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EMPIRICAL PAPER

How to manage endings in unsuccessful therapy: A qualitative comparison of youth and clinician perspectives

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ABSTRACT

Background: Approximately half of those who access child and adolescent mental health services do not show measurable improvement in symptoms. This study aimed to provide practice recommendations for managing treatment endings, particularly when outcomes have not improved. **Method:** Semi-structured interviews were carried out with 26 young people with a history of anxiety and/or depression along with 7 roundtable sessions with 52 mental health clinicians. Data were analyzed using Framework Analysis. **Results:** A common experience for young people when outcomes did not improve was a poor experience of the treatment ending, which often resulted in setbacks in their mental health and feelings of loss and abandonment. Clinicians agreed that ending was hard for young people and reported that they found managing ending hard on a personal and professional level. This was compounded by unrealistically high public expectations about the impact of therapy on outcomes and trying to strike a balance between fostering hope and managing expectations, within a context of inflexible service structures and resource constraint. **Implications:** Recommendations include establishing expectations from the outset and a shared understanding of what outcomes matter most to the young person. This can be achieved through communicating honestly about likely outcomes, while also providing hope.

KEYWORDS: child psychotherapy; mental health services research; outcome research; qualitative research methods

Clinical or methodological significance of this article: Ending child and adolescent support is a complex and delicate process for both young people and clinicians, especially when ending therapy with young people who are not improving. We found that when outcomes did not improve, young people reported that a poor experience of ending treatment exacerbated mental health difficulties. Recommendations for practice are that services establish ways of working that allow clinicians greater flexibility in responding to more challenging endings, embedding reflective practice and supervision into ways of working to support clinicians when making difficult decisions about ending treatment, and managing expectations from the beginning in a way that not only nurtures hope and trust, but also communicates clearly to the young person and family the nature of the support being offered and how it may help them. Current findings suggest the need to review how services can better manage treatment endings so that young people, families, and clinicians can feel more supported to navigate the treatment ending process.

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Introduction

Approximately half of the young people who access treatment from specialist child and adolescent mental health services (CAMHS) do not show measurable improvement in symptoms (Bear et al., 2020; Edbrooke-Childs et al., 2018; Smith & Jensen-Doss, 2017; Warren et al., 2010), and up to 50% of treatments result in dropout (de Haan et al., 2013). This presents a significant challenge for services and raises questions about how unsuccessful therapy should be managed (Wolpert, 2016). Despite this challenge, there remains a paucity of empirical research examining the process of ending treatment, particularly in circumstances where improvement has not been achieved. Understanding this process, as well as exploring the treatment expectations and experiences of young people, is crucial in informing efforts to improve youth engagement and satisfaction with therapy and in supporting clinicians to manage unsuccessful therapy.

Unmet expectations from therapy can result in poor youth engagement, dissatisfaction, dropout, and challenging treatment endings (Greenberg et al., 2006; Kazdin, 1996; Kazdin et al., 1997; Nock & Kazdin, 2001; O'Keeffe et al., 2019). It is, therefore, important that young people are well-informed about what to expect when attending mental health services. Outcome expectancy is defined as the extent to which individuals believe they will benefit from treatment (Constantino et al., 2011; Glass et al., 2001). Outcome expectations reflect patients' prognostic beliefs about the consequences of engaging in treatment and are distinct from other constructs such as treatment motivation and therapy preferences. These prognostic beliefs are based on an individual's prior knowledge, experience, and the experiences of significant others, such as friends and family. Expectations are a complex function of the patient and therapist's characteristics, combined with ongoing appraisals of the treatment's overall course, nature, and effectiveness (Constantino, 2012; Schulte, 2008). The adult literature indicates a positive association between expectations and clinical improvement, typically finding that more optimistic expectations are associated with better outcomes (Brown et al., 2014; Constantino et al., 2018; Glass et al., 2001; Greenberg et al., 2006). However, it is important to consider that the greater discrepancy between treatment outcome expectations and actual treatment outcome, the less effective treatment will be, the more likely the client will be to disengage from the process of therapy, and the less likely they will be to seek help in the future (Noble et al., 2001; Watsford & Rickwood, 2013; Westra et al., 2010; Wu et al., 2020).

From the perspectives of young people, research suggests that there is a degree of uncertainty and a lack of clear understanding about specialist CAMHS, the treatments they provide, and the outcomes that can be expected (Armstrong et al., 2019; Midgley et al., 2016; Watsford et al., 2013; Watsford & Rickwood, 2013). Young people may underestimate the active input required of them, expecting to take a more passive role in treatment, anticipating that providers will lay out a clear pathway to recovery for them to follow (Armstrong et al., 2019; Ronzoni & Dogra, 2012). Emerging research also highlights that young people have diverse views about the outcomes that are most important to them when receiving treatment (Krause, Edbrooke-Childs, et al., 2020). Although reducing core symptoms, such as low mood and anhedonia, is highly valued by most young people, other outcome priorities include improved coping and self-management skills, making sense of past and current experiences, and reduced interference of depression with daily functioning (Krause, Edbrooke-Childs, et al., 2020; Krause, Midgley, et al., 2020). It is important that young people's outcome priorities are integrated into shared-decision making processes about the type of change they would like to prioritize during treatment (Bear et al., *in press*; Krause, Edbrooke-Childs, et al., 2020; Watsford et al., 2013; Watsford & Rickwood, 2013). When it comes to the process of ending treatment, young people report this as a significant event in their life, evoking a range of emotions including feelings of sadness, separation, loss, and, for some, a sense of excitement with the prospect of moving on (Bury et al., 2007). Mental health clinicians have an important role in monitoring and managing treatment outcome expectations and in supporting the individual needs of young people during the process of ending treatment by ensuring they fully understand the expectations and outcome priorities of the young person from the outset of treatment.

From the perspective of therapists working with young people, there is a limited amount of research investigating the process of managing expectations or how to manage the treatment ending process. Research highlights that therapists' experiences of ending therapy can evoke long-term, powerful emotions, as well as self-questioning and protective anxiety, emphasizing that treatment endings can be challenging for therapists as well as for young people (Bamford & Akhurst, 2014; Ling & Stathopoulou, 2020). The literature relating to treatment endings within the mental health field primarily originates from the psychodynamic orientation, manifesting as theoretical, conceptual, and anecdotal

reports from the perspective of the psychotherapist. Endings within this context are conceptualized as “termination” and constitute the intentional final phase of psychotherapy when a client has achieved most of the goals of treatment or when psychotherapy must end for other reasons (Vasquez et al., 2008). Although the importance of termination, and the challenges associated with premature termination, have long been acknowledged within the psychodynamic domain, extant literature within routine specialist mental health care is sparse and very little empirical research exists exploring the challenges of ending unsuccessful therapy beyond anecdotal reports and clinical and theoretical accounts.

Despite statistics highlighting that for many young people treatment will not measurably reduce symptoms, there has been little consideration given to how this can be best managed in practice and what the next steps should be following unsuccessful treatment (Wolpert, 2016). This challenge has been recognized and tackled by the THIRVE Framework, where the mental health and wellbeing needs of children, young people, and families are categorized into five needs-based groupings (Wolpert et al., 2019). The fifth category of THIRVE acknowledges the needs of those young people currently unable to benefit from evidence-based treatment but who remains a significant concern and risk. Currently, there is little training or guidance to assist clinicians when supporting the young people in this group who have not improved with treatment. It is hoped that developing a research base on managing endings, including producing recommendations for practice, will inform and support communication between young people, families, and clinicians, and facilitate young people’s involvement in shared decision-making and choice regarding their own treatment. With enough information, young people, families, and clinicians can work together to weigh up their treatment options in accordance with their own preferences, beliefs, and outcome priorities (Bear et al., *in press*; Krause, Edbrooke-Childs, et al., 2020). To achieve this, a better understanding of youth and clinicians’ perspectives and experiences of mental health treatment when outcomes have not improved is needed.

The Current Study

To address gaps in existing research, this study aimed to better understand the process of ending treatment from the perspectives of young people and mental health clinicians, with a particular focus on outcome expectations and the impact of unmet expectations when outcomes have not improved. A

secondary aim was to develop a set of practice recommendations to support clinicians when ending therapy by integrating the findings of this study with existing relevant frameworks (e.g., Constantino et al., 2011; Wolpert et al., 2019). The research questions were: (i) What are young people’s treatment outcome expectations? (ii) Are treatment outcomes discussed with young people at the outset of treatment? (iii) How are treatment endings managed when outcomes have not improved? and (iv) What are features of good practice for managing treatment expectations and ending treatment, particularly when outcomes have not improved?

Methods

Design

This qualitative study consisted of semi-structured interviews with young people and roundtable sessions with mental health clinicians. Qualitative methods were chosen to provide an in-depth, contextualized understanding of both young people’s and clinicians’ experiences (Denzin & Lincoln, 2011).

Youth Interviews

Interviews were conducted between July and October 2018. One-to-one interviews were chosen to elicit in-depth experiences and insights from young people. The potentially sensitive nature of the content of the conversations meant that a group format was not appropriate.

Participants and Procedure: Youth Interviews

Young people with a history of anxiety or depression were recruited from community settings via opportunity sampling. Participants had to be UK residents, be aged between 14 and 24 years old, and self-report experiencing anxiety or depression either currently or in the past. Recruitment happened through a variety of channels, including social media (e.g., Twitter and Facebook), newsletters sent to youth and clinician networks, outreach to secondary schools, third sector organizations and mental health support groups, and advertisements placed on university and charity websites. Recruitment ceased when additional interviews no longer produced new themes or insights (Marshall, 1996).

Interviews were conducted with 26 young people, mean age = 20.3 years, 73% female. The demographic characteristics of the young people are presented in Table I. Most participants (85%) were

Table I. Participant characteristics.

Participant characteristics	Young people (<i>n</i> = 26)
Age (years), mean \pm SD	20.3 \pm 2.53
Gender	
Female, <i>n</i> (%)	19 (73.1)
Male, <i>n</i> (%)	7 (26.9)
Nationality	
British, <i>n</i> (%)	22 (84.6)
Other, <i>n</i> (%)	4 (15.4)
Ethnicity	
White British, <i>n</i> (%)	17 (65.4)
Other, <i>n</i> (%)	9 (34.6)
Currently in paid employment, <i>n</i> (%)	11 (42.3)
Currently in full-time education, <i>n</i> (%)	17 (65.4)
Highest level of education completed	
GCSE/O-Level/A-Level, <i>n</i> (%)	8 (30.8)
Higher National Certificate and Diploma, <i>n</i> (%)	6 (23.1)
Higher Education (i.e., Bachelor's, Master's, Doctoral degrees), <i>n</i> (%)	12 (46.1)
Currently experiencing anxiety and/ or depression, <i>n</i> (%)	22 (84.6)
Experienced anxiety and/ or depression in the past, <i>n</i> (%)	26 (100)
Long-term mental or physical health condition other than anxiety and/or depression, <i>n</i> (%)	13 (50)
Currently receiving help or treatment for anxiety and/ or depression, <i>n</i> (%)	18 (69.2)
Received help or treatment for anxiety and/or depression in the past, <i>n</i> (%)	23 (88.5)

experiencing anxiety and/or depression at the time of the interview and 100% had experienced anxiety and/or depression in the past. Twenty-three

Table II. Semi-structured interview topic guide.

	Key question and follow-up question(s)
Outcome expectancy	<p>We are interested in the percentage of children and young people with anxiety and/or depression who improve or recover after treatment.</p> <p>What percentage would you expect?</p> <p>What percentage would you expect if they had had no treatment at all?</p> <p>Were you given information about the likely outcomes of the treatment before you started treatment?</p> <p>Would you like to have been told this before you started treatment?</p> <p>At what stage do you think discussions about the limitations of treatment should take place?</p>
Treatment endings	<p>Can you tell me about an experience you have had where the help or support you were receiving for your mental health problems ended?</p> <p>How did this feel?</p> <p>Is there anything that could have improved this experience for you?</p>

participants had a history of both anxiety and depression, one person had experienced only depression and two people had experienced only anxiety. Only two participants had not received some form of treatment for their mental health difficulties. Of the 24 young people who had received treatment, 23 had experienced a treatment ending and 16 reported that the ending they experienced was challenging and that their problems had not been resolved.

First, young people were asked to complete a demographic questionnaire about their age, gender, history of service use and estimates of treatment outcomes. Interviews followed a semi-structured schedule (Table II), were conducted either in person or by telephone and lasted approximately 45 min. With prior consent, all but three interviews were audio recorded. In these cases, the researcher took verbatim notes. All participants were reimbursed for their time with a £10 Amazon voucher.

Clinician Roundtables

Seven roundtable discussions took place in six cities across England between October and December 2017.

Roundtables are a form of academic discussion, which focus on a specific topic of interest. Roundtables were chosen as the preferred qualitative method as it was hoped that a group dynamic would encourage discussion and facilitate exploration of cross-sector and cross-disciplinary experiences and stimulate the exchange of ideas. The format of roundtables is informal and allows for guided discussion rather than a didactic session (Maljanian et al., 2002). Previous work supports the notion that roundtables serve a useful purpose in promoting the exchange of knowledge and solving problems (Turcotte & Pasquero, 2001).

Participants and Procedure: Roundtables

The roundtable sessions were advertised online and through newsletters. From those who registered their interest, a purposive sample of 12 clinicians per session was chosen based on their discipline and experience working in varied child and adolescent mental health contexts.

A total of 52 participants (8 males and 44 females) participated in 7 roundtables, with between 7 and 10 participants per session. The professional roles, backgrounds and therapeutic orientations of the participants varied greatly, including but not limited to: child and adolescent psychotherapist(s), specialist nurse clinician(s), clinical psychologist(s), trainee

clinical psychologist(s), service manager(s), consultant child and adolescent psychiatrist(s), mental health nurse(s), mental health support worker(s), cognitive behavioral therapist(s), systemic psychotherapist(s), mental health clinician(s), social worker(s), and occupational therapist(s). Many participants had more than one role, across different clinical settings, and/or in research and in managerial positions.

Concept Maps (available in the supplementary materials) were shared with participants prior to the session by email and at the start of the session. Concept Maps were developed through preliminary Patient and Public Involvement (PPI) work, the details of which are available in the supplementary materials. The primary function of the Concept Maps was to facilitate conversation and thinking and to provide a basis on which to build the discussion. The discussion was primarily driven by the Concept Maps and structured around agenda items (see Table S1). All seven roundtables were audio recorded and lasted approximately 90 min.

Ethical Considerations

Ethical approval was granted by University College London (UCL) Research Ethics Committee on 4th July 2018 (9777/003) for the youth interviews and on 3rd July 2017 (9777/002) for the clinician roundtables. All research was performed in accordance with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Participants were verbally briefed about the aims of the research, the work conducted so far, and what participation would involve including its voluntary basis and their rights to anonymity, confidentiality, and to withdraw at any point. Care was taken by the researchers to conduct the interviews and the roundtables in a warm and reassuring manner to ensure the participants felt as comfortable and safe as possible. It was hoped this would help reduce any potential researcher-participant power imbalance. All participants provided informed consent.

Analytic Strategy

Interview and roundtable sessions were transcribed verbatim, and the transcripts were anonymized by assigning a unique pseudonym to each participant. Hereafter, participants are identified by their pseudonyms and without indication of their age to provide the highest possible level of confidentiality. Data were analyzed using NVivo11 (Bazeley & Jackson, 2013; Welsh, 2002).

The framework method was chosen as the most appropriate analytic approach for managing the

large dataset, allowing for comparing and contrasting data within and between clinician roundtables and youth interviews, as well as providing a holistic overview of the entire dataset (Parkinson et al., 2016; Ritchie & Spencer, 1994). A framework approach involves five distinct and interrelated stages: familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation.

An initial thematic framework was developed to structure the data, with categories informed by a priori areas of interest from the PPI scoping work and additional issues that arose during the initial data familiarization stage. Indexing was then carried out, where the initial framework systematically applied to each transcript. The coding framework was continually developed and adapted with the cumulative addition of new data from both elements of data collection, producing a superordinate framework informed by the data from all phases. Coding in the initial stages was primarily inductive in nature with limited a priori issues incorporated, whereas coding in the later stages was more deductive, with existing codes being applied to the data, while still allowing for unexpected or new concepts to become apparent and coded accordingly. Summarized data was charted onto a matrix based on this finalized framework. The coded data were then used in a final mapping and interpretation phase of “sense-making”. This involved exploring patterns in the data which were then described as concepts to develop a set of themes to capture participants’ experiences. The framework allowed for comparisons to be made within and across levels of the study phases, including between clinicians working within different cities or in different professional roles. Finally, core themes were developed in relation to how treatment expectations, poor treatment outcomes and treatment endings are currently being managed in practice, what the current challenges are and what the features of good practice are.

Results

Across the 26 interviews and 7 roundtable sessions, several themes were identified for each of the four research questions (see Table III). For themes where both the views of young people and clinicians are represented, the views of young people are presented first, followed by the views of clinicians.

What Are Young People’s Treatment Outcome Expectations?

The demographic questionnaire asked young people to estimate the percentage of children and young

Table III. Key themes identified in the data and their mapping across youth and clinician perspectives

	What makes ending unsuccessful therapy challenging?			How can unsuccessful therapy be managed?
	Youth perspectives	Shared perspectives	Clinician perspectives	
What are young people's treatment outcome expectations?	♣ Diverse expectations	♣ Diverse outcomes		♣ Supervision and reflective practice
Are treatment outcomes discussed with young people at the outset of treatment?	♣ Likely outcomes are not discussed	♣ Managing expectations versus fostering hope	♣ Expectation that services are treating to "cure"	♣ Flexible service models, multi-agency working and informal supports
How is treatment managed when outcomes do not improve?	♣ Taking two steps forward, then three steps back		♣ Strain on clinicians ♣ Complex clinical cases ♣ Pressure on the system ♣ Ongoing risk	♣ Preparation and transition ♣ Shared decision-making, honesty, and hope ♣ Self-management and coping

people with anxiety and/or depression they thought would be recovered or cured with treatment and without treatment. The frequency of responses to these two questions is presented in Table IV. These figures demonstrate that young people believe that recovery is unlikely without access to treatment but even with treatment, recovery is not always possible.

In terms of qualitative analysis of young people's expectations of treatment outcomes, a theme relating to the diversity of expectations was identified.

Diverse Expectations and Outcomes

From the interviews, young people had diverse beliefs and expectations about treatments and their effectiveness. Some were not confident about the outcome of treatment either now or in the future. Most young people spoke about how treatment outcomes depended on the person and are unique to the individual. Participants acknowledged the complexity of foreseeing how well a treatment would work and spoke about factors that may impact

effectiveness. Several young people acknowledged that treatments only work when the young person is engaged and ready:

A person must want to help themselves ... Half the time you've not got that willingness as you're not in that state of mind, so you're not bothered about it. Hard when you're feeling low. (Emma)

Clinicians also spoke about the importance of active participation by the young person. It was discussed that treatments will not work the way they are intended without active engagement and participation. Clinicians spoke about how their involvement and skill as a clinician can only help to a certain point, and beyond that, the young person must want to be helped.

I suppose a lot of our approach to supporting children and young people is around whose responsibility is it to recover and actually ... [Pause] they hold that responsibility. We are facilitating the journey; we are not in charge of it. If that makes sense? (Manager of Psychological Services (third sector))

Table IV. Recovery estimates made by young people in qualitative study.

Estimate	Question	
	Recovery with treatment (<i>n</i> = 24)	Recovery without treatment (<i>n</i> = 24)
0-25% recovered	2 (8.3)	16 (66.7)
25-50% recovered	13 (54.2)	8 (33.3)
50-75% recovered	7 (29.2)	0 (0)
75-100% recovered	2 (8.3)	0 (0)

Are Treatment Outcomes Discussed With Young People At the Outset of Treatment?

Managing Expectations Versus Fostering Hope

Young people reported that likely outcomes from treatment were not discussed at the outset or throughout treatment. There were mixed views regarding the degree of openness clinicians should display and to what extent they should manage expectations from the outset. Some spoke of the potential negative impact of full transparency, citing concerns of reduced hope. However, several young people felt that having a picture of likely outcomes

before treatment would manage their expectations and reduce self-blame and discouragement if the treatment did not work for them.

I think that would be helpful to know because you feel less guilty about it not working and feel less bad about yourself. (Annie)

Other young people spoke of a more complex and nuanced picture, in which personal preference should be at the center.

I think you need be realistic but at the same time it might diminish the hope as well. I think you need to find the balance. (Jamie)

Expectation That Services Are Treating To “Cure”

Clinicians agreed that it is hard to manage treatment expectations, while also fostering hope, in a context where treatments are often ineffective yet are viewed as being effective by the wider public. It was discussed that CAMHS is perceived by other agencies, such as schools, families and the wider public as being the only solution to youth mental health problems. Clinicians had the impression that they were expected to wave a magic wand to make things better and felt that the greatest burden of responsibility lay with them. There was also a sense that there were unrealistically high expectations about the impact of their input on outcomes and that this prevented other viable options being considered, such as informal support, self-management, and coping.

I struggle with that weight of expectations and sometimes that's parents' expectations- understandably and sometimes that's the expectation of the network of services. (CBT Therapist (third sector))

Society sees CAMHS as being wholly responsible for the mental ill-health of children and young people. (Child and Adolescent Psychotherapist and Service Manager (third sector))

A common thread throughout the clinician discussions was that they were working within a system where expectations of success are high, and treatments are expected to cure.

Other health services exist within a framework in which not everyone can be cured and yet I don't feel like our service exists within a framework that not everyone can be cured. So, I still think that we exist within a narrative that says that every child can attain this, and, you know, actually we all know that's not true. (Consultant Child and Adolescent Psychiatrist (CAMHS))

Several clinicians spoke about the notion of “more is better” being commonplace, and that this often supersedes the reality that “more” can cause harm. They discussed that remaining involved until therapy was successful was seen by the public as preferable to ending unsuccessful therapy. This represented a barrier to good practice and had the potential to cause unintentional harm across multiple domains, including creating co-dependency.

Those conversations aren't always held, and I think that's where unintentional harm can occur. You can sort of build anxiety and co-dependency, rather than sort of growth and creativity. (Child Psychiatrist and Researcher (NHS))

How Are Treatment Endings Managed When Outcomes Have Not Improved?

Of the 24 young people who had received treatment, 23 had experienced a treatment ending. Of those 23, 16 reported that the ending they experienced was challenging and premature and that their problems had not been adequately resolved. These treatment endings occurred for several reasons, including lack of improvement, endings that young people felt were premature and rushed because of clinician illness, maternity leave, or a clinician leaving their post, and time-limited treatment because a set number of treatment sessions had been completed. Of note, of the 16 participants who had experienced a challenging ending, none resulted from a mutually agreed decision that treatment should end because outcomes were not improving. These young people reported this as an extremely challenging time in their life: being unhappy about how the treatment ending was managed and feeling let down by services, especially in terms of how the process was communicated. Of the remaining seven young people who reported experiencing a more positive ending, four felt better and did not want or need additional help and three were transferred to receive different types of support (e.g., transitioned to adult services).

Taking Two Steps Forward, Then Three Steps Back

Young people described a host of difficult emotions that resulted from the challenging ending they experienced, including feeling abandoned, pain and sadness. This experience often resulted in a setback in terms of mental health improvements.

Leaving the service felt like a massive loss. (Olivia)

And after most of those my mental health has declined because I just think that it's sort of another person who has sort of run their course and finished with me. Two steps forward, three steps back. (Benjamin)

Clinicians also acknowledged the negative impacts of treatment endings on young people and raised issues of attachment and dependency. They recounted how negative impacts, arising across multiple outcome domains, could act as barriers to ending treatment when it would otherwise have been appropriate to do so. These included emotional effects, deteriorations in mental health, behavioral implications (e.g., disengagement and holding on) and feelings of loss.

Strain on Clinicians

Although it was widely acknowledged that ending was hard for young people, clinicians also reported that they found managing ending hard on a personal and professional level. Clinicians described experiencing immense levels of pressure and anxiety, which acted as a barrier to timely and appropriate ending.

When you are, you know, fighting to survive your working life because you're under so much pressure. You have not got time ... It's just easier to keep going. (Consultant Child and Adolescent Psychiatrist)

Complex Clinical Cases

Clinicians described how the more complex clinical cases were particularly hard to end, including where young people exhibited high levels of risk, attachment problems, or other vulnerabilities, such as family problems, chronic ill health, or learning disability. Clinicians spoke of the challenge of having to manage multiple, often conflicting, perspectives in relation to a young person's care. Some young people were described as having complex attachment relationships and services represented a strong attachment relationship in their life. Clinicians said that it was particularly hard to end with young people if they have poor or complex attachment relationships, without the support of adults around them.

I think, for me, the hardest people to end with the ones who are really vulnerable, really fragile, they're attachment relationships are really poor, they haven't – they're not coming with solid adults behind them coming into a service. (Clinical Psychologist (CAMHS))

Pressure on the System

A catalogue of wider organizational factors was cited by clinicians as compounding the pressure and challenges they faced. These factors were often described as barriers to effectively managing the ending. Clinicians described being faced with pervasive service-level resource constraints and financial pressures, both within CAMHS, and on a national level across health and social care services, exacerbated by increasing levels of need, long waiting lists and high caseloads. Such demands impeded the ease at which clinicians were able to end treatment with a young person, given the demanding and complex nature of such conversations.

Demand sometimes quashes the capacity to have even the time in the diary to have those conversations. (Clinical Psychologist and Director of Psychological Services (CAMHS))

It was widely acknowledged that by continuing with treatment other people on the long waiting lists were not being seen: long waiting lists added to pressures on the treatment ending. In addition to statutory service resource pressures, clinicians described the detrimental impact of funding cuts for non-statutory services and the reduction in other forms of more informal support. This was described as putting additional pressure on CAMHS and caused clinicians to hold on to cases, even if they were not improving, so that young people would not be left without any support at all or to avoid lengthy re-referral processes. Clinicians spoke of their feelings of frustration and concerns that improvements in a young person's mental health may worsen following discharge.

Due to cuts, there really is very little that people can access for support ... and if you feel like you are the only service then you end up thinking that it's not possible to end because there's nothing else for them. And I think that's got harder as resources in the community have shrunk. (Consultant Child and Adolescent Psychiatrist)

There were several discussions about families and the difficult journey they had been on, navigating through CAMHS. Families were described as having gone through an arduous process in getting their child help and treatment and as being fearful of losing support and going back to square one.

We have families who will cling on for dear life, because they are so anxious about, you know, "if you're not in our lives, what else we will have?". Because I think provisions everywhere have been

cut and they know that. They have been passed around before getting to us in the first place. So, I think that creates anxiety in our system as well, that, well if we close, who else have we got to go to? (Psychologist (CYP-IAPT))

Ongoing Risk

Clinicians also spoke about the way in which service models within CAMHS are set up in relation to managing risk. Discussions about risk were a key feature of all seven roundtable sessions. Clinicians spoke about how services were set-up using the recovery model of treatment and were ill-equipped to manage ongoing risk. They reported feeling high levels of pressure regarding holding and managing clinical risk, which in some instances acted as a barrier to discharging young people. They considered there to have been a cultural shift towards personal responsibility, liability, blame, and fear of reprimand in the management of risk. They also reflected that services were not set-up to meet the needs of young people who are too “unsafe” to discharge but who were not suitable for therapeutic work. Services were described as lacking a tier for risk support, meaning that clients were retained because of fears over risk, rather than because services were able to offer something therapeutic.

What are features of good practice in relation to managing treatment expectations and the process of ending treatment when outcomes have not improved?

Supervision and Reflective Practice

It was suggested in the roundtables that strong supervision and reflective practice were integral in mitigating against some of the challenges faced in practice. Both individual and team-based supervision were found to be helpful in dealing with the emotional aspect of ending in addition to assisting with re-formulation and planning. Related to supervision, service culture and robust management and leadership were also deemed important.

... it does seem to me that the reflective practice groups are absolutely essential. Clinical supervision, managerial supervision but also the value of the multi-disciplinary team. Which, if working correctly, challenges you in right places and helps you think in a different way. That's heavy on resources but I think is essential. (Mental Health Clinician (CAMHS))

The importance of clear and thoughtful formation, with a clear and defined treatment plan, was also discussed as being key to managing outcomes,

particularly for more complex cases. Having time to reflect and think about cases was seen as crucial, however, as discussed, time pressures were a barrier to this.

But every six months – if you still had somebody on your books you had to go to the whole team and explain what you were doing and why you wouldn't be discharging them. You had to make the argument. You had to formulate positively what you were doing, or it was the team you were answerable to. (Clinical Psychologist)

Flexible Service Models, Multi-agency Working and Informal Supports

In terms of service models, it was suggested that services would benefit from offering young people and families a “safety net”, including booster sessions, drop-ins, top-ups, phone line duty workers, which would allow young people to be discharged yet have the option of support if needed without being referred. It was also suggested that CAMHS could provide ongoing consultation and risk support to other services. There was some concern that “safety nets” would mean duty workers were inundated with calls; however, other clinicians said the services they worked at already offered this and it was not often used but reassured young people and families that help was there if needed.

That's why we created the drop-in service as well, so when we've finished a piece of work there's a few exit strategies that we'll offer our young people, so they're not just left high and dry as such. Come back, if you want to chat to somebody come back, do you want to do group work? Put your name down for group work you know, so quite often we'll say, “if you need another little top up with your counsellor, give us a ring!” You know? (CBT Therapist (third sector))

Recommendations were made in relation to utilizing existing networks, developing strong cross-agency working and learning, and ensuring high-quality communication across services. It was also suggested that knowing that there is somewhere to signpost people to when considering an ending, which is appropriate and that there is a likelihood of engagement with, is important. Information can then be shared through a well-timed telephone call, with a handover of information between services, while also keeping the young person up to date. It was acknowledged that although drawing on other more informal or non-specialist support services can be an extremely useful tool, there are limitations to this. As mentioned previously, third sector

organizations were considered to have been impacted by cuts to funding and resource pressures in the same way as CAMHS.

Preparation and Transition

Preparation was described key to a well-managed treatment ending. Central to this was ensuring that expectations are set from the beginning, including being upfront about the likely duration of the intervention and the ways in which it might be helpful. It was widely agreed among clinicians that conversations about endings should happen from the beginning and should be well prepared for over a period of transition, with some favoring a tapering approach. Participants suggested setting realistic expectations at an early stage of treatment is important, while also recognizing the importance of maintaining hope that things can get better. Periodic conversations about the ending throughout the duration of therapy, and regular reviews of expectations, was also suggested as best practice. Clinicians emphasized the value of communicating about realistic expectations with professionals in other services involved in supporting the young person and family. Transparency from the start about the possible duration and outcomes of the work can lay better foundations for appropriate collaboration and support from them as treatment ends.

Shared Decision-making, Honesty, and Hope

A collaborative approach, which encompasses communicating honestly about the likely outcomes of treatment while also providing hope to the young person, was considered to be a key feature of good clinical practice. Participants felt this should include developing a shared understanding around what is hoped for from the work. Both young people and clinicians reflected that balancing hope with honesty and transparency about outcomes is complex and there is no simple way of achieving this balance.

Self-management and Coping

As discussed, many clinicians worked in services with treatment models that aimed to “cure” and they felt that there was an expectation from other services and young people that anything other than this was a failure. Self-management and coping were discussed as an alternative to ongoing treatment and CAMHS as the only “expert solution”. Fostering independence, autonomy and responsibility were also deemed key attributes of the process. One clinician

spoke of framing the ending as providing a young person with the skills to go and lead their life.

Actually, it's not an end it's a beginning. So, we're giving them the tools to go out and work and without that they probably won't achieve their goals but what they then have out of it are some coping strategies to help them to go out and achieve their goals (Team Leader Early Intervention Well-Being Service (NHS))

Discussion

Summary of Findings

This study compared youth and clinician perspectives to better understand the challenges of ending therapy, particularly when outcomes had not improved. Most young people had received some form of treatment for their difficulties, however, of those, 16 reported that their problems were not resolved at the point of ending and that this experience was challenging. This often resulted in a setback in mental health improvements and evoked feelings of loss, abandonment, and pain, as well as dissatisfaction about how their treatment ending was managed. This discouraged many young people from wanting to engage in future treatment. It is possible that the negative treatment ending described by young people resulted, in part, from unmet or violated treatment outcome expectations (Watsford et al., 2013).

Expectancy disconfirmation is the discrepancy between clients' initial expectations of treatment compared with their actual experience of treatment (Duckro et al., 1979). Past research has shown that of those with initial positive expectations, 24.5% experienced negative disconfirmation, having more positive expectations than actual experience. Those young people who experienced negatively disconfirmed expectations had a poorer clinical outcome and attended fewer sessions (Watsford et al., 2013). Young people in the current study had diverse outcome expectations for their own treatment. Overall, there was consensus that recovery was not possible without treatment and even with treatment, recovery was not always possible. It is notable that approximately 54% of young people accurately estimated rates of recovery at 25–50% while 38% overestimated rates of recovery (Bear et al., 2020). It is important to note that pre-treatment outcome expectancy data was not available for the current sample. It is, therefore, not possible to determine with certainty whether the negative emotions experienced by participants in this study are due to expectancy violations or other factors.

In addition to the perspectives of young people, roundtable sessions with clinicians provided important insights and context to the wider healthcare system in which they practice. The process of ending when therapy had been unsuccessful was made challenging because of a range of factors, including the expectation that CAMHS should be able to “cure” all youth mental health problems; inflexible service structures; high levels of demand and need compounded by resource pressure on the system; complex clinical cases and concerns of ongoing clinical risk. These results are in line with research conducted to explore the process of ending psychotherapy with volunteer counsellors, where clinicians reported that having flexibility around organizational structures would enable endings to be less difficult and more manageable (Ling & Stathopoulou, 2020). Taken together, findings suggest a need to review how to effectively communicate to young people, their families, and the wider public that not everybody will get better by the end of treatment, and how services can better manage treatment endings so that young people, families, and clinicians can feel more supported during the treatment ending process.

Implications for Clinical Practice

The experiences of young people and clinicians provided a wealth of helpful examples and practical ways of working during the process of managing unsuccessful therapy. Five major themes are discussed:

- (1) **Supervision and reflective practice.** Clinicians reported that strong supervision and reflective practice were helpful in dealing with the emotional aspect of ending and when reformulating and planning cases when outcomes were not improving. It was suggested that a supportive environment could be achieved by embedding reflective practice and supervision into ways of working to support clinicians when making difficult decisions about ending treatment. This included creating a culture within services that are supportive of staff, rather than one which fosters blame and fear. Robust management and leadership were important in setting the example for this culture of working. Other suggestions included circulating an email listing dormant cases to clinicians, prompting staff to consider whether these cases should remain open in their next supervision. Finally, the importance of clear and thoughtful formulation that includes a young

person’s outcome priorities, along with a defined treatment plan, were described as crucial to managing expectations and ending, particularly for more complex cases.

- (2) **Flexible service models, multi-agency working, and informal supports.** It was suggested that services put in place ways of working that allow clinicians greater flexibility in responding to more challenging endings, for example, proving a “safety net” to young people including staggered sessions during the ending process; booster sessions; drop-in sessions post-discharge; drawing on other agencies; and providing ongoing consultation and risk support. The problem of ongoing risk has been addressed in the THRIVE Framework for child and adolescent mental health services (Wolpert et al., 2019). The THRIVE Framework conceptualizes need in five categories: Thriving, Getting Advice and Signposting, Getting Help, Getting More Help and Getting Risk Support. THRIVE proposes that young people and families should be offered risk support in collaboration with other agencies and explicitly not offered ongoing therapeutic interventions. Flexible adaptations to service models may allow clinicians to feel less anxious and fear about young people who have ongoing risk. THRIVE represents an existing framework that can be built upon to manage such cases in clinical practice.

- (3) **Preparation and transition.** Preparation was described as key to a well-managed treatment ending and it was widely agreed among clinicians that endings should happen from the beginning, with a period of transition before the formal ending. Setting realistic expectations early on about the possible outcomes of any given treatment was important in successfully engaging around the treatment ending. It has previously been recommended by others that best practice should involve refraining from promising an unrealistic degree or speed of change, yet being hopeful about prospective outcomes, and that clinicians should avoid threatening a patient’s belief system or sense of self (Constantino et al., 2011). These recommendations also include addressing expectations explicitly prior to commencing treatment, particularly regarding what to expect in terms of response patterns, providing patients with an approximate length of treatment up front,

and regularly checking on patients' outcome expectations and responding accordingly (Constantino et al., 2011, 2012). Clear information is required at the outset of treatment if informed choice is to be exercised and if young people are to be given the opportunity to participate in decision making regarding their own healthcare (Coyne & Gallagher, 2011). The results from the current study highlight the need to establish realistic and shared expectations and priorities about how much the treatment being offered will help and what outcomes matter most.

- (4) **Self-management and coping.** Clinicians recommended that preparation should include establishing effective self-management and coping strategies as alternatives to ongoing therapy. This suggestion supports previous research on youth outcome priorities, where, although young people valued reducing core symptoms, other outcome priorities included improved coping and self-management skills and reduced interference of depression with daily functioning (Krause, Edbrooke-Childs, et al., 2020).
- (5) **Shared decision-making; balancing honesty, and hope.** Both young people and clinicians spoke of the importance of managing expectations from the beginning in a way that not only nurtures hope and trust, but also communicates clearly to the young person and family the nature of the support being offered and how it may help them. A collaborative approach, which encompasses communicating honestly about the likely outcomes of treatment, while also providing hope to the young person was viewed by both groups as being a key feature of good clinical practice. In line with previous research, it is important that young people's outcome priorities are integrated into shared-decision making processes about the type of change they would like to prioritize during treatment (Bear et al., *in press*; Krause, Edbrooke-Childs, et al., 2020; Watsford et al., 2013; Watsford & Rickwood, 2013).

Limitations

The results of this study must be considered in light of methodological limitations. Foremost, both samples were recruited using self-selected,

opportunity sampling and are likely not representative of all young people and clinicians. The youth sample for this study comprised of mostly white females, approximately 50% of whom had completed higher education. As such, those who participated represent only a sub-sample of anxious and depressed youth, and the views expressed may not be representative of the views of all young people. This study used semi-structured interviews which provided a rich account of youth experiences of treatment, yet there may be bias in what was reported. The data gathered were based on what the participants were able to remember, willing to share, and aware of. It is possible that there may have been other aspects of their treatment that the young person was not aware of or had forgotten by the time they were interviewed. Most young people were experiencing anxiety and/or depression at the time of their interview and it is possible that this impacted what they were able to recall or felt able to share. As previously noted by others, results may be subject to further bias in that findings could be led by more articulate young people, while it is more difficult to hear the voices of those who are less articulate (Midgley et al., 2017). Most young people had experienced various forms of treatment at the time of the interview. Therefore, it was not possible to compare the pre- and post-treatment expectations of those interviewed.

In terms of clinicians, it is likely that those who participated were particularly engaged or interested in the challenges posed by treatment endings. While this research established young people's prognostic estimates of recovery based on treatment and no treatment conditions, this information was not available from the clinicians' perspectives. This data would be useful for the purposes of comparing the expectations of young people to that of clinicians and represents a study limitation.

Conclusion

Child and adolescent mental health clinicians are faced with an array of complex challenges when managing expectations and ending treatment with young people who are not improving. Understanding these challenges has been crucial in informing the recommended strategies to improve youth engagement and satisfaction with services and in enhancing treatment outcomes. Recommendations for practice include managing expectations from the outset; establishing a defined period of preparation and transition; being honest yet hopeful about outcomes and facilitating young people's involvement in shared decision-making and choice regarding their own

treatment. On a service level, a supportive environment in which reflective practice and supervision are embedded into the ways of working can help support clinicians when making difficult decisions about ending treatment. Finally, services should endeavor to put in place ways of working that allow clinicians flexibility in responding to more challenging endings.

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