Solution-Focused Brief Therapy in Crisis: Adapting Practice in Pandemic Times

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With massive increases in the number of new requests for support, overstretched resources and reducing referral options, the Brisbane Youth Service Intake Team have needed courage to tackle the seemingly never-ending impact of the COVID-19 pandemic. In surviving the diverse challenges of the last two years, the team has had to work hard to remain grounded amidst the frustrations that can come with trying to respond to the often seemingly unsolvable crises impacting young people who are homeless or at risk of homelessness.

Despite unsustainable workloads and, at times, overwhelming levels of need for housing and a range of health supports, the team have taken the opportunity to refine and evolve their use of Solution-Focused Brief Therapy (SFBT) as one aspect of their practice of crisis and brief intervention. This is very much an ongoing action learning process which has required a resilient commitment to holding the core SFBT principles while flexibly adapting elements of the approach to the unique, ongoing pandemic pressures on youth homelessness services. Working together to hold SFBT practice as a central theoretical framework in their work has been key in enabling the team to not only cope with the escalated complexity and demand but to continue to learn, be inspired and improve practice in their commitment to positive new futures for young people.

At the centre of a multi-disciplinary range of holistic support services for young people experiencing or at risk of homelessness, Brisbane Youth Service (BYS) operates an intake service at its central inner-city hub delivered by a team of skilled youth workers (the team) who are usually the first point of contact for young people in crisis. The team has, for several years, been working on adapting a brief solutions-focused intake and assessment process for young people experiencing or at risk of homelessness. The initial and ongoing impacts of COVID-19 prompted a rapid evolution of the team's use of this practice approach due to the sudden and sharp escalation (approximately 60 per cent initial increase) in the number of young people seeking support. Simultaneously, the team were adapting to a suite of COVID-19 requirements such as screening, cleaning, social distancing, room density limitations and working with masks and face shields. The significant challenges to normal service delivery provided a complex backdrop against which the team had to work harder than ever to hold their balance and sustain good practice responses to vulnerable young people.

Solution-Focused Brief Therapy provided the team with a strong guiding framework that was more critical than ever in a dynamically changing and overwhelmingly complex and high demand service delivery environment. SFBT is differentiated from traditional case management and many social work/human services practice frameworks by shifting focus away from exploring and defining the problem with workers taking a lead role in identifying goals and driving actions to achieve the desired outcomes.[1] SFBT places the focus on the young person's competence and strengths, developing a collaborative partnership approach instead of workers taking the role of competent, knowledgeable leader. This approach uses targeted questions to draw on the young person's own language, experiences of success, exceptions to problem experiences and, in particular, vision of what they want their future to be.[2]

The team adapted the approach dynamically, refining critical elements that made the most difference in managing the level of crisis that has accompanied COVID-19. Changing perspective from seeking to deeply understand challenges to instead exploring alternatives, exceptions to the problem and opportunities that lie ahead was particularly useful in managing high numbers of young people with complex issues. Solving problems is approached by working alongside the young person, moving towards what is wanted, rather than spending time trying to unpack and resolve the unwanted problem.

Actively identifying and testing useful questions to ask young people in crisis was central to successfully implementing SFBT. A traditional SFBT framework takes active and thoughtful vigilance; a strong commitment to choosing the 'right' questions; and reflectively guarding against traditional forms of 'helping'.[3] Counterintuitively, SFBT moves away from being 'helpful', at least in the ways that are commonly expected, instead responding in a way which attunes to what the young person thinks is important in defining their own preferred future. This requires a broad level of practice wisdom, the tip of the iceberg of which is expressed through 'useful' questioning which assists the young person in identifying and mobilising their capacities to the fullest. This approach not only confronts many traditional human services models, it also requires workers to overthrow socio-cultural norms of asking 'what is wrong?' and then offering empathic advice and in-depth explorations of the problem.

In the early days of the pandemic there were strong systemic responses including significant increases in

government income support, a moratorium on rental evictions, an influx of emergency funding, and positive collaborative efforts to reduce community transmission by getting young people into housing. It was, remarkably, easier than usual to provide immediate, short-term solutions. As the first wave passed and COVID-19 became recognised as a longer-term issue, special funding and joint responses were reduced or dismantled but the demand for support did not abate. With the usual methods of addressing crisis needs no longer effective in the context of elevated scarcity of resources and referral pathways resulting from service disruptions and wide-scale increased demand, it became more critical than ever that the team were able to adapt approaches that did not attempt to replicate case-management styles of engagement in a crisis setting.

For the team, a critical, undermining challenge of SFBT in the pandemic was holding the approach while operating within a problem-focused, deficits-based systemic response with a scarcity of housing options accessible for young people. Contrary to Housing First principles, both workers and young people were forced to switch from a strengths and solutions-focus to being deficit-focused in competitively advocating for how 'deserving' young people were of accessing the limited housing options. Young people and their accompanying workers reported experiences of intrusive, traumatising assessments for emergency housing and allocation processes that were perceived as, at times, judgemental, merit-based and punitive and, at best, not congruent with strengths-based or solutions-focused principles.

Adaptations of some aspects of the SFBT approach have been necessitated by the context. While crisis work is, traditionally, a time-limited approach, the complexity of COVID-19 and the flow-on impact on housing and health service accessibility has meant that the 'brief' aspect of the model was somewhat redefined. While retaining an active focus on young people moving forward independently, and a scope-limited focus on immediate solutions to the current barriers, the team was forced to sustain support for longer than the intended 8 weeks of intake support before referral to case management. This became necessary as, while young people could strengthen their own capacity to access suitable solutions and supports, when they did not exist or had extensive waitlists there was little that the young person and worker could do to move forward. Young people had to navigate half a dozen or more solution pathways before one led to an outcome. Where an application for emergency or transitional housing may have had a one in five chance of success pre-COVID-19, this changed to a one in 20 or 30 chance as the number of referrals for every vacancy escalated rapidly.

There remains a severe and ongoing lack of housing options for young people under the age of 18. Young people's readiness to find solutions was increasingly not matched by the available opportunities, and reality-checking, risk-managing and safety planning for unsafe situations became the only option. This unavoidably increases stress for the team who, in lieu of referral pathways, became the only available support option. This in turn sees the team perform a complex juggling act between managing a constant inflow of new young people in crisis and maintaining high caseloads of young people for longer than intended with limited or no on-referral options. While the team are often unavoidably in a position of gate-keeping resources that young people require access to, the approach has nonetheless helped to facilitate a positive and future-oriented focus for young people's self-efficacy.

There were several challenges experienced in using SFBT in this type of crisis setting. A key barrier is the limitation of SFBT in working with young people who are experiencing acute mental health issues. BYS has seen a remarkable escalation in the proportion of young people presenting with mental health issues since COVID-19 began, with a 26 per cent increase in young people reporting diagnosed mental health issues at intake. This meant the team needed to work harder to match their approaches to the young person. In turn, this moving in and out of SBFT thinking impacted their capacity to consistently be immersed in the SFBT approach.

Other challenges impacted workflow management with workers being less able to schedule appointments regularly and consistently with young people across their caseloads, because meetings between the worker and young person were driven by when they were purposeful for reaching a solution, rather than a regular schedule. While crisis work is inherently chaotic, the worker's calm and stable presence is important. A flexible and responsive scheduling of meetings can positively reduce unnecessary appointments, but it can add an additional layer of unpredictability which highlights one of the differences between a planned case management approach and this style of solution-driven engagement. Further, with young people identifying solutions themselves at the heart of the model, it takes discipline for workers who are time-poor and under high demand to hold back from trying to hasten the process by providing their own 'good ideas' for what the young person most obviously 'should/could' do, and this less-directive approach does not work consistently with all highly vulnerable young people.

SFBT has not been the only useful practice framework and tool used, as the team balances and integrates a range of different worldviews and theoretical approaches in responding to the diversity of the work and the complexity of the crises that young people experience. Despite the challenges, the SFBT model has played a part in equipping the BYS intake team to manage unprecedented levels of crisis, navigating multiple and significant systemic barriers and sustaining a sense of optimism, camaraderie, inspiration and admiration for the resilience and strength of young people.

Endnotes

1. Iveson C 2002, 'Solution-focused brief therapy', *Advances in Psychiatric Treatment*, vol 8., pp. 149–157.
2. Trepper T, McCollum E, De Jong P, Korman H, Gingerich W, Franklin C 2010, *Solution Focused Therapy Treatment Manual for Working with Individuals*, Research Committee of the Solution Focused Brief Therapy Association. <*http://psych.hsd.ca/SFBT_Treatment_Manual.pdf*>
3. Ratner H, George E, Iverson C 2012, *Solution Focused Brief Therapy: 100 Key Points and Techniques*, Routledge, London.