**Author's response to reviews**

**Title:** The comparative effectiveness of Integrated treatment for Substance abuse and Partner violence (I-StoP) and substance abuse treatment alone: A randomized controlled trial

**Authors:**

Fleur L. Kraanen (F.L.Kraanen@uva.nl)  
Ellen Vedel (Ellen.Vedel@jellinek.nl)  
Agnes Scholing (H.A.Scholing@uva.nl)  
Paul M.G. Emmelkamp (P.M.G.Emmelkamp@uva.nl)

**Version:** 8  **Date:** 7 February 2013

**Author's response to reviews:** see over
Dear editor,

Please find enclosed the revised manuscript “The comparative effectiveness of Integrated treatment for Substance abuse and Partner violence (I-StoP) and substance abuse treatment alone: A randomized controlled trial”.

We addressed the questions you had as follows:

1. We indeed have data on how many participants were still with their partner at follow up. In the I-StoP condition, one participant was not with his partner at follow-up; in the CBT-SUD+ condition all participants were still with the same partner. We reported this in Table 2.

2. It is true that we hoped to include about 100 participants in the study. Based on previous research, it was expected that about 40% of patients entering substance abuse treatment perpetrated IPV in the past year. However, IPV perpetration prevalence rates in the current study were somewhat lower. Moreover, we aimed to include patients who committed more severe IPV, not patients for whom IPV perpetration had occurred incidentally. Unfortunately, we overestimated the number of participants that were involved in more frequent IPV perpetration in our sample. Since we ran out of financial resources, we were forced to stop inclusion before our target number of 100 participants was reached. We included in the methods-section that we initially aimed to include 100 participants (p. 7). We comment on it in the discussion section that we were unable to include 100 patients because fewer patients reported at least 7 acts of physical IPV perpetration in the past year than we expected (p. 22).

3. In Figure 1, we reported that 52 patients were randomized and that 14 + 16 (30) patients did not complete posttreatment assessment. For participants who did not complete treatment, the last observation carried forward-procedure was used in order to obtain data for intent-to-treat (ITT) analyses. Three participants were not analyzed (2 never started treatment; one did not complete posttreatment assessment himself). Since we conducted completers and ITT analyses, we analyzed data of 19 completers and 49 ITT. We therefore included in Figure 1 that 14 + 16 participants were lost to follow-up (i.e., did not complete posttreatment assessment). In the last step of the flow chart we report the number of completers and ITT that were analyzed in each condition. However, if your opinion still is that we should not report these 30 participants that did not complete posttreatment assessment as ‘lost to follow-up’, we are willing to do so. However, we considered it inaccurate not to report these participants as ‘lost to follow-up’, since it might lead to the assumption that participants did complete posttreatment assessment.
4. We thank you for suggesting that I-StoP could have delayed effects. We report on this at the end of the manuscript by commenting that “…since this is the posttreatment report and effects of I-StoP may be delayed, follow-up results should be awaited to draw more firm conclusions regarding the comparative effectiveness of I-StoP and CBT-SUD+ and effectiveness of both treatments on the long term.“ (p. 26).

We hope that after making the changes described above, you are willing to send out the manuscript for peer review.

Sincerely,

Fleur L. Kraanen
Ellen Vedel
Agnes Scholing
Paul M. G. Emmelkamp