Author's response to reviews

Title: Prevalence Of Problem Alcohol Use Among Patients Attending Primary Care For Methadone Treatment: A National Cross Sectional Survey

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Author's response to reviews: see over
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Resubmission of article

Dear sir or madam

We wish to thank you for your prompt and thorough reviews of our paper, which we now re-submit. We believe we have addressed all the points made by the reviewers in this revised manuscript and would be grateful if you could consider for your journal. I enclose my comments in response to each reviewer (please see tabbed italics).

Sincerely

Dr W Cullen (on behalf of authors)
Response to reviewer #1: M Frischer

Introduction.

Good background and clear objectives, with one caveat. There are several papers describing high rates of problem alcohol use among people being prescribed methadone. Therefore, what new information will this study provide? [major compulsory revision]

*This paper is the first to report on a population attending primary care / general practice (see penultimate paragraph in introduction)*

P4: In Ireland, the number of people seeking treatment for problem drug use for the first time in a one-year period has increased in recent years….although the number of these new cases reporting problem opiate use has fallen during this time
- Presumably this means higher proportion of new cases are non opiate related? [discretionary revisions]

*Yes – I have re-worded this passage for clarity and simplified the statistics*

Method
Clearly described

Discussion

This study is the first to present data on the prevalence of problem alcohol use among a national sample of opiate dependent patients attending primary care for methadone treatment.
- As your findings were similar to those in other settings in Ireland, what are the implications? Presumably, that primary care patients receiving methadone are similar to those in secondary care? [discretionary revisions]

*Yes – patients attending primary care for methadone treatment should therefore be screened for problem alcohol use and should have access to care interventions that address coexisting problem alcohol use. (please see amended final paragraph)*

the possibility of selection bias can not be discounted
- Its not obvious that responders would be biased (e.g. having lower/higher rates of problem drug use) unless non-responders were different. Is this something you have checked? [discretionary revisions]

*A revised strengths and limitations section speaks to this point; although comparison of participating / non-participating GPs is not possible, comparison of participating / non-participating patients is.*

Patients attending primary care for methadone treatment have been reported to be more likely to be employed and to have less severe addiction problems [26]
- despite this similar rates of problem alcohol use? [discretionary revisions]
Have expanded this point to add clarity – ‘This is a cause for concern as according to methadone prescribing regulations in Ireland, one might expect patients attending primary care for methadone treatment to have less severe addiction problems [26]. Patients attending primary care for methadone treatment in other settings were more likely to be employed and to have less severe addiction problems than patients attending addiction clinics [27].

Problem alcohol users actually reported higher rates of concurrent abuse of other substances, with alcohol therefore forming part of a ‘polysubstance misuse’ pattern that has been previously reported.

-Could you clarify this-are you saying that your findings are similar or dissimilar? How much of a literature is there on this? [discretionary revisions]

Our findings disagree with our earlier exploratory work, but agree with work conducted elsewhere which indicates problem alcohol use among opiate dependent patients should be viewed as part of a polysubstance misuse pattern. Paragraph clarified and amended to:

‘Our finding that problem alcohol use was not significantly associated with age or duration in treatment disagreed with our earlier exploratory work which suggested that patients may substitute opiate dependence with alcohol dependence [11]. Instead, we found concurrent abuse of other substances was more common among problem alcohol users, with alcohol therefore forming part of a ‘polysubstance misuse’ pattern – a finding in keeping with work elsewhere [28]. This highlights the importance of problem alcohol use being addressed in conjunction with possible use of and / or addictions to other substances..

Problem alcohol users were less likely to have attended a specialist hospital clinic and less likely to have attended specialist hepatology clinics -than who? I don’t follow this bit. [discretionary revisions]

…than subjects with a normal AUDIT score …revised to clarify

To date, the issue of screening and treatment interventions for problem alcohol use among current or former heroin users attending primary care for methadone treatment has not been explored. -I am not a medical practitioner. Are you saying this has never been addressed? [discretionary revisions]

The issues has been described – but to date no interventions to address the problem have been described in primary care…revised to clarify and have incorporated data below (both published after this paper was originally written)

I found this paper which seems to be saying something similar

“To optimize MMT, alcohol screening should be part of routine assessment and
alcohol treatment should be made available within MMT programs. Moreover, special consideration should be provided to the most vulnerable clients, such as the younger user, those with a long-term and current history of heavy drug use, and those victimized and reporting fair or poor health.”

Limitations

Those noted are in terms of bias. Another is the type of information collected. There is no information on the time course? Of those whose alcohol use was not problematic, might it have been previously? Was alcohol more or less of a problem after heroin use. What about other characteristics other than those mentioned in the analysis-eg social, family problems? Perhaps discussion should focus on what questions have been answered and what issues are raised by the study.

I think I have addressed in a revised ‘limitations section.

I am unsure about the “brief intervention” discussion. Does this literature suggest that this might be difficult with complex cases? Is a qualitative study need to understand more about the relationship between drinking and heroin use? [discretionary revisions]

Yes – this work would indicate a need for further work that would initially inform the design and development of a complex intervention that improves screening and treatment uptake; and the subsequent evaluation of such an intervention in a RCT. This is addressed in a revised final paragraph.
Response to Reviewer #2: Anthony Shakeshaft

Reviewer's report:

General remarks
This is a nicely written paper that presents some interesting data deriving from a population that is very difficult to access. Most of my comments are minor and discretionary, really just trying to give a couple of ideas about how the paper might be slightly improved, but I do think the issue of clustered data needs to be addressed.

Please see below

Major compulsory revisions
None

Minor essential revisions
1. The only real concern with the sampling in the paper is the possibility of a clustering effect, given participants were recruited from 4 different regions and there was over/undersampling from some regions. This would only potentially make a difference to the statistically significant findings - since they are not dramatically significant (p values range from 0.01 to 0.04) they may not remain significant after clustering. There may be good reasons not to allow for clustering, but given the data are clearly regional it would be helpful to make a comment about this as a minimum, that is, to say that it was considered unnecessary because...

Please see below

Discretionary revisions
1. Citing data for the effectiveness of alcohol interventions delivered in primary care may need to be tempered somewhat for this substance using population - while they are accessing primary care services they are not typical primary care patients, so it is difficult to readily accept that the potential effectiveness of alcohol intervention would translate from primary care generally to this population.

First paragraph of discussion amended to read ‘However, it is difficult to see whether this evidence would translate to the care of problem alcohol use among patients attending general practice.’

2. The data collection paragraph on page 6 may be an appropriate place to raise the issue of potentially clustered data.

In the methods section, I have added comment: Individual cases were sampled from a national database and for this reason we did not control for the clustering during sampling.
In the discussion section, I have added comment: ‘Our experience with recruitment for this study would therefore support more targeted approaches to recruitment, with practices / GPs who wish to participate in similar research being identified before sampling, with sampling occurring at the level of the individual practices. While this would have implications for power calculations, with these needing to take account of the clustering effect, it would lead to a higher participation rate and a more efficient use of resources.’

3. The obvious methodological weakness in the paper is the recruitment rate. I think there is room to explore a little more the consequences of the low response rate (it is really 31% of the random sample so the data are almost certainly biased), the comparisons between consenters and non-consenters notwithstanding. For example, you could make the point that the most likely consequence of the bias in this sample is that alcohol and substance use you describe is actually the "good" end of the spectrum - in reality, the overall sample is probably much worse off (on the assumption that those who agreed to the study are probably higher functioning).

New paragraph added to discussion ‘Notwithstanding these similarities, our sample represents only 31% of those randomly sampled from the national database. This sample may represent the more ‘stable’ end of the spectrum, in which case the possibility for our findings to underestimate the prevalence of problem alcohol use can not be discounted.’

4. In the summary of main findings section (page 10-11), I would like to see some comment about what you think the data mean - why is it that those with higher alcohol use are also more likely to use illicit drugs and emergency departments? Is it part of a riskier overall lifestyle? Perhaps it's their pattern of alcohol use - you could compare audit positives with audit negatives on audit question 3 to see if one reason the audit positive cases are more likely to use emergency departments is because they drink to excess on one occasion more often. that has implications for the brief advice physicians may give these patients about their drinking.

Revised section in discussion: ‘The high contact rate with local hospital Emergency Departments supports recently published data which highlights problem alcohol use and problem substance use as important factors in Emergency Department utilisation [10] [29]. Among our sample, this Emergency Department utilisation could be explained by their involvement in high risk behaviours.’
Response to reviewer#3: James Seale

1. The methods section does not provide an adequate description of the research ethics. Was a research ethics committee asked for permission to carry out research on patients? If absent, this is a serious omission.

   Yes – this is indicated in revised methods.

2. The statement in the abstract that a 25% random sample of registered methadone patients were invited by their GP to be interviewed is incorrect and misleading, since so many GPs never responded to the inquiry. Figure 1 should be modified to include the total number of registered methadone patients (2585). The abstract should be modified to indicate the percentage actually invited by their GPs to participate (10.7%).

   Figure 1 and abstract amended accordingly.

3. Studies regarding the role of primary care in addressing problem alcohol use, noted on page 4, were performed on patients quite different from this patient sample. Some of the studies reviewed by Whitlock excluded patients with alcohol dependence; those which included alcohol dependence noted a more modest effect than the reductions described in this paragraph. The authors appropriately mention in their last paragraph that alcohol screening and intervention has not been tested in current and former heroin users. This comment should be included much earlier in the paper. The high percentage of polysubstance users (79%) suggests that specialty treatment, rather than primary care intervention, may be necessary. This possibility should be mentioned in the discussion.

   Comment added to revised introduction and need for integration with secondary care added to amended discussion.

4. The discussion of the implications of the study findings needs to be more focused. Findings suggest that methadone patients with alcohol misuse have more medical emergencies, receive less care for their liver disease, and often misuse other substances, especially benzodiazepines, which may increase their risk of overdose. This suggests to me that they have identified a subgroup of patients with multiple major needs, indicating the need to screen, identify, and test various interventions to address their needs.

   ‘Implications’ section of discussion amended to address this issue.

5. The organization of the discussion was confusing and distracted from the potential impact of the paper’s findings. I suggest that the sentence on the uniqueness of the study (first sentence under “Strengths and limitations…”) be the first sentence of the discussion, and that the “limitations” section be inserted after the comparison with the existing literature.

   Discussion reorganised as suggested in points 4 & 5

MINOR ESSENTIAL REVISIONS
1. Limitations of the evidence base for the so-called AUDIT “zones,” as noted in a previous article by Donovan et al (Addiction, Dec 2006), should be noted.

   Amended discussion to reference this paper and their findings highlighting need for other study instruments to be used in clinical settings

2. The introduction provides a compelling argument for the potential importance of alcohol in methadone patients: comorbidity with Hepatitis C, negative impact on addiction treatment, and factor in fatal opiate overdose, especially if associated with other CNS depressants. These points should be re-emphasized in the discussion, especially since the study found higher use of benzodiazepines in this group (higher overdose risk) and higher Emergency Department use (more accidents or other medical emergencies?).

   Points re-emphasised in ‘comparison to other literature’ section

DISCRETIONARY REVISIONS

1. The link between alcohol misuse and accidents/injuries might be added to link to the higher use of Emergency Department services by alcohol misusers.

   Link suggested in revised discussion.

2. The final sentence of the abstract might be modified to emphasize the potential positive health impact, should effective interventions be implemented for these patients.

   This has been amended accordingly

3. In light of the small sample and skewed distribution of subjects, the authors might consider deleting the last 5 words of the title

   This has been amended accordingly