

CHAPTER 14

Switzerland

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14.1. Introduction

14.1.1. Country description

Switzerland has 6.5 million inhabitants, including 1.6 million people living in the French-speaking part, “la Romandie”. The GNP per inhabitant was estimated at 30,500 Euros in 2002. Population density is 174 inhabitants per km². Some regions are mainly devoted to agriculture (central Switzerland) and wine (Valais, Geneva, Neuchâtel, Tessin). Switzerland is a confederation with 26 cantons. The political power is divided into three levels: federal, cantonal and municipal. Most important political decisions are made on the cantonal level. People are often called on to vote according to the direct democracy system. Four languages are regularly spoken in Switzerland (Swiss-German, French, Italian and Romanche). The three first are national languages.

14.1.2. Alcohol consumption and alcohol-related harm

Although Switzerland 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. All but elderly Swiss have adopted the so-called ‘Anglo-Saxon model’ of drinking (week-end drinking). Switzerland is now at the 11th rank in official European figures, with 9.0 litres per year per adult in 2004. In spite of this decrease, 3 000 deaths are still attributed to alcohol every year and it is the second cause of avoidable death after tobacco¹.

14.1.3. Health services

There is no state insurance health system in Switzerland. A compulsory private insurance system is the basis of health care access. Availability of health services is ensured by a federal law. GPs are well disseminated over the country. Practitioners are well trained and Swiss medicine has a good reputation.

14.1.4. Research on alcohol brief interventions

Hardly any research was carried out in Switzerland on the GP’s role in alcohol-related problems before the WHO Phase III study. A Swiss team was included in Phase III in 1998. In 2000, the team conducted a survey among primary care physicians from Geneva to document and compare GP’ beliefs, attitudes, and practices regarding early intervention, preventive medicine and treatment of established alcohol dependence. 384 GP’s’ received a questionnaire, 195 responded and 185 questionnaires were analysed. The Swiss GPs’ believe they are not really effective in helping patients to reduce drinking despite having been trained to do it. Paradoxically they all think they have a central role to play in the field of early detection of hazardous drinkers. Swiss GPs believe they would feel more confident in managing problem drinkers if they were better trained, if they had a lighter workload and if

* Members of the Phase IV Geneva Steering Committee will be found in Appendix 14.1.

there were supportive government health policies. In summary, GPs wish to be involved in the detection and management of problem drinkers but incentives such as training and health policies have to be developed².

14.1.5. Swiss national campaign on risky drinking

In 1998, the federal government undertook a national campaign, “Ca débouche sur quoi ? (Where does it lead?)” focused on risky drinking. Three kinds of action were implemented. First, TV spots, advertising and radio messages were addressed to the public at a national level. This part of the program represented 70% of the budget invested in the national campaign. Second, municipalities were invited to promote safe drinking at the workplace, sports events, schools, colleges and universities. This program, called “les communes bougent”, was not implemented in the city of Geneva but in a few small towns around it. Third, doctors and especially GPs were invited to participate in training sessions on early detection and brief intervention. About 1000 GPs were trained and customized materials were distributed³.

14.2. Customisation

The Swiss Geneva team involved in the WHO Phase IV study worked on this objective by adapting:

- intervention tools;
- screening strategies;
- training methods;

14.2.1. Adapting intervention tools

We adapted intervention tools from the national campaign and from material developed by a team of investigators in Lausanne (Dr J.B. Daepfen) as we participated in a randomised control trial on alcohol brief intervention implemented in our walk-in clinic. Interns were randomly assigned to two groups: specifically trained in brief intervention (BI) and a control group trained in cholesterol management. Results are still in process.

14.2.2. Adapting screening strategies: Alcohol Use Disorders Identification Test (AUDIT) in French

In collaboration with Dr. Philippe Michaud (co-ordinator of the Phase IV study in France) and Dr. Jean-Bernard Daepfen in Lausanne, Switzerland, we carried out an evaluation of the French translation of AUDIT. The aim of the study was to validate a French version of the AUDIT. We conducted a diagnostic cross-sectional study in three French-speaking areas (Paris, Geneva and Lausanne)⁴.

We examined psychometric properties of AUDIT as to its internal consistency, and its capacity to correctly diagnose alcohol abuse or dependence as defined by DSM-IV and to detect hazardous drinking (defined as alcohol intake >30 g pure ethanol per day for men and >20 g of pure ethanol per day for women). We calculated sensitivity, specificity, positive and negative predictive values and Receiver Operator Characteristic curves. Finally, we compared the ability of AUDIT to accurately detect "alcohol abuse/dependence" with that of CAGE and MAST.

1207 patients presenting to outpatient clinics (Switzerland, N=580) or general practitioners (France, N=627) successively completed CAGE, MAST and AUDIT self-administered

questionnaires and were independently interviewed by a trained addiction specialist. AUDIT showed a good capacity to discriminate dependent patients (with AUDIT \geq 13 for males, sensitivity 70.1%, specificity 95.2%, PPV 85.7%, NPV 94.7% and for females sensitivity 94.7%, specificity 98.2%, PPV 100%, NPV 99.8%) and hazardous drinkers (with AUDIT \geq 7, for males sensitivity 83.5%, specificity 79.9%, PPV 55.0%, NPV 82.7% and with AUDIT \geq 6 for females, sensitivity 81.2%, specificity 93.7%, PPV 64.0%, NPV 72.0%). AUDIT gave better results than MAST and CAGE for detecting "Alcohol abuse/dependence" as showed on the comparative ROC curves. 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: \geq 6 and 12 for females, and \geq 7 and 12 for males (first figure for hazardous drinking diagnoses, second for abuse or dependence).

In France, Dr Michaud developed the FACE questionnaire (for Fast Alcohol Consumption Evaluation or *Formule pour approcher la consommation par entretien*). This instrument, built upon AUDIT, CAGE and TWEAK, is a five-item questionnaire administered by the GP him/herself. 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%, and 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%.⁵

On the basis of these results Dr Michaud constructed an 'easy, simple, short' and efficient 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 colleagues⁶ For this purpose he proposed a study comparing screening activity between three methods used successively (in randomly assigned order) among 77 doctors. This study was carried out in France and French-speaking regions of Belgium (Dr Bernard Dor) and Switzerland (in Geneva).

The French part of the study began in 2002 and in Belgium and Switzerland in 2003. The results seemed to confirm our view of the better acceptability of FACE than AUDIT and AUDIT embedded in a health questionnaire. Details of the results are given below in Section 14.5 and Tables 1 and 2. We now assume that FACE is equivalent to AUDIT in terms of screening properties but seems a preferable tool in French, Belgian and Swiss situations because of a much better acceptability to both doctors and patients⁷.

14.2.3. Adapting training methods

The first experimental training sessions took place in June 2000. 120 GPs' from the Geneva canton participated in a half-day training on early detection and brief intervention (EDBI). The training was divided into four parts.

- (1) Explanations of the results of the survey (see above) and the importance of ED and BI
- (2) How to screen with AUDIT
- (3) How to deliver a BI and when
- (4) How to manage alcohol dependence after a positive screening result

We distributed materials to each participant. We did not undertake an evaluation of this training.

14.2.4. Adapting medical mobilization strategies

GPs from the Geneva canton are very often asked to participate in continuing medical education (as everywhere in Switzerland) and refuse to participate most of the time. To involve GPs, we contacted them through a health insurance network (REMED) which includes three quarters of the GPs who work in the canton.

In the recruitment phase of the study on the acceptability of the screening methods, we used telephone marketing with good results. Half the doctors approached agreed to participate. In some cases, we carried out personal marketing to recruit participants in this study.

14.3. 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 during the first years of the Swiss national campaign. During the first training session with GPs, the Swiss Geneva team faced a lot of resistance to the concept of risky drinking because doctors mainly focused alcohol-related problems and alcohol dependence.

We (Geneva team) also published an article in the Swiss French-speaking medical journal for GPs, “Médecine et Hygiène”. In this article we developed the concept of excessive drinking and the community approach, including GPs, to alcohol problems.⁸

We contributed to two other articles published in a French GP journal (*Revue du Praticien*)

- Intervention brève en médecine générale (“Brief interventions in general practice”) (2003)⁹
- Parler d’alcool reste un sujet tabou (“Talking about alcohol is still taboo”) (2002)¹⁰

In conclusion, the Geneva team always kept in mind the necessity of reframing understandings of alcohol-related issues. In this regard, we should consider that the national campaign did much for this purpose. Unfortunately, no valid and reliable assessment has been carried out.

14.4. Choosing a Lead Organisation and Building a Strategic Alliance

Because we started our work after the beginning of the national campaign, we tried to utilise materials and ideas from it. *L’office fédéral de la santé publique* (OFSP) encouraged us to pursue our specific actions among GPs’ in the canton of Geneva.

14.4.1. Main strategic alliances.

Funding institutions and authorities contributing to our project were:

- **National level** : *Office fédéral de la santé publique*
- **Cantonal level** : *Direction Générale de la Santé, Unité d’alcoologie des hôpitaux Universitaires de Genève*
- **Local level** : *Fondation Armand Slavic pour le développement de la recherche en alcoologie clinique*

Operational alliances were:

- **European level:** *Boire moins, c'est mieux*, Paris, France. *Société scientifique de médecine générale* (Scientific Society of General Practitioners), Brussels, Belgium;
- **National level:** *Swiss Society of General Practice*, *Swiss Society of Internal Medicine*
- **Regional level:** *Association des Médecins Genevois*, *Fédération Genevoise de prévention de l'alcoolisme*, *Unité d'alcoolologie des hôpitaux Universitaires de Genève*, *Groupe des Enseignants en Médecine Générale de la Faculté de Médecine de Genève*, *Institut de Médecine Sociale et Préventive de la Faculté de Médecine de Genève*

14.5. **Demonstration Study (REPEX): collaboration with the French and Belgian teams**

REPEX was a quantitative and qualitative study aiming to evaluate doctors' and patients' acceptance of three screening methods: AUDIT, AUDIT embedded in a health questionnaire (AUDIT-HQ), and FACE. The design allowed 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. GPs participating in the study were asked 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, the GP 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, the reason for not answering in the opposite case. Every participating doctor had to test the three methods in an order assigned at random and had two weeks rest between two test weeks.

This study was conducted also in France and in the French-speaking part of Belgium. 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 three countries - for instance, in Switzerland 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, for which their role was more active. Ten preferred AUDIT, 7 AUDIT-HQ and 6 FACE

FACE was the best screening mode in the three French-speaking countries. However, in the Geneva context it may be necessary to offer a choice of two screening instruments to the doctors (AUDIT, FACE).

14.6. **Conclusions**

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TABLE 14.1

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 % |
| <hr/> | | | |
| | 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) |
| <hr/> | | | |
| 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 |

Interesting findings emerged from the Phase IV WHO collaborative study in Switzerland. First, we trained about 150 GPs' to carry out EDBI. We also participated in an international study focused on the acceptability of screening instruments in routine conditions of general practice. Swiss GPs are not so different from Belgian or French colleagues even if practice conditions are different.

For the future, GPs have told us that prevention is now an important aspect of their work. and they asked us to globalise the preventive approach to major health risk factors such as alcohol, tobacco, overeating and lack of physical exercise. We are considering this request.

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

TABLE 14.2

| Doctors' opinions about the screening methods | | | | | | | | | | | | |
|---|-----------------------|----|--------------------|--|-----------------------|----|--------------------|--|-----------------------|----|--------------------|--|
| (# of doctors agreeing with the opinion). | | | | | | | | | | | | |
| 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

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APPENDIX 14.1

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