

Screening for Alcohol Use Patterns Among Methadone Maintenance Patients

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Abstract: Alcohol use among Methadone Maintenance Treatment (MMT) patients poses a major health risk, exacerbates psychopathology, and increases the risk of death by accidental overdose. Despite these factors, screening for alcohol use remains underutilized in the methadone community. Utilizing a self-report screening measure—the Michigan Alcohol Screening Test (MAST)—and consistent with the literature, we found high rates of alcohol problems among MMT patients. Benefits and limitations of using the MAST to screen for alcohol use patterns are discussed.

INTRODUCTION

Alcohol abuse is widely recognized as a major cause of health and social problems. These and other adverse effects are even greater in patients on a methadone maintenance treatment program (MMT). Up to 57% of such patients report alcoholism (1, 2). Also, there are higher rates of mood disorders, anxiety disorders, additional substance use disorders, and personality disorders in the MMT patient population which are prone to exacerbation by alcohol use (3).

Furthermore, alcohol-abusing MMT patients are reportedly more likely to be involved in criminal activities, continue to abuse illicit drugs, and more difficult to engage and retain in treatment (4, 5). However, of greatest concern to methadone providers is that alcohol is consistently implicated in mortality rates in MMT patients (6). Alcoholism is a leading cause of death for patients in treatment, and alcoholic opiate

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dependent patients have overall lower survival rates over a 10-year period when compared with patients who were moderate drinkers (7). This is further supported by a study that demonstrated in over 97% of accidental drug overdose deaths among illicit drug users in New York between 1990 and 1998 that the three most commonly used substances in combination were opiates, cocaine, and alcohol (8).

Despite the overwhelming evidence of problematic alcohol use in MMT patients, however, testing and/or screening for alcohol use remains underutilized in the methadone community (9).

METHOD

Cases

Participants ($n = 426$) were outpatients in an MMT program, drawn from 22 Clinics across various geographical locations throughout Ontario. Sixty seven percent were male, 33% were female, and the mean age was 36 years. All participants gave written informed consent to participate in the study.

Materials

The Michigan Alcohol Screening Test (MAST), a widely used self-report screening tool, was utilized to detect alcohol use problems in our sample. It consists of 25 items designed to provide rapid and effective screening for long-term alcohol-related problems (10). The MAST has been found to be effective and adequately sensitive to the detection of alcohol problems in opiate dependent individuals (11, 12), and has been found to be a reliable and valid measure that correlates well with DSM-IV diagnostic criteria (13–16).

RESULTS

Overall scores on the MAST found that 76% fell into the “indicates alcoholism” category and that 9% fell into the “suggestive of alcoholism” category. With respect to gender, 81% of the males fell into the “indicates alcoholism” category and 8% fell into the “suggestive of alcoholism” category. Among females, 66% fell into the “indicates alcoholism” category and 11% fell into “suggestive of alcoholism” category. A chi-square analysis was performed to compare the distribution of males and females across alcohol-use categories. Significant differences

were observed in the “nonalcoholic” and “indicative of alcoholism” categories only, $X^2(2, n = 426) = 12.24, p < .05$.

DISCUSSION

Consistent with the literature, our study found a high rate of alcohol problems among the MMT patients in our sample. Our findings also suggest that there may be even higher rates of alcohol problems among MMT patients than was previously found in the literature. One possibility for this finding might be that patients were told that their responses on the MAST were confidential, which, in turn, may have affected the honesty and accuracy of patients' responses to sensitive questions (17). On the other hand, the MAST has also been shown to yield a high rate of false positives (Gibbs, 1983), and hence, in part, this may explain the higher rates of alcohol problems among MMT patients found in our study.

Our study also found that males identified more alcohol problems than females. This is consistent with the findings of Grella et al. (18) who found that at treatment entry to MMT programs, a greater proportion of males identified abusing alcohol than did females. Such gender differences are also evident in the general population (19).

A limitation in using the MAST is the possibility of social desirability bias, that is, the tendency to distort self-reports in a favorable direction (17, 20–22). This might be especially evident in those MMT patients who are in denial of their alcohol use problems, and in those patients who have a vested interest in concealing and/or minimizing their alcohol use as it can impact on their eligibility for take-home privileges (19–23).

Another limitation of this study is that the MAST fails to monitor change over time and, as a consequence, is unable to distinguish between current and previous alcohol use problems. Thus, it strongly recommended that the MAST is utilized in conjunction with regular quantitative urinalysis and a Structured Clinical Interview (based on DSM-IV-TR diagnostic criteria for alcohol-related disorders) in order to more accurately detect alcohol use problems in MMT patients.

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