

## **Transition and Termination: The art of leaving a clinical relationship with vulnerable clients**

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### *Abstract*

There is a beginning, middle, and end to all clinical relationships. Most of our work in the field of social work focuses on engaging clients in services, followed by helping them obtain stability. Too often, references to the inevitable end of the client/clinician relationship are absent during these phases of treatment. Yet, all clinical relationships have an end point. Some have clearly defined time limits, while others use assessment of clinical outcomes to determine when a client is ready for discharge. Even programs serving chronic populations such as the mentally ill, persons with developmental disabilities or persons with chronic medical conditions still experience staff turnover requiring termination issues to be broached with the client. Moreover, the perception of time among vulnerable, marginalized and under-served populations is often very different from the majority culture. Clients who are addicted to substances, for example, often have difficulty envisioning their lives beyond the next week, the next day, or even the next hour. Therefore, more frequent discussions of termination issues are warranted.

### *The Context*

Vulnerable clients have often experienced great incidences of abandonment in their lives. As a result, difficult to engage clients often have a low expectation of service providers and may view discussions involving transition and termination negatively. Acknowledging the inevitability of termination must be done with care. The subsequent benefits in building a clinical relationship, treatment planning, and boundary setting will clearly help when the time comes to say farewell.

Project Bridge is a Health Resources and Services Administration/Special Projects of National Significance funded program. Clients are all ex-offenders with HIV/AIDS. All have substance abuse and/or addiction issues and a significant number are dually diagnosed with mental health disorders. Enrollment is for 18 months of services upon discharged from prison.

### *Begin with the Very First Meeting*

The first contact with a potential client is loaded with possibilities. However, the clinician's agenda and the client's agenda may be very different. It is important for the clinician to maintain a client-centered approach regarding the definition of the problems faced by the client. At this stage the foremost question on the mind of most clients is; "*What can this person do for me?*" Therefore, focus in the initial conversation is on the client's immediate needs and ultimately the client's decision whether or not to enroll in the program.

Yet as a clinician, you must address more than the stated criteria that qualify a person for acceptance into a program. All programs have conditions under which services *will be offered*, conditions under which services *will be continued*, and conditions under which services *will not be continued*. Explanation of each of these conditions is essential in creating healthy boundaries. Moreover, doing so will begin to develop a clearly defined role for the clinician in the relationship. Role definition is the first step in developing a relationship with your client and will help you to address difficult topics in the future. In this manner, issues such as termination can be more readily approached.

Vulnerable clients require all the clarity you can muster, and then some. Project Bridge serves clients with multiple private troubles such as poly-substance abuse, major mental illness, and histories of incarceration and chronic medical problems. Indeed, many of the clients share all these traits. Frequently, persons with traumatic backgrounds turn to the self-medication of illegal or prescription drugs as an escape from their private troubles. Furthermore, substance abusers and clients with active addictions tend to have a different orientation to the world than those in the majority culture. The concept of time, especially with regard to treatment planning, can be frustrating for both client and clinician. Therefore, the clinical relationship with such clients functions most effectively when boundaries are clearly defined and reinforced. Understandably, any lack of clarity can be extremely troublesome in the formative stages of the relationship. Telling your client that your relationship with them will eventually end is imperative. Some clients will forget this conversation about transition and discharge, but it is essential to do it. As always, documentation in the chart is needed to insure that the discussion took place and for future reference.

In Project Bridge the forms and documents associated with the program are viewed as more than a bureaucratic function. Clients are asked to review and sign an “Agreement for Services” document which clearly spells out the array of services provided to them and the time frame under which they will be offered. Similarly, as part of a federally funded research project, clients are required review and sign an informed consent form approved by the Institutional Review Board. Reviewing the documentation required by a program gives a clinician yet another opportunity to discuss roles, boundaries, expectations, and time frame.

#### *Once the Honeymoon is Over*

After the initial one-to-three months of stabilization work clients and clinicians often enter a maintenance phase in the clinical relationship. As clinicians this is the time when the initial question asked by our clients, namely “*What can this person do for me?*” becomes either, “*Do I really need this person anymore?*” or conversely, “*How can I possibly get along without this person?*” Both questions imply significant considerations for how the relationship will be maintained. This is the point at which clients may exert their autonomy and get lost to follow up. Others may feel extremely dependent and visit your office daily. Clinicians need to consider whether the client has been consistently under involved in services or over involved in services. This determination effects the eventual design of the transition and termination phase.

In Project Bridge the clinician is responsible for convening a case conference with the client and all of her/his social service and medical providers every three months. The purpose of the case conference is to review and assess the previous treatment plan, discuss the progress made toward the client-centered goals and objectives, and develop the next treatment plan for the following three months. At this time the clinical social worker also mentions what point the client has reached in Project Bridge’s timeline (15 months to go, or 12, nine, six, or three months). This quarterly reminder is a countdown to termination from the program. Again, such a countdown must be done with reassurances that plans will be made to help support and continue the work that the client has been doing. However, it would be a disservice if clients were not prepared for the eventuality of departure. Sometimes, for the client who has stagnated or stalled in their treatment, this warning bell often serves to motivate them to use the remaining time

productively. It is not uncommon for clients who have been under-involved in the program early on to become increasingly involved as their time in Project Bridge elapses.

There are many precautions you can take to avoid undue stress on the part of the client as you discuss termination. Several clinical techniques are employed to move the client from the more dependent initial phase of treatment, through the maintenance phase, and on toward more self-reliant behaviors.

First, there are teaching and modeling behaviors. While it is important to “do for” the client in the initial stage of treatment, it is detrimental to continue actions that maintain the client’s dependence on staff. For example, when Project Bridge clients exit the prison system, the case manager has already done a great deal of work. This includes scheduling their first medical follow-up appointment, enrolling them on the state AIDS Drug Assistance Program, setting up the Community Free Service health coverage program at our hospital, and making various other referral appointments for services such as housing, substance abuse counseling, food stamps, and clothing assistance.

This initial work is an appropriate way to engage the client and provide a good start toward establishing the client’s stability in the community. Although “hand holding” clients is most often counterproductive, doing so through discharge from prison is an exception. Indeed, further actions must be geared toward fostering independence. Throughout this phase the clinician makes it clear that the tasks s/he is doing for the client will eventually be his/her responsibility. In effect the clinician uses the “do for” requests as an opportunity to engage clients in a discussion about barriers that have prevented them from completing such tasks in the past. Additionally, clinicians engage clients in discussions about their fears of performing certain tasks in the present. Reassurance that the clinician or outreach worker will be more than willing to support the client in a task is paramount.

Second, the beginning of problematic enabling behavior lies within minor examples of enabling behavior. Most adults in the majority culture can deal appropriately with significant persons entering and exiting their lives on a regular basis. Interpersonal relationships are a normal part of the world in which we live. However, persons who have been traumatized and severely marginalized have experienced interpersonal relationships that revolve around an excess of unhealthy issues.

When a person’s life involves drugs, crime, HIV, and mental illness, the person tends to form temporary personal alliances and relationships with others. The basis for these relationships is often defined by the needs that go hand in hand with such circumstances. For instance, drug use, criminal behaviors, and the dynamics involved in sexual and physical abuse breed behaviors such as untruthfulness, disorganization, deceit, denial, manipulation, exploitation, frustration and anger. Our clients exhibit these behaviors because they need coping mechanisms to survive their daily lives. Consequently, minimizing them in the realm of treatment planning and termination of services would be counterproductive.

Under-served clients have a set of preconceived expectations of behavior that clinicians should not perpetuate. For example, vulnerable clients often expect to replicate their prior experiences

with other service providers. Most often, they have had negative encounters with the social service system. Indeed, despite the underlying value of acceptance in the social service community, ex-offending drug addicts with HIV must still overcome this stigma when seeking services. It is the Project Bridge goal to break conventionally held preconceptions of ex-offenders and work toward developing new ones in the social service realm. Toward this end clients are allowed to witness advocacy efforts with other service providers who wish to exclude them because of their record. Doing this helps clients understand the advocate role. It also lets them know that someone believes that their needs are real, relevant and are worth fighting for.

Likewise, you must give clients direct feedback when they give justifications and excuses for why they have not followed through on an activity that they say they need and want. Constructively confronting client behavior, such as active drug abuse, and not being complicit in it is very important. It conveys an understanding of their situation, but makes clear that you are not willing to perpetuate it. Being open and welcoming to further discussion about destructive behaviors is paramount when engaging clients around such behavior. Termination and transition issues should be dealt with similarly...directly and honestly. If you are unclear, the client will most likely read all sorts of alternate possibilities into your meaning.

As clinicians it is necessary to create an atmosphere where a client's feelings regarding termination can be discussed and validated. Such feelings are neither right nor wrong. Still, the way in which such feelings are dealt with can foster progress or hinder it. Both the client and the clinician need a process in which to work these issues out. Clinicians provide the forum for Project Bridge clients, while the supervisors are called upon to help the clinicians. It is important for the professionals to address issues regarding termination as well.

#### *And Now the End is Near*

The final stages of treatment with a client can range from jubilation to heart wrenching. Nevertheless, if one has done the work during the initial and maintenance phases of treatment, the transition and termination discussion should not be a surprise. It should actually be expected as time in the program draws to a close. Often, some Project Bridge clients broach the subject before the clinicians bring it up. On the other hand, fear of abandonment in a client's actions can express an intention to leave the relationship before they are left.

During this phase, you should be encouraging greater independence on the part of your client. Rarely, your client will not need continued case management and follow up, so contacts should be fewer and less intense as the time for termination approaches. Likewise, if there is a transition being made to a new case manager, the client should increase contact with that program while decreasing it with yours. This is not to say that the professionals should not remain in very close contact. It is essential that they do so for a coordinated client transfer. In addition, the new case manager will benefit from your knowledge based upon long association with the client. The case manager should also feel supported by you as they embark on their work with your client.

Regression and relapse is especially strong during this phase of treatment. This potential, despite all the work to set up a smooth transition, is very common. Clients can still feel cast aside or abandoned when termination of services is an actuality. It is essential to continually elicit your client's reactions to the end of the clinical relationship in order to let them voice their fears. You

can then help calm these fears by reviewing the successful work done together over the course of the relationship. Like any process of loss, there needs to be a grieving process in order for all involved to put the experience in perspective and eventually move on.

Finally, with vulnerable populations it is a good idea to address the issue of future contact since it is likely that some form of contact will most likely occur. We are social workers by profession but we are human beings by definition. As such, it is necessary to move on to a newly defined relationship with our clients after their work with us is done. There is nothing wrong with a former client updating you on their progress *or* lack of progress. Yet, boundaries concerning the *former* professional relationship should continue to be clarified and reinforced. Any requests that would require you to act as clinician or advocate *must* be referred back to the new case management program or referred to a separate service. Good advice is always welcome, but maintaining your boundary as the *former clinician* with your *former client* is vital.

### *Conclusion*

As clinical social workers, our work centers on the people we work with every day. We must maintain a professional perspective with our clients in order to perform our jobs properly. It is somewhat ironic that in a helping profession such as ours, resisting over-involvement and caring too much about clients is the best way to really help them. With extremely vulnerable and marginalized populations, fostering dependence on you or your program may feel like help, but it is ultimately very destructive. Your clients need and deserve to learn how to exist in the world with adequate and proper supports, without the enabling behaviors that will replicate the destructive relationships of their past.

As you do your work, keep in mind the following items:

1. Address the inevitability of termination at intake and while setting up the initial treatment plan.
2. Remind the client at regular intervals that their time is limited (at case conferences or during regularly predetermined points in treatment).
3. Remember that the daily clinical relationship in which you engage can hinder or foster the termination and transition issues later. Boundary setting and clarity of role definition is essential.
4. As termination approaches, actively encourage independence as the client becomes empowered and as the new case management program begins to engage.
5. Elicit honest feedback from the client regarding termination, and review the history of the successful work done in the relationship.
6. Use supervision extensively around termination because not only do our clients have a hard time letting go...*so do we*.
7. Finally, you can maintain interest in the client's progress, but *only* within the context of a former professional relationship.