
Solution-Focused Brief Therapy for Substance Use: A Review of the Literature

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Substance use is a prevalent public health issue. Most social workers may encounter substance use in their work with clients and need effective therapeutic strategies for this issue. Since the 1980s, solution-focused brief therapy (SFBT) has been practiced with clients who have substance use problems, and clinical training materials have been developed to help practitioners learn and use SFBT in substance use treatment. Despite the longevity of the use of SFBT in practice, there are no published reviews of outcome studies to guide practitioners using SFBT. This article fills a gap in current literature on SFBT and substance use treatment by reviewing the published studies on SFBT where the focus was on substance use treatment. Five databases were searched to identify eligible studies. Experts and reference lists of relevant studies were also consulted. Nine studies were identified and included in the review. All studies reviewed found promising evidence on SFBT's effectiveness in improving substance use behaviors and related psychosocial problems. Five of the nine studies reviewed showed that SFBT can change substance use and comorbid mental health and psychosocial problems such as depression, trauma, and school- and work-related behavior problems. The article concludes with a discussion of the study results' implications for clinical practice and future research.

KEY WORDS: *effectiveness; literature review; solution-focused brief therapy; substance use*

An estimated quarter of a billion people, or approximately 5 percent of the global adult population, used controlled drugs in 2015 (United Nations Office on Drugs and Crime [UNODC], 2017). About 29.5 million of those drug users, which is 0.6 percent of the global adult population, suffer from drug use disorders (UNODC, 2017). In the United States, alcohol is the most commonly used substance; in 2014, about two-thirds of people aged 12 or older reported alcohol use in the past 12 months with 6.4 percent meeting criteria for alcohol use disorders (Center for Behavioral Health Statistics and Quality [CBHSQ], 2016). The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* indicates that a diagnosis of a substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria (American Psychiatric Association, 2013). Substance use disorders are highly comorbid with other mental disorders and social problems. Approximately half of people who experience a mental illness will also experience a substance use disorder in the course of their life (Kelly & Daley, 2013). Reviews have also found

that comorbidity is especially high between substance use and mood and anxiety disorders (Lai, Cleary, Sitharthan, & Hunt, 2015). This means that most social workers will encounter substance use in their work with clients and need effective therapeutic strategies.

Solution-focused brief therapy (SFBT) is one therapy that has been used with clients who use substances since the inception of the therapy approach at the Brief Family Therapy Center in Milwaukee in the early 1980s (de Shazer & Isebaert, 2003; Hendrick, Isebaert, & Dolan, 2012; Juhnke & Coker, 1997). The long use of SFBT in clinical practice with clients who use substances deserves consideration in the substance use treatment and research. Four clinical books for training clinicians to use SFBT with clients who use substances have been published in the literature along with several other book chapters, articles, and video demonstrations that show how to use SFBT in substance use treatment (see, for example, Berg & Miller, 1992; Berg & Reuss, 1997; Miller & Berg, 1995; Pichot & Smock, 2009). Reddy, Bolton, and Franklin (2017) covered how treatment centers

around the world, including in the United States, Belgium, Poland, Iran, and Chile, have also written about their use of SFBT in substance use treatment (de Shazer & Isebaert, 2003; González Suitt, Geraldo, Estay, & Franklin, 2019; Nameni, Shafi, Delavar, & Ahmadi, 2014; Smock et al., 2008; Szczegielniak et al., 2013). Practitioners from these centers have also offered training to students and clinicians who want to use SFBT with clients who use substances. Despite of the emphasis on using SFBT in clinical practice, there have been no reviews of the literature that examine studies on the effectiveness of SFBT with clients who have substance use problems.

SUBSTANCE USE TREATMENT WITH SFBT

The primary goal of substance use treatment is to eliminate substance use or reduce the harm from substance use in clients. SFBT is a brief strength-based intervention that originated from brief family systems therapy. It is a practical intervention that differs from interventions based on the medical model approaches that rely on lengthy assessments of the client and a disease perspective (Berg & Dolan, 2001). SFBT focuses on enhancing relationships and improving social and living conditions as a means to decrease substance use (de Shazer & Isebaert, 2003; Pichot & Smock, 2009). SFBT focuses not only on the individual, but also on the family and other systems. SFBT practitioners begin where the client is at in terms of their level of motivation for change and aim to help the client improve their lives in every dimension of living—from work to family and interpersonal relationships. The focus of therapy is on amplifying positive behaviors, creating future solutions, and fostering positive emotions such as hope and on the pursuit of self-determined goals.

SFBT provides clients with an opportunity to set their own self-determined goals, and those goals may be directly related to the substance use or to other interpersonal or social problems. Practitioners begin with what the client wants and what their best hopes for solutions are while also addressing substance use (de Shazer & Isebaert, 2003; McCollum, Trepper, & Smock, 2004). Examples of self-determined goals may include saving a marriage, keeping a job, or meeting the demands of probation. The therapist uses a nondirective and collaborative relationship to help clients begin to explore and recognize that the solution to their

problems and the substance use are related. The therapist asks questions that help clients envision how their life would be different without problematic situations like tickets or arrests for driving under the influence, court dates, and family problems. SFBT targets future goals and helps clients to develop their own solutions that may work for their unique circumstances. Focusing on self-determined goals and the preferred future helps clients come to their own recognition of how substance use may be preventing them from living the life they want to live. To develop solutions around the substance use, it is also important to work with the ambivalence of the client and explore their good reasons for using substances as well as reasons for wanting to decrease substance use. In addition, identifying past experiences that helped them cut down on substance use is also a helpful process used in SFBT (de Shazer & Isebaert, 2003; Reddy et al., 2017).

REVIEWS OF SFBT AND SUBSTANCE USE

We were not able to find any review articles on SFBT that were dedicated to its effectiveness with substance use. However, some reviews of the literature on SFBT have covered studies that focus on substance use. For example, Gingerich and Eisenhart's (2000) narrative review of SFBT outcome studies looked at studies on substance use. Two of the 15 studies reviewed evaluated SFBT with substance users. One study found that 36 percent of the group who received SFBT met the study's standard of recovery after the first two sessions, whereas the comparison group only had 2 percent of their participants reach recovery after two sessions (Lambert, Okishi, Finch, & Johnson, 1998). The second study used a single-subject design and found that SFBT was effective in reducing the clients' alcohol use (Polk, 1996). In addition, Kim and Franklin (2009) and Gingerich and Peterson (2013) covered some studies that included substance use outcomes but did not examine in detail what is known about the effectiveness of SFBT with substance use. Individual studies have also emerged that focus on SFBT in substance use treatment along with other comorbid mental health conditions such as depression, trauma, and child abuse (Kim, Brook, & Akin, 2018; Mason, Chandler, & Grasso, 1995; McCollum et al., 2004; Pichot & Smock, 2009; Spilsbury, 2012). Given the lack of reviews to guide practitioners who use SFBT with substance use, there is a definite need

for a review on the effectiveness of SFBT with substance use and related psychosocial outcomes.

AIMS OF THE REVIEW

SFBT has been discussed in the clinical literature as a helpful therapeutic approach for substance use treatment (Gingerich & Eisengart, 2000), and some research studies have emerged that examine the effectiveness of SFBT with substance use (see, for example, Kim et al., 2018; Spilsbury, 2012). Presently, the literature offers little guidance to practitioners on the outcomes of SFBT with clients who use substances, even though studies have been completed. There is a need for a review that looks at the effectiveness of SFBT in substance use treatment. This study provides a review of the published literature on SFBT to examine what is known about the efficacy of SFBT when reduction in substance use is a primary goal and outcome of the treatment.

METHOD

Studies included in the present review had to focus on SFBT for individuals with substance use problems. Studies were not excluded based on countries where they were conducted, publication date, participant characteristics, or study design. However, studies were excluded if they were not published in English. We searched PsycINFO, SocINDEX, MEDLINE, PsycARTICLES, and the Psychology and Behavioral Sciences Collection using the terms (Solution-Focused OR “Solution Focused” OR SFBT OR “Solution-Focused Brief Therapy” OR Solution-Oriented) AND (Alcohol OR Drug OR Substance OR Cocaine OR Marijuana OR Opioids OR Heroin). Experts and reference lists of relevant studies were consulted to identify additional eligible studies. We designed a data extraction form to collect information on bibliography, research design, participants and setting descriptors, intervention descriptors, and study findings. The data collection form was pilot tested with a few targeted articles and was modified before formal data extraction.

RESULTS

Study and Participant Characteristics

From the 1,054 hits, 347 duplicates and 698 studies that fell outside of the review’s scope were excluded, leaving nine studies to be included in the present review. Table 1 presents the characteristics of the nine studies under review. The majority of

the studies were published after 2000, with four studies (44.4 percent) published between 2000 and 2009 (de Shazer & Isebaert, 2003; Froeschle, Smith, & Ricard, 2007; Smock et al., 2008) and four (44.4 percent) between 2010 and 2019 (González Suitt et al., 2019; Hendrick et al., 2012; Kim et al., 2018); one other study (11.1 percent) was published in 1996 (Polk, 1996). Four studies (44.4 percent) were conducted in the United States (Froeschle et al., 2007; Kim et al., 2018; Polk, 1996; Smock et al., 2008); four studies (44.4 percent), in Belgium (de Shazer & Isebaert, 2003; Hendrick et al., 2012); and one (11.1 percent), in Chile (González Suitt et al., 2019). Three of the nine studies (33.3 percent) used the randomized controlled trial (RCT) design (Froeschle et al., 2007; Kim et al., 2018; Smock et al., 2008); two (22.2 percent) adopted the single-case design (González Suitt et al., 2019; Polk, 1996); and four (44.4 percent) used the one-group pre–posttest design (de Shazer & Isebaert, 2003; Hendrick et al., 2012). Two of the three RCTs used active controls (treatment as usual and other treatment) (Kim et al., 2018; Smock et al., 2008), and one used inactive control (no treatment) (Froeschle et al., 2007). Study sample sizes ranged from 1 to 118. Research settings included inpatient ($n = 3$) (de Shazer & Isebaert, 2003; Hendrick et al., 2012), outpatient ($n = 1$) (de Shazer & Isebaert, 2003), school ($n = 1$) (Froeschle et al., 2007), and primary care ($n = 1$) (González Suitt et al., 2019) settings and also a substance use and mental health counseling center ($n = 1$) (Kim et al., 2018), employee assistance program ($n = 1$) (Polk, 1996), and university-based community marriage and family therapy clinic ($n = 1$) (Smock et al., 2008).

The youngest sample consisted of eighth graders, and average participant age ranged from 31 to 46 years according to the four studies that reported average participant age (de Shazer & Isebaert, 2003; Kim et al., 2018; Polk, 1996; Smock et al., 2008). Only the four U.S. studies reported sample racial compositions, and in each sample, about half of the participants were White, with the other half comprising participants from diverse minority racial backgrounds (Froeschle et al., 2007; Kim et al., 2018; Polk, 1996; Smock et al., 2008). The single-subject study focused on a male participant (Polk, 1996), and one study did not report the sample’s demographic information (de Shazer & Isebaert, 2003). The percentage of female partici-

Table 1: Characteristics of Studies Included in the Review (n = 9)

Study	Demographic (Age, Race, Gender), Participant Type	Study Design, Follow-Up Timing, Sample Size, Setting	SFBT (Modality, Length/Frequency)	Delivery Personnel	Fidelity	Comparison	Outcomes (Measurement), Main Findings
de Shazer & Isebaert (2003), Belgium, inpatient study	46.2 yo, race not reported (NR), 33.6% female; individuals with alcohol misuse	One-group pre-test-posttest, 4 yr, n = 1-18, inpatient	SFBT according to the Bruges model (group, 4.5 weeks on average)	NR	NR	None	Abstinence, controlled drinking (measurements NR). One hundred (84%) of the 118 reported either being abstinent (n = 60, 50.1%) or had succeeded in continuing to practice controlled drinking (n = 40, 33.9%). Statistical significance of results, NR.
de Shazer & Isebaert (2003), Belgium, outpatient study	Demographic information NR; individuals with alcohol misuse	One-group pre-test-posttest, 4 yr, n = 72, outpatient	SFBT according to the Bruges model (group, 4.5 weeks on average)	NR	NR	None	Abstinence, controlled drinking (measurements NR). 50% (n = 36) reported being abstinent, and 32% (n = 23) reported success at controlled drinking. Statistical significance of main finding, NR.
Hendrick, Isebaert, & Dolan (2012), Belgium, Study A	21-70 yo, race NR, 40% female; individuals with alcohol misuse	One-group pre-test-posttest, one yr after discharge, n = 30, inpatient	SFBT according to the Bruges model (group, 4 weeks)	NR	NR	None	Alcohol consumption (TLFB). There were significant improvements in drinking habits one year after treatment.
Hendrick et al. (2012), Belgium, Study B	Age and race NR, 40% female; individuals with alcohol misuse	One-group pre-test-posttest, one yr after discharge, n = 30, inpatient	SFBT according to the Bruges model (group, 4 weeks)	NR	NR	None	Percentage of days abstinent, daily intake during drinking days, number heavy drinking days (TLFB). 63.3% patients reported an overall improvement in drinking behaviors. However, no statistically significant change in drinking was found among heaviest drinkers, probably due to small sample size.

(Continued)

Table 1: Characteristics of Studies Included in the Review (n = 9) (Continued)

Study	Demographic (Age, Race, Gender), Participant Type	Study Design, Follow-Up Timing, Sample Size, Setting	SFBT (Modality, Length/Frequency)	Personnel	Fidelity	Comparison	Outcomes (Measurement), Main Findings
Froeschle, Smith, & Ricard (2007), United States	Eighth graders, 6.25% Black, 40% White, 53.75% Mexican American, 100% female; no pre-existing substance use problems reported	Randomized controlled trial (RCT), posttest, n = 80, school	The Systematic Substance Abuse program consisted of an integration of group SFBT techniques, action learning techniques, and community and peer mentorship (group + parent meetings, weekly one-hour group sessions for 16 weeks).	One school counselor, five Mexican American community mentors, and three high school seniors	NR	No treatment	Self-reported drug use (AD/AS), drug use attitude (SASSI-A2), drug use symptoms knowledge exam (researcher constructed exam), self-esteem (PHC/SCS-2), parent-observed social strengths and risk behaviors (HCSBS), teacher-observed social strengths and risk behaviors (SSBS-2). Significance was found between treatment and control groups in drug use, drug use attitudes, knowledge, and teacher- and parent-rated competent behavior scores. Significant differences were not found with regard to self-esteem, negative behaviors as measured by office referrals, and grade point averages.
González Suitt, Gerardo, Estay, & Franklin (2019), Chile	38–60 yo, race NR, 25% female; individuals with alcohol misuse	Single-case design, three observations for the baseline, two observations during the intervention, and one observation one month after the end of the	Linguistically adapted SFBT (individual, three 30- to 60-minute sessions)	Four social workers who received 30 hours of training and 10 hours of direct supervision	Analyzed audio- and/or video-taped sessions and found that 10 of the 13 SFBT techniques measured by the Fidelity Instrument were imple-	None	At-risk substance use (ASSIST), frequency of alcohol consumption (TLFB), depression (PHQ-9), family health (SALUFAM), Alcohol-related consequences (SIP), Well-being (QRS). Participants increased their percentage of days abstinent, diminished consequences of alcohol use, decreased their depression index.

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Table 1: Characteristics of Studies Included in the Review (n = 9) (Continued)

Study	Demographic (Age^a, Race, Gender), Participant Type	Study Design, Follow-Up Timing, Sample Size, Setting	SFBT (Modality, Length/Frequency)	Delivery Personnel	Fidelity	Comparison	Outcomes (Measurement), Main Findings
Kim, Brook, & Akin (2018), United States	31.3 yo, 9.4% American Indians/Alaskan Native, 14.1% Black, 1.6% Native Hawaiian/Pacific Islander, 56.3% White, and 18.8% mixed race; 3.1% reported Hispanic ethnicity, 56.2% female; individuals with substance misuse	intervention, n = 8, primary care RCT, posttest, n = 64, substance use and mental health counseling centers	SFBT (individual, 6–10 sessions)	Master’s-level practitioners who received 40-hour SFBT training and one-hour case consultations	mented in 17 (85%) or more sessions. SFBT clinicians completed the SFBT Fidelity Instrument and clinical directors observed a random number of sessions and rated the session using the SFBT session form. A very high level of treatment fidelity was found.	Treatment as usual (other research supported treatments such as cognitive-behavioral therapy or motivational interviewing)	and increased their self-reported well-being. Substance use severity (ASI-SR), Trauma symptom (TSC-40). No between-groups difference was found; thus, SFBT produced similar results as the research supported treatments that the control group received.
Polk (1996), USA	36 yo, White, male; individuals with alcohol misuse	Single-case design, weekly assessment, n = 1, employee assistance program	SFBT (individual, six sessions)	NR	NR	None	Alcohol abstinence (number days, self report + spouse report), work attendance (number days, company record). During the six-week period, the rates of alcohol abstinence and work attendance increased.

(Continued)

Table 1: Characteristics of Studies Included in the Review (n = 9) (Continued)

Study	Demographic (Age, Race, Gender), Participant Type	Study Design, Follow-Up Timing, Sample Size, Setting	SFBT (Modality, Length/Frequency)	Delivery Personnel	Fidelity	Comparison	Outcomes (Measurement), Main Findings
Smock et al. (2008), United States	31 yo, 28.9% Black, 21.1% Hispanic, 5.3% Native American, 44.7% White; 21.1% female; individuals with substance misuse	RCT, posttest, n = 38, university-based community marriage and family therapy clinic	SFBT (group, six 1.5-hour sessions)	Two marriage and family therapy master's students	Live observation and video-recorded sessions. Six out of seven elements of adherence were followed.	The Hazelden model series "The Primary Recovery Plan"—a traditional problem-focused psycho-educational approach	Interpersonal functioning, symptom distress, and social role (OQ), depression (BDI). Clients in the SFBT group significantly improved on both the BDI and the OQ, whereas no significant improvement was found in the control group.

Notes: yo = years old; NR = not reported; yr = year; SFBT = solution-focused brief therapy; TLFB = Timeline Follow-Back; ADAS = American Drug and Alcohol Survey; SASI-A2 = Substance Abuse Subtle Screening Inventory Adolescent Version 2; PHQCS-2 = Piers-Harris Children's Self-Concept Scale Version 2; HCBS = Home and Community Social Behavior Scales; SBS-2 = School Social Behavior Scales Second Edition; ASSST = Alcohol, Smoking, and Substance Involvement Screening Test; PHQ-9 = Patient Health Questionnaire; SALUFAM = Family health; SIP = Short Inventory of Problems; ORS = Outcome Rating Scale; ASI-SR = Addiction Severity Index-Self-Report; TSC-40 = Trauma Symptom Checklist-40; BDI = Beck Depression Inventory; OQ = Outcome Questionnaire. *Ages reported were average age or (if average age was not reported) age range.

pants ranged from 21.1 percent to 100 percent in the other seven studies (de Shazer & Isebaert, 2003; Froeschle et al., 2007; González Suitt et al., 2019; Hendrick et al., 2012; Kim et al., 2018; Smock et al., 2008). Most of the studies focused on individuals with alcohol misuse ($n = 6$, 66.7 percent) (de Shazer & Isebaert, 2003; González Suitt et al., 2019; Hendrick et al., 2012; Polk, 1996). Participants in two of the included studies (22.2 percent) were individuals with any substance use problems (Kim et al., 2018; Smock et al., 2008), and one study focused on eighth graders who reported nonparticipation in drug prevention or counseling programs (Froeschle et al., 2007).

SFBT Characteristics

Five studies examined modified versions of SFBT (55.6 percent). Four of these five studies focused on a version of SFBT based on the Bruges model (de Shazer & Isebaert, 2003; Hendrick et al., 2012). However, a detailed description of this intervention was not found in English. The other study focused on a version of SFBT that is linguistically adapted to the Chilean population (González Suitt et al., 2019). Three studies tested regular SFBT (33.3 percent) (Kim et al., 2018; Polk, 1996; Smock et al., 2008), and one study was focused on the Systematic Substance Abuse program, which combined SFBT with other intervention techniques (Froeschle et al., 2007). SFBT in two-thirds of the studies ($n = 6$) was presented in group format (de Shazer & Isebaert, 2003; Froeschle et al., 2007; Hendrick et al., 2012; Smock et al., 2008), and one-third ($n = 3$) was in the format of individual therapy (González Suitt et al., 2019; Kim et al., 2018; Polk, 1996). Treatment length ranged from four to 16 weeks and three to 16 sessions. Only a third of the included studies ($n = 3$) reported intervention fidelity assessments (González Suitt et al., 2019; Kim et al., 2018; Smock et al., 2008). Fidelity assessment methods included live observation, video-recorded sessions, and the clinician-completed SFBT Fidelity Instrument. All three studies found good SFBT implementation fidelity.

Study Findings on SFBT's Effects

The nine studies included in this review examined both substance use and psychosocial outcomes. Examples of substance use outcomes included percentage of days abstinent, daily intake during

drinking days, and number of heavy drinking days. Examples of psychosocial outcomes are self-esteem, depression, well-being, trauma symptoms, and work attendance. Most of the studies used reliable and standardized measures. However, only one study used collateral report in addition to self-report for substance use outcomes (Polk, 1996), and the other studies all relied solely on self-report substance use measures such as timeline follow-back (Sobell & Sobell, 1992).

All nine studies included in the present review found promising evidence on SFBT's effectiveness in improving substance use behaviors and related psychosocial problems. The RCT with no treatment control condition found that SFBT, combined with other intervention techniques, was effective in improving drug use behaviors, drug use attitudes, knowledge, and teacher- and parent-rated competent behavior scores among female eighth graders (Froeschle et al., 2007). However, no significant between-group difference was found in self-esteem, negative behaviors, and grade point averages (Froeschle et al., 2007). Results from the other two RCTs found no significant between-group differences and thus suggest that SFBT might be as effective as control interventions in improving substance use severity scores, trauma symptoms (Kim et al., 2018), interpersonal functioning, symptom distress, social role, and depression (Smock et al., 2008) among individuals with substance use problems.

González Suitt et al.'s (2019) single-case study examined a linguistically adapted version of SFBT among individuals with alcohol misuse in Chile. The researchers observed trends of improvement in participants' alcohol abstinence, consequences of alcohol use, depression, and self-reported well-being. The other single-case study found that, corresponding to the SFBT treatment, the rates of alcohol abstinence and work attendance increased in their subject, a White male with alcohol misuse problems (Polk, 1996).

Four Belgian studies used a one-group pre-posttest design to test the Bruges model of SFBT's effectiveness for individuals with alcohol misuse problems. Two of the four studies did not report the statistical significance of their results (de Shazer & Isebaert, 2003). The other two studies reported in Hendrick et al. (2012) yielded mixed findings, with one finding statistically significant and the other not. However, all four studies ob-

served improvements in participants' alcohol use outcomes (de Shazer & Isebaert, 2003; Hendrick et al., 2012). These four studies were the only ones among the nine studies included in this review to report results that indicate long-term treatment effects, as their posttests were conducted one or four years after treatment. The two studies reported in de Shazer and Isebaert (2003) show that 84 percent of the inpatient participants and 81 percent of the outpatient participants reported maintaining their goals of either abstinence or controlled drinking four years after completing the treatment program. One study in Hendrick et al. (2012) found significant improvements in drinking habits one year after treatment. Although the result in the other study in Hendrick et al. (2012) did not reach statistical significance, it shows that 63.3 percent patients reported an overall improvement in drinking behaviors one year after treatment discharge.

DISCUSSION

SFBT has been practiced for more than 35 years with clients who have substance use disorders and has been discussed in the clinical literature as a helpful therapeutic approach. Despite the longevity of the use of SFBT in practice, most studies on SFBT and substance use did not emerge until after the year 2000, and there are no published reviews of outcome studies to guide practitioners who use SFBT. The reason for the delay in the study of SFBT with substance use is not known; it may be because SFBT developed in practice clinics instead of university settings, and, for this reason, the outcome studies on SFBT were slow to emerge. The research on SFBT, for example, has generally grown exponentially since the early 2000s, with many studies appearing after 2010 (Kim, Jordan, Franklin, & Froerer, 2019). This article is timely and fills a gap in current literature on SFBT and substance use treatment by reviewing the published studies that have been completed on SFBT where the focus was on substance use treatment. Nine studies were found that specifically examined the outcomes of substance use. All nine studies found promising evidence on SFBT's effectiveness in improving substance use behaviors and related psychosocial problems. Evidence from four studies suggests that SFBT holds promise for continuing its effects as long as four years post-treatment.

More studies are needed to draw definitive conclusions.

There was a range of quality in the studies from single-case designs to quasi-experimental and RCTs. The strongest research studies were the three studies that used an RCT design. It is interesting that RCT studies showed changes in comorbid mental health and social and emotional behaviors, not only in substance use. These findings are consistent with previous reviews on SFBT that have shown the effectiveness of SFBT with internalizing disorders such as depression and other psychosocial problems such as school- and work-related behavior problems (Gingerich & Peterson, 2013; Kim et al., 2019). These types of issues frequently co-occur with substance use. The Smock et al. (2008) study reviewed here that was conducted with adults in a marriage and family therapy clinic, for example, showed changes in depression symptoms; the Kim et al. (2018) study that was completed with adults in the Child Protective Services (CPS) showed changes in trauma symptoms as assessed by standardized measures. The Kim et al. (2018) study is also important, because it is the first RCT to show changes in trauma and substance use within CPS, even though SFBT has been widely applied in that practice setting. The third RCT study (Froeschle et al., 2007) was completed with adolescent females in a middle school and showed changes in both substance use attitudes and behaviors and also changes in competent socioemotional behaviors.

The three RCT studies in this review suggest that SFBT is able to improve mental health and social and emotional problems along with substance use. These results are also corroborated by other studies in this review that showed similar changes in alcohol use and depression (González Suitt et al., 2019) and in alcohol use and work-related behaviors (Polk, 1996). Not all substance use interventions target psychosocial problems along with decreasing substance use, but the results of this review suggest that SFBT may be an effective intervention to use for clients who have both psychosocial and substance use problems.

Almost all studies reviewed were conducted with adult clients, and the samples were diverse, suggesting that SFBT is being effectively applied with good results with a range of ethnic groups including African American, Latino, and European populations. One SFBT intervention completed in

a primary care setting was linguistically adapted and translated into Spanish (González Suitt et al., 2019). Both genders were represented across the studies, but five of the nine studies focused on female clients. Four of those studies, however, were from the Bruges model in Belgium, and one was with the adolescent females in a school. The majority of studies addressed alcohol use, although two RCT studies measured broader drug use (Froeschle et al., 2007; Kim et al., 2018). For the most part, studies reported adapting SFBT to the substance use population or adding elements from other interventions. In adapting to the adolescent population that used substances, for example, Froeschle et al. (2007) used action learning, community and peer mentorship, and parent meetings. SFBT was delivered in individual and group formats, and the majority of the SFBT interventions reviewed were delivered in a group. Unfortunately, most studies did not describe the SFBT interventions in detail, and only three studies measured the fidelity of the SFBT intervention. This makes it difficult for practitioners and researchers to determine exactly what SFBT interventions were delivered to get the promising results reported.

In this review, the most referenced SFBT approach for substance use was the Bruges model that was codeveloped by SFBT founder Steve de Shazer in an inpatient setting for alcohol use. The Bruges model has only been described in a few articles in English (see, for example, de Shazer & Isebaert, 2003; Hendrick et al., 2012), and, to our knowledge, there are no detailed intervention manuals or protocols available. Fortunately, there are several other ways to learn SFBT from experts in substance use, including three clinical training manuals that were coauthored by SFBT founder Insoo Kim Berg (Berg & Miller, 1992; Berg & Reuss, 1997; Miller & Berg, 1995) and one book coauthored by Teri Pichot and Sara Smock Jordan, who specialize in substance use treatment (Pichot & Smock, 2009). Pichot also operates a training center, the Denver Center for Solution-Focused Brief Therapy (<https://denversolutions.com/about.html>). Other resources and clinical training opportunities are also provided by the Solution-Focused Brief Therapy Association (SFBTA.org), which is an organization that was founded by SFBT developers Steve de Shazer and Insoo Kim Berg.

Based on this review of outcome studies, the SFBT substance use interventions with the strongest research designs and available interven-

tion protocols were the Smock et al. (2008) and Kim et al. (2018) studies. Both of these studies were completed in outpatient settings, and practitioners who wish to use SFBT with clients who use substances may benefit most from studying these articles and contacting the authors for their intervention protocols.

LIMITATIONS AND FUTURE RESEARCH

This review only examined published literature in English and did not include unpublished studies and studies that exist in other languages. Since SFBT is being applied and researched in many different countries, it is possible that other published and unpublished studies may exist that could confirm or disconfirm our findings or even change the results of the current review. Despite this fact, this is the first review to look at outcome studies on SFBT and substance use treatment, and we believe that this current review makes a significant contribution to social work practice. Research on SFBT as a substance use treatment is still in its nascence. When there are more high-quality studies on this topic, systematic reviews or meta-analyses should be conducted.

Another weakness to the results of this study is limitations in the study designs used in the nine studies reviewed. Given the small pool of evidence on this topic, we chose to include all studies regardless of study design. Therefore, the results of this review may be biased by evidence from studies with many methodological weaknesses. Most studies were quasi-experimental and subject to numerous threats to internal validity, and all studies—including the three RCTs—had small sample sizes. When additional RCTs are completed that show similar results, we will be able to more confidently conclude that SFBT is an effective intervention with substance use. However, the studies that are available show considerable promise for use of SFBT in practice and additional research studies. Researchers can improve on the study of SFBT with substance use outcomes by conducting more RCTs with larger sample sizes that will also meet rigorous standards for measurement and fidelity. It is important to build on the settings where SFBT has shown most effectiveness with previous RCT studies such as outpatient mental health, CPS, and school settings.

CONCLUSION

SFBT has been practiced with clients who have substance use problems since the 1980s, and clinical training materials have been developed to help practitioners learn and use SFBT in substance use treatment. This article is the first review to examine outcome studies on SFBT in substance use treatment. All studies reviewed found promising evidence on SFBT's effectiveness in improving substance use behaviors and related psychosocial problems. Five of the nine studies reviewed showed that SFBT can change substance use and comorbid mental health and psychosocial problems such as depression, trauma, and school- and work-related behavior problems. Future RCT studies on clients who have both substance use and psychosocial problems are needed. It is recommended that these studies build on current RCT studies and the practice settings where SFBT has been found most effective.

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REFERENCES

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