

## 6. Level of Care Placement

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

### 6.1 Continuum of Care

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

- **Outpatient Assessment/Outreach.** This is a state funding category to cover initial screening assessments to determine where to place participants in the continuum of care. It can be in a program, part of an outreach effort, or part of a centralized intake unit.
- **Level 0.5 Early Intervention.** This level is targeted at participants who do not meet criteria for abuse or dependence or for whom additional information is being collected. It might include a school-based program or educational program for first-time driving-under-the-influence (DUI) offenders.
- **Level 1 Outpatient Services (OP).** This level is targeted at individuals meeting criteria for abuse or dependence who have stable or manageable symptoms of withdrawal and medical or psychological problems, recognize their problems, appear able to resist use, and do not have a hostile home environment. Care is typically provided for less than 9 hours per week.
- **Opioid Maintenance Therapy (OMT)** can be a service in any of the above levels of care and is often provided in a specialized outpatient setting. It is targeted at participants who meet criteria for opioid dependence, have repeatedly failed earlier treatments, are at high risk of relapse, or are pregnant or likely to engage in behaviors that would put them or others at severe risk.
- **Level 2 Intensive Outpatient Services.** This level is targeted at participants meeting criteria for abuse or dependence who require multiple supportive contacts per week to avoid relapse, are having any medical or psychological problems addressed through consultation/referral, or who have continued to use substances during outpatient care. Treatment can be either an evening program for participants with some structure at home,

work or school (level 2.1 IOP; 9-20 hrs/wk) or partial hospitalization or day treatment for those who lack structure or are in a more hostile environment (level 2.5 PH; 20+ hrs/wk). Treatment consists primarily of counseling and education about alcohol and other drug problems with ready access (within 24 hours by phone) to psychiatric, medical, and laboratory services. Treatment also typically covers coping, nutrition, and vocational issues and may use multisystemic therapy interventions instead of group work.

- **Level 3 Residential/Medically Monitored Inpatient Services.** This level targets participants who have unsafe living environments and need time to develop their recovery skills, and it includes medical monitoring of manageable medical or psychological problems. It can include halfway houses or other low-intensity residential treatments that are typically part of continuing care (level 3.1 HH/LIRT), medium-intensity residential services that typically run fewer than 30 days (3.3 MIRT), longer-term residential treatment programs or therapeutic communities (3.5 LTR/TC), or high-intensity residential treatment or intensive inpatient programs that are designed to also treat medical or psychological problems (3.7 HIRT). A diagnosis of dependence is required for adults and typically (but not always) required for adolescents.
- **Level 4 Medically Managed Intensive Inpatient Services (MM/IP).** This level is targeted at participants meeting criteria for dependence who have acute biomedical, emotional, or behavioral problems requiring on-site medical or psychiatric care 24 hours per day. Typically, this is limited to short-term hospital-based care.
- **Correctional programs.** These are typically therapeutic communities (see Barthwell et al., 1995), and most are similar to level 3.5 but are targeted at participants who may currently be in remission only because they are in a controlled environment. Typically, these programs are a precursor to early release on parole and are targeted toward nonviolent offenders.
- **Detoxification Units.** These can be freestanding units or services associated with a larger unit. They focus on treating intoxication and withdrawal. Depending on both risk of harm and willingness to comply, detoxification can be provided in a setting with 24-hour medical management (level 4-D), 24-hour medical monitoring (level 3.7-D), 24-hour clinical management or “social detoxification” (level 3.2-D), outpatient ambulatory care under close monitoring by a credentialed and licensed nurse (level 2-D), or outpatient without extended monitoring (level 1-D).
- **Specialized service delivery units.** These units typically serve participants across multiple treatment units and provide additional medical (including HIV counseling and testing), psychiatric (including further assessment), family (preservation, childcare, Head Start, contraception), and wraparound (transportation, housing, training, employment, financial, legal) services.

While many services need to be matched at the individual level (see the next chapter), these levels of care (as well as agency and geography) are often associated with access to “bundles of service.” Other typologies can be used as long as the organization agrees on how they will relate the ASAM criteria to the various levels of care. It should be noted that specific models of care

(e.g., manualized interventions, therapeutic communities) are somewhat tangential to this topology and may even cross its boundaries.

## **6.2 Using the GAIN to Address ASAM Patient-Placement Criteria**

Both ASAM PPC 2 (1996) and PPC 2R (2001) provide a detailed description of the criteria for intaking, continuing, or discharging participants from each level of care. Many organizations further adapt this to their specific levels of care or take into account other placement issues (e.g., the court, employers, financing). It should be noted that these are less fixed decision rules than they are a set of overlapping principals upon which to base placement. The core criteria include one diagnostic criterion (A) and six dimensional criteria (B1. Intoxication and Withdrawal Potential; B2. Biomedical Conditions and Complications; B3. Emotional/Behavioral Conditions and Complications; B4. Readiness for Change (formerly Treatment Acceptance/Resistance); B5. Relapse Potential; and B6. Recovery Environment). It should be noted that the first three dimensional criteria tend to be associated with the need for placement in levels of care that can provide the appropriate services or monitoring of acute intoxication or withdrawal (e.g., detoxification, methadone) or other problems (such as treatment of medical or psychiatric problems). The second three criteria are actually more associated with distinguishing between who needs outpatient vs. inpatient or more structured substance use treatment. Moreover, most programs will also consider a range of other issues including the extent of illegal activities, vocational activities, victimization, psychosocial stressors, and time in controlled environment.

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

**Criterion A: Diagnosis.** While anyone can be referred for assessment or early intervention based on substance use, formal treatment is generally limited to those meeting DSM-IV criteria (APA, 1994) for abuse or dependence. Inpatient levels of care will typically be limited to those meeting criteria for dependence. The one exception might be someone in an acute state of intoxication or withdrawal requiring detoxification services before diagnosis can be determined. The prior chapter contains a detailed discussion of substance-related diagnoses. For placement (particularly when services are limited by diagnosis), it is often essential to review other

information when a participant's self-report puts them just below the diagnostic threshold. Some common examples of this are listed below.

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

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

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

**Criterion B1: Intoxication and Withdrawal Potential.** Current intoxication should be evaluated to determine the need for either ambulatory, social, or medical detoxification. Where there is risk of severe withdrawal, placement is directed toward facilities capable of addressing medical or psychological needs. Where there is opioid dependence, consideration should be given to the use of methadone therapy as an adjunct to treatment. More recent work suggests the desirability of considering naltrexone for heavy alcohol users. Below is a list of the risk factors that the ICP will check for related to this dimension.

- High number of current withdrawal symptoms [12+ Sx in S3c]
- Moderate risk only: any current withdrawal symptoms [1+ in Sx S3c1 to S3c99]
- Moderate risk only: any history of seizures [S3a = 1]
- Current d.t.'s or seizures [S39 or S3c10 = 1]
- Getting drunk or high for most of the day weekly [S2s2 > 12]
- Drunk for most of past 48 hours [S2b = 6]
- History of seizures and current withdrawal symptoms [1+ symptoms in S3c and S3a = 1]
- Using daily [S2s1a < 45]
- Using opioids weekly [S2g1 or S2h1 or S2j1 > 12]
- Used in the past two days [S2a-r most recent/highest]
- In detoxification program during the past 90 days [S5a = 1+]
- In substance abuse treatment during the past 90 days [S7d > 2]
- In controlled environment for 13+ of the past 90 days [S2x = 13+ or E3f = 13+]
- In controlled environment for 1-12 days of the past 90 days [S2x = 1+ or E3f = 1+]

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

**Criterion B2: Biomedical Conditions and Complications.** The goal here is to identify the nature of any major biomedical problems, the extent to which they are already being appropriately managed, and the extent to which they pose challenges for the effective delivery of care. For managed conditions, these may simply require minor modification (e.g., allowing a diabetic to have a snack during group) or referral and monitoring. For others (e.g., withdrawal combined with a weak heart or seizures) it may imply the need for more medically managed or inpatient care. Below is a list of the risk factors that the ICP will check for related to this dimension.

- High number of past-year biomedical problems [7+ Sx in P3a-k]
- Allergic to [text from p10av]
- Experiencing health distress in the past two days [P9 = 6]
- Frequent health problems in the past 90 days [P9a > 12]
- Current biomedical problems that frequently interfere with meeting responsibilities [P9b > 12]
- Health problems interfering with responsibilities in the past 90 days [P9b > 0]
- Requires medical assistance in order to attend treatment [P10 = 1 and text from P10v]
- Past-month history of hepatitis [P6a = 3]
- Lifetime history of hepatitis [P6a = 1-2]
- Past-month history of tuberculosis [P6b = 3]
- Lifetime history of tuberculosis [P6b = 1-2]
- Past-month history of other sexually transmitted diseases [P6c = 3]

- Lifetime history of other sexually transmitted diseases [P6d = 1-2]
- Past-month history of other infectious diseases [P6d = 3]
- Lifetime history of other infectious diseases [P6e = 1-2]
- Lifetime pattern of significant health care utilization [Sum P11a-c > 12]
- Emergency room utilization during the past 90 days [P11f > 0]
- Received physical health treatment during the past 90 days [P11e > 2]
- Medical services needed to participate in treatment [P10 = 1 and text from P10v]:
- High needle risk during the past year [R1a-j{NPS} > 4]
- Needle sharing in the past 90 days [R1m > 0]
- Needle use in the past 90 days [R1k > 0]
- High sex risk during the past year [R2a-n{SxRS} > 5]
- Moderate risk only: Substantial sex risk during the past year [R2a-n{SxRS} > 1]
- Multiple sexual partners in the past 90 days [R2p+q > 1]
- Having sex without (barrier-based) protection in the past 90 days [R2r-s > 0]
- Sexually active in the past 90 days [R2r-s > 0]
- Needle use [R1k > 0] may exacerbate health problems related to infectious diseases [any of P6a-e > 0]
- Not eating [R5a > 0] may exacerbate dietary problems [P10j = 1]
- Currently pregnant [P5b = 5]
- Uncertain if currently pregnant [P5b = 4]
- Recovering from (successful) pregnancy within the past year [P5a < 5 and P5b = 1]
- Significant health care utilization in the past 90 days [P11f-j = 1+ or P11k = 1]
- Substance abuse tied to pain during intercourse [R2n = 1]
- Use of alcohol [S2a > 2 or S2a1 > 0] may exacerbate health problems related to hepatitis [P6a > 0]
- Use of alcohol [S2a > 2 or S2a1 > 0] may exacerbate health problems related to pregnancy [P5b1 = 5]
- Use of alcohol [S2a > 2 or S2a1 > 0] may exacerbate nervous system problems [S3a = 1 or P10d = 1]
- Use of analgesics (heroin, methadone, other painkillers) [S2g > 2 or S2h > 2 or S2j > 2 or S2g1 > 0 or S2h1 > 0 or S2j1 > 0] may exacerbate dental problems [P10b = 1]
- Use of analgesics (heroin, methadone, other painkillers) [S2g > 2 or S2h > 2 or S2j > 2 or S2g1 > 0 or S2h1 > 0 or S2j1 > 0] may exacerbate health problems related to injuries [P10c = 1]
- Use of analgesics (heroin, methadone, other painkillers) [S2g > 2 or S2h > 2 or S2j > 2 or S2g1 > 0 or S2h1 > 0 or S2j1 > 0] may exacerbate skeletal problems [P10q = 1]
- Use of analgesics (heroin, methadone, other painkillers) [S2g > 2 or S2h > 2 or S2j > 2 or S2g1 > 0 or S2h1 > 0 or S2j1 > 0] may exacerbate skin problems [P10r = 1]
- Use of crack [S2d > 2 or S2d1 > 0] may exacerbate breathing problems [P10f = 1]
- Use of crack [S2d > 2 or S2d1 > 0] may exacerbate health problems related to tuberculosis [P6b > 0]
- Use of marijuana [S2c > 2 or S2c1 > 0] may exacerbate breathing problems [P10f = 1]

- Use of marijuana [S2c > 2 or S2c1 > 0] may exacerbate health problems related to tuberculosis [P6b > 0]
- Use of sedatives [S2q > 2 or S2q1 > 0] may exacerbate nervous system problems [S3a = 1 or P10d = 1]
- Use of stimulants (cocaine, crack, amphetamines, other stimulants) [S2d, S2e, or (S2pa + S2pb) > 2 or S2d1 or S2e1 or (S2pa1 + S2pb1) > 0] may exacerbate endocrine (diabetes, thyroid) problems [P10h = 1]
- Use of stimulants (cocaine, crack, amphetamines, other stimulants) [S2d, S2e, or (S2pa + S2pb) > 2 or S2d1 or S2e1 or (S2pa1 + S2pb1) > 0] may exacerbate heart/blood problems [P10e = 1]
- Use of stimulants (cocaine, crack, amphetamines, other stimulants) [S2d, S2e, or (S2pa + S2pb) > 2 or S2d1 or S2e1 or (S2pa1 + S2pb1) > 0] may exacerbate nervous system problems [S3a = 1 or P10d = 1]
- Use of tobacco [R4 > 2 or R4a > 0] may exacerbate breathing problems [P10f = 1]
- Use of tobacco [R4 > 2 or R4a > 0] may exacerbate health problems related to tuberculosis [P6b > 0]
- Use of tobacco [R4 > 2 or R4a > 0] may exacerbate health problems related to pregnancy [P5b = 5]
- Sexually active in the past 90 days [R2r-s > 0] while having infectious disease [P6a-d = 3]
- Sharing needles in the past 90 days [R1m > 0] while having infectious disease [P6a-d = 3]
- Legally deaf [P4\_3 = 1]
- Limited hearing [P4\_4 = 1]
- Legally blind [P4\_5 = 1]
- Limited vision [P4\_6 = 1]
- Lost limbs [P4\_7 = 1]
- Difficulties moving hands, feet, or body [P4\_8 = 1]
- Other physical impairment [P4\_99 = 1 and text from P4\_99v]:
- Lifetime history of convulsions, migraines or nervous system problems (such as epilepsy, seizures, strokes or blackouts) [P10d = 1]
- Lifetime history of heart, blood, or circulatory problems (such as high or low blood pressure, endocarditis, irregular heart beats, angina, heart attacks, blood diseases, abnormal bleeding or bruising) [P10e = 1]
- Lifetime history of asthma, shortness of breath, hoarseness, coughing up blood/phlegm or other respiratory problems, (such as bronchitis, pneumonia, emphysema, or wheezing) [P10f = 1]
- Lifetime history of diabetes, thyroid or other problems with how your body controls itself (low or high blood sugar, control of growth, weight, fluids; early or late body development, gland or hormone problems) [P10h = 1]
- Lifetime history of other major medical problems [1+ in P10b-c, g, j-s]
- Use of alcohol or other drugs [S2d1 > 0] may cause problems for current pregnancy [P5b = 5]

The GRRS will also print out a brief history of physical health treatment, any current treatment or medication, an interpretative statement about the apparent need for medical referral,

monitoring, or services and any staff member comments or recommendations recorded in the supplemental patient placement module (XAS).

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

- High internal (somatic, depression, anxiety) distress [13+ Sx in M1a-d, M1f > 12 or M1g > 1]
- High traumatic stress [5+ Sx in M2a-p or M2q = 13+ days]
- High number of behavioral problems in the past year [19+ in M3a-c or 9+ in M3b]
- High number of personality issues [16+ in M4a-x]
- High risk history of self-mutilation [2+ in M4z1-3 or 13+ in M4z4]
- Moderate risk only [1+ in M4z1-3 or 1+ in M4z4]
- Moderate risk only: homicidal thoughts in past year [M1c1 = 1]
- Experiencing mental distress in the past two days [6 in M1e, M2, or M3]
- Frequently bothered by emotional problems [12+ in M1f]
- Frequently bothered by traumatic memories [12+ in M2q]
- Frequently in trouble for behavioral problems [12+ in M3c]
- Experiencing mental distress in the past 90 days [3+ in M1e, M2, or M3]
- High suicidal risk in past year [3+ Sx in M1c]
- Moderate risk only: suicidal thoughts in past year [M1c2 = 1]

- Moderate risk only: having problems with traumatic memories in the past year [1+ in M2a-c]
- High number of behavioral problems in the past year [19+ in M3a-b or 9+ in M3b]
- Moderate risk only: many behavioral problems in the past year [6+ in M3a-b]
- Psychiatric emergency room utilization during the past 90 days [M5f > 0]
- Received mental health treatment during the past 90 days [M5e > 2]
- Lifetime history of mental health treatment [M5 = 1]
- High levels of criminal activity in the past year [4+ on L3a1-19 {GCS}]
- Interpersonal criminal activity in the past year [1+ on L3a8-14 {ICS}]
- Weekly illegal activity for money during the past 90 days [L3e = 13+/90 days]
- Illegal activity for money during the past 90 days [L3e = 1+/90 days]
- Illegal activity other than drug use in the past 90 days [L3d = 1+/90 days]
- Five or more arrests in the past 90 days [L5c > 4]
- Five or more arrests in lifetime [L5 > 4]
- Arrest in the past 90 days [L5c > 0]
- Lifetime history of arrest [L5 > 0]
- On probation during the past 90 days [L6a > 1 or L7\_4 = 1]
- On parole during the past 90 days [L6b > 1 or L7\_7 = 1]
- In jail/prison during the past 90 days [L6c > 1 or L7\_5 = 1]
- In detention during the past 90 days [L6d > 1 or L7\_8 = 1]
- Involved in the criminal justice system in the past 90 days [L5b > 2 or L7\_1-99 > 1]
- History of 3 or more DUI convictions in the past 10 years [L7a > 2]
- Lifetime history of DUI arrests [L5a12 = 1 or L5d14 > 0 or L7a > 2]
- Outstanding warrants that need to be addressed [L8 = 1]
- Substantial illegal income during the past 90 days [V11k > \$499]
- The participant reports high levels of aggression [7+ on E8a-n {GCTS}]
- The participant reports moderate levels of aggression [3+ on E8a-n {GCTS}]

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

**Criterion B4: Readiness for Change.** The goal here is to identify the extent to which the participant is internally and externally (e.g., court/family/other pressure) motivated to go into treatment and change their substance use, as well as issues that might make it difficult (regardless of motivation) for the participant to do so. Outpatient treatment assumes that the participant is sufficiently motivated and able to manage their participation and attendance, though they might need support and encouragement. Methadone maintenance programs and intensive outpatient programs assume that more support and structure is needed in order for the participant to successfully participate. This may also include court or employer mandates. Inpatient treatment is often indicated if there is increasing resistance or poor impulse control. Either after inpatient or another controlled environment, or with a court order, outpatient

treatment may also be combined with a halfway house or sober living or recovery home to achieve this goal. While stages of change theory has traditionally focused on internal motivation, the GAIN views motivation more broadly to include both internal and external factors. If the situation is unclear, it is useful to further examine the participant's perceived pressure to be in treatment (B4), expectations about the length of stay in treatment (B6), barriers to treatment (B7, B9a) and the substance abuse treatment services wanted (S10, S10a). Below is a list of the risk factors that the ICP will check for related to this dimension.

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

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

**Criterion B5: Relapse Potential.** The goal here is to identify people who may need more intensive levels of care because of their risk of relapse. This may be due to low self-efficacy to resist substance use, lack of a sufficient understanding of how substance use is related to their problem (or that it is a problem), or the failure to stop using in a lower level of care. Relapse is also more likely if the participant has reported daily use (S2s1) or the weekly use of opioids (S2). Higher relapse potential would indicate the need for more intensive/structure treatment including inpatient treatment. Those with opioid dependence often require methadone therapy to avoid relapse. If a situation is unclear, it is often useful to further examine if the age of first use was under 15 (S9v), whether there is a history of prior treatment failures (S7), and if there is a pattern of poor impulse control (M3a16-18). Below is a list of the risk factors that the ICP will check for related to this dimension.

- Daily use [S2s1a > 44]
- Low self-efficacy to resist [3+ 0 Sx in S8m-q]
- Low problem orientation [2 or less in S8r-w]
- Using opioids weekly [S2g1, S2h1, or S2j1 > 12]
- Using substances to forget about traumatic memories [M2h = 1]
- First used substances or got drunk under the age of 15 [S9v < 15]
- Reported 3 or more symptoms of dependence/abuse in the past month [S9h-u > 2]

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

**Criterion B6: Recovery Environment.** The goal here is to evaluate the extent to which the recovery environment will support outpatient treatment or if a more structured or controlled environment is required. This includes understanding the risk from the participants living, work or school, and social environment (e.g., extent to which people are using alcohol/drugs, violent, engaged in illegal activity or engaged productively), the availability of social support (e.g., self-help, someone who is in recovery, someone to help deal with day-to-day stress), or satisfaction with current situation or relationship. People with systemically hostile recovery environments (e.g., everyone around them involved in substance use or illegal activities) will often require more treatment and (re)habilitation into a new environment and lifestyle over a longer/sustained period of time. If the participant has spent 13 or more of the preceding 90 days in a controlled environment (S2x), it is often important to consider their pattern of use when they were in the community and able to use and how this community relates to the one where they would be in a given placement (or after discharge). In the GRRS narrative the report is further divided into family environment, substance use in the environment, school environment, work environment, sources of social support, personal strengths, spirituality, satisfaction with the environment, and victimization. Below is a list of the risk factors that the ICP will check for related to this dimension.

- Weekly family problems in the past 90 days [13+/90 days in E3]
- Participant DCFS involved [B2b = 7]
- Participant's children involved with DCFS/state [E4a4 = 1, E4c > 0, or E4e > 0]
- Participant's children have been living with someone else during the past 90 days [E4g > 0]
- Parent involved in life of children [1+ in E4j-p {CAS}]
- Parent perceives own children as having major problems [E4q-v < 12]
- No parent actively involved in adolescent's life [All 0 in B2e-j {PAS}]
- Parent involved in adolescent's life [1+ in B2e-j {PAI}]
- Significant time in a controlled environment during the past 90 days [E2f > 12]
- Some time in a controlled environment during the past 90 days [E2f 1-12]
- Weekly alcohol use by others in home [13+ on E2d]
- Weekly drug use by others in home [13+ on E2e]
- Drug use by others in home [1+ on E2e]
- Environment hostile to recovery [12+ in E5a-fg, E6a-g, or E7a-g or 40+ across them]
- Participant is not close to anyone in recovery [E5f, E6f, and E7f = 4 or skipped]
- The participant has been victimized in the past 90 days [1+ on E9u]
- Lifetime history of victimization [1+ on E9a-d]
- High levels of traumatic victimization [4+ on E9a-r {GVS}]
- The participant is not satisfied with environment [2 or less on E15a1-6]

- The participant reports multiple interpersonal psychosocial sources of stress in the past year [E10\_1-99 > 1]
- The participant reports multiple environmental sources of stress in the past year [E11\_1-99 > 1]
- Minimal to no sources of social support [E12a-j {GSSI} < 2]
- The participant is very satisfied with environment [E15a-f {GSI} > 17]
- The participant is not very satisfied with environment [E15a-f {GSI} < 7]
- Participant involved in civil proceedings [1+ in L1\_1-99]
- May require special education services [B2a < 18 AND V1a = 1]
- In school during the past year [V3 > 1]
- High number of school problems during the past year [V3a-j > 5]
- In school during most of the past 90 days [V3k > 44]
- In frequent trouble at school during the past 90 days [V3p+q > 12 or V3r > 1]
- In trouble at school during the past 90 days [V3p, q or r > 1]
- Worked during the past year [V6 > 1]
- High number of work problems during the past year [V6a-j > 5]
- Worked during most of the past 90 days [V6k > 44]
- In frequent trouble at work during the past 90 days [V6p+q > 12 or V6r > 1]
- In trouble at work during the past 90 days [V6p, q or r > 1]
- High number of financial problems during the past year [V8a-k {FPI} > 5]
- Weekly financial problems during the past 90 days [V8m > 12]
- High number of gambling problems during the past year [V9a-k {PGI} > 5]
- Weekly gambling during the past 90 days [V9m > 12]
- Spending a third or more of income on alcohol or drugs [V11p+q/V11n > 0.33]

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

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

**General Conceptualization of Placement Needs.** The GRRS is organized based on the principals outlined by ASAM (2001) but has been expanded to address other things commonly included in treatment summaries to support review by insurance, Medicaid, and accreditation agencies (e.g., CARF, JCAHO) and treatment planning (discussed further in the next chapter). This include several things that are consistent with but largely absent form ASAM’s manual (e.g., pain assessment, victimization, illegal activity, criminal justice, school or employment mandates, personal strengths). It is also focuses more on placement in relations to specific services or treatment needs rather than overall levels of care. This is because the latter are just a proxy for the “bundles” of available service and may have little or nothing to do with what is actually available in any given community or to a given person. While intake severity is

important, it is also important to consider the interaction of each problem area with treatment and services over time. In assessing placement and treatment needs, figure 6.1 shows how information on the GAIN can be used to help understand whether someone has a current problem, a past history of problems, or no problem (the horizontal dimension) and whether they are currently in treatment, have a history of past treatment, or no treatment history (the vertical dimension). The type of service or treatment becomes more intense as you move from the upper left to lower right corner. Consider, for instance, a given level of current symptom severity. In the absence of any prior treatment history the clinician would generally be more likely recommend a less invasive treatment (e.g., buphenorphine vs. methadone, outpatient vs. residential, etc.). Reporting the same level of problems while already in treatment, in contrast, may be interpreted as a “nonresponse” to treatment and lead to a recommendation to increase the intensity or level of care. Past treatment requires consideration of the recency, speed with which the problem returned, and willingness of the person to try again. The latter is important because while 50% of people recover, most require three to four episodes of recovery before reaching at least a year of sobriety.

**Exhibit 6-1. Interaction of Problem Severity and Treatment over Time**

		Problem Severity		
		None	Past	Current
Treatment History	None	1. No Problem	2. Past problem (consider monitoring and relapse prevention)	3. Problems (consider initial or low invasive treatment )
		<i>Not Logical: Check understanding of problem and recode</i>		4. Problems w/past treatment (consider more intensive treatment and re-intervention strategies)
	Past		5. Treatment with no current problems (review for step down or discharge)	6. In Treatment with Reduce problems (review need to continued or step up)
				Current

Past problems and past treatment suggest the need for increasing levels of monitoring for relapse. Past problems with current treatment suggest the potential readiness to step down or be discharged. No problems with reports of prior treatment suggest that the participant may be misunderstanding or misreporting their symptoms or treatment history and generally should be reviewed and reclassified.

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

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

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

**Organization and Use of the GAIN Recommendation and Referral Summary (GRRS) to Support Placement.** The GRRS (see sample in appendix F) includes a section to evaluate the specific need for treatment based on use, abuse, and dependence for ASAM criterion A and to review the six dimensional criteria for ASAM criteria B1 to B6. The GRRS also incorporates a substance use and treatment history (after diagnosis) and review of a detailed text narrative on age of first use, preferred substance, and substances for which the client perceives a need for

treatment. This is followed by a paragraph for each DSM-IV substance use disorder diagnosis (in order of clinical severity from the S9 grid).

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

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

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

- **B3 (Emotional)** is further subdivided into emotional problems (e.g., somatic, depression, suicide, trauma); behavioral conditions (e.g., ADHD, conduct disorder, pathological gambling, other impulse control problems), violence (physical and verbal); illegal activity (property, interpersonal/violent, other drug related including possession, dealing, prostitution, gambling and probation violations); and cognitive conditions.
- **B4 (Readiness to Change)** includes an optional section on reasons for quitting that has implications for readiness and is also explicitly used to support motivational interviewing protocols.
- **B6 (Recovery Environment)** is further subdivided into family environment; home environment; school environment; work environment; sources of social support; personal strengths; spirituality; satisfaction with environment; and victimization.

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

The last section of the GRRS reviews needs for treatment coordination based on the reports above and the programs and levels of care that best meet the specific services that have been

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

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

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

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