement reflects the feeling part of what the client said (their frustration with the legal system), and the second part is a very bold guess at what the client means but hasn't said directly. What could happen when this approach is used? Well, if the client is 100% consequence-free and committed to using weed, they could agree with you. But many clients deep down have something they don't like about smoking weed or engaging in some hazardous behavior. In other words, since you have argued that change may not be needed, this complex reflection may prompt the client to argue that there are some things that may get better for them if they were to make changes in their marijuana use. These types of bold replies sometimes elicit change talk, which we defined above as statements about their motivation to change.

Let's go back to the very same client statement in Scenarios 1 and 2 and offer an additional way to approach the client in a manner that enhances client autonomy.

Scenario 3:

> ***Client:*** *I love smoking weed. Don't you know it is safer than alcohol anyway and that this treatment is stupid because the powers that be have it all wrong about weed.*
>
> ***Therapist:*** *This must be very tough for you to be in legal trouble, seeing how much you like weed. It also seems like you're not too sure about what you may get out of treatment if you decide to continue on. I wonder how you'd like to proceed.*

In Scenario 3, the clinician is doing a lot of things to enhance the client's perception of autonomy. First, the clinician reflects what the client means but hasn't said (they are frustrated and unclear about what is to be gained from treatment). Second, when the clinician says "if you continue on," it seems to highlight that the client must make a choice. Finally, the last part of the clinician's statement asks the client for their ideas on what they'd like to do, which is inviting them to collaborate. Notice, too, that in Scenario 3, we can see that many of these behaviors are interrelated with the other two dimensions of the motivational interviewing

spirit: **evocation** and **collaboration**. For example, in Scenario 2 you can see that instead of telling the client why they should change, the therapist uses an amplified reflection that may prompt the client to counter argue with a change talk statement about what their life could be like without weed (the importance of these reflections will be discussed more in the section on change talk, p. 135). In Scenario 3 the therapist also refrains from telling the client why weed is bad, instead asking them directly what they want to do. In essence, this is a large component of evocation, which here will be defined as planned efforts to increase the clients' verbalization of why they may want to change and how to go about it (i.e., change talk). We also enhance autonomy by refraining from lecturing or violating a client's autonomy. This is consistent with the MI spirit dimension of collaboration, which we will also discuss further below.

Evocation. Simply put, evocation is any strategic effort the therapist makes to elicit the client's perception of why change may be needed and how the client can bring it about. According to Moyers and colleagues (2010, p. 5), "Clinicians low in Evocation may rely on persistent fact gathering or information giving as a means of facilitating change, and often convey a distrust of the client's current knowledge base about the problem under consideration." So, in a sense, therapists low on evocation distrust that their clients will have good ideas about why it is important to change or how to go about making changes. Being high on evocation is fundamentally different from telling clients why they should change, offering psychoeducational classes that train clients about the course their addiction will follow or what thinking errors they have, or instilling information using the expert stance. Think about evocation as a lecture-and-discussion class where the college instructor is openly inviting students to reflect, discuss, and exchange ideas. This type of classroom environment may be said to be higher in evocation if the instructor covers the material presented but in a manner that elicits key points from the students. Contrast that teaching style with a pure lecture-style course, where the instructor is interested only in imparting facts (the "right" information) to the students. In the pure lecture, the instructor may not trust that the students will learn if they don't stick to the agenda for what (and how) information should be conveyed.

The tricky thing about evocation for many therapists is that it is different from finding an "aha" moment or leading a client to where you want them to go. They may simply not go there. For example, a client may never agree with your conceptualization of their problem. In other words, evocation is not like a police tactic used to force a confession. It is not about getting the client to say what you want to hear in terms of your preferred plan for them. It is about generating what the client's personal reasons are for changing and how they want to go about changing, even if those ideas differ from yours.

Collaboration. Most authors who write about MI refer to collaboration as an active partnership between the client and the practitioner that encourages power-sharing (Moyers et al., 2010; Rosengren, 2009; Naar-King & Suarez, 2011). It is closely related to both respecting the client's autonomy and evocation that it is about yielding the expert stance and integrating clients' goals, values, and ideas into the behavior-change consultation. Examples of behaviors inconsistent with being collaborative include being dismissive of the client's ideas on how to change, arguing that the clinician's ideas are the best ways to change, and failing to elicit client

ideas on how to change. Collaboration is slightly differentiated from the concept of evocation in that it has more to do with planning how to change and less to do with the rationale for change.

6.4 Counseling Skills Associated with Motivational Interviewing (OARS)

Fundamental skills for motivational interviewing form the acronym **OARS**, which stands for **O**pen questions, **A**ffirmations, **R**eflections, and **S**ummaries. Some practitioners may already use many of these skills and may need to do only some fine-tuning. Others with less counseling experience will need more intensive practice of these skills. Regardless of your skill level, supervised practice with feedback from audio-recorded reviews is the gold-standard training method for therapists who are learning how to do motivational interviewing. Below we will briefly describe these skills. For thorough coverage of these skills and interesting and creative ways to practice them, readers are encouraged to see other skill-building texts such as David Rosengren's *Building Motivational Interviewing Skills: A Practitioner Workbook* (Guilford Press, 2009).

Open questions (the O in OARS). Open questions are those that allow the client the opportunity to reply however they want. They are contrasted with closed questions that look for specific information like an address or a yes-no reply. Closed questions may also seek specific information about an amount. For example, the question "How much do you drink?" asks a person to give a specific quantity; a more open way of asking this question would be, "Tell me a little bit about your drinking." Below are some examples of open questions that we frequently use in the CHOICE model:

- Tell me more about this?
- What types of changes are you thinking of making?
- In what ways, if any, has your pot use been problematic for you?
- How can I be of help to you as you make these changes?
- What do you think will help you get from here to there?
- Tell me your reaction to what I just said.

In contrast to open questions, closed questions are defined as questions that have potential to prompt short or yes-no answers. There are certain question stems that usually indicate that a question is closed. For example, questions that start with "have you," "is it," "do you," "will you," or "should you" are all closed. Let's say the client and therapist are talking about a client just having used marijuana, and the client just expressed fear that they will test positive on an upcoming urinalysis. The therapist responds with the question, "Have you thought about talking to your probation officer?" First, this is a closed question because it can be answered with a simple yes or no. Another issue is that by asking this question, you are in essence telling a client about a potential solution you have for them, without asking them what they have already done. A client could potentially get frustrated with you if they have already used this

approach and found it wanting. A more collaborative and evocative open question would be to ask, "So what are you thinking about doing?"

Closed questions can be valuable in some circumstances, since they can be very efficient for finding out needed information from clients. For example, most questions on the Q3 assessment look for specific information and are thus closed questions. By using closed questions, you can collect a lot of clinically useful information very quickly that can also be used to make a fair comparison across different samples. However, using too many closed questions comes with a cost, since they are not great for exploring the meaning of participant responses. For that reason, when we start doing MI in the CHOICE model, we will try to make 70% or more of our questions open.

Affirmations (the A in OARS). Affirmations are any statements the therapist makes to praise the client's efforts, compliment the client, or identify client strengths. Affirmations are one strong way to show compassion for our clients, but be mindful that some clients find it awkward to receive compliments. It is also possible to be overzealous with affirmations, causing them to become meaningless. The trick is to find which affirmations work for you and appear to be well received in the population with which you work. Some examples:

- It seems like you've been through hell. You are a really strong person to be doing so well after going through all that.
- You're a very hard-working person. You've kept so many appointments and you brave the bus system every time to come here.
- You've managed to stay out of trouble with the law even though you're using a lot. That is impressive.
- You have some great ideas on how to make this change.

Reflections (the R in OARS). Reflections are defined here as statements made by the therapist in response to client content. The major purposes of using reflections in MI are to communicate to the client that the clinician is listening, identify underlying feelings associated with the client's story, respond to client anger, and direct the session toward change talk and decisions about next steps.

MI trainers and researchers strive to use many more reflections than questions in their sessions. In fact, one of the standards for judging a good MI session (see section 6.7 on Quality Assurance, p. 164) is having a 2:1 ratio of reflections to questions. The reason for this is that it is easy to fall into what is called the question-and-answer trap (Miller & Rollnick, 2002), which refers to a conversation that sounds increasingly more like an interrogation and has more passive involvement by the interrogated party. Asking too many questions can also communicate that you are the expert (Miller & Rollnick, 2002; Rosengren, 2009) and need to get to the bottom of the problem so you can prescribe the right solution, which is referred to as the expert trap. Again, reflections are specifically used to communicate a deep understanding for your client's situation, label the affective component of client statements, and strategically elicit change talk.

When using reflections, your vocal inflection should go down toward the end of the statement, or it may end up sounding more like a question. It is also important to be mindful of the tone you use when delivering reflections because your voice tone could completely change their meaning. Consider the following statement:

> ***Therapist:*** *So you don't see any need to get help for pot.*

Try saying this statement twice. The first time you do it, try to make it sound sarcastic, as if you can't believe what the client is saying. Which words did you emphasize to do this? In the second go at this, try keeping your voice tone as low as possible and trailing off at the end. If this exercise is difficult to do on your own, that is okay. Training in vocal inflection and supervision will help you sort this out. The key point here is that we must be mindful to avoid making reflections sound like questions or accidentally sounding confrontational.

Complex versus simple reflections. Reflections vary in how deep they go. Some stay very close to the surface, and others seem to dive down to find deeper meaning in the client's statement. Surface-level reflections are referred to as **simple reflections**. For example, if a client were to express frustration with a referral and the clinician replied, "This has made you angry," it would be considered a simple reflection. Reflections that dig deeper or provide more direction to a session are complex reflections, as discussed on p. 128. Simple reflections are a good starting point, but eventually you may start sounding like a parrot if you keep reflecting the same things. Our clients probably also prefer not to hear us using the same exact stems every time we make a reflective statement. That is, if you say "it sounds like" or "it seems like you" or "I'm hearing that" twenty times in a 20-minute session, it may get irritating. You may have learned that using a stem like this is necessary to avoid putting words in someone's mouth. However, we generally think that a long windup is not necessary for a statement to be a good reflection.

Complex reflections are the hardest to learn, since by definition you have to take guesses at the client's meaning and selectively choose which components of the client's statement to focus on in a way that steers the ship toward change talk. It is also sometimes hard for trainers to agree on whether a reflection is complex or simple. A good litmus test is what happens after the reflection is delivered. Did the session seem to move forward into new areas after the complex reflection was used, or did the reflection lead you to a dead end? Did you move away from or toward change talk? This is not to say that complex reflections are foolproof, but rather that they generally do better than simple ones to propel sessions forward into new discussions of motivation for change.

For illustration purposes, below are potential reflections that a therapist may use after a client says "I really love weed":

a) You and weed are like best friends.
b) You can't imagine a life without weed.
c) You smoke all the time.

d) Weed has been the perfect mate for you, and has *never* treated you badly.
e) It sounds like you don't want to quit.
f) Weed has been a great thing for you.

Think for a moment which of these statements direct or take the session where we want to go. That is, think of what the client may say next were you to use each particular reflection. Consider whether some of these reflections may keep the conversation stuck on the status quo or perhaps even lead to an argumentative or coercive conversation about whether change should occur. Remember that the goal of an MI session is not only to use reflective listening but to do it in a way that gets clients to engage in change talk (see section 6.5 on p. 135). The point of this activity is to illustrate that there are many types of reflections, and they vary in how well they propel the conversation toward exploring clients' reasons for changing.

In our view, it seems that statements a, c, e, and f fail to move the conversation toward change talk. Options b and d, by contrast, are probably the best options for promoting change talk. Here's why.

a. This one is too shallow. It is a classic example of a reflection that stays close to what was said. Although it uses a metaphor, it may actually encourage the client to talk about how good weed has been to them. We try to avoid doing things that get the client to talk about what they like about a target behavior. This type of talk favors the status quo (in this case, not reducing drug use) and does not direct the session toward change talk. We avoid such reflections in MI.

b. This would be considered a complex reflection for a couple reasons. First, the client did not say that they couldn't imagine a life without weed, only that they love it. Thus, the therapist is taking a bold guess as to what they meant. Second, since this statement is kind of extreme, ambivalent clients may argue against it. For example, they may backpedal and say something like, "Well, I have thought about cutting down sometime." When they do this, the door has opened a little bit to find out why they think they should cut down. That is what we want to explore in MI.

c. Although this takes a bold guess at meaning and could reasonably be coded as a complex reflection, it doesn't seem to focus the conversation on generating change talk. It seems likely that this type of statement may provoke the client to talk about how much they are using or to get defensive about not really using "that much."

d. This one is complex because of the second half the statement. Since it uses absolute language, it may prompt the client to talk about times when weed is not always the perfect mate. That is, if your client is truly ambivalent, they may respond to such a statement by talking about bad times when weed was not a "perfect mate." If the client does that, you have entered the perfect territory for change talk.

e. This is a good guess at meaning, but it is not as strong as b or d at steering the client toward change talk. In fact, it may prompt the client to talk about why they don't want to change, which is to be avoided in MI.

f. Same as a and e. This could promote the status quo, or sustain talk.

Why you should learn complex reflections. Although a lot of practice is needed to use complex reflections during a session, they are well worth learning. When they hit the mark, they can deepen a session really quickly. Furthermore, they are powerful. In a recent study, adolescents receiving one session of MI experienced greater reductions in their marijuana use when therapists used more complex reflections than simple reflections (McCambridge, Day, Thomas, & Strang, 2011).

Although complex reflections can also be used for gaining a deeper understanding of emotional content, the short MI protocol described here will emphasize complex reflections that direct the session toward change talk. This is because CHOICE sessions are very brief (30 to 40 minutes), and the goal is to resolve ambivalence in the context of making referrals after a Q3 assessment. Thus, much like the end of a football game, you have to "manage the clock" well, which here means not opening avenues of discussion that distract from the goal of the session. Although it is good practice to reflect affective content—and doing so may also build motivation—overuse of such reflections may also lead to long and highly charged conversations that make it hard to accomplish the session goals within the allotted time. Make mental footnotes of other topics to discuss later when ambivalence is lower and the client has (hopefully) engaged in treatment.

Summaries (the S in OARS). Think of a summary as a collection of reflections that serves one of three purposes: transitioning to a new topic, consolidating all the change talk offered by the client, or closing the session. Given that the MI sessions following Q3 administration are generally short, we will focus on change talk summaries and summaries that transition from reasons for quitting to the next steps that should be taken. Here is an example of one that accomplishes both these goals:

> ***Therapist:*** *If you don't mind, let me just check to see whether I understand the reason you're here. You were found to have pot in your locker, which you first thought was totally ridiculous. But you do seem to have some great reasons for wanting to make changes* [***reinforcing change talk***]. *You have noticed some small problems with using, such as not doing as well on tests, having your parents come down on you, and now this. Your main reason for being here is that you want to stay eligible for baseball in school, and you were told you have to complete counseling to satisfy your school's drug policy. Although you're not sure you want to give it up entirely and forever* [***acknowledges autonomy***], *baseball is so important to you that you are willing to stop right now to play ball* [***reinforcing change talk; notice emphasis on "so important"***]. *So, the dilemma now is to figure out how to do just that. I'm wondering what your thoughts are on how you may stop in the short term* [***open question, invites collaboration***]?

In the above summary, the therapist summarizes all the change talk that the client made earlier in the session, adds some emphasis in particular areas that reinforce this change talk (see below), and transitions from talking about reasons for change to the topic of how to change.

6.5 The Role of Change Talk in Behavior Change

What is change talk? We've mentioned change talk above, such as in our discussion of micro-counseling skills. Change talk is defined as in-session client statements about making changes in their behavior. The key point we make is that we not only use OARS skills, we use them in a way that is most likely to generate change talk. To count as change talk, there must be three conditions present:

- **The client statement must be about a particular target behavior.** If you are focusing on substance use issues, discussion about changing other behaviors, like getting more exercise, are not necessarily counted as change talk, unless such discussion is part of the strategy for changing substance use patterns.
- **Change talk happens in the present tense.** Discussion about past changes does not count as change talk unless they were in the very recent past (e.g., changes made between an arrest and completing an assessment).
- **Change talk comes from the client.** The only exception to this is that if the therapist uses a reflection about why a client wants to change that the client subsequently endorses, that too would count as change talk.

There are two main types of change talk. First, **preparatory change talk** is mainly about clients' **D**esires, **A**bilities, **R**easons, and **N**eeds for making changes, or **DARN**. This kind of change talk sets the stage for another kind of change talk, one that actually predicts changes in behavior: mobilizing change talk. **Mobilizing change talk**, as the moniker suggests, is more about behaviors the client intends to do. This includes **C**ommitment statements (e.g., I will, I am going to, I have started…) or **A**ctivation statements (e.g., I intend to), and actions that someone has already taken, called **T**aking steps (e.g., I deleted my dealer's number from my cell phone.) Together, these are called **CAT.** Table 6.1 (below) has some examples of both DARN and CAT change talk as well as strategies used to elicit them.

Do not get too hung up on classifying whether change talk is preparatory or mobilizing. The key thing is that you are able to generate it and respond to it appropriately when you hear it. We will discuss these strategies shortly, but first we will provide a definition of sustain talk, the opposite of change talk, and also briefly discuss the rationale for generating and reinforcing change talk.

Table 6.1 Eliciting different types of change talk

DARN (Desire, Ability, Reasons, Need)—Preparatory Change Talk		
Strategies for Eliciting	**Examples**	**Type**
[*Reflection*] This sounds like something you simply must do.	I really need to quit using.	*Desires*
[*Reflection*] You seem pretty sure this is going to be easy for you.	I could stay sober if I wanted to.	*Ability*
[*Confidence ruler*] On a scale of 1 to 10, how confident are you that you could make this change? Why are you a (enter client response) and not a 0?	A 6. I have stopped before. I know I can do it.	*Ability*
[*Open question*] Why is the time right to make this change?	I want to get a job, and my mom would be happier with me, and I may think clearer.	*Reasons*
(*Importance Ruler*) On a scale of 1 to 10, how important is it for you to make this change? Why are you a (enter client response) and not a 0?	A 3. I have to do this to get off of probation.	*Need*
[*Amplified reflection*] There really is no reason for you to quit using, and you're having no problems at all with your use.	I don't know if I'd say that. I mean, I may be better off if I stopped. This arrest was kind of a wake-up call.	*Need*
CAT (Commitment, Activation, Taking Steps)—Mobilizing Change Talk		
Strategies for Eliciting	**Examples**	**Type**
[*Reflection*] You're ready to do just about anything to make this problem better.	I will do whatever it takes.	*Commitment*
[*Open question*] What do you intend to do?	I intend to stop smoking at lunch breaks.	*Activation*
[*Open question*] What is one small thing you could do this week that may make the problem a little better?	I scheduled an evaluation to see what a shrink thinks. So, maybe I'll ask about getting on an antidepressant when I go.	*Taking Steps*
[*Reflection*] You're ready to get going, and the dilemma now is figuring out how to do this.	I've been thinking about that. I have been trying to avoid my old friends already, and it is going okay.	*Taking Steps*

What is sustain talk? Sustain talk is the exact opposite of change talk. That is, sustain talk is defined as client statements about reasons for wanting to stay the same. In motivational interviewing, we want to avoid saying things that may unintentionally increase sustain talk. For example, we sometimes increase client sustain talk when attempting to persuade clients why they should change. This is because people who are ambivalent tend to present counterarguments when someone is arguing for one side. The goal of MI is to increase change talk and limit opportunities for sustain talk. Examples of sustain talk may include:

- I really like how weed makes me feel.
- Alcohol helps me sleep.
- I live in a small town, and the fast-food restaurant is where everyone hangs out. If I stop eating there, I won't ever see my friends. [*Target behavior is weight loss.*]
- If you had my parents, you'd want to use as much weed as possible.
- But if I stop, the nightmares will come back.

Again, a key point is that sometimes clinicians can prompt sustain talk from their clients if they use techniques that argue too hard for change with ambivalent clients. Below is a brief example:

> ***Client:*** *I don't really use that much.*
>
> ***Therapist*** [*with warm tone*]: *But you are using 3 or 4 times a week, and if you quit you may have better luck finding a job. I know that is something you said you wanted to do.*
>
> ***Client:*** *But I can probably find a job and still use* [***sustain talk***]. *I used every day on my last job, and really things weren't too bad.*

Note that what the clinician said above was not necessarily mean-spirited or harsh confrontation. However, the therapist's strategy was to try to convince the client that their life may be better if they quit. A better strategy would have been to try to draw change talk out of the client using the special techniques we will discuss below. The result was that the client engaged in sustain talk and the conversation did not progress toward more talk about why change is necessary and how to go about it. Next we briefly talk about the reason why change talk is so important.

Why bother eliciting change talk? In several studies, researchers have listened to audio recordings of motivational interviewing sessions and have counted up how much change talk is present. (Yes, people really study this kind of stuff.) They then determined whether the amount of change talk was related to client outcomes. It turns out that it is (Moyers, Martin, Houck, Christopher, & Tonigan, 2009). The more change talk that happens in counseling sessions, the less people engage in drinking and drug use at follow-up (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Moyers et al., 2009). These findings have also been replicated with adolescents (Baer et al., 2008; Engle, Macgowan, Wagner, & Amrhein, 2010), problem gamblers (Hodgins, Ching, & McEwen, 2009), and heavily drinking college students (Vader, Walters,

Prabhu, Houck, & Field, 2010). Although we have more to learn about change talk, there is a good scientific rationale for generating change talk during counseling sessions.

There is also evidence that using the strategies we discuss below will reliably generate client change talk (Moyers & Martin, 2006; Gaume, Bertholet, Faouzi, Gmel, & Daeppen, 2010; Glynn & Moyers, 2010). This is good news because it means that we as clinicians actually have some control over how much change talk we elicit from our clients. In short, these strategies generate change talk, and change talk predicts actual change.

How do we elicit change talk? Table 6.1 (p. 136) displays examples of change talk (both preparatory and mobilizing) as well as statements that are used to elicit change talk. That is, the statements in column 3 are things that may have been said by the therapist right before the client's change talk. These strategies fall under a few general categories, including open-ended **evocative questions**, **change rulers**, and **reflections**. Other procedures are also sometimes used, but we will limit our discussion to these skills.

Evocative questions include:

- So, what do you think you'll do?
- Why is it important to change?
- How might you go about making this change?

Change rulers (a.k.a. scaling questions) can be used to ask clients about the importance of change, readiness to change, and confidence in their ability to change. For example:

- On a scale of 1 to 10, with 10 being completely confident and 1 being not confident at all, how confident are you that you can manage your medications better? Why are you a 6 instead of a 0?

Reflections that generate change talk include:

- Everyone is completely out of line with their concerns, and you have had absolutely no problems with pot that are concerning you (*amplified reflection*).
- You don't want to end up using as much as your mom did.

How do we elicit change talk when clients are only providing weak change talk? Change talk varies in strength, and it is normal for weak or very qualified change talk to emerge earlier in the session. That's okay. Even when we have weak change talk indicating that the client maybe-kinda-sorta-possibly wants to change, we want to hone in on it and elicit more. For example, some clients will make a sustain talk and a change talk statement in the same breath. Consider the statement "I could stay sober if I wanted to" that appears in Table 6.1. This statement seems to indicate an ability (the A in DARN) to stay sober, but it seems qualified in the end, perhaps indicating low desire. What's a counselor to do? One option would be to draw out change talk directed at the need to change, since it appears that we're not dealing

with a confidence problem but rather an importance problem. Here we might use a complex reflection like, "So you could do this, and there haven't been any important reasons for you to make that decision yet." This reflection is deliberately extreme ("there haven't been any") in an attempt to elicit one or two reasons from the client, which can then, in turn, be reinforced.

Reinforcing change talk is kind of like tuning a radio dial to get clearer reception. At first, it may come in a little fuzzy, so we continue to adjust the dial a little bit until we have resolved fuzziness and get clarity. Reception is still fuzzy when we have only a little weak preparatory language (DARN change talk), so we tune the dial by reinforcing the first change talk we hear until we move closer and closer to mobilizing language (the CAT change talk discussed earlier: commitment, activation, and taking steps). When clients are really ambivalent, it is good to spend time focusing on the DARN change talk. This is because if we go straight for how to solve their problem (CAT) without first addressing *why* it is important to solve it (DARN), we would be getting ahead of our clients. In our radio-tuning analogy, this may result in increased sustain talk, which would be like tuning to the completely wrong station, one that is playing music we find distasteful. Some client cues that indicate you have reached the right station and that it may be a good time to talk about CAT include:

- There is less sustain talk than when you started your conversation.
- The client starts making statements of increasing intensity that indicate they are ready to do something. That is, moving from weak statements like "I may want to look into that" to "Yeah, I really need to do something now."
- The client starts asking you for suggestions on how to make changes.

Using EARS to reinforce change talk. Let's talk more about how we tune the dial using **EARS** (**E**laborate, **A**ffirm, **R**eflect, and **S**ummarize). Remember, EARS is the acronym we use for what therapists should do after they hear change talk. In Table 6.2 (below) we present some client change talk statements and examples of the EARS skills that would follow that change talk.

Table 6.2 Reinforcing change talk with EARS (Elaborate, Affirm, Reflect, Summarize)

DARN (Desire, Ability, Reasons, Need)—Preparatory Change Talk		
Type of Change Talk	**Examples**	**EARS Skills (Used After Change Talk)**
Desires	I really need to quit using.	Tell me more about why it is important for you to quit? (E)
Ability	I could stay sober if I wanted to.	You have the skills and dedication to make this work (R)
Ability	A 6. I have stopped before. I know I can do it.	Why are you a 6 and not a 0? (E)
Reasons	I want to get a job, and my mom would be happier with me, and I may think clearer.	You have lots of reasons for quitting. You want to get back to work, may see some improvements with your relationship with your mom, and you're excited [*added emphasis here to make complex*] about the possibility of thinking clearer. So, what are the next steps for you? (S)
Need	A 3. I have to do this to get off of probation.	Being on probation doesn't fit with who you are. (R)
Need	I don't know if I'd say that. I mean, I may be better off if I stopped. This arrest was kind of a wake-up call.	This is a clear signal to you that something has to change. (R)
CAT (Commitment, Activation, Taking Steps)—Mobilizing Change Talk		
Type of Change Talk	**Examples**	**EARS Skills (Used After Change Talk)**
Commitment	I will do whatever it takes.	I think it is outstanding that you are so committed to this. (A)
Taking Steps	I scheduled an evaluation to see what a shrink thinks. So, maybe I'll ask about getting on an antidepressant when I go.	That sounds like a great idea. (A) Tell me more about how life may get better if you start antidepressants. (E)
Taking Steps	I've been thinking about that. I have been trying to avoid my old friends already, and it is going okay.	You're a rock star—already figuring out things that will help you make this change! (A)

When therapists **elaborate** (the E in EARS) on a particular piece of change talk, they go for *depth*. Typically, this involves asking for examples or asking clients to tell you more. For example, if a client says they want to stop drinking so their partner treats them better, an example of elaboration would be to say, "Tell me how you think things would get better with your partner if you stopped drinking." In other words, you elaborate on one specific piece of change talk that seems relevant. This is not the same as asking for new pieces of change talk, as in saying, "What other reasons do you have for changing?" That may generate a longer list, but it sacrifices depth of exploration, which we do when we elaborate. This may be a particularly important skill to use when there are just one or two main reasons to change.

Affirming change talk (the A in **EARS**) happens when you praise the client's change talk. Affirmations are useful when clients tell you about their ideas on how to change or things they are doing to change. In other words, we use them a lot with activation-type change talk that has to do with what a client intends to do, or taking steps-type change talk where they tell you what they have already done. For example, if a client says, "I intend to avoid my using friend," the therapist could say, "That's a great idea [*affirmation*]. Tell me more about how you'd do that [*elaboration*]."

A clinician can also respond to change talk with **reflections** (the R in **EARS**). Reflections are particularly useful for **consolidating commitment**, which means using a reflection designed to simultaneously reinforce DARN language and elicit CAT language. For example, consider a scenario where a) a client has mentioned a couple of reasons for making changes, b) the therapist has elaborated on those reasons, and c) there has been no discussion yet about how to make changes. One reflection that touches on the "how" of change is, "You have a lot of great reasons for making changes, and your dilemma now is to figure out how to stop using." Note that if the client were to respond to this statement by saying something like, "Yeah, I have been thinking about treatment more and more," you have just used a reflection that reinforced the client's previous change talk (in other words, their reasons for changing) and elicited commitment language. It would now be time to ask questions about what they plan on doing next.

Summaries (the S in **EARS**) can also be used to reinforce change talk. We have already provided an example of how to do this in section 6.4.4 on p. 134. Key points to remember when making a change talk summary include:

- Comment on multiple pieces of change talk the client mentioned.
- Try to add some emphasis by using *slightly* more emphatic language than the client used. For example, if the client previously said, "I'd like to have more energy," you could say, "Your life could get a lot better if you had more energy from quitting."
- Use wording that consolidates their commitment. For example, "All these reasons are so important and now may be a great time for you to do something."
- End the summary with an open question that leads to commitment language, like "So, what have you thought about doing to make some changes?"

Summary. Using motivational interviewing well involves learning how to avoid saying things that provoke discussions of remaining stuck in the status quo, using specific strategies that are known to generate change talk, and reinforcing change talk when you hear it. These strategies are incompatible with counseling strategies that emphasize persuasion, such as rigid and noncollaborative education on the harms of the status quo or confrontational tactics.

6.6 The CHOICE (Compassionate Helpers Openly Inviting Client Empowerment) Model

Now that you know some things about the basic philosophy and skills associated with MI, we will turn our attention to the task of using motivational interviewing to give feedback to clients using the Q3 assessment with the CHOICE model. The CHOICE model is aided by completion of a GAIN-Q3 and facilitated by printing out a Personalized Feedback Report (Q3PFR). This report contains a summary of the problems the client reported as well as reminders to the clinician about the major components of the session. We note here, however, that this report is *not* a substitute for spending time learning the skills we discussed above but rather a guide to help keep a clinician focused and organized during a session. The report is not meant to be read verbatim to clients but is instead simply a tool for clinicians. All CHOICE model sessions should be highly conversational, and therapists should integrate the OARS skills throughout. When therapists are beginning to learn this model, it is normal for them to rely more on the Q3PFR, but as they become more experienced with listening skills and using this report, their sessions will be more and more conversational.

Table 6.3 outlines the key steps of the CHOICE model as well as the core MI skills used during each step. These steps include 1) giving an overview of the session, 2) mining for client strengths, 3) agenda setting, 4) using MI to discuss concerns, and 5) session close. Although some MI skills are more likely to be associated with certain steps, we maintain a focus on the MI spirit and use of all the microcounseling skills associated with MI at each step of the way. For example, a client may express frustration or anger at any step in the process, at which time we'd want to use MI skills such as reflection and maintaining a highly empathic stance toward them. In other words, the procedures can be used flexibly, and the therapist should be attuned to the client's cues about what may need to be addressed at any moment. Reflections should be used in all five steps of the model. In the sections below, we include some discussion on using discretion and maintaining flexibility.

Table 6.3 Overview of CHOICE model components and key MI skills used

Session Component	Approximate Time	Key MI Skills Used
Step 1. Overview of session	1–5 minutes	Emphasize autonomy by telling the client that they decide what to do with the information and that they are the experts on their own lives
Step 2. Mining for strengths	5–10 minutes	Affirmations
Step 3. Agenda setting	1–5 minutes	Emphasize autonomy by giving the client choice about topics and asking permission
Step 4. Use MI to discuss concerns: • Elicit DARN • Consolidate commitment • Action planning • Elicit client reaction to recommendations	10–20 minutes	Elicit and reinforce change talk, ask permission to give suggestions, and communicate referrals while adhering to MI spirit
Step 5. Session close	1–5 minutes	Reinforce change talk with summary

CHOICE model Step 1: Session overview (1 to 5 minutes)

It is very important to set a positive tone early in the session while also providing the client with a synopsis of what is to come. Core content to cover in the overview is included in the following principles:

- Mention that you would like to talk to the client about the results of their assessment and review some options on what to do next. Clearly explain your role: You are commissioned to give professional advice, but that they ultimately will have to decide what to do with any information you provide.
- Explicitly tell them that they are the expert on their own lives.
- Tell them that you would like to acknowledge some areas of their life, like school or mental health, where things are going really well; areas of concern, where things are not going as well; and recommendations to address areas of concern, which they may find helpful.
- Finish by asking an open question about how this plan sounds.

Below is an example of how you might cover these points. Throughout the example, we have labeled specific pieces of text with the numbered principle (1 through 4 above) that relates to

it. However, note that verbatim wording is not necessary if you cover the key concepts. In other words, the best overviews are those where interviewers adhere to the MI spirit, cover these main principles when introducing the session, and do not sound robotic when doing it.

> ***Therapist:*** *Now that we've finished up with your assessment, I'd like to speak with you about what changes, if any, you'd like to make. As you know, it is my job to make some recommendations, but I want to stress that no matter what I recommend, you'll have to decide what to do with this information (1). I see you as a partner in this process, and view you as an expert on your own life (2). I'd like to first talk briefly about some things that are going well, and then talk about some areas where I have concerns for you. I'll finish up with making some recommendations, and we can talk about them (3). How does that sound? (4)*

You can see that this overview goes really quickly even though it has a lot of information packed into it. It is concise, yet it covers many of the MI spirit dimensions. Usually, it takes only a moment to do this, unless the client asks you questions (such as about confidentiality) or disputes whether they truly have a choice about taking or leaving your recommendations. For example, mandated clients may tell you that they will have to follow through with whatever you recommend as a condition of probation. If this happens, there are two things to address:

- Reflect the client's affect (usually feelings of frustration with being referred to treatment.)
- Briefly generate and reinforce change talk about their external pressure to get treatment.

Here is an example of how this may sound, which happens right after the therapist has finished giving the overview of the session.

> ***Therapist:*** *How does that sound?*
>
> ***Client:*** *Okay, I guess, but my probation officer is going to make me do whatever you tell me to do, so I don't really have a choice.*
>
> ***Therapist:*** *That has you frustrated, and yet you're here* [***reflection***].
>
> ***Client:*** *Yeah, I'm just here because they say I have to be. I don't really need any help.*
>
> ***Therapist:*** *This is difficult for you, and yet you're willing to make some changes while you're on probation* [***reflection to elicit change talk***].
>
> ***Client:*** *Yes.*
>
> ***Therapist:*** *How would your life be better if you were off probation* [***reinforcing change talk, elaboration***]*?*

Client: *I dunno. Can't you just tell them I don't need any help?*

Therapist: *Well, if it is okay, can we talk about some areas where you have strengths and come back to pot use later? I do have some concerns that I'd like to share, and hopefully we can put our heads together and figure something out. We can definitely come back to your legal situation, since it seems like you think that may improve if you make some changes.*

In this example, the client disagreed that they had a choice in the matter of whether to make changes. The clinician was empathic and highlighted the client's frustration with their situation by using a reflection. Later, the clinician also established that the client is willing to make changes, if only for the period while the client is on probation. This is a good start, but as you can see, the client then seems to give some signs about their motivations for treatment by asking the therapist to fabricate a letter saying that they do not need treatment. Clients who are addicted to drugs will go to great lengths to continue using, and in MI we try to remain compassionate when responding to these types of requests. It is natural for us to feel like we are being manipulated in these situations, and perhaps the biggest dilemma we face is how to keep our composure here.

You may be wondering why the clinician sidestepped the client's comment about telling the probation officer that they don't need any help. There are a couple reasons for this. First, we can't make our clients any false promises. If we are maintaining a relationship with a chief referral source, we need to clearly communicate our professional recommendations with legal authorities. How we address this in the CHOICE model is to acknowledge the client's frustration with the legal process and reemphasize that they have a choice in whether to follow what the courts or others are pressuring them to do. However, at this early stage in the therapeutic encounter, it may be best to avoid a long discussion about what the client needs to do and come back to this issue after establishing more of the client's reasons for change. For this reason, the therapist deliberately tables the conversation about correspondence with the client's probation officer. It would be low evocation, and hence contrary to the MI spirit, if the clinician started talking about all the legal benefits of program involvement and spelling out what they had to do to achieve those benefits.

CHOICE model Step 2: Mining for strengths (5 to 10 minutes)

After introducing the client to the tasks you would like to achieve during the session, the next part of the CHOICE model involves reviewing nonproblematic areas. We do this to start the session off on a positive note by talking about areas where the client is doing well. This portion of the session is tailor-made for affirming the client. This helps build rapport before more difficult topics are addressed.

The core skills used here are to a) have clients elaborate more on why things are going well in each area, b) identify client strengths, c) use affirmations to praise these strengths, and d) ask about how these strengths may help the client deal with other problems that were reported on the GAIN-Q3. Below is an example of a dialogue with a 16-year-old client who was referred to

complete a GAIN-Q3 because of suspicions that the client using marijuana heavily and concerns about their school performance.

Therapist: *Sometimes it is good to talk about what you're doing in areas where you're having no problems. This can help us identify your strengths and tell us something about your skills at solving problems.* [*Referring to Q3 Personalized Feedback Report showing no problems with physical health on GAIN-Q3*] *Your health seems to be really good. What are you doing to keep yourself healthy* [***open question***]*?*

Client [*grunting*]: *I dunno.*

Therapist: *Well, some people exercise regularly and eat well, or they make sure to go to the dentist and doctor regularly to prevent health problems. I'm wondering what you do* [***open question***]?

Client: *Yeah… I exercise.*

Therapist: *Great. Tell me more about that* [***open question***].

Client: *I go to the gym and play basketball every day.*

Therapist: *You must be pretty good if you play all the time.*

Client: *I try to stay on top of my game. I shoot free throws when the competition is resting.*

Therapist: *So, you're a hard worker* [***affirmation***], *and you show up even on days when you don't feel like it, because you know it's good for your game* [***complex reflection***].

Client: *Yeah.*

Therapist: *That's impressive. I'm wondering if your ability to work hard, like you do on your game, may help you with your other problems.*

Client: *Well, you got that right about sometimes not feeling like doing it.*

Therapist: *Tell me more about that* [***open question***].

Client: *Well, I know what I have to do to get out of this mess with my folks, but it's going to suck.*

Therapist: *Just like that day when it's cold outside and you don't feel like shooting 50 free throws, and yet you have good reasons to do it* [***complex reflection; eliciting change talk***].

> ***Client:*** *Yeah. I really need them off my back about the weed.*
>
> ***Therapist:*** *Things will get better if you cut back* [***reflection; reinforcing change talk***].
>
> ***Client:*** *Yeah.*
>
> ***Therapist:*** *Well, it sounds like it is important for you to talk about your pot use. How about we start there?* [*Begin* ***agenda-setting process****, see p. 148*]

A few brief observations about this exchange: First, this youth was initially nonverbal and seemed reluctant to view playing basketball as a personal strength. Some adolescents simply may not respond well to questions like, "What are you doing to keep yourself healthy?" This is common and often requires the therapist to give examples of behaviors to the client. Some other clients may respond a little easier and add more content about other strengths. Here, it is okay to spend a little more time (5 to 10 minutes) elaborating on these strengths and examples of positive coping. Second, notice how the therapist used reflections to generate a little bit of change talk. Finally, notice how the therapist moved into the agenda-setting procedure rather naturally when the timing seemed right. This is a good example of how a computer-generated report can be used to guide a conversational session.

At minimum, the therapist should identify and reinforce at least one client strength during this activity. For clients who are easier to work with than the one described above, however, we would like to see two or three strengths discussed within the time period allotted for this portion of the CHOICE model. Again, therapists must be mindful of saving enough time to accomplish steps 3 through 5 of the model (agenda setting, reviewing concerns, and session close).

How to find client strengths. If you are not already accustomed to looking for client strengths, the Q3PFR can offer you some clues. The Q3PFR will name every section of the GAIN-Q3 in which the participant reported no past-90-day problems and will print out the following prompts:

- How are you doing in these areas? (Reflect and affirm positive/nonproblematic experiences and strengths.)
- What are you doing to ensure that things keep going well in these areas?
- Tell me more about your accomplishments or strengths in these areas? (Reflect and affirm strengths.)
- How may these strengths help you address other problems you might have right now? (If change talk emerges, briefly reinforce by Elaborating, Affirming, Reflecting, or Summarizing (EARS).)

Notice how these prompts correspond with the dialogue above. For example, the clinician quickly identified the client's strength in sports, affirmed it, and then steered the conversation

toward how the client's work ethic in basketball may be related to solving a problem with marijuana.

There are a couple caveats that must be mentioned when trying to mine for strengths using the Q3PFR. First, remember that just because someone didn't report past-90-day problems doesn't mean that these areas were not problematic in the past. An example may be a person who had trouble at work last year and got fired, so work is not a current problem because they are not currently working. We can't always assume we know the whole story behind the client's GAIN-Q3 responses, and we will need to be prepared when the participant's statements differ from what the Q3PFR says (see Step 3). A second possibility is that clients have overcome past problems, so they are not reported as current problems. In this scenario, we want to focus on specific actions taken by the client to overcome these problems, praise them for their abilities and efforts in addressing their problems, and connect these past successes to current problems they are experiencing.

When the client reports past-90-day problems in every section of the GAIN-Q3. One possibility is that a client will have past-90-day problems in all GAIN-Q3 sections. What this means clinically is that your client has multiple problems that are likely interrelated. If this is the case, you cannot approach it from the perspective of what strengths were used to prevent or overcome problems. We like to approach this scenario by using what has been called the **coping question**. Essentially, the coping question asks why things aren't worse given the fact that the client is facing numerous problems. Here is how it works:

> ***Therapist:*** *Based on your assessment you seem to be having a rough time lately. For example, you're missing a lot of school, you're having trouble at work, and you also said you were stressed on most days in the past 90 days. I'm wondering what you are doing to keep your head above water?*

Again, notice that the question deliberately asks the client "what [they] are doing." We ask it this way specifically because as much as possible, we want them to discuss actions they are taking rather than external circumstances. When they discuss personal actions they are taking, we immediately have a positive coping skill or strategy that the client is using, and we can praise the client for using such a skill.

CHOICE model Step 3: Agenda setting (1 to 5 minutes)

In some settings, assessors may want to focus on only one problem area for which they have the most expertise. For example, when the CHOICE model is used in substance abuse treatment agencies that specialize in substance abuse treatment, it may be that the primary target will be substance-using behavior. However, in other settings it may be that there is great interest in triaging more than one domain covered by the GAIN-Q3. For example, case managers using the Q3 who are able to link clients to multiple services may be interested in discussing multiple needs of the client. This latter situation presents a dilemma of how many target behaviors you can address using MI. We recommend covering two or three domains to

be able to preserve the quality of MI that is being provided. Thus, the goal of setting the agenda is to make speedy decisions about what to discuss in a manner that increases client choice (in other words, collaboration). When doing so, we use the following progression:

- Ask the client about their top priority.
- Ask for their permission to talk about other areas as well.
- If the client does not voice their preferences, the clinician should pick discussion areas:
  - Those that they are required to discuss according to agency policy or area of expertise
  - Those for which the client has moderate (1 or 2 problems) to high (3+ problems) problem severity and low or moderate motivation (less than 90% ready to change)

The Q3PFR helps clinicians select which problems to discuss by printing out an agenda-setting table (Figure 6.1), which lists a) each section of the GAIN-Q3, b) the clinical severity range for each section, c) the client's response to the readiness to change item for each problem area, and d) what to focus on when using motivational interviewing in problem areas. *Do not read large portions of this table to the client!* It is especially important that you refrain from directly telling a client that they have high problems and low readiness in a particular area because they may react with sustain talk. The table is meant to efficiently inform therapists about the severity of a client's problems in a particular section of the GAIN-Q3, their motivation level, and how to focus the MI intervention. This is important because our MI intervention progresses a little bit differently depending on how severe the client's problems are and whether they report high or low readiness to make changes in that area. Remember that earlier we talked about how MI is used with clients who have ambivalence about making changes. This table in the Q3PFR helps us identify what is most important to do based on the assessment information.

Let's walk through the possible statements on the Q3PFR's agenda-setting table. (Note: the statements are not numbered on the Q3PFR.)

Statement 0: "Section is skipped because no past-90-day problems were reported." These are the areas that the clinician uses as examples when reviewing nonproblematic areas. It is unlikely that these topics need to be the focus of discussion.

Statement 1: "Collect Readiness to Change and follow skip." This statement prints when the clinician did not administer the reasons for change and readiness to change items at the end of a particular section of the Q3, even though the client reported high or moderate problems in the preceding 90 days. In other words, the clinician either decided not to administer the reasons and readiness items (such as when administering a Q3-Standard instead of a Q3-MI) or did not follow the skip pattern on the GAIN-Q3 correctly. If this is the case, the Q3PFR becomes harder to use because we cannot classify clients on readiness to change in order to know what the focus of MI should be. This means that if the clinician wants to use the CHOICE model with this client, they should go back to the GAIN-Q3 and administer the item on readiness to change, then follow the instructions for the statements described above.

Figure 6.1 Sample agenda-setting table

3. AGENDA SETTING

I want to make sure we talk about anything that is important to you, so you feel like we used this time wisely. What would you like to talk about most? (Client offers preference) Wonderful, let's plan to start there. There are some areas where I have some concerns, which you may or may not share. If it's okay, I would also like to speak with you about our concerns, too. How does that sound?

Section of Report	Severity	Readiness to Change	Focus of Motivation Intervention
4. School	High	High - 90%	Consolidate Commitment, then Action Planning
5. Work	Low	NA	Section is skipped because no past-90-day problems were reported
6. Physical Health	Low	NA	Section is skipped because no past-90-day problems were reported
7. Sources of Stress	Mod	Low - 60%	Elicit Desire, Ability, Reasons, and Need (DARN), then Action Planning
8. Risk Behaviors	Mod	High - 100%	Consolidate Commitment, then Action Planning
9. Mental Health	High	Low - 65%	Elicit Desire, Ability, Reasons, and Need (DARN), then Action Planning
10. Substance Use	Mod	Low - 40%	Elicit Desire, Ability, Reasons, and Need (DARN), then Action Planning
11. Crime and Violence	Low	NA	Section is skipped because no past-90-day problems were reported

Statement 2: "Elicit Desire, Ability, Reasons, and Need (DARN), then Action Planning." This prints when the client has low or moderate readiness to change coupled with high or moderate problems. This means that the therapist should start with eliciting and reinforcing preparatory change talk language because it appears that this is an area where a client is ambivalent about making changes. In other words, clinicians should spend more time in this area talking about *why* change should occur before jumping ahead to discuss *how* to make these changes. They should use EARS to reinforce whatever change talk they hear, which we anticipate will most likely be DARN change talk. Therapists should wait for signs that ambivalence is resolving before moving on to talk about what types of changes are being considered by the client or are recommended by the therapist.

Statement 3: "Consolidate Commitment then Action Planning." Finally, statement 3 prints when the client presents with high or moderate problems but also reports high readiness (90% or greater) to make changes. When this happens, it may be less important to elicit DARN change talk; instead, the course of action is to briefly summarize the reasons for quitting that the participant reported on the GAIN-Q3 (equivalent to DARN change talk), thus consolidating commitment, and then move on to action planning. In other words, this process involves a brief change talk summary followed by a rapid transition into talking about what steps should be taken next to solve problems. This makes sense for clients who are ready to begin changing their behaviors and simply need help brainstorming solutions.

Note, however, that if you choose not to administer the readiness items in a particular GAIN-Q3 section because you know you will not focus your MI intervention on that target behavior, you can ignore the instruction "Collect Readiness to Change and follow skip." Instead, simply focus on areas in which you would like to use MI. An example of this would be if you are employed at a substance abuse treatment agency and do not want to routinely use MI to motivate a person to change their sexual risk behaviors as identified in the Risk Behaviors section.

One final issue that we want to raise about agenda setting is that we have defined high motivation as readiness to change of 90% or greater. Thus, there may be some highly motivated clients who fall below that cutoff for whom it may be best to not dwell on eliciting DARN. That is, there is a large difference in readiness level between someone who reports 20% readiness and someone who 80% readiness. We will follow the "elicit DARN" sequence as in the second statement in Table 6.4 (below) for anyone lower than 90% ready to change, but be watchful for signs that a more rapid transition toward consolidating commitment (see Step 4c on p. 156) may be appropriate. Again, this will most likely apply to clients in the moderate range of motivation who are bordering on high motivation.

Table 6.4 Readiness and problem-severity combinations appearing in the agenda-setting table

Readiness and Problem Severity	Statement Printed in Agenda-Setting Table
0. No problems	Section is skipped because no past-90-day problems were reported
1. Readiness-to-change questions were not administered	Collect readiness-to-change questions and follow skip
2. Low to moderate readiness to change (< 90%) and high or moderate problems (1+)	Elicit desire, ability, reasons, and need (DARN), then action planning
3. High readiness to change (≥ 90%) and high or moderate problems (1+)	Consolidate commitment, then action planning

CHOICE model Step 4: Using motivational interviewing to discuss concerns from the assessment (10 to 20 minutes)

In this step of the intervention, we will apply all the MI components, such as respecting the MI spirit, using microcounseling skills, and generating and reinforcing change talk, to discuss the concerns that were identified on the GAIN-Q3 assessment.

Following the agenda-setting table, the Q3PFR includes detailed information on the problems reported by the client and the corresponding reasons for change in each section of the Q3 (School Problems, Work Problems, etc.). These sections print only when the client has moderate or high problems. In other words, these sections do not print for clients who have not

experienced past-90-day problems; that information was already reported in Step 2 (Mining for client strengths) of the CHOICE model. The Q3PFR displays information on each section of the Q3 in the same order that it appears in the agenda-setting table.

Figure 6.2 Q3PFR problems and reasons for change example

10. SUBSTANCE USE

You reported that your use of alcohol or other drugs had caused you the following kinds of problems in the past 90 days:

- You used alcohol or drugs weekly or more often

You said your main reason for wanting to make changes in behavior related to your use of alcohol or other drugs was "Stay out of trouble.." We went over a list of personal reasons for wanting to change these behaviors. Here are some reasons you gave:

- You don't want to get into trouble with the law
- It costs too much money

Also printed on the Q3PFR are instructions to the clinicians on how to focus the MI intervention. The information that prints varies depending on the client's readiness to make changes in a particular area. If the client reports low or moderate readiness, this part of the report will be labeled "Elicit Desire, Ability, Reasons, and Need (DARN)." If the client reports high readiness, this part will be labeled "Consolidate Commitment." Again, these subsections print this way based on the readiness level of the client.

Figure 6.3 Eliciting DARN example

Elicit Desire, Ability, Reasons, and Need (DARN)

You said that one of your reasons for wanting to make changes in your mental health-related behavior was (*pick one of the reasons listed above)*. Tell me more about this. What other important reasons do you have for making changes? (*Use EARS skills: Elaborate, Affirm, Reflect, and Summarize change talk prior to moving to next steps.*) You also said you were 65% ready right now to make changes in your mental health-related behavior. Why are you at 65% and not 0%? (*Reinforce change talk with reflections that emphasize client's commitment to change.*)

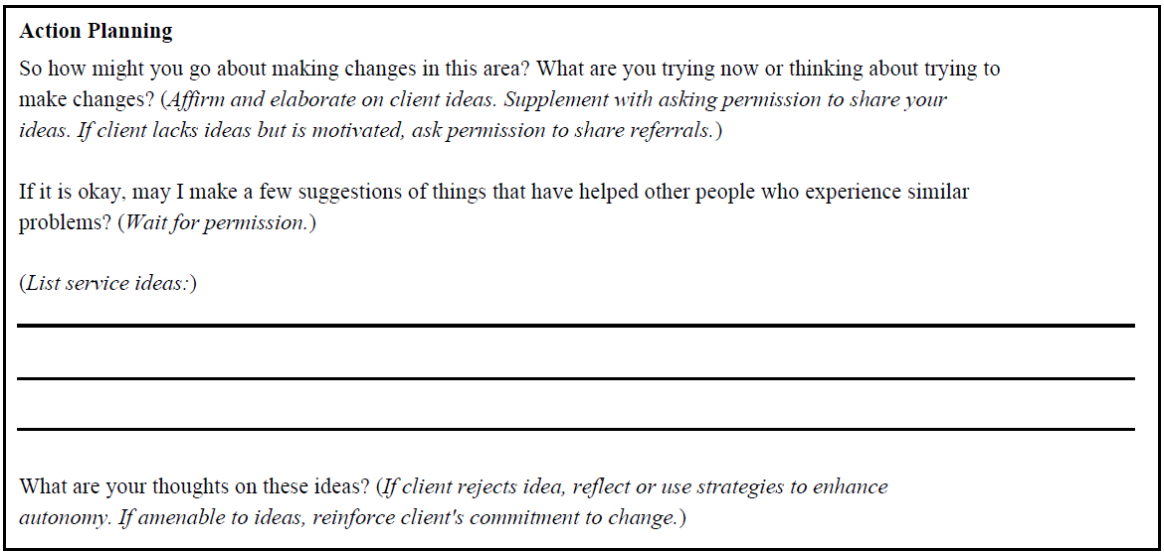
Figure 6.4 Consolidating commitment example

Consolidating Committment

You said that you were 100% ready right now to make changes in your risk behaviors and situations. It seems like you have a lot of important reasons to change, and now is a good time to get started. (*Wait for reaction to this reflection. If client presents sustain talk or balks at "getting started," reflect ambivalence and use procedures to elicit and reinforce DARN (Desire, Ability, Reasons, Need) change talk.*)

Finally, in each printed section of the Q3PFR is a subsection called "Action Planning." In this section the clinician asks the client about what changes they would like to make, suggests recommendations (with the client's permission), and asks the client for their reactions to these recommendations.

Figure 6.5 Action planning template



Action Planning

So how might you go about making changes in this area? What are you trying now or thinking about trying to make changes? (*Affirm and elaborate on client ideas. Supplement with asking permission to share your ideas. If client lacks ideas but is motivated, ask permission to share referrals.*)

If it is okay, may I make a few suggestions of things that have helped other people who experience similar problems? (*Wait for permission.*)

(*List service ideas:*)

What are your thoughts on these ideas? (*If client rejects idea, reflect or use strategies to enhance autonomy. If amenable to ideas, reinforce client's commitment to change.*)

At this point the agenda has been set. Now we progress by briefly referencing the client's problems. Then, we either focus on eliciting DARN or consolidating commitment, depending on whether the client presents with low to moderate or high readiness, respectively. Third, we transition to action planning, where we get the client's plans for change and ask permission to offer some suggestions or referrals. Finally, we ask the client for reactions to the referrals we present.

CHOICE model Step 4a: Brief mention of problems reported on the GAIN-Q3. We begin by briefly mentioning some of the problems the client reported on the GAIN-Q3 assessment. We need not read the entire list of problems, but mention a few that seem most salient to the clinician or client. This is done because it may get too cumbersome to read this whole section, especially if the client has reported most or all of the problems in that section. We highlight problems that the clinician finds particularly concerning (e.g., daily use of substances in the past 90 days) and those for which the clinician wants to learn more. How is this done? By making quick reference to the problems and asking the client an open question. Here is how this may sound for a teenage client with high problems and low readiness to change as reported in the Q3's Substance Use section:

> ***Therapist:*** *Can I tell you some concerns I have about your substance use?*
>
> ***Client:*** *Okay.*

Therapist: *I'm worried about you because you said you were using marijuana every day in the past 90 days, and you've been getting into fights with other people because of your use. Tell me a little more about this?*

Client: *Ah… That, it really is no big deal. My parents are just getting on me hard about my use…*

CHOICE model Step 4b: Eliciting DARN (desire, abilities, reasons, need). For clients with low readiness, we make an almost immediate transition from mentioning some problems to trying to elicit change talk. Here is where we need to use our skills for generating change talk and also our EARS skills to reinforce change talk when we hear it. Consider the following example that continues where we left off above:

Client: *Ah… That, it really is no big deal. My parents are just getting on me hard about my use, but they're the reason I'm using* [***sustain talk; reason for using***].

Therapist: *This has you frustrated, and there is absolutely nothing for them to worry about* [***complex reflection***].

Client: *Right, it is their problem and not mine* [***sustain talk; reason for using***].

Therapist: *This isn't the time for you to change, and nobody can make you change* [***complex reflection***].

Client: *Well… I don't know that I'd say that. Sometimes I think I should just quit fighting them on this* [***change talk; reason***].

Therapist: *You want things to be better with them* [***reflection; reinforcing change talk***].

Client: *Yeah.*

Therapist: *How would your life improve if things were better with them* [***open question; reinforcing change talk; elaborating***]*?*

Client: *Well, I'd have less fights* [***change talk; reason***].

Therapist: *Those are stressing you out* [***reflection; reinforcing change talk***].

Client: *Yeah.*

Therapist [*reading from Q3PFR*]*: You also said earlier that one reason you want to change is so you can "get your life on a better path." Tell me more about what you mean by that* [*evocative question to* ***elicit change talk***]*?*

Client: *I know I can't get a good job if I don't finish school, and the way I'm going, it's not looking good.*

Therapist: *You're not fully convinced, and yet the time may be right to do something about your weed (**double-sided reflection**).*

Client: *Maybe it just isn't worth the hassle* [***change talk; reason***].

Therapist: *Using pot is becoming more inconvenient to you* [***reflection; reinforcing change talk***].

Client: *Yeah* [***change talk; reason***].

Therapist: *And your dilemma now is to figure out if you should do something about it* [***complex reflection***; *directs toward* ***action steps***].

Client: *Yeah, well, I'm not ready to completely give it up, but I could cut down for a bit* [***change talk***].

Therapist: *And that would be really good for getting your life back on track with your parents and school.*

Client: *Yeah* [***change talk***, *agreeing with clinician's reflection on* ***reasons for change***].

In this example, notice how the client initially presented with sustain talk. The therapist used many of the skills we discussed above, such as complex reflections and evocative and open questions, to elicit and reinforce the change talk. Then, when change talk was presented, the clinician reinforced it and drew out more. After hearing some DARN preparatory change talk, the clinician used the reflection, "And your dilemma now is to figure out if you should do something about it." These types of reflections (also called **continuing-the-paragraph reflections)** direct the client toward making a decision about what to do next. This is an important part of reinforcing change talk. Notice that after this reflection the client starts talking about what they are and are not willing to do to make some changes. That is, once we hear some DARN talk, we try to up the ante and use reflections about making decisions or taking steps toward change. This is the directive nature of MI in action. To complete this transition toward action steps, it is often useful to complete what we refer to as a change talk summary that ends with an open-ended question about what the client thinks they will do next. This open-ended question, often phrased "So what do you think you'll do?" is referred to in MI as the **key question**. It has a certain climactic feel to it, since it comes after some change talk has been generated. Below is an example of how this might play out, continuing with our current example:

Therapist: *And that would be really good for getting your life back on track with your parents and school.*

Client: *Yeah* [***change talk***; *agreeing with clinician's reflection on* ***reasons for change***].

Therapist: *So, you're not too crazy about being here because you don't want to completely quit using pot, and on the other hand you really think that your parents will get off your back if you make some changes. You also seem to value your future and are starting to think you may be getting off track. You said you want to finish school and it may be hard to do that if you keep using. These are great reasons for making some changes, and you may be ready to get started now. So, I'm wondering what you think you'll do.*

Client: *I don't know. Aren't you supposed to tell me what to do?*

Once you have established some change talk, or the client has generated some initial goals for change (such as cutting back on pot in our example) or is starting to ask questions about *how* to go about changing, the timing is right to transition toward next steps the client should take. However, recall that the client in our example was initially classified with low readiness, so we started out by eliciting DARN change talk. For clients with high readiness, you can typically spend less time eliciting DARN and move more quickly into the change talk summary. This is the consolidating commitment process, which we'll briefly review next prior to talking about action planning.

CHOICE model Step 4c: Consolidating commitment. For clients with high readiness and moderate to high problems, extensive discussion about their motivation for making changes may not be needed. Instead they need to talk about what to do next. In the CHOICE model, when we have a client who has moderate to high problems and says they are more than 90% ready to make changes, we classify them as "high readiness" on the agenda-setting table. Further, instead of the Q3PFR printing the section entitled "Elicit DARN," you will find a section called "Consolidate Commitment." The steps we follow for clients who are classified with moderate to high problems and high readiness include completing a change talk summary that ends with a reflection about readiness to take action, assessing whether you need to revisit eliciting DARN change talk, and beginning action planning. Here is how this may sound for a fictitious client who reported numerous problems at work and was 100% ready to make some changes. Earlier when setting the agenda, the client said that they wanted to talk with the clinician about work problems.

Therapist: *Okay, so let's start with talking about work. You said you were doing badly at work in the past 90 days and that you worked 30 out of the past 90 days. You're really ready to make some changes in this area, saying that your main reason to make changes was so you could get off the streets. That sounds like something that is really important to you. You said you were 100% ready to do something about this, so it really seems like you want to get started on this right away.*

Client: *Yeah, I can't keep on doing what I'm doing, I've got to make some changes.*

Therapist: *So, what kind of changes have you been thinking about?*

Client: *I need to apply for some jobs.*

Therapist: *That's a great goal. How may you go about that?*

In this example, we have transitioned to talking about action steps much more quickly than we would with someone who is ambivalent about making changes. The therapist did this by using the question, "So what kind of changes have you been thinking about," which is the initial step of action planning (see p. 159). This is because we confirmed that the client was highly motivated to make some changes after we had used the reflection "…so it seems like you want to get started on this right away." So, for this client we did not have to do the second step in the consolidating commitment sequence, which is assessing whether to revisit eliciting DARN change talk. That is, if the client responds to the reflection "It seems like you want to get started" with sustain talk, we would then make a decision to go back to eliciting DARN change talk and then follow the rest of the sequence through action planning. Let's take a look at how this might sound for this same client.

Therapist: *Okay, so let's start with talking about work. You said you were doing badly at work in the past 90 days and that you worked 30 out of the past 90 days. You're really ready to make some changes in this area, saying that your main reason to make changes was so you could "get off the streets." That sounds like something that is really important to you. You said you were 100% ready to do something about this, so it really seems like you want to get started on this right away.*

Client: *Yeah, I can't keep on doing what I'm doing, I've got to make some changes, but I just don't think it will be of any use.*

Therapist: *You want to change but don't know if you can.*

Client: *I need to apply for some jobs but there aren't any out there.*

Therapist: *Your life would be so much better if you had a job.*

Client: *Yeah. I'd no longer have to put myself in harm's way to make money. My moneymaker is taking a beating.*

Therapist: *It's not safe for you to keep doing what you're doing.*

Client: *No, it's not.*

Therapist: *And you're willing to make some changes now for your own safety.*

Client: *I guess. I've been here before, and I always seem to go back to my old ways.*

Therapist: *Sounds like you're not sure you can do it. On a scale of 1 to 10, where 1 is not confident at all and 10 is completely confident, how confident are you that you can find other work?*

Client: *I dunno. Maybe a 4 or 5.*

Therapist: *Why are you a 4 or 5 and not a zero?*

Client: *I've done other difficult things in my life.*

Therapist: *You've survived worse.*

Client: *Not sure I'd say that, but I lost my kids and jumped through all kinds of hoops to get them back.*

Therapist: *You worked like crazy to get them back even though it was tough.*

Client: *Yeah, every step of the way, someone new was telling me I had to take another class, go here at this time, talk to my kids like this, not see this man. I hate social workers.*

Therapist: *When you make up your mind that something is worth doing, you do it.*

Client: *Yeah.*

Therapist: *And the dilemma now is figuring out if working hard to get a new job is worth it.*

Client: *Yeah.*

Therapist: *So how else may your life get better if you get a new job?*

Client: *I could just look myself in the eye a bit more.*

Therapist: *You'd respect yourself more.*

Client: *Yeah.*

Therapist: *So, you've got some great reasons for getting a new job, like being safer and having more respect for yourself. You're not 100% sure you can find a job, but if you make a decision that that's the way you want to go, you've shown in the past you can work like crazy to find one. So, what do you think you'll do?*

In this example, the clinician decided it would be best to backtrack and spend some time eliciting DARN change talk before moving directly into action planning. Even though the client stated on the GAIN-Q3 that they were 100% ready to make changes, they also expressed some ambivalence about making changes when the therapist started to make an initial attempt

at consolidating commitment and rapidly transitioning to action planning. So, the therapist had to restart the process. Also notice that instead of using an importance ruler, the therapist used the confidence ruler ("On a scale of 1 to 10, how confident are you that you can get a job?"). The client had already said that they were ready, but then they told us later that they were not confident that their efforts would pay off. Notice that using this question led us to more change talk about their past successes with navigating the child welfare system, which the therapist affirmed. Although it was kind of a winding road, this exchange led right back to the key question ("So what do you think you'll do?"), which is meant to move the session toward the next step, action planning.

CHOICE model Step 4d: Action planning. Once you have generated change talk and have used the EARS skills to build to a crescendo, you start the action-planning sequence by asking clients about the kinds of changes they are considering making. Remember, client statements on what they are thinking about doing is still considered a form of change talk, so we need to be mindful of reinforcing their ideas as we work toward sharing some of our own. Action planning is not always a linear process, so we need to be mindful of following a few simple guidelines to ensure that we remain true to the MI principles:

- Get the client to elaborate and be more specific about how they will go about making changes
- Affirm their ideas
- Ask permission to express concerns about any of their ideas
- Ask permission prior to expressing our recommendations
- Ask for the client's feedback on our ideas
- Preserve the client's option to choose what to do with our recommendations

Below we have a sample dialogue about how this may sound. We will go back to the teenage client we met earlier who said that they wanted to make changes largely to get their parents off their back. As you recall, the client already mentioned that they didn't want to quit entirely. Let's assume that the therapist already gave a change talk summary and has just asked the key question, which we reprint below to start off this action-planning process.

> ***Therapist:*** *So what do you think you'll do?*
>
> ***Client:*** *I guess my parents would be happy if I stopped altogether.*
>
> ***Therapist:*** *It's not what you want, but if it makes them happy you are willing to do it.*
>
> ***Client:*** *Yeah.*
>
> ***Therapist:*** *How may you go about doing that, if you decide to?*
>
> ***Client:*** *I'll just do it. It won't be a big deal.*

Therapist: *This is going to be super easy for you, and nothing can stop you from staying completely clean for a while.*

Client: *Yes. It is not like I need rehab or anything.*

Therapist: *That would be awful for you, and there is no way you'd ever consider it.*

Client: *Well, I know some friends that have been, and they said it was a joke.*

Therapist: *You're worried that it would be a waste of your time.*

Client: *They just said that other kids in the group were using and telling counselors what they wanted to hear… And so since others were not taking it seriously, my friends just kind of gave up and stopped going.*

Therapist: *You may consider going to treatment if you were seeing someone one on one.*

Client: *Maybe. I don't know if I really need it.*

Therapist: *You have some doubts about whether it would be worthwhile. May I share with you some information about our program here?*

Client: *I guess.*

Therapist: *Well, we use a model that is research-based and that we know works with other teenagers like you. It is a very gentle approach that is about helping you find fun stuff to do rather than using drugs and alcohol. The idea is that you can't quit using and then be bored all the time. It has to be worth it to make changes. The program will also focus on your goals. So for example, the counselor could help you do some planning about school, since you said earlier that one reason for making changes in your use was to do better in school. We can also work on communication with you and your parents, which some teens find useful. It lasts about 10 to 12 weeks, and you would meet with a counselor about once a week. What do you think?*

Client: *I don't know. I'll go if I have to.*

Therapist: *It is up to you. I can't decide whether you should do this or not.*

Client: *My parents are probably going to make me do it if you recommend it, though.*

Therapist: *You're frustrated because you feel like you have no choice.*

Client: *Yeah.*

Therapist: *So on a scale of 1 to 10, where 10 is really important and 1 is not important at all, how important is it for you to go to some counseling like this?*

Client: *4.*

Therapist: *Thanks for the honest reply. And why are you a 4 and not a zero?*

Client: *Because of what we were talking about earlier, getting my parents off my back and doing better at school.*

Therapist: *Those are the main things, and you can see no other benefits of going to treatment.*

In this exchange, the client exhibited some challenging behaviors. For example, they questioned the therapist on whether they have a choice, and the client also remained steadfast that they were not invested in the treatment idea yet. When this happened, the therapist reinforced the notion of choice and also reflected back the client's frustration ("You're frustrated because you feel like you have no choice"). Additionally, the therapist also used the readiness ruler to check in with the client on their perception of the treatment recommendation, renewing her efforts to elicit DARN change talk. Only this time the DARN change talk is in reference to the target behavior of entering treatment, an action step. It is important to note that this is okay to do, as clients sometimes waver when you get to action steps. Again, this example ends with the clinician eliciting more change talk, but notice that the change talk was not necessarily about why to make changes but rather in relation to the target behavior of entering treatment. Ideally, this conversation ends after more DARN change talk is generated and culminates in another key question.

However, there is also the possibility that the client may refuse to go to treatment. In that situation we may need to be flexible and pursue other avenues to change. This situation is a real test of how far we are willing to go to preserve a sense of client autonomy, in that we acknowledge that clients may not want to go about making changes in the way that we want them to. Below, we provide an alternative approach to the same dialogue above, in a situation where the client becomes more adamant about not going to treatment.

Client: *I'll just do it. It won't be a big deal.*

Therapist: *This is going to be super easy for you, and nothing can stop you from staying completely clean for a while.*

Client: *Yes. It is not like I need rehab or anything.*

Therapist: *There is nothing you could gain by talking to a counselor about this.*

Client: *Hell no. Counseling is a joke.*

Therapist: *Maybe you're right and now isn't the time to go to counseling. You'll have to decide. What are your ideas on what would work better for you?*

Client: *I told you, I can stop anytime.*

Therapist: *Can I share a concern I have for you?*

Client: *Yeah.*

Therapist: *I've worked with a lot of people who are coming off of using pot every day, and sometimes I hear people say it will be easy to kick. This may be true for some people, but I've noticed that most people really benefit from having a guide to help them early on. What do you make of that?*

Client: *I told you. I'm not doing it.*

Therapist: *I appreciate your honesty. Maybe now isn't the time and you'll be just fine cutting back on your own. Can I share with you some ideas on how people doing this on their own have gone about making changes without going to treatment?*

Client: *Yeah.*

Therapist: *Some people have found self-help group meetings useful, since there are other people there who are also trying to make changes. Others, however, take a different approach and simply set a goal for how much they will use and then track it to see if they are meeting that goal. That may be a good option for some people, but it sometimes depends on other things, too, like if it is acceptable to your parents or others who are concerned about you. How do those ideas sound to you?*

This example presented the clinician with many obstacles. First, the client agreed with our complex reflection that there was nothing to be gained from treatment. Notice how the therapist, rather than trying to argue with the client, sided with the ambivalence by saying, "Maybe you're right and now isn't the time to do this." This is called "coming alongside" the ambivalence, and it can be hard to pull off in the heat of the moment for many clinicians who are first learning MI. In this example, when the therapist came alongside, the client did not respond with change talk about why it may be good to go to treatment, which is what happens when all goes well in MI. Instead, the client stuck to their guns that they could manage on their own. The clinician decided not to do the hard sell for treatment and instead asked whether they could talk about other options.

We think that this type of scenario will not typically occur for clients who are mandated to attend treatment or comply with your referral. For example, if the clinician uses the reflection "So there is nothing to be gained from coming to treatment" or emphasizes choice by saying, "It is up to you," it will likely prompt some discussion about external pressure or a mandate to

come to treatment. In that scenario, you can follow the ideas presented in the first example of action planning above to emphasize choice, just like we did when this client said that their parents were going to force them to attend treatment.

CHOICE model Step 4e: Interrelated behaviors. Ideally, you will talk about one target behavior at a time and follow the sequence presented in Step 4 of the CHOICE model. However, sometimes when you're talking about one target behavior, you find out that it is intertwined with other behaviors. For example, you may start out discussing making changes in work behavior only to find out that part of why things are going badly at work is because the client is drinking heavily on weeknights and having difficulty getting to work the next day. So, if you are talking about action steps for doing better at work and the client starts telling you one thing they need to do is stop drinking, it is okay to ask them whether you can talk about their drinking now rather than later since it is related to their work difficulties. If this happens, it is okay not to follow the entire sequence as presented in Step 4 and to start fresh on the sequence for the new target behavior you have identified.

CHOICE model Step 5: Session close (1 to 5 minutes)

We finish the CHOICE model sessions by completing a session-close summary and giving referral information that we promised to deliver to the client. This summary is specifically designed to end the session on a positive note.

The key components of the session-close summary are 1) discussion of change talk across all problem areas, 2) reiteration and affirmation of next steps the client agreed to take, and 3) an open-ended question at the end of the summary to ask whether there are any loose ends. Whenever possible, the clinician should be enthusiastic about what was accomplished, commensurate with the extent of the accomplishments and their importance. Thus, the key difference between the earlier change-talk summaries we completed and this session-close summary is that now we are completing a summary transcending all concerns that were discussed and emphasizing next steps that arose from the discussion. Here is how a session summary might sound when the clinician and the client talked about reducing drug use and also monitoring diabetes.

> ***Therapist:*** *We've accomplished a lot today, and it has been great to work with you. Just to recap what we've discussed, you said you want to quit using pot because you're noticing some memory problems and because of the fights you're getting into with your partner. She is constantly nagging you to quit because her allergies are really bad, and the smoke bothers her. So, you said a good first step you said would be to not smoke in the house, and you're really committed to that. You also said you were open to talking to a counselor, so we're going to give you some information and set you up with that right after we finish here. Another concern of yours is that you said you need to start taking care of your diabetes. You were embarrassed by getting type II diabetes and will make a commitment to eating better and checking your sugars as often as your doctor recommends. You think that not smoking pot will help since you get the munchies and eat a lot of junk food when you're high. You agreed to call your physician this week, since you ha-*

ven't been in for a while and may need your sugars and medicine checked. You've made a great start toward working on your goals today! I'm wondering if there is anything else we should discuss before closing today?

6.7 Quality Assurance and Certification on the CHOICE Model

This section describes the certification process for the CHOICE model. Although the criteria used to judge a CHOICE model session are different from those used to judge the quality of a GAIN-Q3 assessment, the process is largely the same. That is, certification involves practicing the CHOICE model, submitting audio-recorded sessions for review by an experienced supervisor, and receiving feedback until the clinician has met the competency standards.

It should be noted that meeting the competency standards for the CHOICE model does not in any way mean that a clinician is an expert in MI. In fact, a dilemma we face in the MI community is promoting high-quality training and use of MI while simultaneously avoiding the expert stance in our dealings with other professionals. That is, just as we try not to hold ourselves out as experts to our clients, we also are mindful of modeling the MI spirit in our dealings with other professionals as they relate to our credentials and experience with MI. Having said this, we also note that the training received in this certification process is similar to that provided in clinical trials. We believe that it is of high quality, and we emphatically encourage people to continue consulting with others who are practicing MI to improve their skills well after they are certified on the CHOICE model.

What are the CHOICE model certification standards? Quality assurance reviewers will listen to your recordings and code your adherence to tasks that are included in each of the five CHOICE model steps (1: Overview, 2: Mining for client strengths, 3: Agenda setting, 4: Using MI to review concerns, and 5: Session close), as well as your overall skill level in using MI. The specific areas rated are summarized in Table 6.5 below. Adherence to the procedures used in the five steps of the CHOICE model is measured along a 5-point scale, with a score of 5 indicating excellent performance. To measure general MI skills, we have adopted some standards from the Motivational Interviewing Treatment Integrity measure (MITI; Moyers et al., 2010). This tool is a very detailed measure of clinician adherence to MI spirit and can also be used to rate competence in OARS and EARS skills.

Competency standards for adherence to Steps 1 through 5 of the model. To obtain certification, clinicians must get a passing score of 1 on all dimensions of the five steps of the model on the same recording. Below we provide guidelines for what would constitute high and low scores for each of these items.

Overview of Session

1a. Sounds conversational: A passing score of 1 would be achieved by an interviewer who is not at all reliant on the Q3PFR script for providing a client with the overview. The inter-

viewer is using language that is comfortable for them or tailored to the participant's level of understanding while retaining the key points that appear in the script. A score of 0 (needs improvement) would be achieved by overreliance on the Q3PFR script, as evidenced by mechanistic word-for-word verbatim reading of the script in a manner that sounds overly slow or mechanical.

1b. Includes autonomy-enhancing statements: A score of 1 would be achieved if the clinician uses the language in the Q3PFR script about the client's ability to choose and appropriately responds to client statements about limited choice. A score of 0 would be assigned if the clinician uses the language in the script and other autonomy-enhancing statements but also includes subtle autonomy-violating statements (e.g., "Well, you're going to have to do this for probation anyway"). A score of 0 may also be given if the clinician does not use the language in the Q3PFR script about client choice or if, in any ensuing discussion in this section, the preponderance of statements appears to minimize choice. This could include the use of confrontational statements such as, "Well, you wouldn't be here if you didn't have a problem, so you better listen up."

1c. Lists and previews tasks to accomplish: A score of 1 indicates that the clinician listed all the tasks that need to be achieved. A score of 0 is assigned if there was no attempt to preview the session activities using the statement on the Q3PFR or if key session tasks were not described.

1d. Ends with an open question: A score of 1 is assigned if the clinician uses an open question. A score of 0 is assigned if the clinician does not ask the client for feedback about the session plan or uses a closed question.

Mining for Client Strengths

2a. Gives brief rationale for reviewing strengths: Clinicians should present a brief yet concise explanation of why we spend time reviewing strengths. A score of 1 is given if the clinician provides a brief and clear explanation. A score of 0 is given if this procedure is not done or if the rationale presented is unclear.

2b. Identifies and affirms client strengths: A score of 1 is given to clinicians who seamlessly and creatively reframe challenging client behaviors or small steps toward change as strengths. Clinicians should sound genuine when delivering affirmations. The clinician should identify a minimum of one strength, even for the most challenging clients. A score of 0 is given for lingering too long and being overzealous in labeling strengths or making minimal or no effort to identify strengths.

Table 6.5 CHOICE model quality assurance rating form

	Rating
1. Overview of Session	
a. Sounds conversational	
b. Includes autonomy-enhancing statements	
c. Lists overview of tasks to accomplish	
d. Ends with an open question	
2. Mining for Client Strengths	
a. Gives brief rationale for reviewing strengths	
b. Identifies and affirms client strengths	
c. Links strengths to current problems	
d. Uses coping questions appropriately (if necessary)	
3. Agenda Setting	
a. Gives client choice about topics	
b. Asks for permission to talk about other topics	
4. Using MI to Discuss Concerns	
a. Follows progression appropriately	
b. Asks for permission to express concerns/recommendations	
5. Session Close	
a. Summarizes change talk heard throughout session	
b. Reinforces change talk	
c. Summary of next steps	
d. Affirmation of client accomplishments during session	
e. Question about any loose ends before closing	
6. **General MI Skills*** (*5 = high adherence; 1 = low adherence*)	
a. Autonomy respect	
b. Evocation	
c. Collaboration	
d. **Total** number of reflections	
e. **Total** number of questions	
f. Reflection-to-question ratio (row 6d divided by row 6e)	
* Adopted from Moyers, Martin, Houck, Christopher, & 2010	

2c. Links strengths to current problems: A score of 1 is given when the clinician facilitates a seamless transition between the discussion of the client's strengths and their current problems, as evidenced by rapid and smooth transition between these two topics. The clinician must ask the open-ended question about how strengths may help with their current problems in order to receive a score of 1. Finally, a 1 is given when the clinician makes connections between current problems and strengths that are not yet obvious to the client through expert use of reflections. A score of 0 is given when there is no attempt made to link strengths with current problems or only weak connections are made. A 0 is also given when the clinician appears to not recognize how the client's strengths transfer to the problems faced by the client.

2d. Uses coping questions appropriately (if necessary): A score of 1 is given when the clinician deliberately uses the word "doing" in the coping question (e.g., *You've got a lot going on. I'm wondering what you are doing to keep your head above water?*) and then finds and affirms at least one strength or positive coping skill in the ensuing discussion. A score of 0 is given if the clinician doesn't recognize appropriate situations for using the coping question, uses vague wording instead of emphasizing what the client has "done" to cope, or fails to affirm client strengths in the ensuing discussion.

Agenda Setting

3a. Gives client choice about topics: A score of 1 is given when the client is first asked what they want to discuss, and when the rational is provided for setting the agenda. We want a clear statement that the purpose of setting the agenda is to maximize the session's usefulness to the client by addressing discussion topics they perceive as important. A score of 0 is given if the client is not asked about their preference for topics, there is no rationale provided for why agenda setting is important in organizing the session, or the clinician reviews their own preferred concerns before the client's. Regarding the latter, a clinician could be rated as a 0 on agenda setting if the client said they wanted to talk about work problems first, and instead of doing this the clinician first talked about substance use problems.

3b. Asks for permission to talk about other topics: A score of 1 is given if the therapist asks for permission to discuss other topics not selected by the client. A score of 0 is given if such permission is not sought. This item will be rated as "not applicable" if the client and therapist agree on all discussion topics, which would render asking for permission unnecessary.

Using MI to Discuss Concerns

4a. Follows progression appropriately (i.e., briefly reviews problems, starts at either DARN or consolidating commitment as appropriate): A score of 1 is given when the clinician briefly reviews the problems reported in the area and then follows the progression of either eliciting DARN (for low-readiness clients) or consolidating commitment (for high-readiness clients). For the DARN sequence, sufficient change talk should be elicited and reinforced before moving on to action steps. This involves identifying reasons for change and rein-

forcing them using the EARS skills. For the consolidating commitment sequence, the change-talk summary should be done appropriately and the therapist should assess whether they need to revisit the DARN step prior to talking about action steps. Finally, the change-talk summary must include mention of the reasons for change and the reflection that now is a good time to make changes. A score of 0 may result from insufficient evocation of DARN change talk prior to moving on to discussing action steps, using an incomplete change-talk summary in the consolidating commitment sequence, or not briefly reviewing the problems reported in a particular area of concern.

4b. Asks permission to express concerns: The clinician receives a score of 1 if they ask permission prior to sharing any concerns or referrals and asks for client reactions to such concerns and referrals using an open question. A score of 0 would result from expressing concerns without first asking permission or asking for reactions afterwards.

Session Close

5a–e. Completes session-close summary: A score of 1 is given if all the following components are present: a) a summary of change-talk statements made by the client across target behaviors, b) use of wording that slightly exaggerates (i.e., reinforces) change talk, c) discussion of agreements made for next steps, d) an affirmation about what the client accomplished in the session, e) and a final question asking whether there are any loose ends. A score of 0 is given if one or more components of the session-close summary is missing.

Competency Standards for Adherence to General MI Skills

6a–c. MI Spirit: We have discussed three MI spirit dimensions: respect for autonomy, evocation, and collaboration. Each of these dimensions is rated along a 5-point scale with a score of 1 indicative of low adherence to the MI spirit and 5 as excellent adherence. We will describe these ratings briefly below, but the MITI manual (available for free download at http://casaa.unm.edu/download/MITI3_1.pdf) contains more extensive detail on how these ratings are scored. To pass the MI spirit component, the average score of autonomy, evocation, and collaboration must be equal to or greater than 4.

6a: Autonomy. Low autonomy scores would be given if the clinician were deliberately and vigorously creating an environment where there is no perception of choice. This could involve using a heavy-handed approach where the central feeling is that the therapist is telling the client why they "should" or "have to" change. Behaviors associated with this include giving unsolicited advice, dismissing the client's ideas as irrelevant or unworkable solutions, and using other heavy-handed approaches to persuade the client about why they need to change, such as labeling the client's behaviors as problematic even if the client does not view them as problematic. High scores are associated with the therapist asking for permission to give advice, telling the client that they will have to decide what to do with the recommendations, using tentative language that respects the possibility that the client

may not change, and vigorously creating an environment where the clinician continually emphasizes the client's choice about whether to change.

6b: Evocation. Low scores on evocation are indicative of weak attempts or missed opportunities to elicit and reinforce client change talk (EARS skills). A score of 5 indicates excellence at eliciting change talk or directing the session forward even when initial efforts do not work or when little change talk is offered. Additionally, the clinician always recognizes when the client has provided change talk and responds accordingly with EARS skills.

6c: Collaboration. Collaboration scores are influenced by how much the clinician validates the client's ideas for how change should occur and integrates them into the planning. Being too prescriptive about how change should occur, dismissive of client ideas, or failing to ask clients how they want to go about changing will lower collaboration scores.

6d. Reflection-to-question ratio. To pass this standard, the clinician must use a minimum of two reflections per question used during the CHOICE session. This is calculated as the number of reflections divided by the total number of both open and closed questions. Thus, a score of 2 or higher is a passing score.

Appendix A
Psychometric Analyses of the GAIN-Q3 Screeners

The psychometrics of the GAIN-Q3 have been created using data from a client population. Since all Q3 screener items (i.e., those items common to the Q3-Lite, Q3-Standard, and Q3-MI) are also found in the GAIN-I, we are able to examine the psychometric properties of the Q3 screeners using GAIN-I data.

Information is available for specific subgroups of clients, including those categorized by age, gender, and race and ethnicity. Tables with the full array of psychometrics and scale norms can be found on the GAIN Coordinating Center's website (http://www.gaincc.org/resources). In this appendix, psychometric information on the Q3 scales is presented for two age groups: adolescents (12–17) and adults (18+). Because screeners are designed to be efficient, we have reviewed both their internal properties and how well they predict the corresponding full-length GAIN-I scale scores in terms of concurrent and discriminant validity.

Alpha reliability

Internal consistency of the Q3 screeners was examined using Cronbach's alpha. The alpha values for each Q3 screener appear in Table A1 (adolescents; p. 174) and Table A2 (adults; p. 175) along the bottom. Screeners with an alpha greater than or equal to .70 are **bolded** in the tables. For comparison, the alphas for the corresponding full-length scales appear along the left side. This comparison is important because the size of the alpha is directly related to the number of items and will generally go down for a screener with fewer items.

The 53-item Total Disorder Screener has excellent internal consistency for both adolescents and adults (.90). Four of the nine screeners demonstrate good internal consistency for adolescents and adults (School Problems, Internalizing Disorders, Externalizing Disorders, and Substance Use), as indicated by reliability coefficients greater than or equal to .70. In addition, for adolescents the Crime and Violence Screener shows evidence of good internal consistency (.72); the same is true for the adults' Work Problems (.76) and Physical Health (.70) Screeners.

The Sources of Stress and Risk Behaviors Screeners fall short of typically accepted levels of internal consistency for both adolescents (.62, .67) and adults (.56, .64). For adolescents, the Work Problems and Physical Health Screeners also fall short of an acceptable level of internal consistency. For adults, only Crime and Violence falls just shy of the .70 cutoff. This is likely a function of the reduced number of items in the scale, lower internal consistency, and more

heterogeneous presentations than those referred to in the screener items. Considering the nature of these particular screeners in each population, the results are not surprising. Given their youth, many adolescents do not have jobs; they also are relatively healthy, though a certain segment will experience illnesses like asthma or mild allergies. Both the Sources of Stress and Risk Behaviors Screeners are composed of experiences that, although they capture their constructs very well (see validity results below), are not exhaustive lists of problems in those areas. Adult experiences of criminal and violent behavior may be more varied than represented by the items on the Crime and Violence Screener. In light of the results below on validity, efficiency, and prediction accuracy, these particular reliability results are not cause for concern. They do suggest, however, that the screener scores in these areas behave more like indices (i.e., problem counts) than scales (i.e., latent dimensions or syndrome scores).

Concurrent and Discriminant Validity

Concurrent and discriminant validity are both subcategories of construct validity (Campbell, 1960). For concurrent validity, we must show that measures of constructs that theoretically *should be* related to each other *are indeed* observed to be related; for discriminant validity, we must show that measures of constructs that theoretically *should not be* related to each another are indeed observed to be *unrelated*. To support the statement that a measure has construct validity, it is necessary to show evidence for both concurrent and discriminant validity.

Tables A1 (adolescents) and A2 (adults) display the correlations between each of the Q3 screeners (columns) with their related full-length GAIN-I scales (rows). The correlations along the tables' diagonals show evidence of strong relationships between the corresponding full-length and shortened scales. For adolescents, of the 10 total screeners in the Q3 (the tenth is the Total Disorder Screener), 7 are correlated at or above .90, with the remaining 3 at or above .86. For adults, 7 of 10 are correlated above .90, with the remaining 3 at or above .82. This represents strong evidence for concurrent validity given the correspondence (or convergence) between similar constructs.

Along the bottom of Tables A1 and A2, the average nondiagonal correlations are displayed. These are the average correlations between each Q3 screener and all unrelated full-length GAIN-I scales. To support the claim for discriminant validity, these values should be smaller than the diagonal correlations and, preferably, as small as possible. The values for individual screeners in Table A1 (adolescents) range from .14 for the Work Problems Screener to .40 for the Externalizing Disorders Screener. The values for individual screeners in Table A2 (adults) range from .04 for the School Problems Screener to .40 for the Externalizing Disorder Screener. All of the nondiagonal correlations fall well outside of the 95% confidence intervals for the diagonal correlations. This pattern of results provides evidence for discriminant validity given the results discriminate between dissimilar constructs.

The last columns of Tables A1 and A2 show the correlations for the Total Disorder Screener (the total symptom count across the individual screeners) with each of the full-length GAIN-I scales. The Total Disorder *Screener* is expected to be and is most highly correlated with the

Total Disorder *Scale*, which is the sum of the full-length scales from the GAIN-I (bottom row). For both adolescents and adults, this correlation is .96. While the Total Disorder Screener's correlations with the individual GAIN-I scales (which include all the symptoms on which the Total Disorder Screener is based) are higher than most of the other nondiagonal values in the tables, the Total Disorder Screener's average nondiagonal values (.62 for adolescents and .59 for adults) still fall outside the 95% confidence interval of the diagonal correlations. This provides strong evidence that the Total Disorder Screener scores are indeed measures of total severity rather than being driven by any one area.

Efficiency

The main reason for shortening scales is to save time. However, in doing so we do not wish to damage the accuracy of the measure. The best-case scenario would be to measure efficiently and accurately using the fewest items possible.

The total number of items in the Q3 screeners as presented in Tables A1 and A2 is 53, while the total number of items in the collection of GAIN-I scales is 222. Thus, the Q3 screeners as a whole are only 24% the length of their corresponding GAIN-I scales. In addition, the overall correlation between the GAIN-I scales and the GAIN-Q3 screeners is .96. As we saw above in the evidence for concurrent validity, the individual Q3 screeners are also highly correlated with their corresponding GAIN-I scales. Despite the fact that the set of Q3 screeners is less than one fourth the length of the corresponding full GAIN-I scales, the Q3 screeners are able to measure just as accurately.

Dennis and colleagues (2006) introduced a measure of efficiency that can be computed for each screener as defined by Equation 1:

$$(1)\ \text{Efficiency} = \frac{\#\ \text{of GAIN-Q3 screener items} \,/\, \#\ \text{of corresponding GAIN-I scale items}}{\text{diagonal correlation}}$$

Thus, efficiency goes down (good) with the fewer the items used in the screeners and up (bad) the less the screener is correlated with its corresponding full scale. The efficiency measure can be interpreted as the adjusted percent of items required to get virtually the same measuring information as obtained using the full-length scales. The goal is for all measures to have an efficiency measure less than 1. The efficiency measure for each Q3 screener is displayed in Tables A1 and A2 along the bottom. For adolescents these measures range from .15 to .55, while for adults they range from .15 to .54, thus demonstrating quicker measurement without a significant loss of information.

Table A1. Correlations between GAIN-Q3 screeners and GAIN-I scales

Adolescents (N = 10,625)

Full GAIN-I Scale	GAIN-I Number of items	GAIN-I Cronbach's Alpha	School Problems Screener (SPScrY)	Work Problems Screener (WPSscY)	Physical Health Screener (HPScrY)[b]	Sources of Stress Screener (SSScrY)	Risk Behaviors Screener (RBSscY)	Internalizing Disorders Screener (IDScrY)	Externalizing Disorders Screener (EDScrY)	Substance Disorders Screener (SDScrY)	Crime & Violence Screener (CVScrY)	Total Disorder Screener (TDScrY)[c, d]
Training Problem Scale (TPS)	8	0.79	**0.91**	0.11	0.20	0.28	0.22	0.22	0.36	0.27	0.34	0.52
Employment Problem Scale (EmPS)	8	0.72	0.12	**0.92**	0.13	0.16	0.17	0.13	0.14	0.14	0.14	0.28
Health Distress Scale (HDS)	11	0.72	0.22	0.12	**0.87**	0.37	0.37	0.49	0.37	0.36	0.25	0.59
Stress Combined Scale (StressSum)[e]	26	0.76	0.23	0.19	0.38	**0.86**	0.40	0.48	0.39	0.26	0.31	0.63
HIV Risk Scale (HIVrisk)	36	0.83	0.21	0.16	0.39	0.44	**0.90**	0.50	0.44	0.37	0.42	0.71
Internal Mental Distress Scale (IMDS)	43	0.94	0.26	0.14	0.55	0.51	0.47	**0.90**	0.55	0.41	0.33	0.75
Externalizing Disorder Combined Scale (BcsPgsSum)[f]	43	0.94	0.37	0.15	0.39	0.42	0.45	0.53	**0.92**	0.45	0.50	0.79
Substance Problem Scale (SPSy)	16	0.83	0.29	0.15	0.36	0.26	0.40	0.40	0.43	**0.92**	0.40	0.67
Crime & Violence Scale (CVS)	29	0.90	0.27	0.12	0.27	0.35	0.49	0.30	0.52	0.39	**0.89**	0.67
Total Disorder Scale (TotSum)[g]	220	0.97	0.44	0.22	0.57	0.59	0.66	0.73	0.78	0.62	0.63	**0.96**
GAIN-Q3 Number of items			4	4	4	8	10	6	7	5	5	53
GAIN-Q3 Cronbach's alpha			**0.71**	0.66	0.57	0.62	0.67	**0.74**	**0.79**	**0.76**	**0.72**	**0.90**
GAIN-Q3 efficiency[h]			0.55	0.55	0.42	0.36	0.31	0.15	0.18	0.34	0.19	0.25
95% CI for diagonal R Lower limit			0.90	0.91	0.86	0.85	0.90	0.90	0.91	0.92	0.88	0.96
Upper limit			0.91	0.92	0.87	0.86	0.91	0.91	0.92	0.93	0.89	0.96
Average nondiagonal R[i]			0.25	0.14	0.33	0.35	0.37	0.38	0.40	0.33	0.34	0.62

[a] All correlations are significant at $p < .01$.

[b] Two items on the Q3's Physical Health screener are combined into one item on the GAIN-I. Thus, the number of items on the Q3's Physical Health screener is given here as 4 rather than the actual 5.

[c] The Total Disorder Screener includes all the items in the nine screeners to the left.

[d] Because two Q3 items are combined into one GAIN-I item in the Physical Health screener as noted above, the total number of items on the Q3's Total Disorder screener is given here as 53 items rather than the actual 54.

[e] The Stress Combined Scale is calculated by combining the Other Sources of Stress Scale (mOSSI), the Personal Sources of Stress (mPSSI), the Financial Problems Scale (FPS), and homelessness in the past year (hmlesspy).

[f] The Externalizing Disorder Combined Scale is calculated by combining the Behavior Complexity Scale (BCS) and the Pathological Gambling Scale (PGS).

[g] The Total Disorder Scale is calculated by combining all the GAIN-I long scales, the Internalizing Mental Distress Scale (IMDS), the Externalizing Disorder Scale (BcsPgsSum), the Crime and Violence Scale (CVS), the Substance Problem Scale (SPSy), the Training Problem Scale (TPS), the Employment Problem Scale (EmPS), the Health Distress Scale (HDS), the Stress Combined Scale (StressSum), and the HIV Risk Scale (HIVrisk).

[h] Efficiency = (# of screener items / # of full scale items) / **diagonal** correlation.

[i] This is the average correlation of the screener with the eight (nondiagonal) full GAIN-I scales in the column (not including Total).

Table A2. Correlations between GAIN-Q3 screeners and GAIN-I scales

Adults (N = 10,175)

Full GAIN-I Scale	GAIN-I No. of Items	GAIN-I Cronbach's Alpha	School Problems Screener (SPScrY)	Work Problems Screener (WPScrY)	Physical Health Screener (HPScrY)[b]	Sources of Stress Screener (SSScrY)	Risk Behaviors Screener (RBScrY)	Internalizing Disorders Screener (IDScrY)	Externalizing Disorders Screener (EDScrY)	Substance Disorders Screener (SDScrY)	Crime & Violence Screener (CVScrY)	Total Disorder Screener (TDScrY)[c, d]
Training Problem Scale (TPS)	8	0.86	**0.96**	0.06	-0.03	0.01	0.01	-0.02	0.12	0.02	0.15	0.14
Employment Problem Scale (EmPS)	8	0.77	0.06	**0.92**	0.18	0.28	0.24	0.21	0.24	0.25	0.20	0.43
Health Distress Scale (HDS)	11	0.81	-0.01	0.15	**0.90**	0.33	0.31	0.50	0.34	0.26	0.14	0.55
Stress Combined Scale (StressSum)[e]	26	0.83	-0.03	0.31	0.39	**0.82**	0.46	0.51	0.43	0.37	0.27	0.67
HIV Risk Scale (HIVrisk)	36	0.86	0.00	0.25	0.39	0.46	**0.87**	0.53	0.49	0.40	0.34	0.72
Internal Mental Distress Scale (IMDS)	43	0.96	0.01	0.25	0.57	0.51	0.50	**0.92**	0.64	0.42	0.30	0.80
Externalizing Disorder Combined Scale (BcsPgsSum)[f]	43	0.94	0.13	0.28	0.39	0.43	0.47	0.59	**0.93**	0.45	0.46	0.79
Substance Problem Scale (SPSy)	16	0.91	0.02	0.27	0.30	0.30	0.42	0.41	0.44	**0.96**	0.34	0.68
Crime & Violence Scale (CVS)	29	0.87	0.16	0.18	0.16	0.29	0.37	0.27	0.51	0.32	**0.88**	0.56
Total Disorder Scale (TotSum)[g]	220	0.97	0.10	0.37	0.57	0.63	0.67	0.79	0.79	0.63	0.51	**0.96**
GAIN-Q3 Number of items			4	4	4	8	10	6	7	5	5	53
GAIN-Q3 Cronbach's alpha			**0.82**	**0.76**	**0.70**	0.56	0.64	**0.78**	**0.80**	**0.88**	0.66	**0.90**
GAIN-Q3 efficiency[h]			0.52	0.54	0.41	0.38	0.32	0.15	0.17	0.33	0.20	0.25
95% CI for diagonal R Lower limit			0.96	0.92	0.89	0.81	0.86	0.91	0.93	0.96	0.88	0.96
Upper limit			0.96	0.93	0.90	0.82	0.87	0.92	0.94	0.96	0.89	0.96
Average nondiagonal R[i]			0.04	0.22	0.29	0.33	0.35	0.37	0.40	0.31	0.27	0.59

[a] All correlations are significant at $p < .05$, except SPScrY by HDS, HIVrisk, and IMDS; and TPS by SSScrY, RBScrY, and SDScrY. All diagonal correlations all significant at $p < .001$.

[b] Two items on the Q3's Physical Health screener are combined into one item on the GAIN-I. Thus, the number of items on the Q3's Physical Health screener is given here as 4 rather than the actual 5.

[c] The Total Disorder Screener includes all the items in the nine screeners to the left.

[d] Because two Q3 items are combined into one GAIN-I item in the Physical Health screener as noted above, the total number of items on the Q3's Total Disorder screener is given here as 53 items rather than the actual 54.

[e] The Stress Combined Scale is calculated by combining the Other Sources of Stress Scale (mOSSI), the Personal Sources of Stress (mPSSI), the Financial Problems Scale (FPS), and homelessness in the past year (hmlesspy).

[f] The Externalizing Disorder Combined Scale is calculated by combining the Behavior Complexity Scale (BCS) and the Pathological Gambling Scale (PGS).

[g] The Total Disorder Scale is calculated by combining all the GAIN-I long scales, the Internalizing Mental Distress Scale (IMDS), the Externalizing Disorder Scale (BcsPgsSum), the Crime and Violence Scale (CVS), the Substance Problem Scale (SPSy), the Training Problem Scale (TPS), the Employment Problem Scale (EmPS), the Health Distress Scale (HDS), the Stress Combined Scale (StressSum), and the HIV Risk Scale (HIVrisk).

[h] Efficiency = (# of screener items / # of full scale items) / **diagonal** correlation.

[i] This is the average correlation of the screener with the eight (nondiagonal) full GAIN-I scales in the column (not including Total).

Validation of Interpretive Cut-Points

The Q3 cut-points were validated based on sensitivity (the percentage of people with disorders on the full GAIN-I correctly identified by the Q3), specificity (percentage of people without a disorder on the full GAIN-I correctly excluded by the Q3), and the percentage of area under the curve (AUC) in a receiver operating characteristics (ROC) analysis plotting the sensitivity (y-axis) against 1 minus specificity (x-axis). The optimal cut-point is the one closest to or above 90% sensitivity, 90% specificity, and 90% of the AUC (with values of 80% being good and 70% being fair). These analyses were done separately for adolescents and adults for the total Q3 and for each of the nine individual screeners.

Table A3 shows the sensitivity, specificity, and area under the curve for cut-points of 1 or more, 2 or more, and 3 or more symptoms on the total and each of the nine screeners relative to respective diagnoses for each dimension for both adolescents and adults. The Total Disorder Screener requires a cut-point of 2 or more for adolescents and adults to get an acceptable balance of sensitivity and specificity. The Total Disorder Screener was very well behaved, with 99% of the area under the curve for both adolescents and adults.

For both adolescents and adults, all the screeners have at least 92% of their area under the curve. However, as illustrated in Table A3, there is no one optimal cut-point with at least 90% sensitivity and specificity across all the screeners, though optimal cut-points for both adolescents and adults are identical.[1] A cut-point of 1 is optimal for both adolescents and adults for the Work Problems, Sources of Stress, Externalizing Disorders, Substance Disorders, and Crime and Violence Screeners; a cut-point of 2 is optimal for both adolescents and adults on the School Problems, Health Problems, Risk Behaviors, and Internalizing Disorders Screeners. Having only one cut-point would potentially enable the sorting of clients into those who *probably do* and *probably don't* have actual problems as identified by the full GAIN-I scales.

Because the value of the single cut-point varies by scale—with cut-points of 1 and 2 both identified as optimal depending on the scale—we chose to approximate the sorting of individuals into three triage groups based on their screener scores. A score of 0 indicates an unlikely diagnosis, 1 to 2 indicates a possible diagnosis, and 3 or more indicates a probable diagnosis. This is a reasonable approach given the lower cut-point (1) has at least 90% sensitivity for all but two of the screeners for adolescents (Sources of Stress and Substance Disorders) and all but one of the screeners for adults (Externalizing Disorders). Even so, the sensitivities of the scales that do not reach the preferred minimum of 90% are still in the upper 80s. For these scales in their respective client groups, there is a slightly increased risk for overidentification of cases deemed "possible diagnosis," when in fact there would not be a diagnosis on the longer scale. In addition, the upper cut-point (3) has at least 90% specificity for all screeners for both adolescents and adults (with the lowest specificity value at .98 for this cut-point). Thus by using

[1] On the School Problems Screener, a cut-point of 2 is optimal for adolescents while a cut-point of 1 is only very slightly better for adults. Given a cut-point of 2 for adults functions so close to the cut-point of 1, the cut-point of 2 is deemed optimal for both adolescents and adults.

a cut-point of 3 to separate those who *possibly do* and *probably do* have a diagnosis, there is very little risk of mistakenly identifying someone as having a diagnosis when in truth they do not.

Comparisons of the ROC curves by ages suggest that the Q3 worked slightly better for adults than adolescents on the School Problems, Health Problems, Sources of Stress, Risk Behaviors, Internalizing Disorders, and Substance Disorders Screeners; the Q3 worked slightly better for adolescents than adults on the Work Problems, Externalizing Disorders, and Crime and Violence Screeners.

Table A3. Sensitivity, specificity, and area under the curve (AUC) between GAIN-Q3 cut-points and self-reported GAIN-I diagnoses by age[a, b]

		Adolescent (n = 10,625)			Adult (n = 10,167)		
Screener[b]	Cutoff	% Sensitivity	% Specificity	% AUC	% Sensitivity	% Specificity	% AUC
School Problems Screener (SPScrY)	≥ 1	**99**	64		**99**	**95**	
	≥ 2	**91**	**91**	**97**	**93**	**99**	**99***
	≥ 3	70	**100**		64	**100**	
Work Problems Screener (WPScrY)	≥ 1	**99**	**93**		**99**	87	
	≥ 2	80	**99**	**98**	84	**98**	**98***
	≥ 3	40	**100**		52	**100**	
Health Problems Screener (HPScrY)	≥ 1	**96**	67		**99**	55	
	≥ 2	75	**95**	**92**	**91**	90	**96***
	≥ 3	38	**100**		64	**100**	
Sources of Stress Screener (SSScrY)	≥ 1	87	**100**		**90**	**100**	
	≥ 2	53	**100**	**94**	64	**100**	**95***
	≥ 3	30	**100**		40	**100**	
Risk Behaviors Screener (RBScrY)	≥ 1	**100**	68		**100**	48	
	≥ 2	89	**99**	**98**	**95**	**94**	**98***
	≥ 3	61	**100**		77	**100**	
Internalizing Disorders Screener (IDScrY)	≥ 1	**98**	67		**100**	60	
	≥ 2	87	**90**	**95**	**95**	85	**97***
	≥ 3	66	**98**		81	**97**	
Externalizing Disorders Screener (EDScrY)	≥ 1	**90**	**100**		86	**100**	
	≥ 2	77	**100**	**95**	70	**100**	**93***
	≥ 3	60	**100**		53	**100**	
Substance Disorders Screener (SDScrY)	≥ 1	88	**100**		**91**	**100**	
	≥ 2	69	**100**	**94**	79	**100**	**96***
	≥ 3	49	**100**		68	**100**	
Crime & Violence Screener (CVScrY)	≥ 1	**94**	85		**93**	82	
	≥ 2	65	**99**	**94**	57	**99**	**92***
	≥ 3	43	**100**		33	**100**	
Total Disorder Screener (TDScrY)	≥ 1	**100**	51		**100**	37	
	≥ 2	**98**	87	**99**	**99**	82	**99**
	≥ 3	**96**	**99**		**97**	**100**	

[a] Sensitivity is the percent of people with a diagnosis on the GAIN-I who are correctly identified by a screener at or above a given cut-point; specificity is the percent of people without a diagnosis who are correctly rejected by the screener at or above a given cut-point; AUC is the area under the curve formed by the value for 1-specificity on the x-axis and the sensitivity value on the y-axis.

[b] Results are relative to detecting a moderate or high problem on each screener's associated full GAIN-I scale.

*These AUC values are significantly different by age at $p < .05$.

Appendix B
GAIN Cognitive Impairment Screener

(see p. 21 for instructions)

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

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

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

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

b. About what time is it?
(Circle 3 for any error)..... 0 3

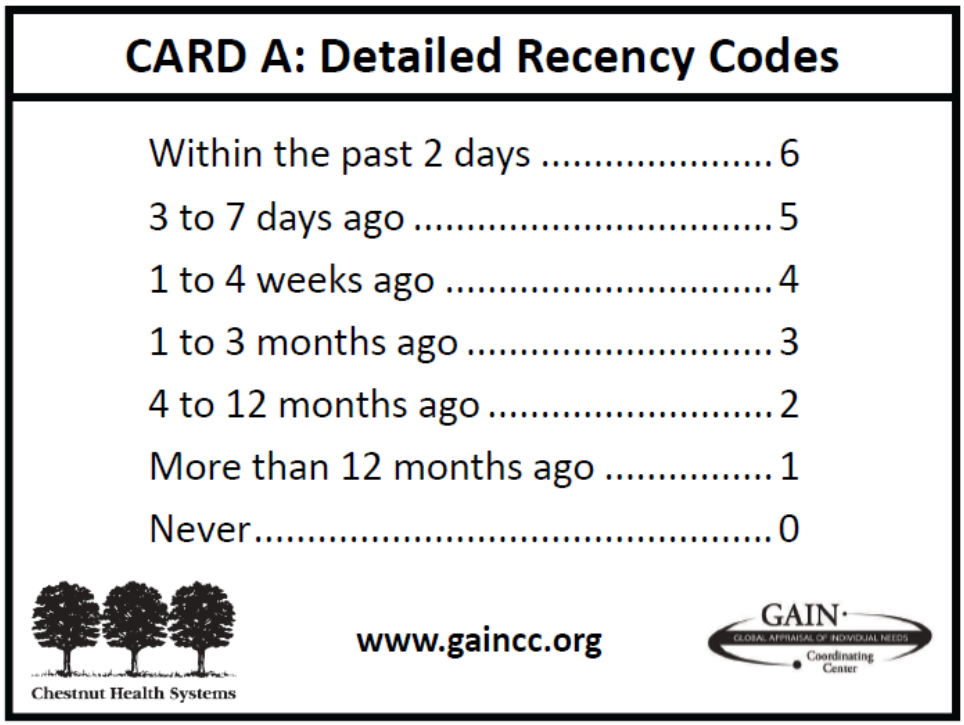
d. Please count backwards from 20 to 1.
[20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1]
(Circle 2 for one error, 4 for 2 or more errors) 0 2 4

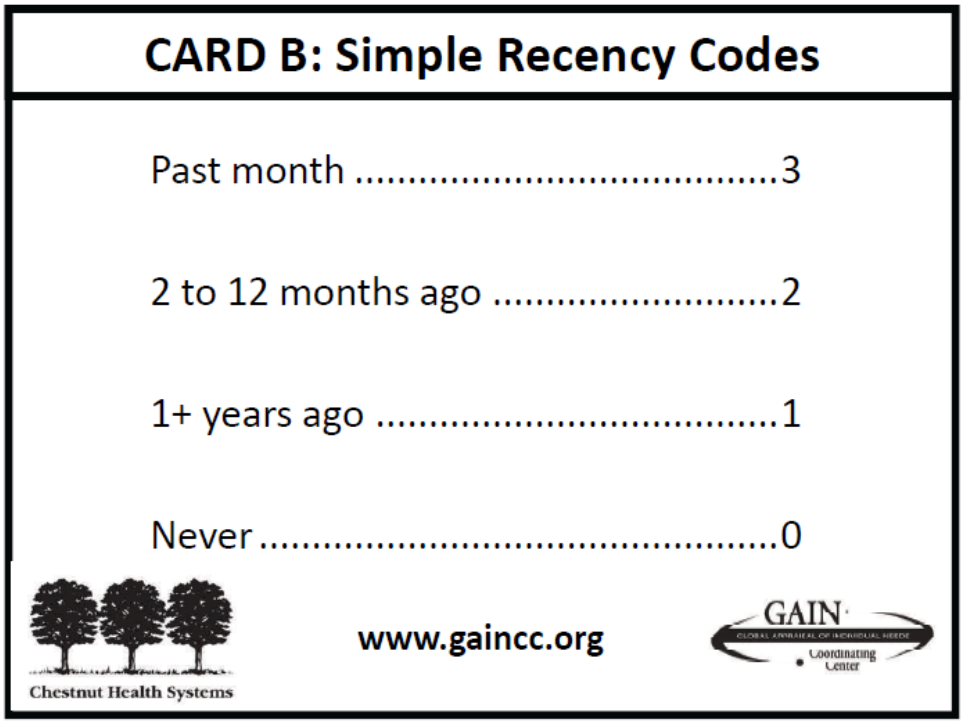
e. Please say the days of the week in reverse order.
[Sat, Fri, Thurs, Wed, Tues, Mon, Sun]
(Circle 2 for one error, 4 for 2 or more errors) 0 2 4

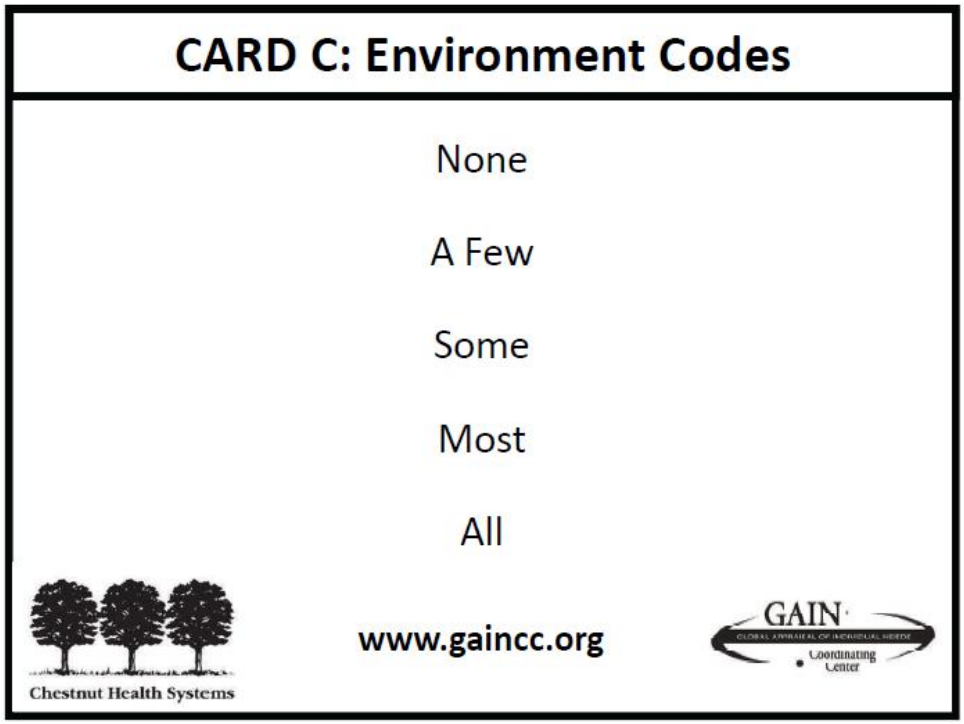
f. Please repeat the phrase I asked you to repeat before.
[John / Brown / 42 / Mark Street / Detroit]
(Circle 2 for each subsection of /text/ missed)..... 0 2 4 6 8 10

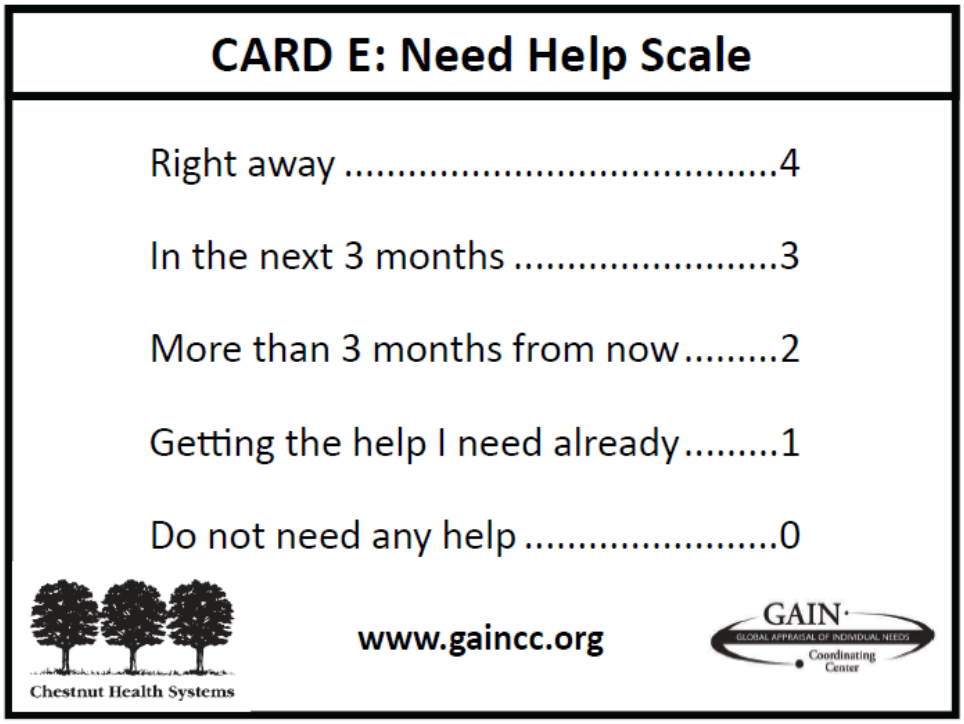
g. **(Add up scores from a through f and record)**..... |__|__|

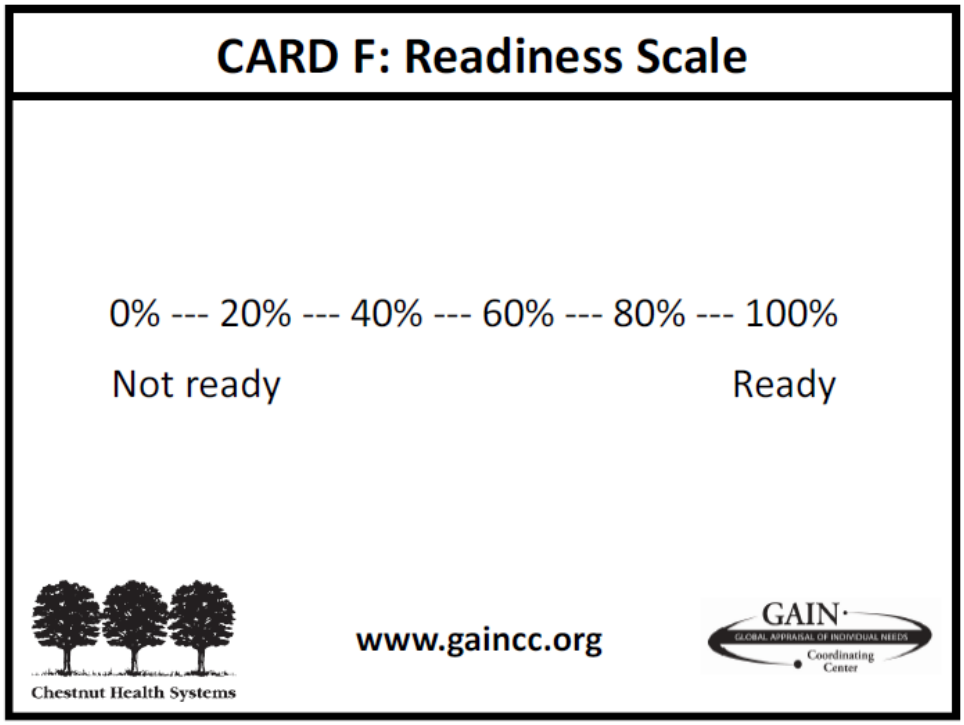
Appendix C
GAIN Response Cards

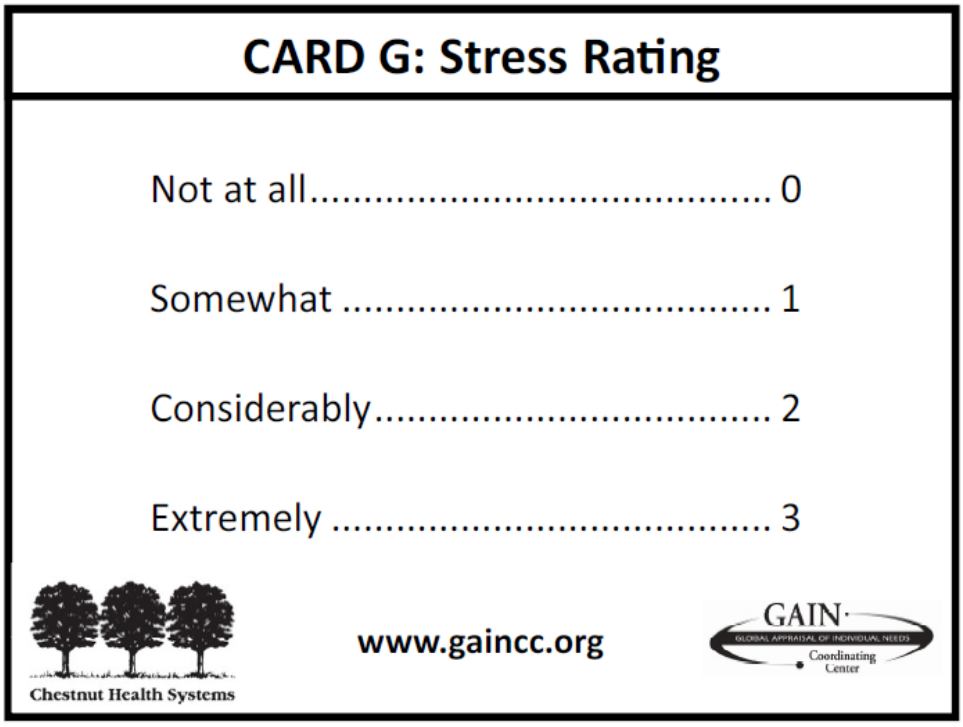


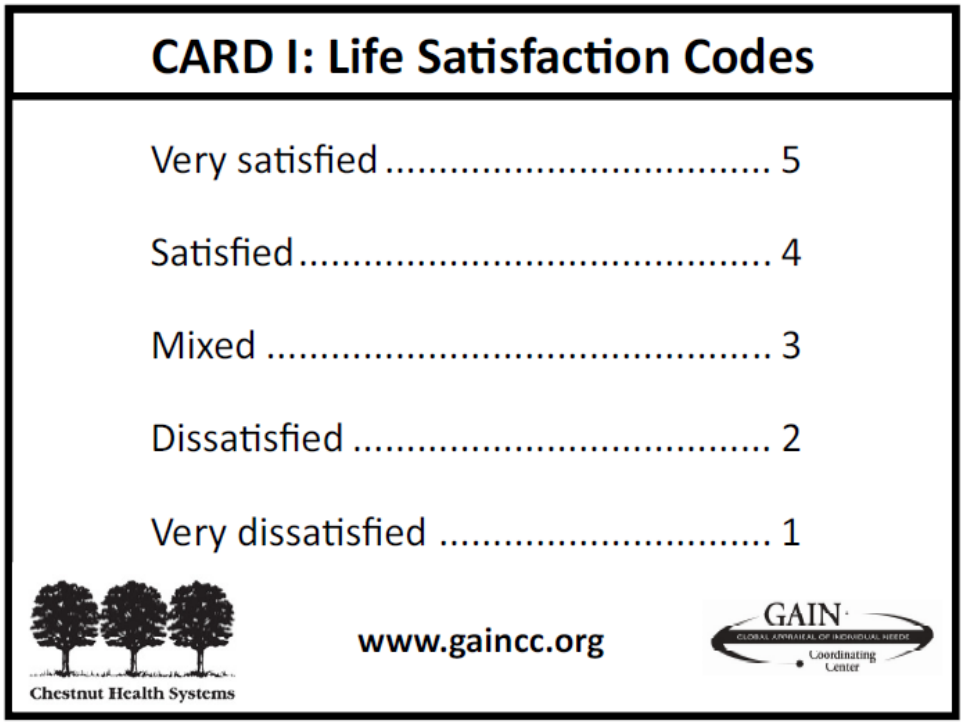

CARD B: Simple Recency Codes
Past month 3
2 to 12 months ago 2
1+ years ago 1
Never 0
Chestnut Health Systems
www.gaincc.org
GAIN
Coordinating Center

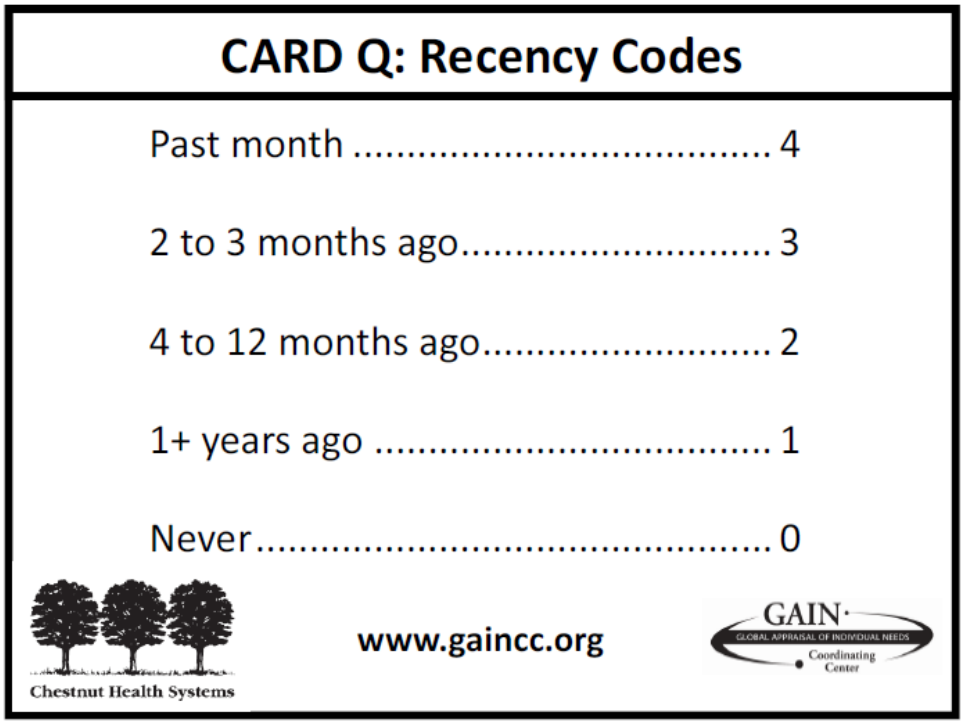

CARD C: Environment Codes
None
A Few
Some
Most
All
Chestnut Health Systems
www.gaincc.org
GAIN
Coordinating Center


CARD E: Need Help Scale
Right away 4
In the next 3 months 3
More than 3 months from now.....2
Getting the help I need already.....1
Do not need any help 0
Chestnut Health Systems
www.gaincc.org
GAIN
GLOBAL APPRAISAL OF INDIVIDUAL NEEDS
Coordinating Center


CARD F: Readiness Scale
0% --- 20% --- 40% --- 60% --- 80% --- 100%
Not ready
Ready
Chestnut Health Systems
www.gaincc.org
GAIN
GLOBAL APPRAISAL OF INDIVIDUAL NEEDS
Coordinating Center


CARD G: Stress Rating
Not at all..... 0
Somewhat 1
Considerably..... 2
Extremely 3
Chestnut Health Systems
www.gaincc.org
GAIN
Coordinating Center


CARD I: Life Satisfaction Codes
Very satisfied 5
Satisfied..... 4
Mixed 3
Dissatisfied 2
Very dissatisfied 1
Chestnut Health Systems
www.gaincc.org
GAIN
Coordinating Center


CARD Q: Recency Codes
Past month 4
2 to 3 months ago..... 3
4 to 12 months ago..... 2
1+ years ago 1
Never..... 0
Chestnut Health Systems
www.gaincc.org
GAIN
GLOBAL APPRAISAL OF INDIVIDUAL NEEDS
Coordinating Center

Appendix D
Instructions for Self-Administration

Thank you for completing this assessment! A staff member will fill in some administrative information and read a brief introduction. The staffer may also work with you to establish some memory anchors (which we'll write at the end of this sheet) and give you a brief mental checkup to make sure that you're able to complete this form. The staffer will then give you a copy of the form to fill out on your own or will set you up on a computer to fill in the responses on screen. Here are some guidelines.

- Many of the questions, such as these yes-no questions or the questions that ask you for the last time something happened, have numbers that represent the response choices, so please circle the number for the most accurate response. Select only one response for these questions.

PH4.	You want to make changes in your health-related behaviors because...	Yes	No
a.	you will feel better.	(1)	0
b.	you will stop worrying about your health.	1	(0)
c.	you will be able to participate in more activities.	(1)	0
d.	you will get more done.	(1)	0
e.	you won't be in pain.	1	(0)
f.	other people will stop bothering you about your health.	1	(0)

- Questions that you answer in your own words are called "verbatim items." All of them are marked with response lines and the letter v. Your answers to verbatim items don't need to be long, but please write neatly.

A4a. In a few words, can you tell me why you are here today? (What is your main reason for coming to treatment?) (Do not ask, "Any others?")

v1. I was referred by my guidance counselor

- Questions that ask you how many days or times something happened should always be answered with a number. If the answer is none or zero, please print 0 in the open box. Print all responses that go in boxes flush to the right, as shown below:

SP1e. **During the past 90 days**, on how many **days**...

1. were you absent from school or training for a full day? ..... |__|6| Days
2. did you go to any kind of school or training? ..... |5|8| Days

- "MENTIONED" in capital letters over the response choices means that you should mark yes for all the responses that apply to you and no for all those that don't. If you have anything to report that isn't mentioned in the list, circle yes for the last item (99) and fill in the verbatim line.

B13. What kinds of diplomas, degrees, work-related certificates or licenses have you received? (Any others?)

		MENTIONED Yes	No
1.	High school diploma	(1)	0
2.	Passed GED (general equivalency diploma)	1	(0)
3.	Adult Basic Education (ABE) certificate	1	(0)
4.	Junior college or associate's degree	(1)	0
5.	Bachelor's degree	(1)	0
6.	Advanced college degree (master's or doctorate)	1	(0)
7.	Vocational or trade certificate	1	(0)
8.	Trade license apprenticeship	1	(0)
9.	Commercial driver's license	(1)	0
99.	Other degrees or licenses **(Please describe)**	1	(0)

v. _____

- There are instructions throughout the assessment in square brackets and boldface, as shown below. Some of these instructions tell you to skip items that do not apply to you, such as questions about treatment if you've already told us that you've never been to treatment. Never skip further than directed or you'll miss important items.

MH2h. When was the **last** time, if ever, you were treated for a mental, emotional, behavioral or psychological problem by a mental health specialist or in an emergency room, hospital or outpatient mental health facility, or with prescribed medication? 4 3 2 (1) 0

[IF MH2h IS LESS THAN 3, GO TO MH3a]

- Some questions are marked "Clarify and code," which means that you should write down the answer in your own words. A staff member will later code the response that best fits your statement, which may require them to ask for some additional information.

- Depending on the version of the instrument you are given, you may see a box labeled "For Staff Use Only" about halfway through each section. If you see one of these, skip the items in the box and the rest of the items in that section and go to the next section. A staffer will administer any required items from these skipped sections after you complete the assessment.

- If you are not sure about an answer, please try to give us your best guess. If you change your mind about an answer, please cross through the old answer and select the new answer.

- If you honestly don't know the answer to a question, write "DK" to the right of the response or response box. We encourage you to answer all the questions, but if there are any that you really don't want to answer, write "RF" to the right of the response or response box. It is important that you either answer each question or write "DK" or "RF." Otherwise, we'll think that you just missed the answer by mistake and we'll ask you about it again.

CV1.	When was the **last** time you...						
a.	had a disagreement in which you pushed, grabbed or shoved someone?	4	(3)	2	1	0	
b.	took something from a store without paying for it?	4	3	2	1	0	DK
c.	sold, distributed or helped to make illegal drugs?	4	3	2	(1)	0	
d.	drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0	RF
e.	purposely damaged or destroyed property that did not belong to you?	4	3	2	(1)	0	
f.	were involved in the criminal justice system, such as jail or prison, detention, probation, parole, house arrest or electronic monitoring?	4	(3)	2	1	0	

- If you do not understand something and want to go over it with a staff person, put a question mark to the right of the item. If you need a break, write the time on the page where you stop, and after your break, write the time you started up again on that same page.

- If you have any questions, please ask, either now or when turning in the completed assessment.

If we establish a memory anchor to help you recall the different time frames mentioned in this assessment, we'll write it here:

90-day anchor: v. _____

If the last time something happened was before this event, answer either "4 to 12 months ago," "More than 12 months ago," or "Never" depending on when it was. If the last time something happened was between this event and today, answer either "2 to 3 months ago" or "Past month."

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