

CHAPTER 10

France

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10.1. Introduction

10.1.1. Country description

France has 62 million inhabitants, including two million people living in the overseas regions (the French Caribbean islands Guadeloupe and Martinique, French Guyana and the island of La Réunion in the Indian Ocean). One in six people lives in the Paris region, Île-de-France. The GNP per inhabitant was estimated at 25,700 Euros in 2002. Population density is 107 inhabitants per km². Some regions are mainly devoted to agriculture and wine and spirits production is of major economic and cultural importance. The 'alcohol lobby' and the 'peasants' lobby' both have a real influence on political decisions.

A first rapid social evolution changed the face of French society after WWII, with the transformation of the peasantry into an industrial working class. (The proportion of the population working in or for agriculture has fallen from 50% to 3%). A second change occurred after the mid-1970s crisis, with the rise of a service economy (now 71% of GNP) and the decline of industry.

10.1.2. Alcohol consumption and alcohol-related harm

These social and economic changes influenced drinking patterns in the second part of the 20th Century. Although France has remained near the top of international statistics for average alcohol consumption for more than half a century, there has been a constant decrease first in consumption and then in alcohol-related morbidity (e.g., liver cirrhosis) and mortality. Drinking every day during meals, generally wine (or beer in the East and North, cider in Normandy and Brittany), which was the norm until the 1960s, has become the behaviour of a minority, mainly the elderly, the industrial workers and the peasants; the so-called 'Anglo-Saxon model' of drinking was adopted first by the elites, then by youth, then by the majority of the population. It is the main reason for the rise in spirits and beer consumption, the decline of wine, and the rapid decrease in overall average consumption which is now at the 4th rank in official European figures, with 10.3 litres per year per adult. In spite of this decrease, 45,000 deaths are still attributed to alcohol every year and it is the second cause of avoidable death after tobacco.

10.1.3. Health services

Prevention programmes and the medical treatment system may have contributed to this phenomenon. Public health and prevention are poorly developed in France and, for alcohol-related problems, prevention has been mainly entrusted to an NGO, now called *Association nationale de prevention en alcoologie et addictologie* (ANPAA: National Association for Prevention of Alcohol and Drug Addiction). The treatment of alcohol-dependent patients was left to psychiatric hospitals up to the 1960s and then to specialised in-patient clinics, but since the mid-1970s a rather dense network of out-patient clinics has been developed with the initial intention of offering excessive drinkers a place to assess the risk related to their drinking and receive advice. However, these centres rapidly became devoted to 'alcoholics'. Two hundred and fifty (250) of these centres now exist in France and about 100,000 people receive care in them each year.

Availability of health services is ensured by ‘social security’, an obligatory insurance funded by both workers and employers which makes up 35% to 100% of health expenses (75% on average). Life expectancy is high: 75.6 years for men and 83.1 years for women. Primary health care is provided only by general practitioners (GPs). Most of the 60,000 GPs are independent professionals directly paid by their patients on centrally fixed tariffs; the social security funds reimburse the patient’s expenses after the event. Few GPs have a receptionist in the surgery. Most work alone but a quarter share an office with fellow GPs or other health professionals. Continuous medical education is poorly organised, though there is a high density of CME associations (13,000).

10.1.4. Research on alcohol brief interventions

Little research was carried out in France on the GP’s role in alcohol-related problems before the WHO Phase III study. French teams were included in Phase III, in particular during its Strands 1 and 2¹. One clinical trial was conducted in 1995². Half of GPs were trained for screening only, the other half for screening and brief intervention (5-10 minutes advice). Patients included in this study were males reporting drinking more than 280g per week. An important effect was seen in patients in both conditions (half had reduced consumption to under 280g per week) but no differences were found between groups. This study was considered by its authors as disappointing. The only effective intervention ever published in the field by a French team concerns smoking cessation³.

At the beginning of WHO Phase IV study in 1999, ANPAA decided to develop a programme called *Boire moins c’est mieux* (BMCM: “Less is better”) in collaboration with the WHO study group. This programme had nationwide objectives and implications but the research aspects were mainly situated in the *Île-de-France* region (11 million inhabitants). The four general goals of Phase IV have been developed during the last four years⁴.

10.2. Customisation

BMCM worked on this objective by adapting:

- intervention tools;
- screening strategies;
- training methods;
- GP mobilization strategies.

10.2.1. Adapting intervention tools.

With a commission from the Social Security Public Health Department, in 1998 the *Comité Français d’éducation pour la santé (CFES)* developed a screening and intervention instrument *Alcool, ouvrons le dialogue*, based upon Prochaska and DiClemente’s⁵ approach – a 10-page tear-off pad and a waiting-room poster containing an invitation to ‘open a dialogue’ about alcohol consumption. In the contents, the AUDIT questionnaire was not used as a systematic screening tool but as a self-administered evaluation of the patient’s initiative following an interview.

In 1998-99 BMCM carried out a series of focus groups (with two medical ‘peer groups’, 10 doctors in each) to determine needs for screening and intervention materials in general medical practice. The French GP’s situation has 3 main characteristics: (1) they are paid on a fee basis and receive the same amount whatever they do during the consultation, which is partially reimbursed to the patient by the social insurance fund after the event; (2) they work alone in their offices (group practices do exist but usually doctors share the business premises); and (3) they usually have no assistant present in the practice, only a ‘telephone secretary’ to deal with appointments. The results

of the focus groups were clear: doctors considered they could participate in such a public health strategy but they wanted something easy, simple and short, and would appreciate an extra fee for this extra work. The Drink-less booklet, translated into French, and CFES' *'Ouvrons le dialogue'* were examined during these focus groups and useful recommendations were provided to our team⁶.

In 1999, Social Security, which had become the common funding institution of both CFES and BMCM, demanded the development of a common instrument. On the basis of the focus group results, BMCM had chosen the 'very short, one-shot counseling session' strategy and CFES wanted to keep its own more motivational and opportunistic approach. The compromise solution consisted of two different booklets that have been available since the beginning of 2002. The first is designed for patient's information, i.e., it gives the meaning of alcohol-related risk, explains the 'standard drink' concept (in France a standard drink contains 10 grams of pure ethanol), and the 'safe limits' (now 21 drinks/week for males and 14 drinks/week for females). The AUDIT and the CAGE questionnaires are given, together with a diary for self-recording a week's consumption. The cover displays a very neutral dialogue situation.

The second booklet is called 'How to Reduce Alcohol Consumption'. It has the same cover but its contents are aimed at a change in drinking habits, rehearsing the qualitative and quantitative goals, highlighting the role of motivation and giving advice for reduction of consumption. The two booklets can be ordered separately or can be included in a kit containing 30 copies of each, a poster (with the same picture as on the booklet cover) and an 'instruction manual' for the doctor, as a reminder of the CFES approach. The kits are delivered free of charge at doctors' request. In addition to this kit, BMCM developed a simpler instruction for use published in an article in 2003 in the *Revue du praticien-médecine générale*, the main French journal for GPs⁷.

The contents of an 'ideal' brief intervention, as promoted by BMCM, are summarized by a 'check-list' as follows: feed-back of screening test results; information on alcohol-related effects on health; explanation of the standard drink; discussion of personal motivation for change; fixing clear objectives; methods for reducing consumption; verification of the patient's consent; delivering the booklet and offering a second consultation if the patient wishes.

The FRAMES acronym⁸ serves as a general framework for advice. Role-play in training sessions and the experience related by doctors show that this kind of brief intervention lasts between 5 and 10 minutes.

In January 2002 we trained 10 GPs in a 2-hour session on screening methods and brief intervention. The focus group held two weeks after this showed that most doctors experienced difficulties when delivering a brief intervention. The main reason was the low level of screening activity, mainly done when symptoms were present; these GPs still thought of alcohol mainly when there was possible alcohol abuse or dependence present and guilt feelings attached to loss of control could explain screened patients' reluctance to enter a discussion about their drinking habits. In subsequent training sessions, we insisted on role-playing screening situations so that the screening would be seen in a more natural way. Following this, more or less systematic screening seemed to be better accepted by the doctors.

10.2.2. Adapting screening strategies

In collaboration with Dr. Pascal Gache in Geneva (co-ordinator of the Phase IV study in Switzerland) and Dr. Jean-Bernard Daepfen in Lausanne, Switzerland, we carried out an

evaluation of the French translation of AUDIT. The results show that, in French as in the other languages, AUDIT is an efficient screening test, with high sensitivity and specificity and two cut-offs in each gender: ≥ 6 and 12 for females, and ≥ 7 and 12 for males (first figure for a hazardous drinking diagnoses, second for abuse or dependence)⁹.

Following recommendations from the focus groups at the beginning of the programme, BMCM wished to offer French GPs a screening questionnaire more adapted to their professional situation than AUDIT. According to the participants' view, AUDIT had two major defects: (1) it is a self-administered waiting-room questionnaire, and when there is no secretary present it is difficult to persuade waiting-room patients to complete it; (2) it seemed too long for use as an interview questionnaire.

On inspecting the similarities between most screening instruments used more or less for the same purpose, we hypothesized that we could develop a sufficiently short interview questionnaire by identifying the most discriminating questions among 9 taken from different sources: AUDIT¹⁰, CAGE¹¹, TWEAK¹² and the Five-shot questionnaire¹³. We wanted to obtain an 'AUDIT-like' questionnaire, that is: (1) having two cut-offs, so as to separate patients in an intermediate situation capable of benefiting from a brief intervention; and (2) with at least the same informative values. The study described below was performed in the first six months of 2001. The result is a questionnaire, called FACE (for Fast Alcohol Consumption Evaluation or *Formule pour approcher la consommation par entretien*) made up as follows (Table 10.1)¹⁴.

TABLE 10.1
The FACE questionnaire

Questions	In French	In English	Source	Scoring
1	A quelle fréquence vous arrive-t-il de consommer des boissons contenant de l'alcool ?	How often do you have drinks containing alcohol ?	AUDIT 1 Five-Shot	0 to 4 (like in AUDIT)
2	Combien de verres standard buvez-vous lors d'une journée ordinaire où vous buvez de l'alcool ?	How many drinks do you have when you drink alcohol ?	AUDIT 2 Five-Shot	0 to 4 (like in AUDIT)
3	Votre entourage vous a-t-il déjà fait des remarques au sujet de votre consommation d'alcool ?	Have you ever been annoyed about your drinking ?	CAGE TWEAK Five-Shot	No = 0 Yes = 4
4	Avez-vous déjà eu besoin d'alcool le matin pour vous sentir en forme ?	Have you ever drunk first thing in the morning to get rid of a hangover ?	CAGE TWEAK Five-Shot	No = 0 Yes = 4
5	Vous arrive-t-il de boire et de ne plus vous souvenir le matin de ce que vous avez pu dire ou faire ?	Have you ever drunk and forgotten the next day what you could have said or done ?	TWEAK AUDIT 8	No = 0 Yes = 4
Total				0 to 20

The interpretation of the score is comparable to that of AUDIT: for women, hazardous drinking from 4 to 8, dependence above 8; for men, hazardous drinking from 5 to 8, dependence above 8. In our study the informative values of AUDIT and FACE are sufficiently similar: for hazardous drinking males, FACE cut-off > 4 , sensitivity 87.8%, specificity 74%; for hazardous drinking females, FACE cut-off > 3 , sensitivity 84.4%, specificity 84%; for abuse or dependence, both genders, FACE cut-off > 7 , sensitivity 75%, specificity 95.8% .

On the basis of these results we constructed an ‘easy, simple, short’ and efficient enough screening questionnaire but we needed to clarify whether it was more acceptable than AUDIT or than the AUDIT embedded in a health questionnaire validated by Daepfen and colleagues¹⁵. For this purpose we prepared a second study comparing screening activity between the three methods used successively (in randomly assigned order) among 76 doctors. This study was carried out in France and French-speaking regions of Belgium and Switzerland with, respectively, Dr Bernard Dor and Dr Pascal Gache.

We began the French part of the study in 2002 and in Belgium and Switzerland in 2003. The results seemed to confirm our opinion of the better acceptability of FACE than AUDIT and AUDIT embedded in a health questionnaire. Details of the results are given below in Section 10.5 and Table 10.2. We now assume that FACE is equivalent to AUDIT in terms of screening properties but seems a better tool in French, Belgian and Swiss situations because of a much better acceptability to both doctors and patients¹⁶.

10.2.3. Adapting training methods

The first experimental training sessions were completed in January and March 2002. They were based upon the conclusions of our qualitative approach, i.e. the focus groups. Having concluded that GPs do not need so much information on the consequences of alcohol consumption, we mainly used the concept of hazardous drinking, using a figure of the ‘risk pyramid’ adapted from Skinner¹⁷. The usual content of a training session is:

- (1) how to carry out a brief intervention (check list);
- (2) role-play, with some examples of professional situations where a brief intervention is to be given;
- (3) situations in which excessive drinking, according to participants, could be suspected, so that they can realize how frequently they should think of asking questions about alcohol consumption;
- (4) the advantages of a more systematic approach to detection, either psychologically-speaking or for public health;
- (5) the public’s confidence concerning the GP’s role in alcohol-related problems.

Up to the end of 2004, we had trained nearly 400 GPs and 140 occupational doctors. All the members of our team have been trainers. The duration of sessions varied from two hours to two days (for occupational doctors); in this case the second session occurred a week after the first. A two-day session seemed optimal because doctors could test the screening and brief intervention in the interval and react on the second day; but we feel that the shorter sessions also gave ‘good enough’ results, as shown in a demonstration study.

10.2.4. Adapting medical mobilization strategies

In France, telephone marketing to disseminate new medical practices had not been used before our programme. BMCM developed a randomised controlled study in which mail was compared with mail plus telephone marketing. The content of the marketing followed the advice of a communications specialist and was tested before widespread use among a panel of GPs.

The effects of an economic incentive were also evaluated in the French medical context. For this purpose we compared two 3-month phases, the first without payment and the second with an additional fee paid by BMCM in proportion to detection and brief intervention activity. The level of this incentive (the amount given for each action) was determined by reference to the present

consultation fee: 1/10 for a screening questionnaire (2€) and 1/2 for a brief intervention (10€). We hypothesized that this economic stimulation would produce, not only an increased subscription to training sessions, but also enduring activity in detection and brief intervention.

BMCM tested the effects of a community action in one of the 4 sites where the research project was carried out, Saint-Quentin en Yvelines. With the financial help of the *Syndicat d'agglomération nouvelle* (Community Council) and the operational support of the *Institut de promotion de la santé* (Health Promotion Institute), BMCM developed a programme combining meetings with opinion leaders, letters to associations, debates based on a movie, an information letter to every household inserted in the Community Council monthly magazine, and a poster on every bus stop shelter.

The results of various combinations of these incentives are presented below in the section on demonstration studies (10.5).

10.3. Reframing Understandings of Alcohol Problems

The main objective here was to shift the social (and, therefore, medical) representations of alcohol-related problems from 'alcoholism' to 'hazardous drinking'. A previous attempt to do this occurred in France in the 1970s. The creation of the *Centres d'hygiène alimentaire* (Centres for Healthy Nutrition) was a response to the need for counselling heavy drinkers to reduce their consumption. But, as mentioned above, these centres have rapidly been transformed into outpatient clinics for treatment of alcohol dependence. The concern about risky drinking was re-introduced through the WHO Phase III study, with the works of Rueff and his collaborators Huas and Bouix (Paris)¹⁸⁻¹⁹, Gache (Besançon)²⁰, and Chambonnet (Nantes)²¹. Nevertheless, secondary prevention had almost disappeared from the French medical scene after the early 1980s. At the instigation of the Social Security Prevention Department, the former *Comité Français d'éducation pour la santé* (now *Institut national de prévention et d'éducation pour la santé*: INPES), began in the late 1990s to design a new strategy that included leaflets for screening and intervention aimed at general practitioners and media campaigns (radio, TV and magazines). The transformation of the MILDT (Inter-departmental Mission against Drug Use and Dependence), through the inclusion of alcohol and tobacco into its competences, was also a trigger for a new way of considering the link between alcohol use and alcohol-related harm.

BMCM's first attempt to capture the public's attention was an article in *Le Monde*, the leading national newspaper, by Pascal Gache and Philippe Michaud in 1999²².

ANPA's decision to carry out the BMCM programme is, of itself, an important development. Until the official beginning of the programme in 2000, ANPA was mainly dealing with primary prevention and treatment of alcohol dependence, with little involvement in secondary prevention.

In association with governmental and social security authorities and with ANPA, in its annual media campaign INPES has decided to insist on the fact that regular alcohol consumption above the threshold of 3 10g-drinks a day may affect the individual's health, even in absence of dependence or drunkenness. Three campaigns have been launched with this theme (2001, 2002 & 2003) and BMCM played a role on the steering committee.

Five articles in the GP press have already been published by our team and the GPs working with us in *Le généraliste* and *La revue du praticien médecine générale*. The chief of these are:

- "Brief interventions in GP practice" (March 2003)⁷

- “The general public trusts the GP on alcohol, tobacco and drugs” (June 2003)²³
- “Detection of hazardous drinking in general practice and in occupational health: let’s FACE it” (January 2004)¹⁴

The *Revue du praticien* also published papers in relation to Phase III study by Chambonnet²¹ (Nantes, 1998), Bouix¹⁹ (Paris, 2002) and Huas² (Paris, 2002).

In 2001, the *Institut national de la santé et de la recherche médicale* (INSERM: National Institute for Health and Medical Research) completed a review of the medical consequences of chronic excessive alcohol consumption in which strong evidence was collected for each disorder, apart from dependence²⁴.

In 2001 the highest administrative authority in Ministry of Health (*Direction générale de la santé*) prepared a public plan to reduce the alcohol-related burden and this was presented in September 2001 by the Minister himself, Dr Bernard Kouchner. Dissemination of early intervention was considered to be one of the 3 major priorities. This aspect was highlighted by the Minister during the press conference and reported by press agencies and several daily newspapers.

In March 2003 the *Société Française d’alcoologie* (SFA: French Scientific Society of Alcoholology) organised a 2-day meeting on ‘Alcohol-related Harm Beyond Dependence’, where Phase IV and the BMCM programme were presented. Proceedings and recommendations were published in SFA’s journal at end 2004²⁵.

This activity is not sufficient to change GPs’ opinions about their ability and legitimacy for implementing early detection and brief intervention but it is noticeable that the results of a poll conducted on behalf of BMCM among a sample of 1600 persons showed that general public is ready to consider that the danger of excessive drinking does not consist only in dependence and traffic accidents. The same sample showed a very high level of confidence about doctors’ ability to respond to alcohol-related problems.

The major action of BMCM regarding the reframing concern was carried out in March 2003. We arranged a conjunction between: (1) the meeting of the SFA on March 13-14; (2) the WHO Phase IV investigators meeting in Paris on March 14-17; (3) a press conference involving most partners, the Ministry of Health and Social Security national board and Prof. Nick Heather on March 17; (4) a new mass-media campaign directed at the general public; and (5) publication of our main results in the GP press. These initiatives were successfully realised and two national newspapers, including *Le Monde*, and two GP journals (*Le Quotidien du médecin* and *La Revue du praticien*) published articles or editorials on the need to reduction of alcohol-related harm and the programme *Boire moins c’est mieux*.

In conclusion, the project began the task of reframing but placed it on a long-term footing in which governmental agencies and professional associations continue to play a key role.

10.4. Choosing a Lead Organisation and Building a Strategic Alliance

The BMCM programme aims at the nationwide dissemination of early detection and brief intervention but the research has been mainly carried out in the Parisian administrative region. The strategic alliances have been mainly built at these two levels, national and regional, and they are justified in political, financial and operational terms.

10.4.1. Lead organisation.

ANPA (since 2003 ANPAA) is a non-profit NGO founded in 1872 as the ‘National League Against Alcoholism’ and then renamed the ‘National Committee for Defence Against Alcoholism’. It has two main activities: primary prevention and the management of outpatient alcohol-care units (*Centres de cure ambulatoire en alcoologie*) disseminated throughout the nation - in total 120 out of the 250 units, which supply about 40% of consultations for alcohol dependent patients at a national level.

ANPAA counts about 2500 members and 800 employees. Its board of administrators decided in 1999 to integrate the BMCM programme into ANPA as a new department devoted to secondary prevention. The programme has two steering groups: (a) within ANPA, for management purposes, meeting as often as necessary; (b) with funding institutions, twice a year. Administratively, BMCM is placed under the direct responsibility of ANPAA’s director. The scientific responsibility is held by Dr Philippe Michaud.

10.4.2. Main strategic alliances.

Funding institutions and authorities contributing to BMCM’s budget until 2003 were:

- **National level** : *Direction générale de la santé* (Ministry of Health, Public Health General Direction); *Mission interministérielle de lutte contre la drogue et la toxicomanie* (Interdepartmental Mission against Drug Use and Dependence - this ‘mission’ belongs to the Prime Minister services); *Caisse nationale d’assurance maladie* (National Social Insurance Fund) and its prevention fund; *Ligue nationale contre le cancer* (National League against Cancer); *Institut national de prévention et d’éducation pour la santé* (National Institute for Prevention and Health Education); *Laboratoires Merck Liplha-santé* (Pharmaceuticals).
- **Regional level** : *Conseil régional d’Île-de-France* (Parisian Regional Council); *Caisse régionale d’Assurance maladie* (Social Insurance Regional Fund); *Direction régionale des affaires sanitaires et sociales* (Regional Directorate of Social and Health Affairs); *Mutualité sociale agricole* (National Farmers’ Social Insurance Fund); *Conseil général du Val-d’Oise* (Community Council, Département du Val-d’Oise).
- **Local level** : *Syndicat d’agglomération nouvelle de Saint-Quentin en Yvelines* (Greater City Council, Saint-Quentin en Yvelines).

Operational alliances were :

- **International level**: *Société scientifique de médecine générale* (Scientific Society of General Practitioners), Brussels, Belgium; *Département de santé communautaire, Hôpital universitaire de Genève* (Geneva Hospital Community Health Department), Switzerland.
- **National level**: *Institut national de prévention et d’éducation pour la santé* (National Institute for Prevention and Health Education); *Société Française d’alcoologie* (Scientific Society of Alcoholology); *Union nationale des associations de formation médicale continue* (National Association for Continuous Medical Education); *Sylia-Stat Corporation*, medical data statistical processing; *Unité de santé publique, Hôtel-Dieu de Paris* (Public Health Department of a Parisian public hospital).

- **Regional level:** *Observatoire régional de santé d'Île-de-France* (Regional Health Watchdog); *Formations et développements* (Association for Training and Development Strategies); *Société de médecine du travail de l'Ouest de l'Île-de-France* (Union of Occupational Doctors - western Parisian region); *Union régionale des médecins libéraux* (Regional Representative Council of Practitioners).
- **Local level:** *Institut de promotion de la santé de Saint-Quentin en Yvelines* (Institute for Health Promotion); *Comités départementaux de prévention de l'alcoolisme du Val-d'Oise, Pontoise, du Val-de-Marne, Créteil, des Hauts-de-Seine, Nanterre* (local committees for prevention of alcoholism); *Directions des affaires sanitaires et sociales des départements du Val-d'Oise, Pontoise, de Seine-et-Marne, Melun, des Yvelines, Versailles, de l'Essonne, Evry*.

Other alliances:

- **Operational alliances in other regions inside ANPAA:** *Comités régionaux de prévention de l'alcoolisme* (Regional Committees for Prevention of Alcoholism) in the following regions: Aquitaine (Bordeaux), Burgundy (Dijon), Franche-Comté (Besançon); Brittany (Rennes), Rhône-Alpes (Lyon).

Although there has been no formal alliance, all these bodies have been involved in different ways. The first group of funding institutions are mainly public health authorities that have strongly supported the programme, both in the objectives and in the operational aspects, by facilitating the reframing, by publishing recommendations, especially the Public Health Directorate of the Ministry of Health. This political support could determine a major decision still in the balance - the creation of a 'prevention consultation' with an extra fee. On the operational side, the alliance with the National Institute for Prevention and Health Education has been especially useful for the intervention booklets, and with the Institute for Health Promotion of Saint-Quentin en Yvelines, for the community action at that site.

10.5. Demonstration Studies

Two demonstration studies were initially planned, the main being TMP - Three Methods for Promotion (of early identification and brief intervention) and the other, REPEX - REPérage des buveurs EXcessifs (identification of heavy drinkers) intended as a preliminary study. But a third soon seemed to be necessary, prior to REPEX, to develop the 'easy, simple, short' screening interview questionnaire that French GPs seemed to want (DAME – *Dépistage au moyen d'un entretien*, interview screening). Thus three quantitative studies were decided on: DAME was successfully concluded in 2001; REPEX was completed in France in July 2002 and in Belgium and Switzerland in November 2003; TMP began in September 2002 and ended in August 2003.

10.5.1. DAME

DAME is a validation study with an original design. Given the objective, i.e., to create a questionnaire as discriminating as AUDIT for two diagnoses (hazardous drinking and alcohol dependence), we used 9 questions in total taken from existing questionnaires to select items giving the highest discrimination between the groups studied (heavy drinkers/not heavy drinkers or dependent/not dependent).

The AUDIT questionnaire was completed by patients in the waiting room before consultation at the researcher's invitation. The 9 questions under test were asked, after consent, by the GP during

the consultation. ‘Gold standard’ diagnoses were performed by the researcher, an experienced addiction specialist, by means of an interview carried out after the medical consultation.

We conducted the study with 41 GPs working in Paris or on the outskirts of Paris. Seven hundred and seven (707) files were collected (40% men), but 120 were excluded, including 48 refusals and 19 non-French speaking patients. Because of the geographic characteristics of the medical population, many patients were originally from Northern Africa and culturally Muslim, which explains the high level of abstainers (39.9%) in the patient sample. Seventy-three patients (41 men, 32 women) reported they drank more than the safe limits (210g or 140g per week); among these 11 presented three or more of the DSM-IV diagnostic criteria for substance abuse (9 men, 2 women) and 25 for the alcohol dependence diagnosis (19 men, 6 women). Average consumption among drinkers was 181g per week (men) and 84g per week (women). The low number of dependent patients, especially in women, obliged us to recruit men and women for the analysis.

A logistic regression analysis selected a cluster of questions with the required property and without any correlation (or with only a weak correlation) with each other. This logistic regression was successively run on with the two diagnoses in each gender. The questionnaire built up with this selection procedure finally gave an assessment tool, FACE (see above), as efficient as AUDIT.

10.5.2. REPEX

REPEX was a quantitative and qualitative study aiming to evaluate doctors’ and patients’ acceptance of 3 screening methods: AUDIT, AUDIT embedded in a health questionnaire, and FACE. The design sought comparisons between ‘real’ and ‘optimal’ levels of screening, given the definition of “patients eligible for screening”: aged 18 or more; not having had a consultation in the last 7 weeks. The GPs participating in the study had to screen in a naturalistic way, i.e., for the AUDIT, with questionnaires at patients’ disposal in the waiting room and a poster inviting them to fill it in; for the FACE, with an interview about alcohol during the consultation. If they worked with an assistant, he or she could encourage patients to answer the waiting-room questionnaires, but not actively help to complete them. During one week for each method, doctors had to note in a diary the age and gender of every patient seen, the reason for exclusion if any, the results of the screening test if the patient was eligible and had answered the questionnaire, and the reason for not answering in the opposite case. Every participating doctor had to test the 3 methods in an order assigned at random and had two weeks rest between two test weeks.

This study was conducted in France, in French-speaking parts of Belgium and in Geneva, Switzerland. Twenty-three (23) GPs participated in France, 23 in Belgium and 31 in Geneva. The results are summarised in Tables 10.2 and 10.3.

It is noticeable that the presence of a full-time assistant raises the levels of screening in the 3 countries - for instance, in France where this assistance is statistically linked with a much higher rate of screening with AUDIT (50.6% of usable questionnaires if there is a full-time assistant, versus 40.2 % if not, $p < 0.0001$) and with AUDIT-HQ (36.6 % of usable questionnaires if there is a full-time assistant versus 27.8% if not, $p < 0.01$).

In Geneva, questionnaires were also given to the assistants. Twenty-one (21) answered a final questionnaire and most preferred self-administered questionnaires with which their role was more active. Ten preferred AUDIT, 7 AUDIT-HQ and 6 FACE.

Our overall conclusion is that it may be necessary to offer a menu to the doctors, so that all can choose and be at ease with the screening tool. But FACE seems to be the most acceptable after the research experience, for doctors as well as for clients, even when there is a well-motivated assistant at the doctor's practice.

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TABLE 10.2

REPEX: main results in the 3 samples : (a) patients

Patients samples			
	France	Belgium	Geneva
AUDIT	N= 1617 eligible 52.1 %	N= 768 eligible 60.9 %	N= 1593 eligible 41.7 %
HQ*	N= 1677 eligible 51.6 %	N= 679 eligible 54.3 %	N= 1595 eligible 45.6 %
FACE	N= 1779 eligible 48.8 %	N= 689 eligible 60.1 %	N= 1610 eligible 42.8 %
	France	Belgium	Geneva
AUDIT	31.1 % + help** 10.7 %	61.3 % + help** 13.0 %	71.4 % + help** 2.6 %
HQ*	22.7 % + help** 7.7 %	61.5 % + help** 7.9 %	64.6 % + help** 3.0 %
FACE	87.1 %	95.0 %	88.8 %
** + help : questionnaire completed with doctor's help			
% of eligible patients for whom usable questionnaires are available (errors in scoring)			
	France	Belgium	Geneva
AUDIT	41.8 % (1.2 %)	74.3 % (3.4 %)	74.0 % (2.0 %)
HQ*	30.4 % (5.6 %)	69.4 % (11.4%)	67.6 % (4.5 %)
FACE	87.1 % (21.6 %)	95.0 % (12.0 %)	88.8 % (8.5 %)
	p< 10 ⁻⁸ (p<10 ⁻⁸)	p< 10 ⁻⁸ (p<10 ⁻⁴)	p< 10 ⁻⁸ (p<10 ⁻⁵)
Patients' opinions about the screening methods : % of patients agreeing with the opinion			
	France	Belgium	Geneva
Number of responders	AUDIT 102 HQ* 78 FACE 162	AUDIT 70 HQ* 55 FACE 82	AUDIT 227 HQ* 151 FACE 253
I was not disturbed by the questioning	AUDIT 87.2 HQ* 95.7 p=0.038 FACE 95.1	AUDIT 97.1 HQ* 94.9 NS FACE 91.5	AUDIT 95.6 HQ* 96.6 NS FACE 98.0
It invaded my privacy	AUDIT 49.0 HQ* 46.3 p<0.001 FACE 28.5	AUDIT 26.6 HQ* 28.1 NS FACE 25.9	AUDIT 37.6 HQ* 34.7 NS FACE 31.6
It made me speak of alcohol with my doctor	AUDIT 68.4 HQ* 64.4 p<0.007 FACE 49.7	AUDIT 56.5 HQ* 51.9 NS FACE 40.2	AUDIT 49.0 HQ* 37.8 p=0.10 FACE 45.2
The doctor gave me advice about my drinking	AUDIT 32.6 HQ* 33.8 NS FACE 43.4	AUDIT 38.1 HQ* 34.0 NS FACE 26.3	AUDIT 32.1 HQ* 23.3 p=0.07 FACE 35.5
I would accept to answer once a year	AUDIT 90.0 HQ* 92.2 p=0.003 FACE 77.6	AUDIT 98.4 HQ* 96.5 NS FACE 94.9	AUDIT 87.0 HQ* 89.7 p=0.085 FACE 92.8

*HQ = AUDIT embedded in a Health Questionnaire

NS = not significant

TABLE 10.3

Doctors' opinions about the screening methods (# of doctors agreeing with the opinion).																														
	France (N=23)				Belgium (N=23)				Geneva (N=31)																					
Questionnaire was intrusive	AUDIT	2			AUDIT	4			AUDIT	6			HQ*	3	NS	HQ*	4	NS	HQ*	0	NS	FACE	5		FACE	6		FACE	9	
Questionnaire scoring can't be made in routine	AUDIT	8			AUDIT	2			AUDIT	3			HQ*	9	p=0.014	HQ*	6	NS	HQ*	6	NS	FACE	1		FACE	3		FACE	1	
My screening was as complete as possible	AUDIT	6			AUDIT	16			AUDIT	23			HQ*	5	p<0.001	HQ*	13	NS	HQ*	16	p=0.68	FACE	17		FACE	15		FACE	22	
Patients found questionnaire too long	AUDIT	1			AUDIT	2			AUDIT	11			HQ*	14	p<10 ⁻⁶	HQ*	12	p<10 ⁻⁴	HQ*	18	p<10 ⁻⁴	FACE	0		FACE	1		FACE	1	
Doctors' global impressions (# of doctors agreeing with the opinion)																														
	France (N=23)				Belgium (N=23)				Geneva (N=31)																					
Preferred method	AUDIT	4			AUDIT	4			AUDIT	8			HQ*	1		HQ*	4		HQ*	4		FACE	17		FACE	13		FACE	18	
Method possibly in line with medical routine	AUDIT	1			AUDIT	2			AUDIT	3			HQ*	0		HQ*	3		HQ*	3		FACE	13		FACE	10		FACE	12	
	More than one method 5				More than one method 7				More than one method 13																					
A systematic screening could be achieved in routine	Yes	14			Yes	14			Yes	23			Yes with restrictions	7		Yes with restrictions	7		Yes with restrictions	7										

REPEX: main results in the 3 samples : (b) general practitioners

*HQ = AUDIT embedded in a Health Questionnaire NS = not significant

10.5.3. TMP Study

TMP is a complex study designed to answer the question, 'Of the following elements, which are useful for an efficient approach to EIBI dissemination among GPs: telephone marketing, community action, economic incentives?' The research was carried out in four cities: Evry, Cergy-Pontoise, Marne-la-Vallée, Saint-Quentin en Yvelines (Table 10.4).

The study had two phases. In the second an economic incentive was added, being the extra fee proposed for each screening (2€) and each BI (10€). Every trained GP was paid monthly on the base of his or her activity, recorded by sending a copy of the questionnaires used for screening. At the end of the first phase, we also paid all doctors for the work already done but they were not aware that this would happen before the end of the term. The community action is described above (Section 10.2.4) and was conducted in a single site during both phases (Saint-Quentin). The telephone marketing, unusual in the French medical context, was tested through a randomised controlled trial. The telephone marketing grid and presentation were adapted from the work of

Lock and colleagues²⁶, with the help of a French professional. The results are described in Table 10.5.

TABLE 10.4
Description of geographic sites in TMP study

	Evry	Cergy-Pontoise	Marne-la-Vallée	Saint-Quentin en Yvelines	TOTAL
Population (census, 1999)	79 726	178 656	246 607	142 737	647 726
Distance from Paris	28km (S)	30km (NW)	13km (E)	25km (SW)	
Number of GPs	60	138	203	115	516
Specificity of dissemination strategy	None	None	One phase only (2 nd)	Community action	

TABLE 10.5
TMP main results

	Criteria		Number of GPs trained / number of contacts		Screening activity (mean / trained GP)		BI activity (mean / trained GP)	
	Tests		X ²	p	F (or H)	p	F (or H)	p
Effect of telephone marketing (TM)	RCT (all sites, 2 phases)	Mail+TM	60/373	10 ⁻⁷	107,0	0,49	20,1	0,31
		mail	9/382		146,6		31,6	
Effect of economic incentive	Phase comparison (three sites)	phase 1	24/292	0,49	28,9	<10 ⁻⁴ (H)	6,3	<10 ⁻⁴ (H)
		phase 2	45/463		157,3		29,8	
Effect of community action	Site comparison (two phases)	SQEY	18/199	0,57	111,1	0,31 (H)	17,0	0,69 (H)
		CP+ Evry	26/359		59,6		11,9	

F : Snedecor's test for comparison of means (ANOVA, variances equal)

H : Kruskal-Wallis' test for comparison of means (variances different)

There is strong evidence for the efficiency of telephone marketing (on participating in training sessions) and economic stimulation (on activity of trained doctors); although a better result was found in Saint-Quentin where we achieved the community action, the difference was not significant for the same criteria cited in Table 10.5. However the proportion of inhabitants of Saint-Quentin screened during the action (1999 persons, 1.4 % of total population) is much higher than that measured in the comparison sites Cergy-Pontoise and Evry (1620 persons, 0.6 %, p<10), and this difference could be attributed to the influence of the community action.

Two post-intervention studies were conducted: the first was a postal survey about changes in doctors' perceptions and practice on alcohol-related risk, which showed no statistically significant differences between before and after (but the low rate of respondents resulted in a lack of statistical power); and the second, a qualitative study which indicated that integration of EIBI activity in

medical practice is realistic for trained GPs and also changes their overall relationships with patients²⁷.

10.6. Conclusion

At the end of 2003, *Boire moins c'est mieux* had largely fulfilled some of the objectives of the Phase IV study in France. The first apparent success is the mobilization of a wide strategic alliance, both for funding and for action. The second is the study's contribution to reframing understandings of alcohol issues and the movement towards a policy that gives GPs (and, in the second place, occupational doctors) a major role in secondary prevention. The third is the creation and continuity of a team that has adopted the objectives and methods of the Phase IV study. This team has created and validated the instruments essential for EIBI for French practitioners and is now able to continue towards the target of nation-wide dissemination, notably by its capacity to train the trainers.

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