

Anna Freud
National Centre for
Children and Families

In search of an ending

Managing treatment closure in challenging circumstances in child mental health services

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Acknowledgements

We are grateful to the young people in Leeds, Bristol and Birmingham who shared their views and experiences of treatment endings at our consultation groups, which were facilitated by Common Room.

We are also indebted to over 60 practitioners for their contributions to roundtables in London, Birmingham, Manchester, Leeds, Liverpool and Bristol in the autumn of 2017, including Marion Astin, Hannah Beal, John Bisset, Maggie Bisset, Subreena Charlemagne-Odle, Jo Costi, Vicki Curry, Catherine Eastwell, Dr Roberta Fry, Jane Gray, Ms Sarah Gustavus Jones, Mr Graham Lee, Dr Melanie Merricks, Dr. Penny Netherwood, Anna Pemberton, Dr. Emily Ryan, Hayden Stothard and many more.

As well as informing this report, the practitioner roundtables were conducted as empirical and academic research which will be written up by and disseminated via academic publications as part of a PhD being undertaken by Holly Bear in the Research Department of Clinical, Educational and Health Psychology, University College London. Some of the preparatory work for the roundtables was completed in conjunction with Holly's research, specifically a thematic analysis of initial scoping work on treatment endings which guided our thinking, and the production of a discussion aid which helped to frame our conversations at the roundtables. We look forward to being able to disseminate Holly's further research through the Anna Freud Learning Network in the near future.

Introduction

Child and youth mental health services are currently responding to high levels of need with finite resources. At the same time, data shows that not everyone improves or is better at the end of treatment and, for many, difficulties in their lives will be ongoing. Yet practitioners are not generally trained to manage endings when the person is not better and there is no guidance on this from NICE or from other bodies. The public are taught to expect specialist help will make the difference. In this context, ending mental health treatment can be challenging.

During 2017, the Anna Freud Learning Network has been in dialogue with practitioners working in a range of settings, and with young people, to fully explore the factors that can make ending treatment a challenge, approaches that are helpful, and how we can improve things.

In this report we review the challenges and suggest some ways forward. There are three particular areas that warrant ongoing attention or investigation.

The first is the importance of drawing attention to the fact that there will be an ending, from the start. In this report we talk about how best to support an early conversation about the time-limited nature of treatment and the therapeutic relationship.

The second, and tied to the first, is the need to communicate openly about limitations in how, how much, or how far, the treatment being offered will help. Our conversations have made clear the importance of establishing realistic expectations – with young people and families accessing services, other professionals, and with the public at large – to challenge the notion that mental health services could provide a "cure all" to problems that can be complex, enduring and recurring.

Finally, we emphasise that further work is needed to help services, families and individuals to most effectively draw on types of support that they can use without a mental health professional being present.

The issues raised here are relevant to services, commissioners, and service users. We hope this report will raise the profile of under-acknowledged issues in our child and youth mental health systems and services, and support the sector in moving forward. We are grateful to all those colleagues who have contributed to this work through their engagement in the Anna Freud Learning Network and look forward to continued collaboration in these areas.

A summary of our recommendations

The practitioners involved in this work shared a rich variety of suggestions and approaches that help them to end treatment in difficult circumstances. We have summarised these below, but also note that all treatment endings are different, and that many of these recommendations will make sense in some circumstances but not in others.

1. Beginning with the ending

It is important to be clear upfront about any parameters for the work: are there fixed rules or guidelines as to how long the help will go on for? Are there any defined review points? Establishing mutual trust is key to a therapeutic relationship, and being clear about boundaries is part of this.

- Share with the child or young person, and their parents or carers, what they might realistically expect. For example:
  - the likely duration of the work
  - that we know that any one type of help might help some people more and others less
  - that problems and difficult feelings are a part of life – and some could persist or recur
  - that there are different ways that interventions can help, or things get "better". For example:
    * your feelings might improve, or your symptoms reduce
    * you might be handling life better, for example getting back on track at school
    * you might understand more about what is going on for you
    * you might learn better ways to cope with difficult feelings.
- Think about how you might talk together about "progress"
  - talk about hopes. Identify your different and shared goals for the work
  - look at outcome measures that could help track how things are going.
- Aim to have shared expectations with other agencies and with families or carers as well as with the young person you are working with.



2. Planning for the ending

- Using routine outcome measures can help structure conversations about how things are progressing, and open up conversations about moving forward.
- Know what other services do and how they might be able to help (for example, if you can't). There might be somewhere the young person is more likely to engage or be helped.
- Give a choice about when and how the therapy ends where possible. Options might be:
  - doing a summary letter, or a review of your work together and what's changed
  - having a goodbye session
  - staggering the final sessions, or offering a check-in or follow-up session.
- Make sure other relevant people in the child/young person's life know about the ending. A well-timed phone call, with the young person's consent to CAMHS, GP or school can be helpful – especially if they are part of the support plan!
- Consider and discuss the other supports that are available after the ending, for example, other groups and activities, drop-in services, peer support, support in school.
- Put in place a relapse plan, crisis plan or support plan.

3. Talking about the ending

- "Leave the door open": some find it helps to say to the young person or family that they can come back if they need to – perhaps within a defined timeframe. This can feel like a safety net and calm anxieties.
- Understand your work together as part of a process, one phase in a long life:
  - "this phase of the work has ended, you might need to come back later so we can do some more work, and that's fine"
  - share that it's normal to have problems or difficulties sometimes: "it's common to meet a new situation where you need something again. It's not unusual, not a failure"
  - "it's not an end, it's a beginning": empower the young person to take new tools and strategies and go out and achieve their goals. In some cases, time and space to consolidate the work can be helpful.

4. Supporting one another as professionals

- Service culture and robust management and leadership are important. Have open conversations about possible risks and avoid a blame culture. For example, this might help where a young person's problems are quite worrying and the service's help isn't making much of a difference.
- Put in place ways of working that allow practitioners flexibility in responding to more challenging endings. For example, the ability to offer staggered sessions, follow-ups, re-engagement with the service, or drop-in services.
- Support from supervisors and other practitioners can be a big help in thinking about whether it is time to end. For example, one service has staff group supervision that focuses specifically on endings: they ask questions like "what will be achieved with more sessions?"
- Support from supervisors and colleagues also helps practitioners when they need to handle some emotional impact from the ending. For example:
  - where a child is in difficult or disrupted circumstances, it can be particularly complex to decide what role the therapeutic help is playing, and when to end
  - supervision groups offer a safe space for practitioners to share their own vulnerabilities or reflect on areas of incompetence.
- Multi-agency meetings and multi-disciplinary teams are of great value where more than one service or professional is working with a child, young person or family:
  - be really clear with other professionals (from the beginning) what you are going to offer and when it is going to end.
  - be understanding of how the situation might feel for professionals with responsibilities in other services – for example, social care or education. This is important where the decision to end is challenging. Ensuring those professionals understand the mental health perspective can help them to contain any anxiety they are feeling about the child or young person; a collaborative approach may also help them to feel the problem (and in some cases the risk) is shared.

5. Helpful tips for practitioners

- It is important to accept you might not always be able to help. You could:
  - ask "have you been a good enough therapist?"
  - acknowledge that continuing to be in a child or young person's life where the help isn't helping can create its own risks: consider the impact on them of extending their experience of "treatment failure"
  - consider that there might be other people out there who could help
  - appreciate that it might not be the right time for the young person to engage with your service, but they may come back for help later
  - bear in mind that people are often grateful for the help they've had.



Background to this report

Our interest in this area arose out of conversations that were taking place across a broad range of cross-sector learning events, trainings and seminars – among them those arising from the i-THRIVE Community of Practice,[1] CORC outcomes research,[2] and ongoing PhD research hosted in the Evidence Based Practice Unit.[3]

This work grew out of three ongoing strands of work that had been active since 2016:

1. Child Outcomes Research Consortium (CORC) analysis of outcomes across child mental health services involved in Improving Access to Psychological Therapies.[4] This found that around half of all children did not show measurable change at the end of treatment. This led the authors to consider what was being done for these children and how decisions about endings were being reached. A series of regional events were hosted by CORC to explore these findings and consider implications.

2. Work undertaken by Miranda Wolpert in collaboration with colleagues working in paediatric palliative care at UCLH (Maggie Bisset and Jonathan Martin) on how to discuss endings when cure was not likely. This led to the development of a cross-disciplinary one-day training course that has since been successfully rolled out as part of the i-THRIVE academy.

3. PhD work led by Holly Bear (supervisor Miranda Wolpert) on endings in therapy that drew on and contributed to both of the above and has contributed to the current document.

In the light of these three strands of work, in 2017, the Anna Freud Learning Network decided to initiate a collaborative dialogue, to improve our understanding of why ending treatment can feel challenging, particularly in the context of limited clinical improvement, and to share helpful approaches to ending when symptoms persist and continue to feel unmanageable.

We invited colleagues – practitioners occupying a wide range of roles in both voluntary and statutory mental health services – to join seven roundtable discussions, in Manchester, Liverpool, Leeds, London, Birmingham and Bristol over the autumn of 2017. Over 60 colleagues contributed, bringing perspectives that spanned specialist mental health, community-based services, social care and the looked after sector, and school-based provision. Diverse disciplines were also reflected, including psychiatry, psychology, nursing, counselling and emotional wellbeing support and guidance. We are grateful for the honesty and richness of colleagues' contributions.

Alongside these roundtables we held three consultation groups with young people in Leeds, Bristol and Birmingham, facilitated by Common Room.

The rich and diverse conversations with practitioners and young people brought to light a wide range of ways of approaching challenging treatment endings, which this report shares. These encompass practical approaches as well as a reframing of aspects of the discourse around specialist mental health services and their limitations.

[1] www.implementingthrive.org
[2] www.corc.uk.net/what-corc-does/research-analysis-and-evaluation
[3] www.ucl.ac.uk/evidence-based-practice-unit
[4] Wolpert, M., Jacob, J., Napoleone, E., Whale, A., Calderon, A., & Edbrooke-Childs, J. (2016). Child- and Parent-reported Outcomes and Experience from Child and Young People's Mental Health Services 2011–2015. London: CAMHS Press

What makes endings challenging?

Across our discussions, the process of ending was recognised as a crucial part of treatment. Practitioners and young people alike pointed out that, for many, reaching the end of a piece of work is an achievement, a milestone worthy of celebration – although some feel more prepared than others for the therapeutic relationship to end.

However, our conversations also confirmed that the end of treatment is often an anxious time for children, young people and families, as well as for professionals, and that the factors that contribute to making treatment ending difficult are complex and various.

Unrealistic expectations, from all parties

Participants in the roundtables identified the weight of expectation on specialist child and youth mental health services to "fix" a young person's problems, as well as a pressure to continue treatment when a child or young person does not seem to be "better".

> *"Other services exist within the framework that not everyone will be cured. Our services still exist within a narrative of all children being able to attain cure."* **Practitioner**

Practitioners suggested that there is insufficient dialogue about what the negatives might be in continuing a treatment that is not helping. They reflected on the possible impact on a young person of continuing to engage with a treatment that is not having a positive effect. Alongside this, they highlighted the risks of building up a dependency on a service, or obstructing the development of self-management skills.

Accepting the limits of therapy is a challenge many participants have or continue to struggle with. One referred to a certain feeling of omnipotence among child and youth mental health practitioners – a well-intentioned belief that they can and will solve the problem a child is experiencing. Participants connected this to an unwillingness at a societal level to accept that there may be situations where it is beyond our powers to prevent children's suffering.

Practitioners' guilt or distress where improvement is less than hoped for

The endings that many practitioners find most challenging are those in which a child or young person does not feel better. Practitioners said that they can feel that this is because they have not delivered the support as well as they might have, have not delivered the right kind of support, or have not worked for long enough with the young person.

> *"There is the belief that if only the right thing is offered things can be fixed... to be honest and pragmatic doesn't sit with our psyches. If only we work hard enough. If only we were better practitioners."* **Practitioner**

Practitioners in these situations may experience feelings of hopelessness, helplessness or guilt, which can result in a desire to offer more, and to hold on to a young person or family for longer than clinical judgement might dictate.

Children, young people and families' fears about going it alone

When a course of treatment has been completed and the outcomes hoped for have not been reached, young people and families may experience anxieties that are challenging for practitioners to manage.

Practitioners reflected that young people and families may be at an early stage in accepting that some of the symptoms they are experiencing may be ongoing and may struggle to understand why the decision to discharge is being made when things do not feel "better".

> *"A percentage of families will cling on for dear life – they think: "if you're not in our life, who will help?" They've been passed around so much already. This generates anxiety in the clinician. There are family and clinician factors at play."* **Practitioner**

Young people said that at the end of treatment they commonly experience worry about their ability to manage without the support they had been receiving. Some said they had experienced a loss of confidence about being able to cope once the "security blanket" had been removed, concerned that they might end up feeling worse than when they started therapy. The ending can feel particularly difficult if it seems arbitrary, and they do not understand why the work needs to finish.

Practitioners reflected that the end of treatment can be an anxious time for families too, who may also question their ability to manage without the support of the therapist, particularly if behaviours they find concerning are still present. For families who have ongoing worries about a child or young person's mental health (for example, in the context of past suicide attempts), moving on from treatment can be daunting.

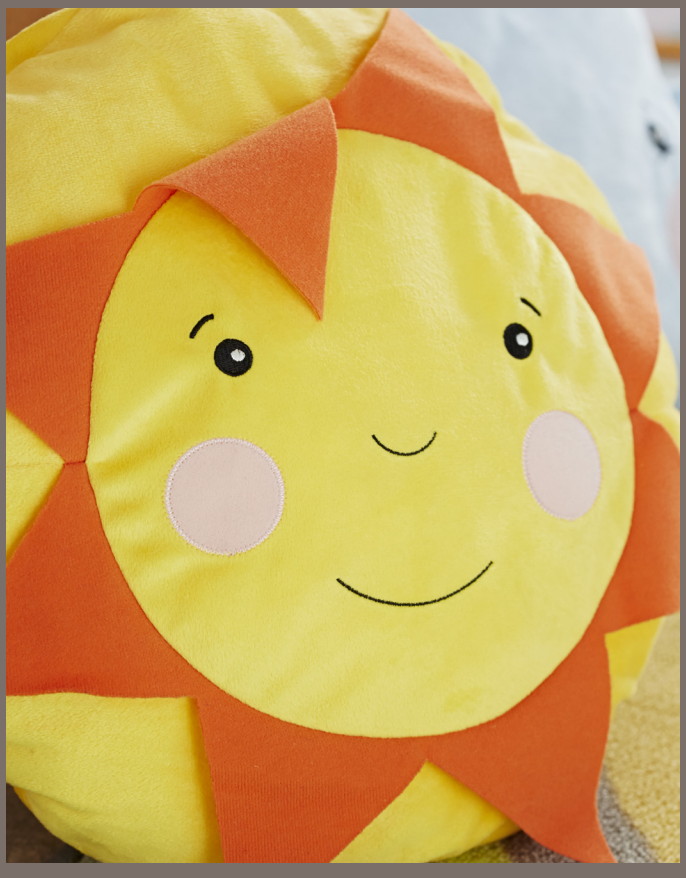
Both practitioners and young people also noted that negotiating conflicting views on readiness to end can present a challenge – for example, in some instances a young person may feel ready to apply the strategies they have learned during treatment without the therapist, but their family are keen to extend the support.

Dealing with feelings of abandonment or broken attachment

The end of treatment not only means the end of a particular kind of support, but often the end of a relationship between a young person and their family and the practitioner delivering that support.

Young people shared that the relationship ending, aside from the work itself finishing, can feel difficult and upsetting. Several participants felt that they had developed close relationships with practitioners, and that the ending of this was a loss, or experienced a feeling that the practitioner no longer cared about them when the work ended. Others felt angry and dismissed, especially when they had not been involved in the decision to end. Young people also reflected that ending contact with the wider service, as well as the direct relationship with a practitioner, can feel significant.

> *"You build a strong relationship with people that you tell personal stuff to and then they leave and it reminds you that it's just a service and they're just doing they're job."* **Young person**



But practitioners expressed that they too can struggle to let go of the relationship they have developed with a child, young person or family. One participant shared that it is possible to get overly attached to a service user, especially when other clients feel difficult compared to that one individual.

Practitioners were sensitive to service users' feelings about the end of a therapeutic relationship and, in longer-term interventions in particular, conscious of being the most consistent relationship in the lives of some of the children and young people they work with, making an ending feel particularly challenging.

> *"I find endings very hard because if I've been working with someone for 3 years, I really don't want to let them go. And I can't show that to them, I have to contain it."* **Practitioner**

Concerns about ongoing risks

Ending treatment with a child or young person when risk remains emerged as a theme across our roundtables. Some practitioners felt cases should remain open while there were any ongoing concerns around safety. For others a case would be closed where a time-limited course of treatment had reached its end, or where treatment was having little positive effect, notwithstanding ongoing risks.

Regardless of approach, many agreed that potential risk contributed to anxieties around endings. Largely this was related to concerns over the safety and wellbeing of the child or young person, but there were also concerns about personal and organisational liability.

Some pointed to an increase over recent years in practitioners' anxiety about risk, and tied to this a propensity to limit risk as far as possible. This could be by holding cases for longer than clinical judgement might otherwise suggest, or by trying other interventions which felt unlikely to work in order to demonstrate that all avenues have been exhausted. While it was acknowledged that anxiety around risk is well intentioned and often well placed, there were also concerns that it can lead to unhelpful blame and fear cultures developing in services.

> *"The buck might still stop with you, rightly or wrongly, if something has happened and you had closed that cases."* **Practitioner**



Anxieties that long waiting lists may prevent easy access to future help

Alongside judgements about ongoing risk, practitioners said that long waiting times to re-access mental health services could contribute to a reluctance to end treatment. This is compounded when young people and their families have experienced difficulties accessing services in the first place. Not only was it felt that long waiting times can lead to raised expectations of mental health services among families and young people, but that it can add to their anxiety about ending and about having to repeat the process of accessing support should a young person's mental health deteriorate in future.

> *"You can tell people they can come back, but that's not containing enough because of their experiences of access."* **Practitioner**

Long waiting times also impact on practitioners' feelings about setting expectations at the beginning of treatment: there can be a disinclination to be explicit about therapeutic limitations in early conversations with a child, young person or family who have been waiting for support for some time.

Respecting the concerns of other professionals, and responding to diverging views about the role of the mental health treatment

Practitioners reflected that managing the anxiety of professionals working in other parts of the system can contribute to the complexity of ending treatment where some difficulties are ongoing.

> *"When there's a clear mental health risk it's easy to say 'this is my responsibility'. It's harder when you don't see the mental health risk. You have to be really clear then with other professionals what you're going to do and when it's going to end."*
> **Practitioner**

There was a recognition that all services – from mental health to schools and social care – are experiencing resource pressures. In this context it can feel challenging to step back and think across agencies about what is needed, and the best support to offer to help a child or young person thrive. Practitioners were sensitive to fellow professionals' anxieties where risk remained at the end of mental health treatment: many empathised and felt guilt about leaving other professionals to hold risks, even where their clinical judgement suggested it was appropriate to end a particular intervention.

Differing views across agencies can add to the difficulty of ending a treatment. In some cases, practitioners said that colleagues assumed ongoing adverse life events to signal ongoing mental health risk. In these cases, practitioners might meet resistance closing a case.

> *"It's hard to be a lone voice in the system if you want to discharge, but others don't feel it's appropriate."*
> **Practitioner**

Practitioners also reported differing views across services about what a positive outcome is, and how progress is measured. A school-based practitioner shared that, in their context, seeing an improvement in attainment and attendance is a priority, even where the goals of practitioner and young person focus on something else; for example, feeling more able to manage symptoms. Where a child or young person is not engaging with school, some practitioners experienced a pressure to continue therapy until the young person had returned, regardless of whether or not the young person wanted the mental health support to end.

Concerns about a lack of other available sources of support

Practitioners shared that ending treatment feels particularly challenging when other sources of support are not available or accessible. Although the landscape of available support differs across the regions we visited, many practitioners raised concerns about depleted resources in the voluntary sector. This included reduced access to services like youth clubs, mentoring services or community centres where a young person can find an appropriate adult who cares and will listen to their concerns.

Practitioners worried that they were signposting on to organisations that could cease to exist in six months' time, due to funding pressures. In some areas the main sources of support outside of specialist services were internet- or phone-based support.

Being conscious of the limited capacity of non-specialist services to hold a child or young person for some led to a reluctance to close cases. Some practitioners suggested that their role in these circumstances can morph into a general supporting role, rather than providing a specific treatment to address the young person's mental health difficulty specifically.

How can we move forward?

Our engagement with practitioners and young people has highlighted a range examples of helpful practice and practical ways of working that can support mental health services to address treatment endings in circumstances where this may feel challenging. At an over-arching level, we feel there are three key messages emerging from this dialogue for the sector, which are outlined below.

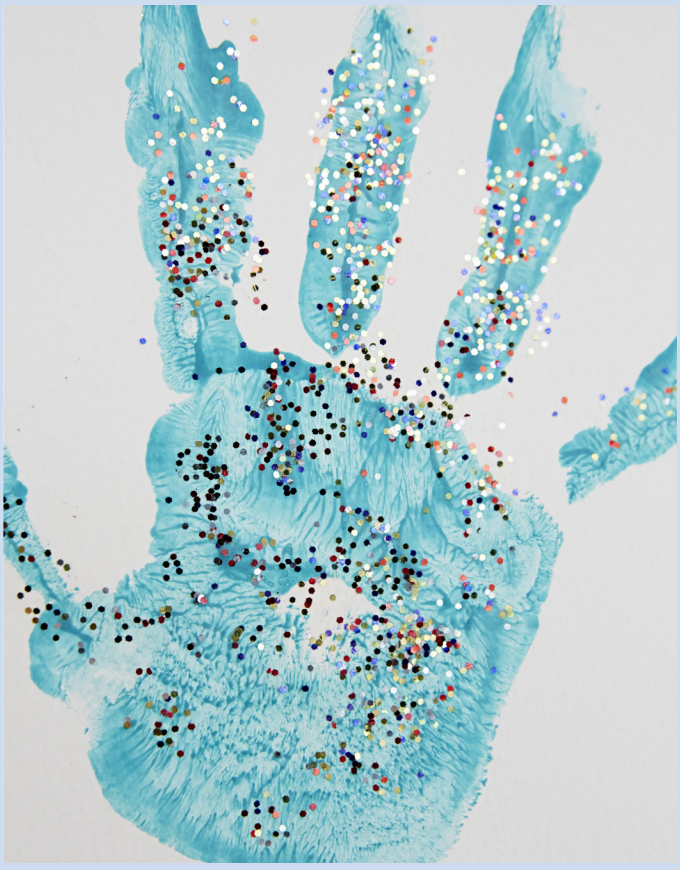
1. Talking endings from the beginning

Our conversations highlighted the importance of practitioners talking about the time-limited nature of treatment and the therapeutic relationship as early as possible in their engagement with families, children and young people, and other professionals.

We need to develop an appropriate language in order to have the early conversations that practitioners and young people suggest are vital to helping prepare service users for the end of treatment. This language should be one that nurtures hope and supports trust to develop, as well as clearly communicating the boundaries around the support and the therapeutic relationship:

- Practitioners need to feel equipped to use this language to initiate conversations about the end of treatment from early on, and to understand when and how it is appropriate to raise this topic according to the needs and circumstances of the child, young person or family.
- Relevant training and supervision could have a role to play in building confidence and competence in this area.
- Space should be scheduled early on to discuss the end of treatment – to establish the relationship from the very beginning as one which will at some stage end.
- Any parameters for the work should be clear, including, for example, its likely duration, any rules or guidelines as to how long the help will go on for, and any defined review points.

Practitioners generally agreed that establishing mutual trust from early on is important, and being clear about boundaries is part of this. Young people also emphasised that communication from early on about when the end of treatment might be expected is vital in supporting them to prepare for the ending. They also felt an understanding of **why** treatment must come to an end is important in helping them to come to terms with the end.



The end of the work may most helpfully be approached as **a process** rather than a discrete event. Practitioners and young people agreed that this process should run throughout the treatment journey, with the ending frequently discussed to allow the child, young person or family to prepare as thoroughly as possible, and to ensure the time-limited nature of the work is held in mind.

2. Realistic expectations

The outcomes data that we have suggest that many children and young people will continue to experience difficulties after accessing specialist services, that any one intervention will help some more than others, and that some difficulties are enduring. Practitioners also spoke of the complexity they work with, wherein young people are embedded in contexts that mental health professionals may have little influence over, and where other agencies have limited power or resources to intervene.

Unrealistic expectations of the outcomes likely to be achieved from accessing mental health support can:

- have a negative impact on the way mental health practitioners view themselves and their work
- make the end of treatment feel even more challenging for children, young people and families when they do not see the outcomes they had envisaged.

Practitioners at our roundtables called for a broader recognition of the limits of mental health services – not only by colleagues in mental health and allied sectors, or by service users, but also by the media and in public discourse. Their hope was that we consider the likelihood of a positive outcome in child and youth mental health in the same way we think about the likelihood of a positive outcome from a physical health treatment.

Setting realistic expectations early on about the possible outcomes of any given treatment is important in successfully engaging around the treatment ending, especially where this might feel challenging for those involved. In discussing realistic expectations with service users, practitioners and young people suggested that peers:

- recognise the importance of maintaining hope that things can get better, but also that this is not necessarily tied to length of treatment
- refer to the evidence base – explaining that research shows that the intervention is more helpful for some people than for others, that for some people symptoms and difficult feelings may persist and recur, and that we are still trying to understand why that is
- take a collaborative approach and develop a shared understanding around what is hoped for from the work
- consider what a good outcome would look like – whether that means an improvement in feelings or symptoms, feeling better able to understand and cope with difficult feelings, or feeling more able to get on with life (returning to school or college, for instance)
- regularly review expectations throughout the treatment journey
- reassure the young person that while it may not be possible to make things perfect, the practitioner will work alongside them; and use the language of "doing with, not doing to"
- acknowledge and celebrate what the young person has invested – time, effort, money, emotional availability – even when outcomes may be less than hoped.

Young people reflected that honesty about the likely outcomes of treatment can prevent them from feeling negatively about themselves and disappointed towards the service when treatment ends. Practitioners considered that sharing with the child, young person or family what they might realistically expect from the work is particularly important when the prognosis is a difficult one.

Practitioners emphasised the value of communicating about realistic expectations with professionals in other services involved in supporting a child or family. Clarity from the start about the possible duration or outcomes of the work can lay better foundations for appropriate collaboration and support from them as treatment comes to a close.

Periodic conversations about the ending throughout the duration of therapy, and regular reviews of expectations, can also help. Multi-agency meetings and multi-disciplinary teams can be valuable in building mutual understanding about the capabilities and constraints of all players, helping to contain professional anxieties about a child or young person,

> *"You have to be really clear then with other professionals what you're going to do and when it's going to end."* **Practitioner**

and as a shared forum for addressing concerns about ongoing risk.

Practitioners themselves need to accept that there may be limits to what can be achieved given the particular situation or time.

When a treatment ending feels uncomfortable or unsatisfactory, mental health practitioners found it could be helpful to:

- accept that nobody is able to help in the way that they want to all of the time, and ask themselves the question "have I been a good enough therapist?"
- bear in mind that people are often grateful for the help they have had
- consider that others may be able to support the young person in a way that is more helpful to them at this moment – be that a friend, teacher, family member, or another mental health professional in the same or a different service
- reflect that while it might not be the right time for the young person to engage with your service, they may come back for help later
- be mindful of the possible risks in continued involvement in a person's life where the support is not helping: for instance, what is the impact of extending someone's experience of "treatment failure"?

3. Other types of support

Given the likely persistence of some difficulties following treatment, any conversation about treatment ending should consider approaches or support outside of specialist services that might help children and young people manage their own mental health and wellbeing.

To do this more effectively we need to deepen our understanding of the range of non-specialist strategies available to address mental health difficulties, and better understand the evidence and mechanisms that make some strategies more attractive and impactful for particular young people or situations than others.

The Anna Freud National Centre for Children and Families is currently investigating this area, carrying out a systematic review of the literature and consulting with young people and a range of professional stakeholders. We look forward to further engaging the Anna Freud Learning Network in this area.

Practitioners and young people highlighted how understanding and drawing on the full range of supports and assets outside of mental health services that are available to a child, young person, or family can be key in managing the end of treatment.

Young people and practitioners suggested:

- beginning this process before the end approaches
- discussing and trying out different self-management strategies, so a young person develops a sense of what is helpful for them if they feel they are struggling, and the confidence to use these after treatment ends (with examples being relaxation techniques, thinking tools, mindfulness practice, journaling)
- co-producing a self-management plan, crisis plan or relapse plan

Working together to assemble a "back-up team" was also suggested. The team could be approached for help or support – for example, friends, family, teachers, and other trusted sources of support.

Young people suggested involving some of these people in treatment reviews, to equip them to offer support after treatment ends. They also suggested informing friends about an anticipated treatment ending, to make them aware of this change, and that it could be a difficult time.

Practitioners also advised early communication with other organisations and agencies about the fact that the end of treatment is approaching. This might involve, with the young person's consent, a well-timed phone call to school, to colleagues in social care, or a local voluntary sector service the practitioner is signposting the young person to. Practitioners hilighted the value of pre-empting the ending, particularly when working with someone approaching the age of transition to adult services.

Other practice recommendations for services

There is a range of ways in which services can help practitioners to address and manage challenging endings. Key suggestions are discussed below, in relation to supervision and support, collaborative approaches, and structure and flexibility.

Supervision and support

Practitioners emphasised the importance of feeling supported by their service – by colleagues and by management – in making difficult decisions about ending treatment. As well as the sense of not being alone in reaching a decision that feels

challenging, they stressed the value of a supportive organisational culture, rather than one rooted in blame or fear.

Helpful working practice mentioned in certain services included:

- circulating an email listing dormant cases to clinicians, prompting them to consider whether these cases should remain open in their next supervision
- group supervision focused on endings, allowing dialogue with colleagues with no emotional attachment to the young person. Challenge can be helpful in considering whether it is time to end, why a practitioner might want to offer more support, or what they hope to achieve by continuing.

A collaborative approach

Practitioners were in favour of giving the young person a choice in how and when a treatment ends wherever possible. Young people said that feeling involved in planning an ending was a crucial factor in making it a positive experience.

Young people appreciated the pressures that services are working within and understood that support cannot continue indefinitely. However, even when it is not possible to offer any flexibility with regard to the end, they emphasised the value of an open conversation about the ending and being provided with space to discuss any concerns they have about it.

> *"Take into account young people's views and involve them in any decision that has to be made. Talk to young people about how things can happen and in a way they are comfortable with. Sometimes something has to happen but they should be involved."* **Young person**

Structure and flexibility

Practitioners hold a range of views about how best to balance clear treatment boundaries with flexible and responsive care. However, many considered a structured approach to be helpful in working through a challenging ending. While preferred approaches vary according to the service, intervention, service user, and practitioner, some useful practice examples were discussed:



- some practitioners and young people found tapering the ending helpful. Reducing the frequency of sessions can allow a young person space to try out the strategies they have learned and to grow in confidence, while having the reassurance of the next appointment in mind
- offering the opportunity to re-enter the service if needed – bypassing waiting lists – for a specified period
- offering an optional "booster" session after the end of formal treatment
- inviting young people and families to contact their practitioner by phone after the treatment ends to discuss any concerns
- offering "top-up" sessions or access to group work
- providing opportunities to remain involved with the service, through drop-in groups, or participation roles.

These arrangements were felt to reduce anxiety, and help the young person to feel "held". Participants explored the risk of encouraging dependence on services and, balanced against this, empowering young people to try to manage independently while having the security of falling back on the service if needed.

Some practitioners shared that they offered flexibility to service users around re-engaging with services "under the radar", without the knowledge or support of management because it felt important to do so as part of the treatment ending. While a few participants expressed concerns about being overwhelmed by requests for ongoing help if they "left the door open", this didn't seem to be happening in the contexts where it was offered.

Conclusion

During autumn 2017, the Anna Freud Learning Network invited a broad range of child mental health practitioners and young people to engage in a dialogue about their experiences of managing endings in challenging circumstances.

The active interest with which people responded, and their subsequent participation in roundtables and workshops across the country, affirm that this is a live, important, and under-acknowledged issue for child and mental health systems and services.

We have drawn attention to three areas in particular which we feel to be crucial. The first is the importance of talking endings from the beginning: it is vital for practitioners to find a language that not only nurtures hope and trust, but also communicates clearly to service users the time-limited nature of treatment, from the outset of a therapeutic relationship.

The second is the need to establish, among all parties, realistic and shared expectations about how, how much, and how far the treatment being offered will help. Participants in our roundtables suggested that widespread reluctance to accept the limitations of mental health treatments can compound the difficulties experienced by practitioners and by children, young people and families when treatments end in circumstances which remain challenging.

Finally, given the widespread persistence of some difficulties following treatment, we stress the need to deepen our understanding of the range of non-specialist strategies available to address mental health issues without a mental health professional being present. The Anna Freud National for Children and Families is carrying out a systematic literature review and engaging young people and professionals in this area, and we look forward to further engagement over 2018.

We are grateful to participants for their openness and honesty. Their contributions have offered a rich insight into the issues, and enabled us to draw out a series of recommendations which will aid services, commissioners, and service users in moving work forward in this area. Our thanks go out to all colleagues who have contributed through their engagement in the Anna Freud Learning Network and we look forward to continued collaboration in the future.







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