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Update on current research

Excessive use of alcohol and local medical practice

The promotion of early detection and short-term intervention (RPIB)

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In 2006 the French health authorities are setting up a strategy for the widespread dissemination of the RPIB on alcohol to general practitioners. This initiative is motivated by the existence of a World Health Organisation (WHO) programme to combat the excessive use of alcohol and by the implementation of various regional strategies aimed at promoting the RPIB. Moreover, it is in line with one of the objectives of the government's 2004-2008 plan to combat illicit drugs, tobacco and alcohol. In order to support the strategy chosen at national level, the public authorities have asked the OFDT to gather the information available about the RPIB and produce a report on the status of the initiatives to promote the RPIB that are already under way in the five regions {1}. After giving a brief outline of the RPIB, this edition of *Tendances* will list the principal factors involved in disseminating the RPIB in local medical practice and the ways in which the Ministry of Health is at present responding to them.

What is the RPIB?

The RPIB aims to achieve a reduction in the consumption of alcohol to below the risk levels defined by the WHO, that is to say:

not more than 21 glasses per week for men; not more than 14 glasses per week for women;
not more than 4 glasses per occasion;
no alcohol in certain circumstances (pregnant women, while driving, while taking certain types of medication, while doing dangerous jobs or practising dangerous sports, in the case of certain pathologies);
one day without alcohol per week.

The excessive use of alcohol can be screened by using numerous questionnaires.

These include the AUDIT (Alcohol Use Disorders Identification Test) which was promoted by the WHO and then translated and validated in French. In spite of its qualities (sensitivity and reliability), the AUDIT can be difficult to use in ambulatory care {2}. Hence, a team has endeavoured to devise a questionnaire better adapted to the expectations and constraints of the

daily work of general practitioners: the FACE (form for use during interviews to assess consumption) {3}.

The AUDIT and the FACE are the two questionnaires usually presented to general practitioners during current RPIB training sessions. However, the doctor remains free to choose which tool to use from among all the questionnaires now available.

There is no simple definition of the notion of short-term intervention. Depending on the context and the opinions of researchers and doctors, variants in its content and duration or the way it is carried out are observed. However, any short-term intervention will include the following components: it is addressed to excessive drinkers and is aimed as a priority at reducing their alcohol consumption and not at achieving abstinence. The doctor is recommended to adopt a non-judgemental attitude based on empathy and respect for the patient's responsibility regarding his behaviour {4}.

It has been agreed to summarise the phases of a short-term intervention as follows. The phases are usually summarised by the acronym FRAMES:

To give the patient the results of his detection test (or feedback);
To make the patient accept responsibility (behavioural change is the choice of the patient, not the therapist);
to advise him about moderation (advice);
to demonstrate to the patient the ways in which he could modify his alcohol consumption (menu);
to use kindness, not to judge (empathy);
to let the patient act on his change and encourage him in it (self-efficacy).

What do we know about the efficacy or efficiency of short-term interventions?

Almost all research demonstrates that short-term intervention leads to a short or medium-term reduction in alcohol consumption in drinkers who exceed the risk levels defined by the WHO. Long-term analysis (more than 10 years) has not succeeded in demonstrating that short-term intervention, not accompanied by special measures, can lead to significant reductions in alcohol consumption. Therefore, according to the criteria of the *Preventive Service Task Force* {5}, the degree of validity and reliability that can be attributed to the conclusions of the efficacy studies conducted is high or acceptable. The promotion of the RPIB is therefore seen as desirable. What does it cost? Direct disbursements include the cost of the time spent by the professional in conducting the RPIB and the cost of the equipment needed to carry out the intervention. To this are added various associated costs: training the professionals, complementary mobilisation strategies (communication campaigns, dissemination of brochures, possible remuneration for training courses), the increased number of consultations and the use of specialised structures {6}.

Although there have been few economic studies on short-term interventions concerning alcohol, those that have been produced show that the RPIB offers a good cost/effectiveness ratio {7 – 9}.

As a rule, it must be concluded that the cost of the RPIB is offset by the potential gains derived from reduced medical costs {10}.

The challenge of the RPIB in local medical practice

The disturbances associated with the excessive use of alcohol are a major challenge for public health. In France, 30% of people who consult their general practitioner have an alcohol consumption higher than the risk levels defined by the WHO {20}. However, this question is difficult to examine in the framework of a medical consultation. Overall, the vast majority of doctors think that alcohol is an important problem in general medicine, but it is only at a late stage, when the misuse of alcohol becomes harmful or is accompanied by dependency, that it becomes a medical concern {21}. In the opinion of general practitioners, this state of affairs is the result of a misunderstanding of the problem of excessive alcohol use, how alcohol is perceived, a reluctance to use screening tools and a professional culture essentially based on a clinical set of references concerned with care rather than prevention. Thus, many doctors misinterpret the risk thresholds and associate alcohol problems with dependency. Ranging from simple use to dependency, their representations leave little room for excessive alcohol use {21 – 22}. Moreover, they are still sensitive to the alcohol taboo. They find it difficult to start a conversation on the subject. Doctors are afraid of being intrusive and worry about how their patients might react if they did so {23 – 24}. Moreover, although a majority of them consider themselves competent to recommend moderation, only 37.5% of them think their intervention has been effective. To be precise, only 2% of general practitioners state that they use ready-made questionnaires to help them discern risk factors or screen a pathology {25}.

In spite of this overall situation, general practitioners are ideally placed in the care system to detect excessive alcohol use and to take action concerning it. In fact, they are consulted by nearly three quarters of the French population every year {26}. Patients believe doctors are legitimate and competent to tackle alcohol problems {27}. In fact, all health professionals and authorities attribute a decisive role to general practitioners in screening and taking charge of excessive alcohol use {28 – 29}.

Hence, the challenge of a national dissemination of the RPIB consists of mobilising those participants and then training them to recognise and treat this specific problem. These are ambitious objectives. In fact, according to many of the professionals involved in training courses, alcohol is not a very motivating subject. Moreover, the aim of training courses is to induce ambitions to acquire much fuller knowledge concerning alcohol. Their objective is to encourage the absorption of new representations concerning the product and the adoption of preventive practices and health education that can be transposed to other forms of risky behaviour.

A shared basis for recommendations

For an optimum promotion of the RPIB to general practitioners, those involved have devised regional strategies covering the necessity of combining three main lines of action: media publicity, training and complementary mobilisation and support action.

Long before any consideration on the “technique” of the RPIB to be promoted with doctors, it would be necessary to set up action on a scale that is at the same time more global and more thorough among the representations that frame the perception of alcohol. All communication actions – the specialised press, brochures, the Internet – agree with this objective, but it cannot be fully achieved without mass media intervention targeting both the professionals concerned and the general public.

General practitioners are among the professionals who receive the greatest volume of information and all kinds of requests. Therefore, unless continuous medical training in fact becomes compulsory with priority emphasis placed on the subject of alcohol, an offer of training in the RPIB will not receive a significant hearing without the implementation of a strategy to canvass doctors in the form of telephone marketing or face to face interviews. These two mobilisation strategies have demonstrated their effectiveness both in the WHO's studies {9, 30} and in regional experiments. Payment for training sessions would also be an essential component in encouraging the recruitment of doctors.

Moreover, training constitutes an unavoidable stage in encouraging the practice of the RPIB. According to those involved in regional action, awareness campaigns, even if varied and individual, would not suffice. In order to convince general practitioners that the RPIB is feasible in routine practice, two ingredients seem decisive: the inclusion of role-play in the training session and actually putting the RPIB into practice between two training sessions. In other words, an "action training" type of arrangement is recommended, focused on delivering operational messages based on the practitioners' own experiences.

Moreover, in order to ratify the practice of the RPIB, it would be necessary to repeat the messages (communication action throughout the course) and generally, to use the language of those involved, to envisage giving "repeat injections" until the doctors themselves take the procedure on board.

It is equally necessary to consider the problem presented by alcohol-dependent patients and to target future generations of doctors during their initial training. RPIB training comes down to emphasising the importance of disturbances related to the use of alcohol which do not amount to dependency. But the message cannot be heard if doctors are not at the same time supported in the problems they encounter with dependent patients. Without this help, it is most unlikely that the RPIB will inspire the full cooperation and enthusiasm of practitioners.

Moreover, the scope of the objectives being aimed at means that the RPIB must be included in initial medical training. Generalising the knowledge and skills required regarding excessive alcohol use and, more widely, regarding prevention, requires such inclusion. Lastly, in the opinion of those involved in regional strategies, it is not realistic to hope to mobilise general practitioners to adopt the RPIB without agreeing that it implies the work of a full-time professional who deserves a form of recognition and esteem, particularly from the financial point of view.

All the foregoing points show a consensus as regards the optimum dissemination of the RPIB to general practitioners. However, the organisational terms and conditions governing the implementation of this dissemination must take account of the wishes, partnerships and financing arrangements that can be mobilised locally. This is one of the conclusions that emerge from the regional onographies [1] (see regional tables).

[1] Note du traducteur: Ce mot "onography" ou "onographie" ne semble pas exister. Est-ce peut-être une faute de frappe?

The effectiveness of short-term interventions in international literature

A large number of researchers have taken an interest in the effectiveness of short-term intervention in excessive alcohol consumption over the last thirty years. The studies made enable summaries to be produced in the form of meta-analyses {6, 11 – 16}. Except for one – because of a lack of statistical homogeneity {13} – all the meta-analyses available in international literature agree on the effectiveness of the short-term intervention. As a rule, they show that an intervention consisting of a short counselling session is more effective in reducing excessive alcohol consumption than no intervention at all. It should, however, be remembered that the studies included in the various meta-analyses have differing characteristics, depending on the way the short-term intervention is defined (duration, content, intensity), and the duration of patient monitoring (between 2 months and 10 years) or the indicators used to measure the change in the patient's behaviour regarding alcohol (clinical markers, stated information on weekly alcohol consumption, number of days of illness). In spite of the methodological limits of the various studies, researchers agree that the effectiveness of short-term intervention is demonstrated beyond all reasonable doubt {17 – 18}.

1. On average 6 to 12 months for the short term and 2 to 5 years for the medium term.
2. By way of comparison, 6.3% of doctors stated that they used ready-made questionnaires on the subject of tobacco, but this is still a rare practice.

A desire for national dissemination

In the light of these findings, the position adopted by the Ministry of Health and the Inter-Ministerial Mission to Combat Drugs and Drug Addiction (MILDT) is characterised by the wish to use this shared basis of locally acquired knowledge and skill while allowing each territory to choose the method of organisation and implementation best suited to the resources available locally.

The Ministry of Health and the MILDT have declared their desire to disseminate the RPIB nationally. They are calling on the regional health authorities to promote new initiatives in territories that are not yet mobilised and to support existing projects.

The DRASS are invited to monitor the lasting nature of financing arrangements, pool energies and clearly define roles so as to minimise potential leadership problems. In fact, the experiments already conducted have shown that DRASS involvement was a decisive factor in the dynamism of projects.

With that aim in mind, a national piloting committee was set up at the end of 2005. It works to construct tools for transmission to the regions to encourage the widespread dissemination of the RPIB. The OFDT will set up a monitoring system to supervise the achievement of the objectives assigned to this dissemination strategy.

Ile-de-France (1998): implementation of the WHO's references

In the Ile-de-France, the RPIB was promoted in the framework of the ANPAA's "*Drinking less is better*" programme (BMCM). The strategy implemented faithfully reiterates the requirements of Phase IV of the WHO project. Thus, the people involved conducted several "research actions" to adapt the RPIB's tools to the French context and to test several methods of mobilising general practitioners. This measure made it possible to formalise a training system aimed at general practitioners – nearly 400 general practitioners trained – and future trainers. Lastly, a large communication drive was conducted with general practitioners and the general public to help disseminate new representations regarding alcohol-related problems.

Aquitaine (2001): a regional health programme (PRS), a "research action", a strategy with an exhaustive scope

In Aquitaine, the 2001-2006 alcohol PRS made the dissemination of the RPIB to health professionals a clear priority. On those bases, two specific projects saw the light in the Gironde and the Basque Country. Conducted by the Agir 33 network, the strategy followed in the Gironde led to an assessment of the action. Nearly a hundred general practitioners were trained in the RPIB and the effect of the training courses on their actual practices, their experience of alcohol-related problems and the behaviour of their patients were assessed {31}. Conducted by the RESAPSUD network in the Basque Country, the strategy aimed at being exhaustive: to train all the 300 general practitioners in the territory. To do this, two training systems were combined, the continuous medical training system (FMC) and the organisation of friendly interviews in the general practitioner's own surgery. In all, more than 200 general practitioners were trained in one year.

Champagne–Ardenne (2002): "a network culture"

In Champagne-Ardenne, the promotion of the RPIB forms an active part of the ADDICA network. Thus, the spirit of the strategy deployed is stronger than the problems related to drinking excessive alcohol. It takes its place among the combined problems linked to risky behaviour needing a renewal of professional practices. The promoter aimed to mobilise several types of professionals in a network-based operation, the dissemination of a "network culture" encouraging the acquisition of new practices to tackle risky behaviour, including the RPIB in the case of alcohol. In this framework, nearly a hundred general practitioners were trained.

Burgundy (2003): integration into the continuous medical training system (FMC)

Conducted by the regional ANPAA (CRPAT), the promotion of the RPIB here came within the framework of "customary" training evenings in local FMC organisations.

This strategy originated from the notion that the widespread mobilisation of general practitioners should be long lasting. It could not be done outside the familiar training channels that constitute their preferred social meeting places.

In the space of one year, nearly 100 general practitioners were trained.

Brittany (2004): development of preventive consultations

In Brittany, it was initially considered that the promotion of the RPIB would take place in the FMC system. Following a lack of reactivity to the FMC system, the entities conducting the project (URMLB, DRASS, ANPAA) finally opted for an approach better suited to the characteristics of the territory, based on visits to general practitioners by prevention professionals.

The WHO's project

Launched in the early 1980s, the WHO's project on detecting and tackling alcohol-related problems in local medical practice comprises four phases.

Phase I of the project led to the development of the AUDIT questionnaire.

Phase II is an effectiveness study. It resulted from international collaboration involving 10 countries and 1,655 at-risk consumers. The principal result of this research showed that for men a five minute intervention reduced their consumption (on average by 25% more than the control group) and improved their state of health compared with a sample group without any intervention.

Phase III of the WHO's project concerned the conditions necessary for the dissemination of the RPIB. In a first phase, a postal survey was conducted on the knowledge, practices and attitudes of general practitioners concerning prevention and early intervention in alcohol-related matters. The difficulties identified by general practitioners were shortage of time and training, and the lack of support from government authorities. Then, a qualitative study was conducted on the obstacles to the dissemination of the RPIB and the factors favouring it. Lastly, a random study assessed the different strategies for mobilisation, training and support, enabling the use by doctors of a scanning and short-term intervention kit to be promoted – the Drink Less Programme.

The results showed that telephone marketing was the most cost-effective mobilisation strategy and that training accompanied by telephone support increased levels of actually using the method in practice.

The last phase of the WHO's project – Phase IV – aims to promote the widespread dissemination of the RPIB in routine practice. Each participating country is free to decide on the most appropriate strategy for achieving that aim. There is no pre-established protocol to be followed. General guidelines only are offered: adapt the RPIB's tools; encourage the dissemination of new social representations in alcohol-related matters; set up a "self-starting organisation" likely to promote the project in the country and form "strategic alliances" with all involved to fix the strategy in the national context; conduct feasibility studies {19}.

Methodological reference points

The OFDT's report "*RPIB: strategies for promotion, early screening and short-term intervention in alcohol-related matters with general practitioners*" is based on two distinct types of research. Firstly, an analysis of the national and international literature (existing articles and publications on general notions of the RPIB, and the attitudes and roles of general practitioners, effectiveness studies, etc.), and secondly, in-depth investigations at regional level (case studies) conducted on the spot (in Aquitaine, Burgundy, Brittany, Champagne-Ardenne and the Ile-de-France). A total of about fifty interviews were conducted with the promoters and entities involved in local strategies for promoting the RPIB (general practitioners, the social milieu, institutional authorities, entities representing general practitioners).