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REVIEW

THE EFFECT OF BRIEF INTERVENTIONS ON REDUCING ALCOHOL CONSUMPTION IN ADULTS: A SYSTEMATIC REVIEW

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ABSTRACT

Objective: to synthesize evidence on the effects of brief interventions on reducing alcohol consumption among adults. Method: systematic review study, protocol registered in the International Prospective Register of Systematic Reviews, registration no. CRD42020153034. The search was conducted in 2020, in electronic databases and randomized clinical trials that evaluated the effects of Brief Interventions in adult alcohol drinkers were included. Results: 11 articles were evaluated. All studies performed, in the control and experimental groups, a test to identify the pattern of alcohol consumption, with feedback offered to the user afterwards. The interventions use methodologies that encourage the user to make a decision, as well as maintain the decision made and avoid relapse. Conclusion: this research contributes to health care teaching and assistance, through reflections on the identification of alcohol abuse and compiled on the application and impact of Brief Interventions.

DESCRIPTORS: Systematic Review; Alcohol Abuse; Brief Psychotherapy; Treatment Outcome; Harm Reduction.

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INTRODUCTION

The consumption of alcoholic beverages is configured as a serious public health problem, due to the physical, social, family, and psychological damage it causes to the user, besides increasing the cases of violence, accidents, and deaths. The harmful use of this substance is considered the seventh risk factor for premature mortality and the first for the indicator Disability-Adjusted Life Year (DALY) - years of unproductive life due to disability - and the main risk factor for the global burden of disease in the world[1].

In Brazil, about 40% of the population has consumed alcoholic beverages in the past 12 months[2]. Of the world's young adult population, aged 15 to 64 years, 3.6% have alcohol use disorders[3].

Given this scenario, the World Health Organization (WHO) has recommended the use of brief interventions (BI) as a strategy to provide quick assistance to alcohol users. To perform BI, a screening test is used, usually the Alcohol Use Disorders Identification Test (AUDIT), and then the principles of feedback, accountability, provision of information, options, and motivation to change heavy drinking behavior and always in an empathetic way; these are represented by the acronym FRAMES (Feedback, Responsibility, Advice, Menu of option, Empathy, and Self-efficacy)[4].

This study is based on the premise of the need for actions to reduce alcohol consumption; therefore, it is justified by the importance of synthesizing evidence about the effects of BIs to assess the possibility of using them and, consequently, their impact on risky/harmful drinking behavior. Furthermore, no other studies aiming at this synthesis were found in the literature. Thus, we aimed to synthesize evidence on the effects of brief interventions on reducing alcohol consumption among adults.

METHOD

This was a systematic review of randomized clinical trials (RCT), prepared according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist[5]. The review protocol was registered in the International Prospective Register of Systematic Reviews (PROSPERO), registration no. CRD42020153034. There were no changes in the protocol.

To formulate the review objective and question, the PICOS strategy was used, in which Population (P): adult alcohol users; Intervention (I): brief intervention; Comparison/control (C): other interventions; Outcome (O): reduction in alcohol consumption; and Study design (S): randomized clinical trials[6]. Thus, we obtained the following question: what is the effect of brief interventions on reducing alcohol consumption among adults?

The inclusion criteria established were primary studies whose design was a randomized clinical trial and that evaluated the use of BIs in adults (≥18 years old and ≤59 years old), in both genders, to reduce alcohol consumption, with no follow up limitations. Exclusion criteria were studies with adolescents or the elderly; research that used more than one complementary therapy in combination with BIs; that evaluated the use of BIs to reduce the consumption of other psychoactive substances; studies with an approach to mental disorders associated with alcohol consumption.

The search was performed in the databases: Medical Literature Analysis and Retrieval System on-line (MEDLINE) via Pubmed, Excerpta Medica database (Embase), CENTRAL Cohcrane, Latin American and Caribbean Literature in Health Sciences (LILACS) and Nursing database via Virtual Health Library, Index to Nursing and Allied Health Literature (CINAHL)

and Database in the field of psychology (PsycINFO). In addition, secondary searches were performed in other sources: in Clinical Trials Registries, for example, ClinicalTrials.gov (National Institutes of Health, NIH, USA) and The Brazilian Clinical Trials Registry (via the Brazilian Clinical Trials Registry Platform - ReBEC). No limits of temporality, language, or setting where the study was conducted were applied, to reach the largest number of articles and not restrict the search. It is noteworthy that two researchers carried out the search strategy in all databases independently. The bibliographic program EndNote was used to store, organize, and manage all the references.

Initially, the strategy for searching the studies was composed of a combination of controlled descriptors and keywords, according to the indication offered in each database. In order to broaden the search strategy, a combination of controlled descriptors and keywords was performed by means of the Boolean operators "AND" and "OR".

The search occurred in December 2020, and was conducted by two independent reviewers, in case of disagreement, a third reviewer was consulted and so occurred in all stages of extraction and evaluation of the studies. Initially, titles and abstracts were read, and then the full texts. The authors were not contacted for any questions.

For data extraction, a standardized form based on previous studies[7-8] was used, including: study identification (title, journal impact factor, country of study authors, year of publication, host institution, funding); methodological characteristics (study design; objective; research question or hypotheses; characteristics of the sample, experimental and control groups, recruitment method, losses, duration of follow-up and statistical analyses); main findings and implications for clinical practice; and conclusions. The level of evidence[9] of the studies was also classified. Data were extracted and organized in a synoptic table for qualitative analysis.

The methodological quality of the randomized clinical trials was assessed by the Jadad Scale[10], whose score ranges from zero to five, with studies scoring <three considered low quality and studies scoring ≥three classified as high quality. Internal validity and risk of bias for RCTs were assessed using the Cochrane Risk of Bias tool from the Cochrane Collaboration Handbook for Systematic Reviews of Interventions, version 5.1. 0[11], which assesses seven domains: I) Randomization sequence allocation (selection bias); II) Secrecy of allocation (selection bias); III) Blinding of participants and staff involved (performance bias); IV) Blinding of outcome assessors (detection bias); V) Incomplete outcomes (attrition bias); VI) Selective outcome reporting (publication bias) and VII) Other sources of bias. Based on these domains, studies are classified into low, high, or uncertain risk of bias.

Considering that most of the studies evaluated presented significant methodological differences (analysis instruments and intervention methods), this heterogeneity prevented the performance of meta-analysis. Thus, we chose to perform a qualitative synthesis of the data in this systematic review.

RESULTS

2,071 studies were identified, but after the entire selection process, as described in Figure 1, this study was operationalized with 11 articles.

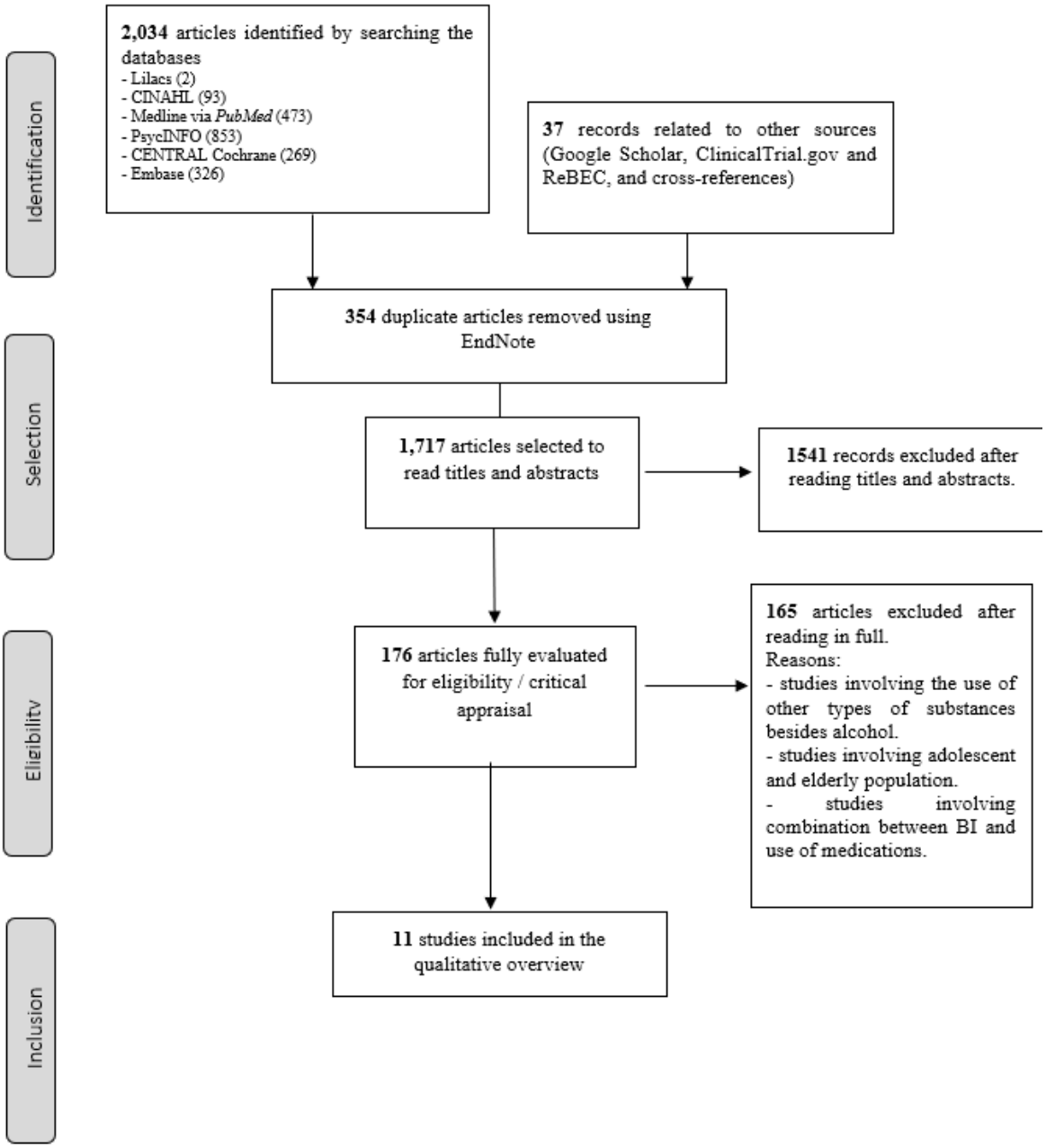

Figure 1 - Flowchart of the eligibility of papers found according to PRISMA. Teresina, PI, Brazil, 2021
Source: Authors (2021).

Of the 11 studies that operationalized this article, four were conducted in England and the others in various countries, including South Korea, Switzerland, India, Poland, South Africa, and the United States of America. Seven of the studies were published between the years 2010 and 2019 (Chart 1).

Chart 1 - Description of the studies included in the Systematic Review. Teresina, PI, Brazil, 2021 (continues)

Authors - Year (Country)	Intervention		Results	Jadad score
	Experimental Group	Control Group		
Burnhams et al. 2015[11] (South Africa)	n=168 Team Awareness (TA). Session duration: 8 h. Follow up: two weeks and three months	n=157 Lecture on well-being. Duration of session: 1 h	The results show that TA had the greatest impact on risky drinking practices and hangover effects.	4
Clarke, Field, Rose 2015[12] (England)	n=52 Feedback personalizado sobre consumo de álcool e questionário relacionado ao álcool. Duração: 10 a 15 minutos; Follow up: duas semanas	n=51 Only completed the alcohol-related questionnaire on the UK Department of Health's Change4Life website. Duration: 15min.	Both groups significantly reduced alcohol consumption and the frequency of binge drinking, but there were no significant differences between the groups on any of these measures.	4
Kaner et al. 2003[13] (England)	n=136 G1: extension training (n=68). Duration: Average of 8.6 minutes. G2: training plus phone support (n=68). Duration: 5 minutes connection. Follow up: three months	n=76 Written guidelines, directions.	The cost-effectiveness ratios were similar between intervention groups, showing that the effectiveness of the interventions will depend on whether such lifestyle advice is routine practice or an additional activity for primary care.	4
Wood et al. 2007[14] (USA)	n=168 Brief motivational intervention (BMI) followed by Alcohol Expectancy Challenge (AEC). Duration: 45 to 60 min. Follow-up: one, three and six months.	n=167 AEC followed by BMI. Duration: 45 to 60 min.	BMI produced significant decreases in heavy drinking and problems, while AEC produced significant decreases in heavy drinking. There was no evidence of an additive effect of combining the interventions.	2
Korcha et al. 2012[15] (Poland)	n=152 SBIRT* method with 15-to-20 minute session. Follow-up: three and 12 months	n=147 Conversations with professionals.	Patients who showed greater motivation to change their drinking behavior were significantly more likely to reduce the amount of drinking at three months; however, at 12 months this change was already significant.	2
Pal et al. 2007[16] (India)	n=45 Motivational interview (MI) based on the FRAMES protocol. Duration: two sessions of 30- to- 45 min; Follow-up: one and three months	n=45 They received simple advice (SA) from trained professionals.	There was significant improvement in many consumptions and quality of life parameters in the BI and SA groups. Significant differences were observed in interventions, with a decrease in the severity of dependence, as measured by past 30-day alcohol use, and improvement	5

			in physical and psychological quality of life in those who received BI compared with those who received SA	
Gaume et al. 2017[17] (Switzerland)	n=296 Immediate Brief Motivational Intervention (BMI). Follow-up: six months	n=276 AUDIT application and feedback.	Among non-heavy episodic users, there was a protective effect of BMI on weekly alcohol use ($p<0.05$). Among heavy episodic users, there were no significant effects of BMI.	5
Jo et al. 2019[18] (South Korea)	n=748 on-BEAM** assessment of drinking behavior in three steps Duration: 23 to 30min Follow-up: four weeks	n=748 Assessment with AUDIT without normative feedback.	On-BEAM was effective in reducing participants' alcohol consumption. The intervention group reported consuming less alcohol in the past week than the control group.	5
Allen et al. 2011[19] (London)	n=221 The intervention lasted up to four sessions. Follow up: three and 12 months	n=220 Conducting a health check and general health promotion, feedback in the form of a letter.	It was possible to involve men who drink dangerously in a brief intervention aimed at reducing alcohol-related harm. However, the results regarding effectiveness are ambiguous.	5
Dench, Bennet (2000)[20] 30-50 years old (United Kingdom)	n=24 SOCRATES 8A and discussion about effects of alcohol and reflection of feelings. Duration: two sessions of 10 to 15min Follow up: six weeks	n=27 A round of conversation with the user, with the objective of the user identifying the harmful side of his consumption.	At one week after the intervention, the motivational participants reported significantly higher levels of problem recognition. The motivational group's post-intervention scores group were significantly higher on the Execution Scale and significantly lower on the Ambivalence Scale.	3
Finn, Andréasson, Hammarberg (2020)[21]	n=133 Patients in primary care. Maximum of five 15min sessions; 30min only in the first because of feedback; Method 15 Follow up: 6 and 12 months after.	n=138 Patients in specialist care. Feedback from the initial assessment, delivered by a physician. - Decision making. -pharmacological and/or psychological treatment.	The change in consumption occurred from the beginning to the six months follow-up and was maintained until the 12 months follow-up. This study indicates brief treatment of alcohol dependence in primary care with Method 15 as a viable method.	3

*Screening, Brief Intervention, and Referral to Treatment **Online assessment of drinking behavior and normative feedback.
Source: Authors (2021).

Chart 2 shows the risk of bias of the studies, according to the Cochrane Handbook of Systematic Reviews of Interventions version 5.1.0 classification. Of the 11 articles that make up this review, seven present low risk of bias, since they describe clearly and objectively how the allocation in the control and experimental groups, losses, and outcome occurred.

Chart 2 - Summary of the risk of bias of the ten included studies, according to the Cochrane Handbook of Systematic Reviews of Interventions version 5.1.0. Teresina, PI, Brazil, 2021

Source	Random sequence generation (selection bias)	Allocation concealment (Selection bias)	Blinding of participants and staff involved (performance bias)	Blinding of outcome assessors (detection bias)	Blinding of outcome assessors (detection bias)	Selective Outcome Report (Publication bias)	Other sources of bias	Classification	Level of Evidence[9]
	Risk of bias domains								
Burnhams et al. 2015[11]	(+)*	(+)†	(?)†	(?)†	(+)‡	(+)*	(+)‡	Low	1B
Clarke et al. 2015[12]	(+)†	(-)†	(+)†	(?)†	(+)*	(?)‡	(–)†	Low	1B
Kaner et al. 2003[13]	(+)*	(-)*	(–)†	(-)*	(-)*	(-)‡	(-)‡	High	2B
Wood et al. 2007[14]	(+)*	(+)*	(+)†	(+)*	(+)*	(-)*	(?)*	Low	1B
Korcha et al. 2012[15]	(+)*	(+)*	(?)†	(?)‡	(+)†	(+)‡	(–)†	Low	1B
Pal et al., 2007[16]	(+)*	(-)*	(–)†	(-)*	(-)*	(-)*	(?)*	High	2B
Gaume et al. 2017[17]	(+)†	(+)‡	(+)†	(+)†	(+)*	(+)*	(?)†	Low	1B
Jo et al. 2019[18]	(+)†	(+)‡	(+)†	(+)†	(+)*	(?)*	(?)†	Low	1B
Allen et al. 2011[19]	(+)†	(+)‡	(+)†	(+)†	(+)*	(?)*	(?)†	Low	1B
Dench, Bennet 2000[20]	(+)†	(-)‡	(+)†	(-)†	(?)*	(+)*	(?)†	High	2B
Finn, Andréasson, Hammarberg 2020[21]	(+)	(-)	(-)	(-)	(+)	(+)	(+)	High	2B

*(+) – Low risk of bias; †(–) – High risk of bias. ‡(?) – Uncertain risk of bias.

Source: Authors (2021)

Among the tests used to screen for alcohol use, the AUDIT was cited in five studies, three other studies cited their own questionnaire, two cited the Rapid Alcohol Problems Screen (RAPS4), and one used the CAGE (Cut down, Annoyed by criticism, Guilty, and Eye-opener).

Questionnaires were used to check the risks of alcohol consumption, including: Quick Drinking Screen; Rutgers Alcohol Problem Index (RAPI); Timeline Follow Back Questionnaire (TLFB); UK Department of Health's Change4Life website alcohol-related questionnaire; The 21-item Short Inventory of Problems; Addiction Severity Scale (ASI); The Drinker Inventory of Consequences (DrInC); and Socrates 8A.

The studies also verified the willingness to change and stage of change on the part of alcohol users, as well as their quality of life and refusal to drink, using, respectively, the Readiness to Change Questionnaire (RCQ), WHOQOL-bref, and Drinking Refusal Self-Efficacy Questionnaire (DRSEQ) scales. In addition, questionnaires designed by the authors themselves were used to collect sociodemographic data.

All articles conducted a test to identify the pattern of alcohol consumption, with feedback offered to the user afterwards, as recommended by the WHO, an action performed in the control and experimental groups. The interventions were performed in different ways: one study adopted the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method, five adopted motivational interviewing, one cited that it followed the FRAMES principles, one used Team Awareness (TA), one used Personalized Brief Intervention (BPI), one conducted outreach training and telephone support, one conducted on-BEAM (assessment of drinking behavior and normative feedback) and a discussion method on alcohol effect and reflection.

Yet another study used Method 15, which is divided into three stages: identification of alcohol problems and brief advice; assessment, with a 30-minute feedback; and pharmacotherapy with one of four pharmaceuticals: acamprosate, disulfiram, naltrexone, or nalmefene and/or four sessions based on cognitive-behavioral therapy and motivational interviewing.

As for the duration of the intervention sessions, there was variation: five studies adopted a time of five to 20 minutes, three adopted 30 to 60 minutes, and only one study adopted a time of eight hours. Two other articles did not report the length of each session.

Six performed the follow up after three months, two studies performed it after six months, one study performed the re-evaluation after one, six and 12 months, another study performed six and 12 months after IB, and only one study did not perform follow up, doing a single session. All performed up to four sessions. Method 15 proved to be effective up to 12 months after the application of IB, and IBM proved to be effective up to 30 days later for reducing alcohol consumption and improving physical and psychological quality of life. The use of the SBIRT method showed increased motivation to change behavior up to three months, and was not found 12 months after IB. The other studies did not describe follow-up evaluations. As for the means of communication used, face-to-face interviews prevailed (n=nine) and only two contacts by telephone.

Regarding effectiveness, TA, personalized feedback, on-beam, discussion method, and method 15 were shown to be effective in reducing alcohol consumption. There was divergence among motivational methods: three studies observed reduction in alcohol consumption[14,16,21], the effectiveness of IBM will depend on counseling[13], study found ambiguous results regarding effectiveness[19]. The SBIRT method concluded that drinking reduction was directly related to motivation for habit change.

DISCUSSION

The interventions used in the 11 studies focused on the user's awareness of his harmful form of drinking through the use of questionnaires and scales with subsequent feedback. Then, the intervention itself was performed by means of techniques and methodologies to help the user make a decision (abstinence, reduction of consumption), as well as options for activities that would help maintain the decision made, in order to avoid relapse[15,17].

These studies adopted important questionnaires and scales, which pointed out significant criteria to be evaluated, in order to group solid arguments for the user himself to certify his harmful pattern of alcohol consumption[14-16], both for himself and for the people who live with him.

For counseling steps and menu of options recommended by the WHO, the Brief Motivational Intervention (BMI) was highlighted, which consists of person-centered counseling. The help offered aims to lead the user to think about his behavior in the context of values and goals, decide whether change is necessary and, if so, how it can best be achieved[14,19,21].

TA consists of a training program that addresses behavioral risks among employees, their coworkers and, indirectly, their families, aiming to promote social interaction, facilitate the destigmatization of help-seeking, and encourage proactive behaviors, such as bringing the user closer to people who can support him in moments of craving[11]. The application of this technique proved to be effective in reducing consumption, mainly due to the sharing of experiences, development of empathy, trust, and mutual help among participants. It is noteworthy the importance of the facilitator in creating a judgment-free and welcoming environment.

The BPI consisted of face-to-face counseling with information on health and social consequences, charts with statistics of health problems, a list of benefits that would result from reducing alcohol consumption, and guidance on techniques that could assist in reducing alcohol consumption. Each participant set their own personalized drinking reduction goal[12] and some were able to achieve their goals, showing that BPIs are effective in reducing drinking.

The SBIRT methodology was used, an evidence-based practice used to identify, reduce and prevent the use, abuse and dependence on alcohol and other drugs[16], and has proven to be an effective tool[22]. SBIRT is in accordance with the protocol of the Manual for Use in Primary Care prepared by the WHO[23], this methodology consists of conducting screenings with screening instruments for drug use, implementing BI for at-risk users, and making referrals for cases of probable dependence. It showed effective results among the participants.

The use of BI is considered promising, since these techniques can be implemented in a varied universe, such as primary care or emergency services. Moreover, several aspects contribute to its large-scale use, such as low cost and easy application. For alcohol use disorders, beneficial responses have been observed, especially in the short term[24].

Another strategy raised, the on-BEAM, is conducted on the web for high-risk alcohol consumers, through assessment, normative feedback, and motivational planning, with the goal that participants determine their own behavioral changes[18]. To conduct motivational planning for behavioral change, participants answered several questionnaires, including: the Drinking Consequences Inventory (DrInC) - used to assess problems resulting from drinking[23], the Readiness to Change Questionnaire (RTCQ) to verify their readiness for change[18]. After assessing participants' self-efficacy to control their desire to drink in certain situations using the Refusal to Drink Self-Efficacy Questionnaire[23], personalized and comprehensive results based on their responses were provided as normative feedback. An important step is the definition of goals by the users, and once again the importance of the mediator in facilitating the users to recognize their needs and elaborate their goals[11,18] is highlighted.

The BI is based on principles that highlight, among some aspects, harm reduction, stages of change, and motivation. Its use is not restricted to specific environments, allowing, therefore, its application when there is an opportunity[25].

As for the conduction of BI, they should be carried out by trained professionals, not necessarily with college degrees[13-14,19,21]. The duration of the sessions varied according to the objective, the questionnaires used, and the participants. However, the WHO recommends that the time of each session be limited, focused on the problem, lasting from five minutes, as a brief orientation, to 15 to 40 minutes[23].

Regarding the effectiveness of interventions, although the studies did not show

statistically significant differences between the control group and the intervention group, it should be considered that the goal of reducing the pattern of alcohol consumption was achieved by all studies. A study conducted in India[16] found a significant reduction in the severity of dependence in those who received BI compared to the control group, a result similar to a study conducted in South Korea[18]. Another study found that the effectiveness of BI is related to its ability to promote behavior change readiness in the user, as those alcohol users with better behavior change readiness reduced their consumption more[18].

It is noteworthy that key elements for effective implementation and positive results of BI in the context of alcohol use consist of training and capacity building of professionals, especially nurses. The impact of using this tool has the potential to prevent and reduce alcohol consumption, thus avoiding its multiple consequences[26].

The main limitation of this study was the lack of time delimitation of the follow up in order to obtain homogeneous samples that would allow the stipulation of the validity of the interventions; however, this was not the objective of the study, so there were no losses.

CONCLUSION

The results of this review point to effects of BIs in reducing the pattern of alcohol consumption, however, one cannot judge whether the reduction is one-off, which was considered a limitation for this study.

This research contributes to teaching, research, and health care, through reflections on the importance of early identification of alcohol abuse and application of BIs, the results of their use, and, consequently, the impact among those who use alcoholic beverages. Therefore, this tool should be incorporated into the practices of health professionals, with a view to the benefits that can be acquired, modification of alcohol consumption and minimization of its damage.

In this sense, we suggest the development of new randomized clinical studies that perform follow-ups with regular time intervals, and we also encourage other reviews that perform meta-analysis to compare the results in order to verify the durability of the interventions. The development of maintenance sessions after time intervals is also encouraged, in order to increase the durability of the interventions and ensure greater efficacy and achievement of goals by the users.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - Lima LA de A, Silva Júnior FJG da, Santos GVA de A, Costa APC, Sales JC e S; Drafting the work or revising it critically for important intellectual content - Lima LA de A, Silva Júnior FJG da, Santos GVA de A, Costa APC, Sales JC e S; Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - Lima LA de A. All authors approved the final version of the text.

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