



# AlcoholismAnswers.net

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## In This Issue

- Diagnosis & Referral
- Developing Standards
- Addiction Stages

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<http://livinglifeboomerstyle.net/>  
<http://alcoholismanswers.net/Assess.aspx>  
<http://alcoholismanswers.net/Forms.aspx>  
<http://asam.org>  
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## PATIENT INTERVIEWS

Why bother with additional interviewing once you know the patient is addicted?

If a physician told you have cancer you might want more information; i.e., what stage is it, what treatment options are available and are there secondary medical problems. With all

During the thirty plus years I worked in addiction treatment I observed numerous changes in the treatment field. The training, education and experience required to demonstrate a professional level of skill in diagnosis, recommendations and delivering treatment has increased several times. Thanks primarily to organizations such as ASAM <http://asam.org>, NAADAC <http://naadac.org>, CAADAC <http://caadac.org> and other organizations the special skills needed to work in the addiction field have been clarified, recommended and improved for anyone working in the addiction field.



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If you have friends who are interested in addiction treatment and recovery please forward this newsletter to them. If you have suggestions for a topic contact me and if possible I will include the information in a newsletter.

## Diagnostic Interview and Recommendations

In this fourth newsletter I want to discuss the necessary skills required to complete an effective diagnostic interview and include recommendations. I definitely believe that adequate diagnosis is the most difficult task in treating addiction and requires the most skill. Diagnosis will generate a problem list and, based on this list, will develop a treatment plan and referral recommendation. So from this assessment interview and the

potential terminal illnesses diagnosis and recommendations frequently are complicated if the patient is to be offered the best treatment outcome.

Why not confront the patient about conflicting information and obvious denial in all staff patient contacts?

Most of the time the diagnostic interview is performed when the patient is in detox and feels very ill.

Confrontation tends to stop the patient from giving information so the interview would likely be of no value. This is an attempt to solve a problem before the problem has been identified. If the staff person goes into the interview without a clear goal it becomes evident they don't know what they are doing.

Isn't a recovering alcoholic qualified to treat other alcoholics?

A recovering alcoholic can be helpful to other alcoholics. However, that does not qualify them to

recommendations rest much of the success or failure of patient's treatment.

First I will focus on the setting. It needs to be private and the interviewer should not be behind a desk or between the patient and the door. If the patient has been exhibiting any paranoid features it might be a good idea to sit beside the patient. In some cases it can be useful to model some of the patient's posture and speech patterns, but more about this at another time. There should not be anything that will provide a distraction. Early in treatment patients often have a great deal of difficulty with focusing. Most issues in the setting are just a matter of common sense and after a few hair raising experiences the staff person will learn to make the necessary adjustments.

Some years ago I was assessing an extremely paranoid patient and a quarter fell out of my pocket. When I picked it up and started to put it back into my pocket the patient said, "What are you doing taking my quarter?" He seemed quite upset. I gave him the quarter, apologized and continued on with the interview. To do otherwise might have been catastrophic.

This part will refer to importance of the interviewer's attitude about the patient and the purpose of the interview. The purpose of the interview is to get as much information relevant to the patient's recovery needs as possible in a short time. For most interviewers it works to tell the patient it is somewhat of a boring interview and may be redundant; however, it is required by law and the insurance carrier. With discipline on the interviewer's part the patient will usually present the specific information without any particular resistance. Most of the time I found it worked to speak in a monotone and move along as fast as the patient is able. It is not the time to confront any real or imagined denial or to attempt therapy. It is not a good practice to ask open ended questions. In a therapy session open ended question can at times have a purpose; however, in a diagnostic interview it leads to confusion and useless data.

At times the patient will clarify their psychological history in a few words. When I inquired about psychological history with one patient he replied "When I went to San Quentin the prison psychiatrist told me I was criminally insane." This same patient had stated his closest contact was one of the higher echelon officers in the Hells Angels. Later on the history he gave proved to be quite accurate. Actually, he was a model patient.

Several years ago when I was training interns on diagnosis and recommendations, some of the interns complained about limiting time and avoiding open ended questions. Some of them believed it was necessary to spend a lot of time doing the interview and having the patient talk a lot after being asked open ended questions. Rather than argue with them we started

treat alcoholics in a professional setting anymore than having a broken arm doesn't qualify one to be an orthopedic physician.

Aren't the mental health professionals the most qualified to treat addiction?

No, not unless they have the training, education and experience required to be an addiction professional. In fact, numerous studies have shown that mental health professionals without proper addiction credentials have not been successful at addiction treatment. Addiction treatment is based on a separate body of knowledge.

Next issue: Details on the Addiction Chart

a study on interviews that included the time spent and the quality and usefulness of the information. Some weeks later everyone in that group came to the conclusion that about 45 minutes seemed to be optimum length of time. It became apparent that interviews that lasted 2 hours or more were very nearly useless. Either the patient was unwilling or unable to participate or the interviewer was encouraging story telling. The long interviews contained a lot of information; however, little of it was of any use in the patient's treatment. Generally long interviews were a matter of the patient telling stories without any real direction. Many of the long interviews had to be completed a second time to get the required information. It was the group's conclusion that the long interviews were a problem primarily because the interviewer was seeing himself in the role of a therapist and not performing a structured interview.

The interviewer needs to have great clarity in both the physical and psychological symptoms of addiction. I developed a chart that many of the staff members found helpful in determining the progression of the problem. You can download the chart by going to <http://alcoholismanswers.net/Forms.aspx> or if you just want to check it out without downloading it goes to <http://alcoholismanswers.net/Assess.aspx> It is necessary to be able to read the patient's medical chart and understand what it means, particularly in regard to their addiction problem. Understanding the patient's psychological status so that it can be determined when and how the patient should start the next phase of their treatment. And, of course, referral, both short term and long term, is part of the recommendations.

The person doing the interview should be able to start a treatment plan that is simple and easy to understand by the patient and the staff.

An overview of the counselors areas of competence are medical, psychological, legal, ethical, insurance coverage, referral and an in-depth knowledge of addiction.

Ernie