

Indian J Med Res 143, June 2016, pp 682-684  
DOI:10.4103/0971-5916.191920

## Commentary

### Family substance use screening: less to hide, more to gain

A relentless rise in undertreated or untreated substance use disorders highlights the magnitude of the challenge the society is facing and a critical need to identify evidence-based, practical approaches in order to effectively screen people at high risk for unhealthy alcohol use, tobacco and drug use, increase early detection of substance use disorders, and offer the proper care they need. The Family CAGE (an acronym of four questions on alcohol use) is a brief questionnaire adapted from the original CAGE questionnaire devised by Frank *et al*<sup>1</sup> and studied by Basu *et al*<sup>2</sup>, in this issue under a format encompassing drug use (AID=Adapted to Include Drugs). The study examines the validity and associated characteristics of the questionnaire for the diagnosis of alcohol and other substance use disorders as well as the inter-rater reliability between one family member and the substance user. The results were drawn from a cross-sectional analysis of two samples: treatment seeking substance-using patients, and individuals receiving outpatient psychiatric treatment while not pursuing treatment for substance use disorders. In both groups, the scores of the Family CAGE-AID and the traditional CAGE-AID questionnaires were significantly correlated. In the psychiatric sample, a correlation between the scores of the questionnaire and ICD-10 symptom score was observed, along with a moderate but significant agreement between the scores of substance users and family members. Family CAGE-AID was found to be sensitive and specific for the diagnosis of substance dependence formulated using ICD-10 criteria<sup>2</sup>. There are a few points to consider. Because of the design of the study, family members' acceptance of the questions about other members' alcohol and drug use problems is unknown, which needs further study. The authors acknowledged that a limited range of substance use

diagnoses and disease severity in the study sample limited the generalizability of study findings, and that psychiatric evaluation was not performed to control for the quality of responses among participating relatives. However, the findings demonstrate the practicality and potential utility of a family screen instrument for alcohol and drug use problems. Among future applications, the involvement of multiple family members in the interview, and confirmation studies in large samples at the primary care level and within different age ranges should be considered. Following evaluation, data gathered on interventions outcome and follow up assessment will be of interest.

The interpretation of the role of the family in the life of a person with addiction is culturally charged. Family involvement is an important and recognized focus in the Indian and other societies. Both the patient's immediate family and extended family are considered to be essential for whatever form of intervention is delivered. Because problem substance use can disrupt basic family and social ties, restorative efforts to preserve an individual's familial and social network are important contributors to control and limit the adverse effects of alcohol or drug use problems<sup>3</sup>. In western countries, protection of sensitive medical information is privileged. Indeed, many family members may not wish the clinician to reveal knowledge of a family drug use problem to the drug user<sup>1</sup>, though the family denial of the severity of the condition may be more common and could have a negative impact. Individuals who had a family member treated for the problem of alcohol or drug use carry high burden of personal medical care costs<sup>4</sup>, and present more often with mental disorders, digestive system problems, injuries, or other medical conditions<sup>5</sup>. A reasonable expectation from family screening is that the family will benefit from sharing

the problem irrespective of the drug user's outcome, yet more research needs to be conducted on this point.

A family-centered screen and intervention appears to hold the promise to address important core issues of addiction, though the clinical response may largely depend on family dynamics that are ultimately difficult to predict, and relies on the timely ability of the physician or other providers to conduct family intervention if needed. Once the problem is identified, the professional should flag and address consequences of addiction for the family member, and provide psychoeducation about substance use problems, in addition to offer proper referrals for treatment of more severe cases. Clinicians, especially those who care for multiple family members, should pay careful attention to maintain therapeutic neutrality and not 'ally' with the non-drug using family member, nor blame him or her for delaying a solution to the problem. For example, in response to the strain of caring for a loved one, a codependent relationship is frequently observed, where the person without addiction may help maintain the condition of addiction through his or her enabling behaviours<sup>6</sup>. This is a pathological response to stress, and the provider should properly refer the family member to needed treatment, separate from treatment involving the loved one. Thus, it is essential that health care providers become familiar with local resources and supports for families.

The study of short screens for alcohol and drug use disorders has contributed to identifying clinical targets and areas in need of further investigation<sup>7</sup>. For example, screening and brief intervention seems to be less effective in the treatment of drug use problems compared with alcohol problems<sup>8</sup>. This may depend on multiple factors, including patient severity, treatment readiness, and the presence of adequate social support and follow up measures. Thus, screening components should be routinely strengthened, and easily accessible treatment services may be needed when brief interventions are insufficient, together with primary care referral options to address risky substance use and associated physical and mental co-morbidities. In the case of complex health care systems, amid the maze of doctors' offices, hospitals, outpatient services, insurance systems, patient-support organizations, and other components, chronic disease management has benefited from the help of care navigators to steer patients through multiple tasks and successfully complete referral<sup>9</sup>. The patient navigator role, which originated from the medical treatment domain, has demonstrated effectiveness in improving patient

outcomes. In the expectations of many, navigators who are culturally sensitive health care workers and usually come from health profession occupations should be able to assist and accompany eligible substance-using patients from the larger community to appropriate and specific health care services. In particular, they will help with addressing some of the significant barriers to health service utilization and access to treatment of addictions, much like a caring family member would do, if he or she was more knowledgeable. In sum, the patient navigator model is a promising strategy to link family, patient, physician, and community resources for promoting and maintaining global lifestyle modification in people living with a chronic substance use disorder.

Currently, there is a great need for clinically feasible drug misuse screening tools to improve early detection of problem substance use, and the study by Basu *et al*<sup>2</sup> is an important advance. The system theory indicates that changes in one individual may bring about changes in the system with a rippling and persistent effect, and this method applied to the family can predict radical changes<sup>10</sup>. Following a bio-psychosocial approach, a patient centered intervention remains the priority. Thus identifying a significant nuclear sample of patients with their families and involving primary care physicians is a reasonable attempt to begin to address and then resolve the multilayered problems posed by individuals with a substance use disorder.

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### Acknowledgment

Both authors (PM and L-T Wu) received research support from the U.S. National Institutes of Health (UG1DA040317, R01MD007658, and R01DA019623). The sponsoring agency had no further role in the writing of the report or the decision to submit the paper for publication. The opinions expressed in this paper are solely those of the authors.

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