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RESEARCH ARTICLE

Quasi-randomized trial of solution-focused brief therapy intervention for readiness to change and alcohol and other drug use in a Brazilian community-based treatment center

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Abstract

Objective Strategies to increase readiness to change may enhance community-based substance use treatment outcomes. This study evaluated the effect of solution-focused brief therapy (SFBT) on readiness to change and substance use compared to treatment as usual (TAU) in a Brazilian community-based substance use treatment center.

Methods One hundred two adults ($M = 36.79$, $SD = 10.29$) were quasi-randomized into SFBT or TAU groups. Assessments were completed at baseline, post-test, and 1-month follow-up. The primary outcome was the changes in readiness to change at post-test and 1-month follow-up. The secondary outcome was the change in substance use at 1-month follow-up.

Results Through Quade non-parametric analysis of covariance (ANCOVA), both groups decreased tobacco, alcohol, and cocaine/crack use at 1-month follow-up, but SFBT had greater reductions in alcohol use ($p = .05$). ANCOVA analysis demonstrated no differences between groups on readiness to change at any time point. However, among participants who used multiple substances ($n = 59$), SFBT showed higher readiness to change at post-test ($p = .05$).

Conclusions These findings strengthen the evidence that SFBT holds promise for positive community-based substance use treatment outcomes.

Keywords: community-based treatment; readiness to change; solution-focused brief therapy; substance use disorders; substance use treatment

Clinical or methodological significance of this article: Solution-focused brief therapy has been highlighted as an effective treatment for substance use, yet this intervention is not well known in Brazil and no study has examined its effects on readiness to change. The present study evaluated the effect of a solution-focused brief therapy session on readiness to change and substance use in a Brazilian community-based substance use treatment setting using an experimental design. Results suggest that solution-focused brief therapy may reduce alcohol use and improve short-term, readiness to change among people who use multiple substances.

Introduction

Alcohol and drug use remain a major public health problem with an estimated 269 million people aged 15–64 worldwide having consumed a drug in 2018 (UNODC, 2020). In Brazil, this issue is equally

concerning, with approximately 2.3 million Brazilians aged 12–65 years having alcohol use disorder, 4.9 million having tobacco use disorder, and 1.2 million having other substance use disorder (SUD) in 2015 (Bastos et al., 2017). SUD's have important

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implications for the health, well-being, safety, and social development of people who use substances, their families, and communities (UNODC, 2020). Addressing such consequences requires increased implementation of evidence-based drug treatment strategies worldwide (UNODC, 2020). One promising and cost-effective evidence-based strategy is community-based substance use treatment (Hafford-Letchfield et al., 2020; Mojtabai & Zivin, 2003; Vuong et al., 2018).

Brazilian Community-Based Substance Use Treatment

In Brazil, community-based substance use treatment is primarily provided by the Psychosocial Care Centers for Alcohol and Drugs (CAPS-ad), and was implemented throughout the country by the Brazilian Universal Health System in 2002 (Brasil et al., 2004). These services represent a significant landmark in the evolution of public policies related to alcohol and drugs, disrupting the traditionally dominant model of psychiatric asylums. Key innovations include the integration of the CAPS-ads into the community and their emphasis on voluntary treatment through an individual-centered approach committed to promoting the autonomy, citizenship, and human rights of people with SUD (Sampaio & Bispo Júnior, 2021). The centers' multidisciplinary team (e.g., physician, psychiatrist, nurse, psychologist, occupational therapist, social worker, nursing technician) offers a continuum of care, ranging from walk-in sessions to specialized treatment. The team's diverse composition is fundamental for providing a holistic approach to people who use substances, encouraging diverse paths to treatment (UNODC, 2008). The walk-in session is a comprehensive screening interview aimed at establishing a strong therapeutic relationship and constructing a personalized treatment plan, which is crucial for treatment adherence and success (Leite et al., 2018; McCormick et al., 2019; Roy et al., 2020; Sampaio & Bispo Júnior, 2021).

Despite the importance of walk-in sessions, there has been a notable absence of studies specifically evaluating the interventions used during these sessions. Only three clinical trials evaluating substance use treatment efficacy have been conducted at CAPS-ad. One study showed that psychosocial rehabilitation plus homeopathy was more effective than treatment as usual (TAU) plus placebo in reducing cocaine use and cravings (−11.7%) (Adler et al., 2018). A second study found that a mindfulness-based relapse prevention program for tobacco was more effective in decreasing anxiety and depression symptoms and carbon monoxide level than a cognitive behavioral therapy intervention (Pumariega et al., 2020).

Finally, a third study demonstrated that the combination of motivational interview, group therapy sessions, and topiramate had greater reductions in quantity, frequency of use, and money spent on crack cocaine during the first 4 weeks of the treatment compared to motivational interview, group therapy sessions, and placebo (Baldaçara et al., 2016).

Relevance of Readiness to Change for Substance Use Treatment Outcomes

While a few clinical trials have assessed substance use treatment at CAPS-ad, the focus has been limited, leaving a significant gap in optimizing interventions during the walk-in session. The walk-in session is the first appointment received by help-seekers and presents a strategic opportunity to enhance readiness to change (RTC). RTC has been conceptualized by the trans-theoretical model (TTM) as how ready someone is to change a behavior which involves five stages of change (e.g., precontemplation, contemplation, preparation, action, and maintenance stages; DiClemente, 2018; DiClemente et al., 2004; Prochaska & DiClemente, 1982). However, a qualitative research with CAPS-ad professionals demonstrated that the walk-in session was used almost exclusively for screening, potentially limiting its efficacy and utility (Silva et al., 2020). In addition to substance use screening, strategies to increase clients' RTC during the walk-in session may enhance CAPS-ad treatment outcomes.

Interventions tailored to increase RTC are crucial for the reduction in substance use at the initial phases of treatment, given the high ambivalence about changing substance use among individuals seeking care (DiClemente et al., 2004; Miller & Rollnick, 2013). Studies indicate that RTC is critical to improve treatment outcomes (DiClemente et al., 2004; Hesse, 2006; Project MATCH Research Group, 1997). Among 952 individuals who received outpatient treatment for alcohol use, increased RTC at baseline was associated with a higher percentage of days abstinent and a lower number of drinks per drinking day during 1-year following treatment (Project MATCH Research Group, 1997). Furthermore, a study with 87 people who used multiple substances showed that RTC substance use upon admission for maintenance treatment with either methadone or buprenorphine was associated with decreased substance use at 18-month follow-up (Hesse, 2006).

Solution-Focused Brief Therapy for Substance Use

One promising intervention to enhance RTC of people who use substances is solution-focused brief

therapy (SBFT). This approach has been highlighted as an effective treatment for substance use (De Shazer & Isebaert, 2004; Franklin & Hai, 2021; Froeschle et al., 2007; Kim et al., 2018; Smock et al., 2008; Suitt et al., 2019), particularly with less motivated clients (Zhang et al., 2018). SBFT is a strength-based, goal-oriented approach that emphasizes resources, moments when the problem did not happen, and past successes rather than the causes of the problem (De Shazer et al., 2007). Its core interventions and assumptions are hypothesized to contribute to increased motivation to change and support the change process (Lewis & Osborne, 2004; McCollum et al., 2004). SBFT facilitates and amplifies these changes by elucidating facilitating factors to natural changes (e.g., avoiding or reducing substance use), believing that change leads to change, focusing on conversations about change, and highlighting the clients' strengths and resources (Lewis & Osborne, 2004; McCollum et al., 2004). A randomized controlled trial with 204 university students demonstrated that solution-focused approach produced a significantly greater increase in goal approximation and adoption of action steps to solve a real-life problem compared to problem-focused condition (Neipp et al., 2016). Although these results may be encouraging given that the adoption of action steps is related to RTC, to the authors' knowledge, no study has examined the direct effects of SBFT on RTC regarding substance use.

Importantly, the literature indicates various positive outcomes for substance use treatment associated with SBFT. For instance, a study showed that SBFT improved interpersonal and social functioning and lowered distress and depression symptoms of people who experienced SUD compared to a control group treated with the traditional problem-focused psychoeducational approach (Smock et al., 2008). In a hospital setting, inpatients (84%) and outpatients (81%) reported continued abstinence or controlled drinking four years after completing a SBFT-based program (De Shazer & Isebaert, 2004). Among adolescents, SBFT integrated with interactive teaching methods decreased drug use and favorable attitudes toward drug use and increased social competence and knowledge of drug use effects compared to an assessment-only control group (Froeschle et al., 2007). A randomized controlled trial with adults in outpatient substance use treatment showed that both SBFT and TAU counseling services groups decreased drug use (Kim et al., 2018). Finally, a single-case study with eight participants indicated that SBFT contributed to decreased alcohol use (Suitt et al., 2019).

This intervention was designed to be brief (Zhang et al., 2018) and can be conducted in one session

(Courtnage, 2020), making it particularly well-suited for settings like CAPS-ad. Despite its potential, SBFT is not well known in Brazil (Franklin & Hai, 2021; Martins et al., 2013) and has not yet been implemented in community-based substance use treatment centers. Although some research has examined substance use treatments conducted within CAPS-ad, to the authors' knowledge, no studies have specifically evaluated a specific intervention conducted during the walk-in session. Additionally, the investigation of the effect of SBFT on RTC and substance use is needed to support the practices of professionals utilizing more systemic interventions for substance use. Hence, the current study aimed to evaluate the effect of SBFT on RTC and substance use compared to TAU in a CAPS-ad. We hypothesized that SBFT would increase RTC and reduce substance use compared to TAU.

Methods

Design

This was a two-arm, quasi-randomized controlled trial involving adults who used alcohol and/or other drugs, recruited at a CAPS-ad in the southeast of Brazil. This service provides free, voluntary substance use treatment to people over 18 in an outpatient care setting within the community, focusing on psychosocial rehabilitation and harm reduction. Similar to other countries, its interventions align with the principles and recommendations for community-based substance use treatment elaborated by UNODC (2008). A distinguishing feature of CAPS-ad is its open-door system, eliminating the need for referral to treatment and thereby enhancing accessibility while tailoring services to clients' needs. The treatment starts with a walk-in session (TAU) on the same day clients seek treatment. During this session, a personalized treatment plan is constructed that consists of therapeutic activities provided at CAPS-ad (e.g., therapeutic group, maintenance group, pharmacotherapy, counseling, therapeutic workshops, day program, home visits, social events involving family and community to foster social integration, and/or family group support) and/or additional referrals to other services (e.g., homeless shelters, social services for low-income families, family violence services, primary care services, emergency units for abstinence crises).

Participants

Participants were eligible if they were at least 18, sought a walk-in session at the center, completed

the screening, and were not referred by court order. A total of 129 clients were invited to participate in this study. Seventeen did not meet inclusion criteria and 10 declined to participate (see Figure 1), for a final sample of 102 participants ($M = 36.8$; 74.5% male; 62.7% African descendants; See Table I). Participants were allocated equally to TAU and SFBT groups ($n = 51$). The minimal estimated sample size was calculated using g-power software v3.1 (Faul et al., 2007) for analysis of covariance (ANCOVA) using an alpha of 0.05, a power of 0.8, and a medium effect size (Cohen's $d = 0.6$) resulting in 90 participants.

Procedure

Quasi-randomization procedures were used to allocate participants to the TAU or SFBT groups based on the order in which they presented for care. For example, the first participant was assigned to the TAU group; the next was assigned to the SFBT group; and so on. After reading and signing the informed consent form, participants completed a series of questionnaires, immediately followed by intervention. Follow-up assessments occurred immediately post- and 1-month after the SFTB/TAU (see Figure 1). A group of trained research assistants administered baseline and follow-up assessments. This study was approved by the University's Research Ethics Committee (CAAE 05227218.9.0000.5407) and registered in the Brazilian Registry of Clinical Trials (<https://ensaiosclinicos.gov.br/rg/RBR-2kcbxz/>).

Measures

Demographic information. At baseline, participants completed a questionnaire assessing age, gender, race, relationship status, education, employment, and faith/religion. Socioeconomic status was identified using the Brazilian Economic Classification Criteria, which assesses the householder's level of education and number of household items.

Readiness to change. The University of Rhode Island Change Assessment Scale (URICA) is a 24-item used to evaluate the RTC ranging from 1 (strong disagreement) to 5 (strong agreement) (Szupszynski & Oliveira, 2008). Internal consistency (Cronbach's alpha) was 0.65 at baseline, 0.63 at post-test, and 0.44 at 1-month follow-up. A Readiness Ruler was also used to measure RTC, in which participants indicated how ready they were to change their behavior on a 0–10 scale (Miller,

1999). Both measures were completed at baseline, post-session, and 1-month follow-up.

Alcohol and drug use. The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) was used to assess alcohol, tobacco, cannabis, cocaine, stimulants, sedatives, inhalants, hallucinogens, opioids, and other substance use. The ASSIST is an 8-item scale assessing substance use patterns during the last three months (Henrique et al., 2004; WHO ASSIST Working Group, 2002). This scale was used to identify substance use at baseline only. At baseline, the scale's internal consistency (Cronbach's alpha) was 0.79 for alcohol, 0.54 for tobacco, 0.78 for cannabis, and 0.62 for cocaine. Similar to prior research, reliability was not calculated for amphetamines, inhalants, hallucinogens, opioids, and others because of the small number of users (Henrique et al., 2004). At the 1-month follow-up, participants indicated the frequency of past-month use of alcohol, tobacco, and other drugs. To coincide with the baseline measurement (the second question of the ASSIST test), responses were coded as 0 (no lifetime use), 1 (never in the last month), 2 (monthly or less), 3 (weekly), and 4 (daily).

Intervention conditions

The walk-in consisted of a session of TAU or SFBT offered on the same day clients sought treatment. A member of the center's multidisciplinary team (e.g., social workers, nurses, psychologists, and occupational therapists) conducted the TAU. SFBT was offered as a replacement for TAU and conducted by a doctoral-level graduate student with a clinical psychology background. The therapist completed training and supervision in SFBT and the intervention protocol. The treatment protocol was informed by SFBT to ensure internal validity and treatment integrity. Training included readings, individual feedback, and completing at least one session under the supervision of a licensed clinical psychologist (CMCW) with extensive experience in substance use interventions and trained in SFBT. Before starting data collection, the graduate student also experienced four months of ethnographic immersion at the study site to gain familiarity with the service's procedures and population base. All sessions were transcribed after the intervention and discussed in individual, biweekly supervision. The supervisor analyzed the transcriptions to ensure consistency of the intervention with the protocol regarding content and SFBT style (described below).

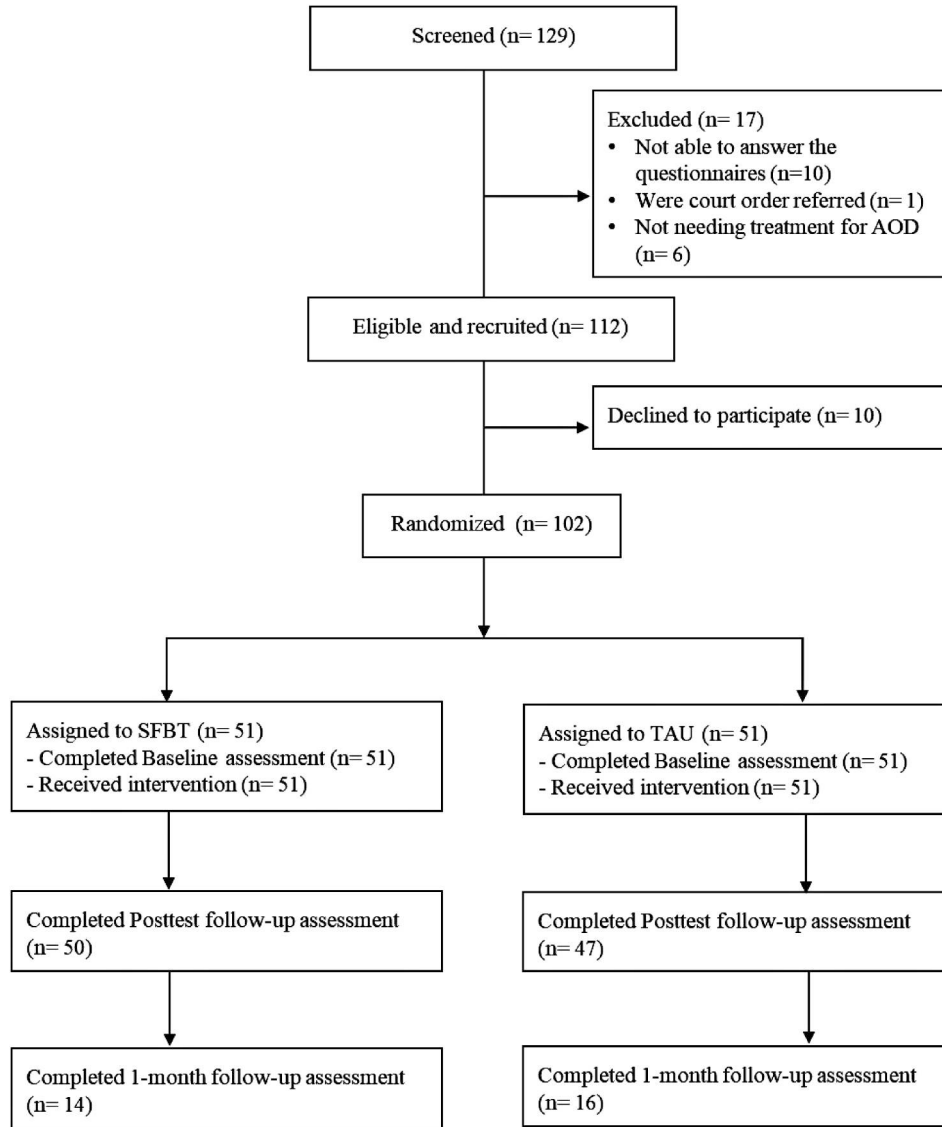


Figure 1. Flow of participants of the study according to Consolidated Standards of Reporting Trials (CONSORT). SFBT = solution-focused brief therapy, TAU = treatment as usual.

TAU. Participants completed a 30- to 50-minute session of TAU already performed by the CAPS-ad. This intervention was a comprehensive screening interview about sociodemographic information, substance use pattern and history, reasons for seeking help, psychopathological symptoms and comorbidities, medications used, as well as work, legal, social, and familial aspects. This initial encounter also aimed to establish a therapeutic relationship and collaboratively construct a personalized treatment plan. To facilitate a collaborative therapeutic relationship, the professional engaged in a non-judgmental, comprehensive listening, respecting the clients' autonomy (Sampaio & Bispo Júnior, 2021). However, the intervention was not goal-oriented and lacked a specific structured therapeutic

intervention. By the end of the session, the professional described the activities provided, explained the treatment process, and defined a personalized treatment plan with the client that would include participation in therapeutic activities at CAPS-ad (e.g., therapeutic group, pharmacotherapy, day program, and/or family group support). The treatment plan could also include other referrals (e.g., homeless shelters, social services for low-income families, family violence services, primary care services, emergency units for abstinence crises).

SFBT. Participants completed a 50-minute SFBT session characterized by an empathetic and non-judgmental style. The therapist began the intervention by encouraging clients to talk about themselves,

Table I. Baseline sample demographics

Demographic	SFBT	TAU	<i>t</i>	<i>df</i>	χ^2	<i>df</i>
Age, <i>M</i> (<i>SD</i>)	36.7 (9.6)	36.9 (11.1)	.07	100		
Gender (%)					1.86	1
Male	41 (80.4)	35 (68.6)				
Female	10 (19.6)	16 (31.4)				
Race (%)					1.51	1
African descendent	29 (56.9)	35 (68.6)				
White or Caucasian	22 (43.1)	16 (31.4)				
Marital status (%)					.04	1
Single	29 (56.9)	30 (58.8)				
Stable relationship	22 (43.1)	21 (41.2)				
Education ^a (%)					4.83	3
Incomplete middle school	18 (35.3)	21 (41.2)				
Complete middle school	11 (21.6)	12 (23.5)				
Complete high school	15 (29.4)	17 (33.3)				
Complete undergraduate school	7 (13.7)	1 (2.0)				
Formally or informally employed (%)	34 (66.7)	26 (51.0)			2.59	1
Socioeconomic class ^a (%)					1.66	2
Low income	43 (84.3)	47 (92.2)				
Middle income	5 (9.8)	2 (3.9)				
Homeless	3 (5.9)	2 (3.9)				
Faith/Religion ^a (%)					.33	1
Yes	44 (86.2)	42 (82.3)				
No	6 (11.8)	8 (15.7)				
Missing	1 (2.0)	1 (2.0)				
URICA <i>M</i> (<i>SD</i>)	9.93 (1.59)	10.08 (1.58)	.50	100		
Readiness Ruler <i>M</i> (<i>SD</i>)	6.71 (2.69)	7.14 (2.65)	.82	100		

Note. SFBT = solution-focused brief therapy, TAU = treatment as usual, URICA = University of Rhode Island Change Assessment Scale.
^a Fisher's exact test was used for the education, socioeconomic class, and faith/religion variables due to <5 expected frequencies in at least one cell.

often leading to conversations about their substance use and reasons for seeking treatment. The therapist listened respectfully and acknowledged the participants' suffering without asking questions about the problem. After this initial conversation, client and therapist defined a clear goal (e.g., reduction in substance use or improving general health condition) to work on during the remaining time. The miracle question was used (De Shazer et al., 2007) to help participants visualize their future without the problem ("Imagine that you woke up tomorrow morning and the [problem] had miraculously disappeared, what would you be doing (or saying to yourself) differently?"). Next, the therapist explored situations when clients would typically use substances but had successfully avoided or limited their use. Coping-related questions were asked to understand how participants managed their substance use. Throughout the session, the therapist affirmed the client's strengths and solutions already working for them. Scaling questions were also used to help participants evaluate their substance use and motivation to make behavioral changes. Toward the session's end, participants received feedback summarizing the conversation. This feedback was intended to encourage participants to increase the

use of effective strategies. Participants were also invited to construct a personalized homework assignment to help them continue moving toward their treatment goal. Before ending the session, the therapist left the room to discuss the case and personalized treatment plan with the center's multidisciplinary team. The intervention ended with the therapist and participant building a personalized treatment plan that included referrals (e.g., homeless shelters, social services for low-income families, family violence services, primary care services, emergency units for abstinence crises) and the type and number of therapeutic activities to attend at CAPS-ad (e.g., therapeutic group, pharmacotherapy, day program, and/or family group support).

Data analysis

A priori descriptive analyses were used to report frequency, means, and standard deviations. Correlations and chi-square analyses were conducted to examine associations between groups, considering demographics and primary outcome variables.

The primary outcome was the changes in readiness to change at post-test and 1-month follow-up. A

series of repeated measures analysis of covariance (ANCOVAs) tests were conducted to compare the SFBT and TAU groups' RTC (URICA and Readiness Ruler) at post-test and 1-month follow-ups. Because using multiple substances is associated with higher ambivalence to change (Kim et al., 2022), additional exploratory ANCOVAs were conducted to compare intervention effects on these variables in participants who reported using one versus multiple substances (>1) at baseline. Since most participants used tobacco ($n = 65$), tobacco use was not considered when creating these two groups. Two participants who reported abstinence and five who reported only using tobacco at baseline were excluded from these additional analyses. Age, race, gender, and baseline URICA and Readiness Ruler values were included as covariates for all analyses.

The secondary outcome was the change in substance use at 1-month follow-up. The effect of SFBT and TAU on substance use was assessed using the Quade non-parametric ANCOVA (Marôco, 2021). Baseline substance use was included as a covariate for each of these analyses. The effect size for ANCOVA and Quade non-parametric ANCOVA was assessed by Cohen's d , where $d = 0.2$ was considered small, $d = 0.5$ medium, and $d = 0.8$ large effect size (Cohen, 1988). All statistical analyses considered a significance level ≤ 0.05 .

Results

Baseline Characteristics

At baseline, participants presented an average of 10.00 ($SD = 1.58$) for URICA and 6.92 ($SD = 2.67$) for the Readiness Ruler. Alcohol ($n = 76$) was the most used substance in the past three months, followed by tobacco ($n = 65$), cocaine ($n = 59$), and cannabis ($n = 35$). Because of the low prevalence of past 3-month use of amphetamines ($n = 1$), inhalants ($n = 3$), sedatives ($n = 2$), hallucinogens ($n = 3$), opioids ($n = 0$), and a mix of cannabis and crack ($n = 1$), consumption analyses focused only on tobacco, alcohol, cannabis, and cocaine outcomes at 1-month. There were no baseline differences between groups on demographics, RTC (see Table I), or substance use (see Table II). Correlation analyses showed that there was no association between the baseline and follow-up scores for the RTC and substance use variables. Five participants did not complete the post-test following the intervention ($n = 97$, 95.09% follow-up rate), and 72 did not complete the 1-month follow-up ($n = 30$, 29.41% follow-up rate). The follow-up rates did not differ by group. There was no demographic, RTC, or substance use difference between completers and

noncompleters other than race. Specifically, more African descendants ($n = 51$, 70.8%) did not complete the 1-month follow-up compared to white participants ($n = 21$, 29.2%, $\chi^2(1) = 6.851$, $p = 0.009$).

Primary Analyses

There were no significant differences between groups on the URICA or Readiness Ruler at the post-test or 1-month follow-up (all $ps > .05$; see Table III).

Among participants who used multiple substances ($n = 59$), the mean score of RTC as measured by URICA did not differ between SFBT and TAU groups at any time points (all $ps > .05$). However, the Readiness Ruler score was significantly higher for SFBT at post-test ($F(1,50) = 4.01$; $p = .05$). Effect size increases in the Readiness Ruler values were moderate at post-test ($d = .55$). There was no significant difference in RTC as measured by Readiness Ruler at 1-month follow-up (see Table IV). Among the group of participants who used only one substance ($n = 36$), the mean score for RTC as measured by URICA and Readiness Ruler did not differ between SFBT and TAU groups at all time points (all $ps > .05$; see Table IV).

Secondary Analyses

Participants in the SFBT group reduced their alcohol consumption at the 1-month follow-up significantly more than those in the TAU group ($F(1, 28) = 4.12$, $p = .05$). Effect size reductions in alcohol consumption were moderate at the 1-month follow-up ($d = .77$). No other substance use differences were found between groups (all $ps > .05$; see Table III).

Discussion

This study evaluated the effect of SFBT on RTC and substance use compared to TAU in a Brazilian community-based substance use treatment center. Findings indicated that both groups decreased tobacco, alcohol, and cocaine/crack use at 1-month follow-up, but SFBT had greater reductions in alcohol use. TAU and SFBT groups did not differ in RTC at any time point. However, among participants who used multiple substances, SFBT showed higher readiness to change at post-test. These results have significant impacts as this is the first study examining the potential of SFBT to increase RTC and reduce substance use in a specific intervention within the walk-in session in a Brazilian nationwide community-based substance use treatment center. Prior literature highlights the need for

Table II. Pre-post frequencies for drinking and drug use

Outcome variable/Group	Baseline					1-month						
	No lifetime use	Never	Monthly or less	Weekly	Daily	χ^2	df	No lifetime use	Never	Monthly or less	Weekly	Daily
Alcohol ^a (%)						2.44	4					
SFBT	4 (7.8)	10 (19.6)	5 (9.8)	14 (27.5)	18 (35.3)			2 (3.9)	7 (13.7)	1 (2.0)	3 (5.9)	1 (2.0)
TAU	2 (3.9)	10 (19.6)	9 (17.6)	16 (31.4)	14 (27.5)			0 (0.0)	5 (9.8)	4 (7.8)	2 (3.9)	5 (9.8)
Tobacco ^a (%)						2.92	4					
SFBT	10 (19.6)	8 (15.7)	0 (0.0)	4 (7.8)	29 (56.9)			2 (3.9)	4 (7.8)	0 (0.0)	1 (2.0)	7 (13.7)
TAU	9 (17.6)	10 (19.6)	1 (2.0)	1 (2.0)	30 (58.8)			5 (9.8)	2 (3.9)	1 (2.0)	0 (0.0)	8 (15.7)
Cocaine/crack ^a (%)						6.73	4					
SFBT	12 (23.5)	11 (21.6)	6 (11.8)	15 (29.4)	7 (13.7)			2 (3.9)	7 (13.7)	1 (2.0)	3 (5.9)	1 (2.0)
TAU	15 (29.4)	5 (9.8)	2 (3.9)	15 (29.4)	14 (27.5)			4 (7.8)	7 (13.7)	3 (5.9)	1 (2.0)	1 (2.0)
Cannabis ^a (%)						3.93	4					
SFBT	12 (23.5)	19 (37.3)	2 (3.9)	4 (7.8)	14 (27.5)			2 (3.9)	7 (13.7)	0 (0.0)	2 (3.9)	3 (5.9)
TAU	18 (35.3)	18 (35.3)	3 (5.9)	5 (9.8)	7 (13.7)			6 (11.8)	7 (13.7)	1 (2.0)	0 (0.0)	2 (3.9)

Note. SFBT = solution-focused brief therapy, TAU = treatment as usual. ^aFisher's exact test was used for all the substance use variables due to <5 expected frequencies in at least one cell.

Table III. Pre–post mean, standard deviation, median, and effect sizes for motivation and substance use outcomes for SFBT and TAU groups

Outcome variable/Group	Baseline		Post-test M (SD)	1-month		Post-test			1-month		
	M (SD)	Median		M (SD)	Median	F	df	d	F	df	d
URICA						.00	1,91	.00	.13	1,23	.20
SFBT	9.93 (1.59)	—	10.16 (1.58)	9.48 (1.06)	—						
TAU	10.08 (1.58)	—	10.38 (1.60)	10.02 (1.61)	—						
Readiness Ruler						2.62	1,92	.35	.58	1,23	.35
SFBT	6.71 (2.69)	—	7.61 (2.25)	7.38 (2.50)	—						
TAU	7.14 (2.65)	—	7.43 (2.43)	7.94 (2.21)	—						
Alcohol						—	—	—	4.12*	1,28	.77
SFBT	2.63 (1.36)	3.00	—	1.57 (1.22)	1.00						
TAU	2.59 (1.20)	3.00	—	2.44 (1.26)	2.00						
Tobacco						—	—	—	.60	1,28	.29
SFBT	2.67 (1.71)	4.00	—	2.50 (1.70)	3.50						
TAU	2.65 (1.71)	4.00	—	2.25 (1.88)	3.00						
Cocaine/crack						—	—	—	3.01	1,28	.67
SFBT	1.88 (1.42)	2.00	—	1.57 (1.22)	1.00						
TAU	2.16 (1.64)	3.00	—	1.25 (1.13)	1.00						
Cannabis						—	—	—	.16	1,28	.20
SFBT	1.78 (1.58)	1.00	—	1.79 (1.48)	1.00						
TAU	1.31(1.41)	1.00	—	1.06 (1.29)	1.00						

Note. SFBT = solution-focused brief therapy, TAU = treatment as usual, URICA = University of Rhode Island Change Assessment Scale. **p* = .05.

expanding evidence-based substance use treatment (UNODC, 2020), especially in low- and middle-income countries (Suasnar & Walters, 2020). Furthermore, research should focus on the walk-in first session in CAPS-ad to improve treatment adherence and success (Leite et al., 2018; Sampaio et al., 2021; Silva et al., 2020).

Although previous studies showed that higher RTC, as measured by URICA and Readiness ruler, respectively, predicted a reduction in drinking for outpatients (Project MATCH Research Group, 1997) and polydrug use (Hesse, 2006), our findings revealed that mean scores for RTC, using the URICA and Readiness Ruler, remained fairly stable across all time points for both groups. Similar to our results, Siegal et al. (2001) found no changes in RTC (as measured by URICA) at 1-month and 6-month following crack cocaine treatment. Our lack of differences between groups may be because CAPS-ad treatment is based on the harm reduction paradigm, and clients may have had different treatment goals (e.g., reduce or stop using only one substance or all the substances). Accordingly, RTC can differ depending on the type of substance and treatment goal (DiClemente et al., 2004).

Among participants who used multiple substances, the SFBT group demonstrated significantly higher RTC scores at post-test, but only as measured by Readiness Ruler. This result indicates that SFBT may be better at increasing immediate RTC for those who use multiple substances and should be

explored in a larger sample. This finding has potential implications for psychosocial practice since multiple substance use is a major health problem and is common in community-based substance use treatment (Leite et al., 2018). The use of multiple substances might be associated with higher ambivalence toward changing substance use (Kim et al., 2022), increased risk of comorbid psychiatric and health problems, overdose (Ellis et al., 2023; Fernández-Calderón et al., 2020), and poor treatment adherence and outcomes (Daigre et al., 2021). Herein, effective interventions to increase RTC among this subset of individuals are critical. Furthermore, a comparative meta-analysis found that strength-based methods used in psychotherapy, including SFBT, were associated with more favorable immediate treatment outcomes (Flückiger et al., 2023).

Interestingly, among participants who used multiple substances, RTC as measured by URICA did not differ between the two groups. While one study showed that the URICA predicted treatment outcomes for participants using only one substance (e.g., alcohol; Project MATCH Research Group, 1997), another study failed to find predictive validity of URICA for treatment outcomes among alcohol, drug, or combination of alcohol and drugs use samples in community-based drug use treatment centers (Blanchard et al., 2003). Maybe URICA is less reliable for evaluating RTC among people using multiple drugs. The discrepant results across URICA and Readiness Ruler in this study may

Table IV. Pre–post mean, standard deviation, and effect sizes for motivation outcomes among participants who use multiple substances and one substance

Outcome variable/Group	Baseline <i>M (SD)</i>	Post-test <i>M (SD)</i>	1-month <i>M (SD)</i>	Post-test			1-month		
				<i>F</i>	<i>df</i>	<i>d</i>	<i>F</i>	<i>df</i>	<i>d</i>
Participants who use multiple substances									
URICA				1.73	1,50	.35	.12	1,11	.20
SFBT	10.21 (1.30)	10.07 (1.43)	9.31 (.86)						
TAU	10.08 (1.66)	10.34 (1.61)	9.93 (1.84)						
Readiness Ruler				4.01*	1,50	.55	1.39	1,11	.70
SFBT	6.25 (2.96)	7.61 (2.06)	7.00 (2.28)						
TAU	7.00 (2.85)	7.07 (2.87)	8.45 (1.92)						
Participants who use one substance									
URICA				.55	1,28	.29	1.28	1,3	1.31
SFBT	9.26 (1.88)	9.99 (1.80)	9.42 (1.23)						
TAU	10.08 (1.53)	10.63 (1.63)	10.55 (1.35)						
Readiness Ruler				.04	1,29	.00	2.39	1,3	1.77
SFBT	7.26 (2.33)	7.63 (2.65)	7.33 (2.88)						
TAU	7.24 (2.54)	8.00 (1.63)	5.67 (2.89)						

Note. SFBT = solution-focused brief therapy, TAU = treatment as usual, URICA = University of Rhode Island Change Assessment Scale. * $p = .05$.

reflect the differences in these measures. For example, URICA results from summing contemplation, action, and maintenance scores and subtracting precontemplation score. In contrast, Readiness Ruler asks participants to rate how ready they are to change their behavior. It is possible that SFBT positively influenced participants' short-term willingness to change their substance use while having less impact on their belief that they could maintain future changes. However, this requires further investigation.

Our findings indicated that both groups decreased their tobacco, alcohol, and cocaine/crack use at 1-month follow-up, with SFBT demonstrating greater reductions in alcohol use than the TAU group. This finding is in line with exploratory studies that indicated that people enrolled in SFBT reduced alcohol consumption (De Shazer & Isebaert, 2004; Suitt et al., 2019). Although depressive symptoms were not assessed in this study, SFBT has been found to reduce depressive symptoms among people who use substances compared to a control group (Kim et al., 2018; Smock et al., 2008). Alcohol consumption is associated with depression (Churchill & Farrell, 2017) and may be one reason why alcohol use decreased significantly more in the SFBT group compared to TAU group. Future research should investigate the influence of SFBT on both mental health symptoms and substance use in treatment-seeking adults. Although more research is needed, our findings suggest that SFBT and TAU were efficacious in reducing other types of substance use.

Limitations

These findings should be considered within the context of their limitations. Like other controlled trial within Brazilian community-based substance use treatment, the attrition was significant (Adler et al., 2018). This attrition rate reflects the drop-out commonly found in community-based substance use treatment centers worldwide (Leite et al., 2018; Wagner et al., 2018). Given the low follow-up rate (<30%), the results of the present study are not easily generalizable to other contexts. Future research should examine the impact of SFBT on noncompleters and strategies to reduce drop-out in community-based substance use treatment centers. The low power sample for both primary and secondary outcomes at 1-month follow-up, as well as for the primary outcome among the group of participants who used only one substance, most likely reduced our ability to detect differences between the two groups. Yet, the presence of significant differences in alcohol use between TAU and SFBT groups even with this lower power sample is a promising preliminary result that SFBT may benefit people who use alcohol. This study focused on an area of clinical practice (SFBT) that has an emerging evidence base. Furthermore, the effect size was also evaluated to address the risk of a type I error, which showed a moderate effect size for statistically significant results. Although these results are promising in the alcohol and other drugs field, they should be considered preliminary and evaluated in a larger sample.

Notably, the URICA showed questionable internal consistency at baseline and post-test, and poor internal consistency at the 1-month follow-up. The ASSIST also demonstrated questionable internal consistency for tobacco and cocaine. Because most of the population receiving treatment in CAPS-ad used multiple substances, we could not enroll people who only used a type of substance. The primary outcomes were not measured separately for each substance to avoid increasing the assessment time, which could impact outcomes. Importantly, the current real-world study addressed the gap between clinical research and clinical practice caused by excluding people who use multiple substances from efficacy trials (Rounsaville et al., 2003). Between the post-test and 1-month follow-up, participants could have attended the appointment(s) described in their personalized treatment plan constructed at the end of both TAU and SFBT sessions. However, the personalized treatment plan of the SFBT group was constructed based on a case-by-case discussion with the center's multidisciplinary team to ensure both groups' plans followed the same standards and to reduce the impact of onward referrals on the 1-month follow-up. Another limitation includes the relatively short follow-up period. The effect of constructing solutions for tobacco, cannabis, and cocaine use may take longer to manifest as participants become aware of the importance of changing their substance use and confident regarding their abilities to make changes over time. Thus, future research should investigate the long-term impact of SFBT on RTC and substance use. This study analyzed a session of SFBT; however, future research may wish to examine a booster session to effectively sustain engagement in the change process and the increases in RTC over time. Future implementation studies should train service staff to deliver SFBT to ensure the intervention is feasible within this setting.

Conclusion and Implications

This study contributes to the literature on brief substance use interventions by evaluating the effect of SFBT on RTC and substance use in a Brazilian community-based substance use treatment setting using an experimental design. Overall, our results provide further support for the potential of SFBT as a valuable tool for substance use treatment in community-based settings. Our findings suggest that SFBT may improve RTC in the short-term, especially among people who use multiple substances, and may reduce alcohol use for those attending a community-based substance use treatment.

The implications for practice include advancing knowledge in SFBT that has an emerging evidence base. This is the first study examining the potential of SFBT to increase RTC and reduce substance use to offer evidence of support to the walk-in session of CAPS-ad. As a real-world study, it addressed the evidence gaps within a hard-to-reach population with a complex substance use pattern, such as the use of multiple substances. Another implication of our findings is that people experiencing multiple substances and wishing to change alcohol use may benefit from a goal-oriented intervention, which emphasizes solution-focused conversations, clients' strengths, and a hopeful posture toward the future from therapists. Our study suggests that providing intervention when the person seeks care may improve treatment outcomes. Since SFBT had stronger effects on RTC among people who used multiple drugs, community-based substance use treatment may consider drug use patterns when constructing a treatment plan to address the needs of both people experiencing multiple substance use and single substance use.

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Disclosure Statement

No potential conflict of interest was reported by the author(s).

Data Availability Statement

The data that support the findings of this study are available from the corresponding author (CNPA) upon reasonable request.

Ethical Approval

This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the University's Research Ethics Committee (CAAE 05227218.9.0000.5407).

Informed Consent from Participants

Informed written consent was obtained from all participants.

Clinical Trial Registration

This study was preregistered with the Brazilian Registry of Clinical Trials (<https://ensaiosclinicos.gov.br/rg/RBR-2kcbxz/>).

Author Contributions

CNPA contributed to the study design, protocol design, performance of the solution-focused brief-therapy intervention, data management, data analysis, writing- original draft preparation. CMCW contributed to the study design, protocol design intervention fidelity monitoring and writing- reviewing and editing, supervision. MRGCZ contributed to the data analysis, writing- reviewing and editing. AMY contributed to the data analysis, manuscript design, writing- reviewing and editing, supervision.

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