

Concern and Confidentiality: GPs' Responses to Young People in Distress and their Parents

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1. Introduction

1.1 Background to the research

This research developed out of an earlier study (Stanley and Manthorpe, 2001a) which explored the experiences and perceptions of parents whose children had taken their own lives. The parents identified GPs as key sources of support and information at times when they were seeking to understand and meet the needs of distressed or disturbed young people. However, parents also reported difficulties in communicating with their GPs about their children's problems and found that professional codes of confidentiality constituted a barrier to feeling informed about their sons' or daughters' needs and treatment. While some parents valued their GPs' support, others described their GPs as having little knowledge of relevant services for young people in distress.

Despite the shift of mental health services to the community and the proliferation of new initiatives which aim to be proactive and timely, there are few mental health services which can be directly accessed by the general public. The GP continues to be the gatekeeper to most specialist mental health services as well as providing assessment and intervention for the majority of those who seek help with mental health problems (Goldsmith and Huxley, 1992). In the field of mental health care, the GP has the advantage of offering a universal service that does not carry the stigma attached to specialist services and he or she is often perceived to be a known and trusted professional. However, it needs to be acknowledged that young people are likely to be less frequent users of primary care than their parents. GPs also have access to the history of a patient and his or her family, although the shift to large group practices means that patients rarely experience the continuity of care from one practitioner that might have been available previously from smaller practices.

By the age of 16, over half of young people attend GP appointments on their own (Macfarlane and McPherson, 1995). However, Jacobson (2002) noted that many young people do not experience primary care services as sensitive to their needs. While young people's rights to receive a confidential service from their

GP were established by the Gillick Ruling in 1986, young people themselves are often confused about whether they will receive to a confidential service and the Royal College of General Practitioners and Brook (2000) have produced a toolkit which emphasises this point and stresses that health professionals have a duty to maintain patients' confidentiality 'whatever their age or maturity' (p.10). General Medical Council guidelines (GMC, 2000) are clear that, even when there are risks of death or serious harm, or where a patient is considered incapable of giving consent to disclosure because of mental health problems, a GP should try and encourage the patient to agree to disclosure and inform the patient if disclosure takes place against their wishes.

The National Service Framework for Mental Health (Department of Health, 1999) has focussed attention on the key role of the GP in the delivery of mental health services and there have been some concerns expressed about GPs' capacity to perform this function (Department of Health, 2001; Neary, 2003). In particular, there have been suggestions that GPs require increased training and knowledge in the field of mental health (McCulloch, 2003) and the development of GPs with a Special Interest (Department of Health, 2000) may go some way towards meeting some of these concerns.

The National Suicide Prevention Strategy for England (Department of Health, 2002) has little to say about the role of GPs in suicide prevention. However, a number of studies have demonstrated that contact with the GP may increase prior to suicide and attempted suicide (Matthews et al, 1994 and Appleby, 1996) and such researchers have argued that GPs have a role to play in suicide prevention. Michel (2000) notes the difficulties GPs encounter in supporting suicidal patients who may not disclose their thoughts or intentions and in providing aftercare to patients who have attempted suicide but fail to keep appointments. He notes that continuity of care, availability at times of crisis, and a proactive approach to patients at risk of suicide are key aspects of suicide prevention in primary care.

1.2 Research Objectives

Our research study aimed to explore how GPs would manage the difficult task of responding

both to a distressed young person who might be at risk of suicide and their parents. We were interested to determine how GPs dealt with issues of confidentiality regarding a young person who, although an adult, was still dependent on his/her parents. A number of commentators emphasise the increasingly prolonged dependence of young people on their parents (e.g. Apter, 2001) and illustrate the economic and social consequences for families and individuals. In this study, we sought to examine how GP services respond to this extended transition to adulthood when a young person's status is further blurred by vulnerability.

We were also interested to discover how GPs approached the task of engaging with and assessing a young person whose mental health needs were potentially serious but not wholly evident or clear. GPs' awareness and access to relevant services for young people was another issue highlighted by the earlier study which warranted further exploration. A number of reports (Audit Commission, 1999; Mental Health Foundation, 1999) have identified shortfalls in mental health services for young people and there have also been concerns expressed about the availability and co-ordination of mental health services for students (Stanley and Manthorpe, 2002; Royal College of Psychiatrists, 2003). Such problems will impact on GPs' capacity to offer effective mental health care to young people. Young people remain a key target in suicide prevention, particularly young men (National Institute for Mental Health in England, 2003) and mental health promotion for this group is seen as an important role for colleges and universities by the National Suicide Prevention Strategy for England.

1.3 Research Methodology

A qualitative approach which allowed for in-depth exploration of decisions and dilemmas was adopted for this study. Thirty GPs were recruited to the study on behalf of the research team by academic GPs who combined research and clinical roles. This approach served to identify interviewees who were willing to give up time freely to participate in research interviews. However, it needs to be acknowledged that this was not a random sample of GPs but rather a group of motivated

and interested practitioners who were prepared to opt into the study. It is likely that our interviewees' readiness to participate was informed by an established interest in and sympathy with the study's focus on young people. The research findings may therefore constitute examples of informed or good practice with young people in primary care rather than representing the full spectrum of GPs' practice with this patient group.

GPs participated in prearranged telephone interviews with the project's researcher. Prior to the interview they were sent a copy of a scenario in two stages which they were told they would be invited to discuss during the interview. The scenario, which is reproduced in the appendix of this report, concerned Ben, a 20 year old student who had come home to live with his parents having taken a year out of university. Ben is described as under-weight, reclusive and uncommunicative with little emotion.

In the first stage of the scenario, the GP is visited by Ben's mother who communicates her concerns about her son. The GPs were asked a number of questions to elicit how they would respond to a situation where Ben's mother asked for help while reporting that Ben was unwilling to seek it for himself. The second stage of the scenario depicts Ben as attending a consultation with the GP and disclosing previous suicidal thoughts and treatment with anti-depressants while at university. The interviews focussed on how GPs would assess and treat Ben as well as exploring the issue of further contact with his parents.

The telephone interviews were recorded and transcribed and the transcripts were analysed thematically. The study was approved by the NHS Research Ethics Committee and all research participants have been anonymised in this report.

1.4 The GPs and their Experience

The three areas from which the 30 GPs were recruited to the study were selected in order to provide a range of contrasting settings. Ten interviews were completed in each of the three sites which included: a rural area, a metropolitan area and Greater London. The age and gender of the GPs participating in the study are shown in Table 1.

	Male	Female	Total
Under 40	4	8	12
40 and above	10	8	18
Total	14	16	30

The gender split among GPs in the sample reflects the increasing numbers of women in general practice in England and Wales and the age distribution is also similar to the national picture (Royal College of General Practitioners, 2000). Two of the GPs were of Asian origin, the rest of the group defined themselves as white European.

Three of the 30 respondents were still undertaking their GP training, the remainder had a range of experience which stretched from six to 29 years in general practice. The group as a whole had an average of just over ten years of experience as a GP. This was therefore in the main an experienced group of practitioners. In line with current trends, none of the GPs interviewed worked in a single-handed practice. The smallest GP practice had two full-time equivalent GPs, the largest consisted of eight. Only five of the 30 GPs worked in practices which employed less than four full-time equivalents. The majority of the group therefore had easy access to colleagues who would be able to offer support and advice and most of the group indicated that dilemmas of confidentiality, such as that presented in the scenario used in the research, would be discussed with their GP partners.

1.5 Relevant Experience of Young People at Risk

In order to ascertain how regularly they encountered young people at risk, GPs were asked whether they had experience of cases similar to that in the scenario they were given. Whilst a number felt that 'emotional issues' or 'mild depression' were fairly common among young adults, serious cases involving psychosis or high levels of concern were considered to be rarer. However, virtually all interviewees had dealt with one or more such cases:

Yes, it [severe mental illness] often presents around this age and so I think that we've all seen one or two in our careers. They give up University and then go completely ...

Two key issues emerged from the GPs' accounts of previous similar experiences. A number of GPs described the difficulty of working with a suicidal young person who did not disclose suicidal thoughts or level of distress. Such accounts are consistent with the examples provided by Michel (2000) and emphasise the powerlessness felt by professionals in these cases:

I have had patients who have come in and said, 'oh, these tablets were working really well, I'm much much better; I've started doing this, I've started doing that.' I'm a lot less worried and a few days later they've killed themselves. And there's absolutely nothing you can do about that, because you can't get the information out.

When considering previous experience of issues of confidentiality, GPs frequently made links to other areas of their work with young people. Their experience of providing sexual health advice and services to teenage girls was cited as particularly relevant to the issues of confidentiality raised by the scenario used in the study. Regular experience of this type of work, together with the thrust of the guidance provided by the Gillick Ruling, which allows young people to consult health services confidentially providing they are deemed 'competent' by whoever is treating them, had clearly allowed the GPs to develop considerable clarity and confidence regarding young people's rights to confidentiality:

We frequently have a lot of experience with the teenage health clinic and I have a lot of experience with young girls with unwanted pregnancies who go for terminations and will not allow us to tell their parents.

GPs also saw their experience of working with young people who were using illicit drugs as offering opportunities to rehearse issues of confidentiality in relation to young people and their parents:

It happens quite regularly with the substance misusers. Yes, because the family knows that something's going wrong. Parents come in to

say: 'I think he's using drugs'. It's very difficult because they can't get them to come in, or if they do come in, I certainly can't feed it back to parents and so on.

2. Engaging and Treating Young People

This section outlines the approaches to working with young people identified by GPs in response to the scenario they were asked to consider. In exploring their responses, we report the majority opinions and views, but we also highlight those areas where there was a range of views expressed. We consider first, the strategies for engaging with Ben, the young man featured in the scenario, and second, the GPs' role in treatment.

2.1 Engaging with the Young Person

The extent to which GPs would feel it appropriate to contact the student directly following a parent's request for their help varied. For some GPs, it was not seen as either their role or necessarily effective to make contact, of any sort, with a young person in such circumstances. One expressed the view that a GP should not insist on any contact, even though this might be difficult for worried parents to accept:

Ben at twenty is grown up, so we can't drag, we can't even at a younger age, we can't drag him in. I would just have to encourage Mrs Smith to try and get him to come in. I don't feel that there is anything. I can't go round or I can't phone Ben up and say 'You know, your mum thinks there's something wrong with you, will you come in and see me?' I think that would have to come from him. Which is very difficult sometimes.

Other GPs felt that it might be appropriate to get in touch with the young person, and reveal that his mother had been to the surgery to discuss her concerns. Four suggested writing to the student to ask him to see them or at least to say that he would be welcome to call. One GP suggested this course of action if Mrs Smith had been unable to encourage Ben to make an appointment on his own or with his mother:

(If) she said that she didn't think he'd do any of these things, I'd certainly offer to write to him, suggesting him to come in.

More directly, another group of GPs indicated that they might consider telephoning Ben:

I guess it is possible to try and ring him at home and say, you know, your parents have come to see me and they're very concerned about you and have asked me to talk to you and try a direct approach. Like I say, I have never actually been in a situation where I've had to try that, but I guess that would be the next stage and see what he says and ask him directly on a one-to-one.

Other GPs focussed on whether they should make a home visit. This was seen as possible, without Ben's agreement, if there were suggestions that he was actively presenting a risk to himself (suicide) or to others (violence or psychosis). If Ben agreed to such contact, through discussion with his parents, then some of the GPs would be likely to make a home visit:

If Ben wouldn't come to the surgery, but would accept a home visit, then I'd come and visit him at home if that's what he wanted, but I couldn't just turn up and say I'd come because his mother wanted me to.

A small minority of GPs said they would be willing to make a home visit without agreement from Ben:

I would be prepared to make a visit to him on a one-off, without his consent, you know.

However, others were conscious that such a visit might not work if Ben then refused to see them:

(It) doesn't always work in practice, because they may not open the door. They may not allow you in, you know, so visiting isn't you know, always successful.

Only one of the GPs was more directive and indicated that she/he would urge Ben's parents to 'bring him' to the surgery:

(I) would probably tell her to book him an appointment and bring him, to put him in the

car and bring him. To be a little bit pushy on it with him.

In describing their attempts to engage with Ben while respecting his wishes, a number of GPs reported that they might discuss Ben's situation with their colleagues at this stage. For example, one GP said that she/he would discuss the case with a mental health specialist:

I would want to talk with one of the Clinic's Psychiatrists, really, because it's most important, also it is most important to maintain the young person's trust and it's in the middle of the spectrum which is a bit murky.

Another would debate the situation with colleagues:

You have to be very careful, I think. Sometimes you do it to maintain a good relationship with the parents, or you have to do it because the person may be at risk. It's very difficult to know. I mean it's the sort of situation I would easily discuss with my colleagues, just to get some clarity.

Two main judgements appeared key in considering how proactive an approach to adopt at this early stage in their contact with a young person: the first was the GP's perception as to whether Ben was at risk or whether the problem required immediate attention. If, in their judgement, as a result of talking further to Mrs Smith or acquiring other information, high levels of risk were evident, setting in course powers for compulsory assessment and/or treatment under the Mental Health Act 1983 might be necessary. In such circumstances, Ben's agreement was not essential but was clearly very helpful in assessing the level of risk presented:

Basically, if what we are talking about is serious enough to be a significant risk of suicide, then really I would have to go round and visit.

A second consideration was the impact of precipitate or unwelcome attention from the GP on the long-term relationship with Ben. For example, one GP observed:

If (mother) was very concerned about his behaviour I might visit randomly, but I am extremely cautious of that. You can really set things up badly. Mother tells the Doctor and the Doctor comes round to see you. Mother says she's called the Doctor, immediately your relationship with the patient is doomed.

Some GPs considered that Ben might be prepared to talk with other people, rather than the doctor, and suggested voluntary organisations, or a nurse, as being less threatening for somebody who felt that there might be something wrong with them, but didn't want to admit it. Such ideas also extended to involving the local community mental health team.

Overall, the GPs' views on engagement with a young person like Ben covered a wide spectrum ranging from no contact to a position where the young person might receive a visit or be brought to the health centre without previous discussion. This hierarchy of intervention indicates the degree of discretion available to the GP and highlights the potential variation in practice.

2.2 The GP as Provider of Treatment

While many GPs conceived their role as encompassing assessment and treatment if possible, there were some variations in what they felt able to offer. Some considered that a specialist assessment would be required in order to access specialist services:

He may benefit from simple non-directive psychotherapy or a cognitive behavioural approach, or even a psycho-dynamic one. So you can't make decisions about that until you've done an assessment which is not something I would do. It would need to be done by a psychologist or psychiatrist.

For other GPs, referral to a counselling service was a frequently suggested course of action. These included general NHS services, young people's services or voluntary sector organisations. Most of those GPs who discussed these services were able to identify a specific service in their area and reported on previous use of it within their practice.

However a small group of GPs envisaged assuming a significant role in assessment and

treatment. For some this appeared to be a consequence of limited services on their area or very lengthy waiting lists. One GP spoke of his/her role in seeing a patient like Ben:

I'd try to see them myself frequently and make a relationship. I'd try to offer treatment, I'd try to find appropriate management. Somebody I saw a couple of years ago who I really had quite a lot of worry over, eventually I managed to get her some cognitive analytical therapy, which is not particularly easy to get in our area.

This type of involvement was difficult for GPs and some outlined the other pressures on their time:

Yes and it's a lot of hard work, it's very time consuming because there aren't good resources available ... so you don't have a 10 minute consultation. I think last time I actually saw the person at a particular time, I set aside a time, half an hour or something, on a fairly regular basis to try and give some support.

Other GPs, although not considering themselves to be appropriate providers of counselling indicated that they were able to provide a form of 'holding' care whilst their patient was waiting for an appointment:

It's a long time which is why I would plan that I would see him in the meantime really.

Of those who considered such an ongoing series of consultations, some felt that these would be relatively informal:

I would want to probably spend a number of sessions talking to Ben and trying to get to know him and reduce his resentment of me interfering.

Others, however, saw this as a form of treatment:

I might be keen to at least start some sort of therapeutic intervention myself, I mean we would be talking about four to six months.

It was clear therefore that in a context of limited resources, some GPs were prepared to devote a considerable amount of their own time and skills

to engaging with treating a young person like Ben. We turn now to consider GPs' comments on the nature of their relationship and communication with Ben's parents or family.

3. Engaging with Parents

This section discusses the main themes identified in the GPs' accounts of their work with parents. These were: **reassuring** parents, **sources of help** for parents, and the broad **messages** they might wish to deliver to parents'.

3.1 Reassuring Parents

In general, the GPs appeared to have considerable sympathy for the parents of someone in Ben's situation. Some drew on their personal lives to relate to the parents' needs:

I mean, I've a 20 year old son myself. I'd hate to be in this position. I'd want her to be reassured, but I am bound by the confidentiality, so I'd try to be as reassuring as I could without letting anything go.

GPs both wanted to reassure the parents (particularly the mother who featured in the scenario) that they were taking their concerns seriously and also to convey to parents that there was not necessarily any cause for alarm (unless levels of risk were high or the situation was deteriorating). For some GPs, this reassurance was perceived as offering parents a substitute for detailed information on their son. One suggested that a GP might say something to parents along the lines of:

I am very sorry, I appreciate your situation, that you are worried about him. You must be reassured that I will do everything that I can do, that he will allow me to do, to get him better, but I can't discuss what that is. I can't even tell you that he has been to see me.

Another GP thought that they might be able to provide rather more information:

You can reassure her that you did see him.... So you can be reassuring without actually divulging what went on in the consultation.

Some GPs felt it important to emphasise their availability to parents. They noted that they

would tell parents that they could come back if they felt things were becoming worse, or if they wanted to discuss things further. For example, one said they would tell Ben's mother:

You know if things are changing, the situation's getting worse and you're getting more concerned, then you need to come back and we'll review it.

In general, it was acknowledged that it could be difficult to acknowledge a parent's concerns while keeping Ben's confidence. One GP commented:

I don't want to lie to her (mother) but at the same time, her being a concerned parent, I don't want to leave her worrying and thinking nothing's happened.

Some GPs did acknowledge that the parents' concern might be difficult to handle and perhaps exaggerated:

Often in these situations you are caught between wondering whether you are dealing with an over-concerned, fussy mother or whether they are dealing with someone who is properly ill in some way, or who has a problem in some way and one needs to try to strike a balance between those.

3.2 Support for Parents

In the context of their general sympathy with Ben's parents, the GPs identified parents' possible need for help for themselves, what type of help this might be and its potential sources. As noted above, for some GPs, this meant keeping communication open with the family, so that the mother felt she could 'continue to come to discuss concerns with me'.

Others felt that it might be helpful for the parent(s) to see another person in the primary care practice; for example:

If the family, if the mother sort of became depressed or very anxious I would encourage them to see one of my colleagues.

Some GPs suggest that the student's parents might also benefit from the support provided by

their own networks, such as family members. One considered advising the parents to:

..... pull in other family members who might be prepared to talk or friends.

Others felt that local support networks could be of use to the family:

The incidents that I noted (similar case) I did, in fact, advise mum to seek advice from one of the voluntary agencies.

The study therefore identified a range of ways in which the GPs might make and develop contact with Ben and with his parents. Some were more willing to be proactive and to engage with Ben more forcefully, despite his signalled reluctance to receive help. Likewise, many GPs seemed prepared to provide support to Ben's parents. Some chose to take on these roles themselves, others were more inclined, or more willing, to draw on other resources.

3.3 Messages for Parents

The GPs participating in the study were asked what messages they had for parents who were experiencing problems similar to those described in the scenario. A number of GPs acknowledged the difficulties of trying to provide care and support for children moving into adulthood and wanted to share this recognition with parents:

Sometimes it really does feel that you leave the parents in it. You know, really leave them very bereft and unsupported, but that's one of the problems of this age group really.

One of the most common responses to this question was the suggestion that, in caring for children who had reached adulthood, parents needed to combine a sense of 'being there' for their child with the ability to 'let go' and recognise a young person's independence:

My advice is usually to sort of keep in there but sort of back off. If he has had the independence of being away - he has been away for two years - he is not going to be terribly happy about coming back and back into the maternal bosom sort of thing. And that would be my worry and I would advise her to just stick with him, but from a distance.

Also linked to this theme of acknowledging a young person's right to independence was the suggestion made by some GPs that it might be easier for a young person to talk to someone else close to him other than his parents:

Whether he would actually respond better to people who he doesn't regard as a parental role or his peers.

GPs also wanted to offer parents reassurance by stressing that people do recover from depression, or by emphasising that they were right to seek professional help:

I think that this is an entirely legitimate part of general practice and I think parents should be very strongly encouraged to come and talk about their concerns to their GP.

A small number of GPs also felt that parents should be encouraged to make use of services provided by the voluntary sector or referred to appropriate support groups or internet sites.

Some of the messages delivered by the GPs reiterated the messages of parents who had lost a child through suicide and whose views were reported in the authors' earlier study (Stanley and Manthorpe, 2001a). Since many of the GPs interviewed were themselves the parents of young adults, a few referred explicitly to their own experience of parenting in interview. It is therefore not surprising that some of their suggestions had much in common with those of other parents. An emphasis on the importance of keeping communication open with a young person was identified by the authors' previous study, here it emerged again:

I would try to keep their lines of communication open. Don't get cross with him because he's not talking to you about it. Because if your relationship with him breaks down, then he may not immediately around him have other people he can talk to.

Another theme explored in the earlier research was parents' limited capacity to recognise the signs and symptoms which can distinguish disturbance or abnormal behaviour from normal. GPs suggested that it might be valuable for parents to be able to recognise symptoms of

both mental health problems and substance abuse.. However, in common with the findings of the earlier study, they recognised that it was not always easy for parents or professionals to distinguish between normal and abnormal behaviour in young people:

Well I think that the first thing is what I say to all parents really. Is there a drugs issue here? It's number one - always think about that because drug use is now normal ... so we assume that when we see a twenty year old, we are seeing someone who is using something or has done relatively recently, even if it is just a small amount, we are not very interested in it.

4. Working with Parents and Young People

This section explores GPs' ideas on how they would address issues that involved both young people and their parents. As carers, parents would be involved in providing information to inform assessment of need or risk. Their own needs for information, as outlined in the scenario, also raised questions regarding professional codes of confidentiality and the GPs' views on this area of practice are also reported here.

4.1 Exploring Needs and Risks

The GPs identified what they considered to be significant factors in exploring the background to a young person's problems as typified by the scenario they were asked to comment on. They gave examples of the types of questions they might ask of a young person or, with permission, of those who might be able to provide background history and information, such as parents. The issues which GPs saw as relevant to explore were also factors which could be used to inform judgements about risk. The GPs reported a wide range of issues they might consider or seek information about: in research of this type it was not possible to place these in order of priority or degrees of seriousness. The range of factors identified appeared to derive from GPs' knowledge and experience about young people in general and the many difficulties or life changes that young people may encounter at times of change. What emerged was that many of the factors considered by the GPs could be seen as

'normal' for a young person and were not, inevitably, indicators of long-standing or serious problems.

One factor identified as important to address in assessment was that changes in behaviour in a young person could indicate that the person was taking illicit drugs. Some considered that such activity was not uncommon among young people in general, others saw it as a particular temptation of student life:

Then, you know, there's the drug side of things. Some children go off to University and get sucked into drugs and it gets out of hand.

Such concern about drug use was reflected in GPs' advice which, in some instances, aimed to alert parents about warning signs for drug use. These could include 'tell-tale signs' such as 'tremor, pin-point pupils or dilated pupils, agitation or restlessness'. GPs envisaged communicating to parents possible explanations for their child's unusual behaviour and also sought to elicit background information that might contribute to assessment. Such conversations also seemed to play a role in indicating to parents potential avenues of help.

Similar queries were also raised in respect of excessive drinking of alcohol. Like drugs, alcohol use was seen as relatively commonplace among young people and students but many of the GPs considered the possibility that a young person, as in the case of the scenario, could be drinking too much. For example, one GP asked:

What about alcohol? It may well be a depressive response to it.

Some of the GPs thought that parents might be able to recognise symptoms of alcohol abuse if these were drawn to their attention.

Other possible 'crises' or events that might have impacted negatively on a young person included the possibility of a relationship breakdown as indicated in the scenario. For example, one GP reflected:

The scenario is not desperately unusual in that people do have relationship break-ups and feel pretty unhappy afterwards for a

period of time, and so if you assess that he was, if you like normal, but, well, reacting to a normal situation in a normal way, this I think that would be perfectly feasible...

A couple of GPs wondered if the type of relationship was one where the young person might have special difficulty in voicing distress or seeking support. One felt that young men were sometimes less able to cope with a relationship breakdown, another speculated that speaking about the failure of a same sex relationship might be particularly difficult in some families. Issues of emergent sexual identity, however, were not otherwise raised by the GPs.

The GPs also indicated other potential ways in which parents' information would be helpful in determining the level of risk for the young person. Concerns about safety might be intensified if the GP learned that the young person had been harming himself. However, such harm could be relatively minor and did not inevitably mean that the GP would take action. Again, GPs indicated that if parents had not noticed self-harm they might be encouraged to look out for its signs.

A number of GPs were concerned that behavioural distress might signal the onset of serious mental health problems, such as schizophrenia. Such views however were less likely to be voiced to parents. GPs noted the vulnerability of young people to psychosis. One GP observed:

So because this is a young man he's absolutely the right age range for the psychotic episode of a schizophrenic illness and so you have to think is he saying things which do seem very odd indeed? Is he behaving very suspiciously towards particular individuals or categories of individuals? And is he doing things that would like be suggesting that he feels in any way persecuted and paranoid?

While the possibility of a first episode of a severe mental illness was voiced by several GPs, a small number also noted that they would want to know about or would consider any possible family history of mental ill health.

4.2 Confidentiality

The interviews revealed two main points about confidentiality. The first was that doctors were, on the whole, clear about their professional obligations and the justification for these. Second, they indicated understanding of the difficulties this position might lead to when parents sought information or felt particularly anxious or concerned. The interviews also provided some examples of how a GP might talk to parents in circumstances where a young person was in distress but still maintain confidentiality between doctor and patient.

The GPs were clear that a young person's right to confidentiality was important and had to be observed in all but extreme circumstances. There was agreement that such situations would occur when there was danger to other people or when the young person presented a danger to himself, for example, of suicide or self-harm. As noted earlier, GPs made frequent parallels with a young person's right to confidentiality in respect of contraception, a right enshrined in their views by the Gillick Ruling, which confirmed that doctor/patient confidentiality extended to children who were able to understand the issues involved. One GP commented about confidentiality:

It goes back to the Gillick ruling ... So if he was quite a mature fifteen year old and knew what was going on, then the confidentiality would be there. It would need to be.

Some of the GPs mentioned that they would talk to their colleagues if issues about confidentiality were troubling them or if they wanted to discuss their actions. Others also reported that legal advice from the Medical Defence Union was available and helpful:

So if we were not sure we would talk to our colleagues and we would also possibly on occasions talk to the Medical Defence Union, who are wise men who help us with medical legal insurance and things.

As with colleagues, such discussion could be helpful in thinking through the issues:

(The MDU) have a lot of guidance on what you should and shouldn't do. They think very laterally and they're very, very helpful really ... I would go to my colleagues as well.

The GPs' readiness to seek advice and consult their colleagues reflected their general acceptance that, while responsibilities to maintain confidentiality were very clear, at times these were difficult to manage if relatives, such as parents, were involved in the case of a young person,. One referred to a 'slight bending of the rules' in such circumstances another to the rules being 'slightly more blurred', for a young person, particularly if still a child (a fifteen year old, for example). While all were very clear that they were fully able to breach confidentiality in situations of high risk or danger (and many also referred to obligations to breach confidentiality in situations of possible child abuse), they noted that in practice this could be contentious and difficult. One GP noted that parents could feel particularly strongly about being 'entitled' to know what is happening in respect of their child:

... it's very thorny and you often end up on the wrong side of the parent because they perceive you as not helping them.

In order to manage this 'awkwardness' as one GP described his/her position, the GPs outlined how they might handle their relationships with a young person and the parents. A number indicated that they would explain the rules of confidentiality to parents and that, in the long term, this was often in everyone's best interests. GPs also envisaged explaining to parents that the rules of confidentiality benefited all concerned. As one GP illustrated in outlining a possible conversation with a young person's mother, the GP would not discuss *her* problems with him:

... you wouldn't be pleased if you were in difficulties, with your son, and that usually keeps them quiet.

Many of the GPs were keen to emphasise that they were not 'writing parents' concerns off' by maintaining confidentiality: some explained how they might be willing to enter into a general discussion with parents or that they would acknowledge parents' concerns directly:

I can say I am really sorry, I know that's difficult.

This GP outlined how a general conversation with a parent might unfold:

I can hear what she (mother) is saying and I can make notes on his record about what she said, so that if I do see him then I've got an aide memoire from what his mum's said, but then I can't say anything specific about him at all. I can just talk in general, for example, about depression, changes in life like going away to university, all those things, but nothing specific about (him). And certainly nothing from his past history that she may or may not know.

The GPs also spoke of the risks of breaching confidentiality in terms of 'sabotaging' any relationship with the young person. One explained:

The benefits of providing the confidential service are far greater than the problems that they cause, because it encourages young people to access you.

Some GPs also suggested that one way through difficulties over confidentiality would be to ask the young person to consider possible alternatives. These might include raising the matter of parental concern or seeking permission to talk to parents. One outlined what he/she might ask the young person:

You know, would you mind if I discussed (things) with your parents? If your mother phoned me, you know, do you want me to talk to her? And if he says no, I'm categorically not to discuss with her.

Acting as an intermediary in this way, some of the GPs felt able to maintain communication with parents and the young person. One explained how he or she would relay information, such as:

I would tell her that he had specifically said that he didn't want to be discussed with his parents. But that I would be very keen to pursue looking after him, to maintain some continuity of care.

Another outlined how confidentiality could in his/her experience be seen as very positively and that this might reassure parents:

If I did betray that confidence ... not only am I in trouble medical/legally but it will also damage the relationship. He is not likely to open up again. Because he will think 'I might say anything to the doctor and he is now going to tell my mum'.

Overall, GPs were clear about their duty of confidentiality and its limits. They identified a range of approaches for explaining to patients and families what the rules were and the benefits of these. Some were able to provide examples of ways in which they would encourage a young person to consider their parents' position, and some outlined how they might make use of parents' information and convey an understanding of parents' concerns to a young person. As a group, the GPs were able to describe a number of approaches which enabled them to use the professional code of confidentiality flexibly and ensure that it was understood by patients.

5. The Wider Service Context

Although GPs represent the front-line service for young people in distress, they are also the gateway to a range of other specialist services. While some of these, such as community mental health services, may require a referral from the GP, others may be more easily accessed but GPs still have a role to play in providing information about service and recommending it to patients. This section considers GPs' awareness and use of relevant services, what they reported about the availability of such services and their knowledge of university support services which might be considered as particularly relevant to the case of Ben, a university student.

5.1 GPs' Awareness and Use of Services

Although, as we have shown already, a number of the GPs interviewed were prepared to invest a substantial amount of their professional time and effort in supporting a young person who might be at risk, they also evinced some awareness of other services which might be appropriate for patients like Ben. The two types of service most likely to be identified as relevant were counselling services

and community mental health services. Just over a third of respondents considered that counselling would be helpful, and counselling services based in their own health centre were singled out by a couple of GPs:

Yes, we have a counsellor in our practice...

In a few cases, GPs identified a need for psychotherapy or cognitive therapy:

I mean counselling would be another option or some sort of cognitive or cog-analytical therapy or cognitive behavioural therapy.

Over half the group considered referring Ben's case to community mental health services or for a psychiatric assessment. Referral to a psychiatrist or to the community mental health team was associated with cases where levels of risk were known to be high:

If you think he's a serious suicide risk, you would offer a psychiatric referral.

Nearly a third of the group thought that groups or counselling services which were specifically targeted at young people would be useful for Ben. Some GPs mentioned a specific local service which they were familiar with:

I mentioned [Young People's Service] as well. I don't know whether that's a national scheme or just where I work, but it's basically for young adults aged 18 to 25 and deals with all sorts of mental health, drug, alcohol, all those types of issues as well. And they are usually quite good because you can refer them to [Young People's Service] and they can then find out what those needs are. And then, according to their needs, assess them and then arrange for appropriate treatment, counselling, whatever is needed.

Other GPs did not necessarily have access to such a service locally, but emphasised the value of having specialist skills in working with young people available:

Another possibility for management other than just sort of referral to a CPN (Community Psychiatric Nurse) or whatever, might be to refer him specifically to a

young person's centre and again it would depend on you know, what the local facilities were, but I know some areas do have a sort of counselling and general advice centres for under 25s. And quite often some of their workers are good at teasing out the different issues around this, because they deal with it all the time.

Nearly a third of GPs identified the contribution which various voluntary sector organisations might be able to make to Ben's care:

We use some voluntary sector [groups], we use MIND, we refer people to MIND or there is a sort of church based counselling service which patients have been to and found quite good.

The Samaritans were also identified as another relevant voluntary organisation which Ben might be encouraged to contact.

Some GPs proposed introducing the student to relevant sources of information such as leaflets or the internet. In recommending such sources they emphasised the need to recommend them in an informed manner:

We've got a leaflet that has things like the MIND helplines on them and all the different helplines, crisis support things that they can ring. I don't say to patients to look on the internet, I say 'look on the internet and these are the sites I would suggest'.

Finally, a small number of GPs suggested a number of non-medical, alternative types of intervention or help. These included homeopathy, social and sporting activities, and careers advice. In doing so, they seemed keen to normalise Ben's problems:

There are lots of different ways to approach life problems. Maybe he needs to get in touch with his local friends and have a social life, or to go to the gym, do a workout or, lots of different ways back to mental health or, if he's a really keen musician, probably playing the piano recently, and that would help him.

5.2 Availability of Services

When the availability of the services outlined above was raised, it became clear that, in many cases, the GPs' willingness to devote their own time and resources to seeing the young person was a means of filling the gap created by waiting lists for secondary services. A number of the GPs commented that, in a crisis, a fast response could be obtained from community mental health services:

I'd have got the community mental health team involved in him and they have rules which mean that if you say refer someone to them who is at high risk of suicide, they have to see them within – they have to contact them within four hours and have to have seen them within 24 hours.

However, GPs stressed that referral to a psychiatrist or community mental health team was the exception. Most mental health needs are managed within primary care (Goldberg and Huxley, 1992) as this GP noted:

Well, we don't often involve a psychiatrist until someone is pretty seriously ill.... If he is seriously suicidal, then we would refer him off as an emergency to the Community Mental Health Team, but if we decide that he was simply depressed, then the majority of people respond to seeing us, being given anti-depressants of one sort or another, and time.

Ben's problems, as presented to the GPs, did not constitute a crisis situation since the study aimed to explore practice in cases like the scenario, where the risk of suicide was present, but difficult to assess. Most of the GPs therefore focused on services offering medium or long-term treatment and support.

However, for the majority of GPs, long waiting lists to access counselling or therapeutic services left them with few options. Although one GP reported that their practice counsellor could see patients within a week, most GPs who considered referring the student to their practice counsellor detailed waiting lists ranging from four weeks to eight months:

We do have access here to a social worker, to a counsellor, although there is a waiting list to see them. A significant waiting list, like three months which is useless at times.

[the]practice counsellor tends to be well easier to access[there's] a huge wait....routine stuff's probably four or five months.

A couple of GPs noted that their practice counsellors might be reluctant to take on cases where there was a significant risk of suicide or where there were substance misuse problems:

General practice counsellors, I think, usually have strict criteria about that sort of thing. So there's a possibility that he might not be suitable for counselling, he might need more formal intervention, depending on what sort of suicide risks I thought there was.

Our counsellor will see anyone who is over the age of 16. She's got quite a lot of experience and it would be in the office for four to six sessions after an initial assessment. They tend not to get involved with alcohol and drugs as a feature.

Given the frequencies of suicidal thoughts (Hawton et al, 2002) and substance misuse in young people (Home Office, 2003), criteria such as those described above might exclude a significant number of young people from receiving a service.

Those GPs who lacked a practice counsellor were reliant on either NHS counsellors (working for a local mental health trust or another part of the primary care trust) or psychology services. Although initial assessment could be obtained comparatively quickly, long waiting lists for treatment were reported:

....once they've had an initial assessment, I think that they're put on a different waiting list where they've actually got to wait for counselling. But you know I wouldn't be too surprised if we're talking two, three, four months, you know, maybe even six to eight months.

Full psychotherapy, you know, three times a week stuff is about a year and a bit, and

ordinary counselling: anything from two to six months.

Psychology referral: they are seen probably within a few weeks for assessment, but months before they can start treatment.

The value of cognitive behavioural therapy was emphasised by two GPs, but both reported difficulties in accessing it locally:

...if he is depressed, what helps is cognitive behavioural therapy, but getting that here is virtually impossible.

In the GPs' experience, services targeted on young people were likely to be more readily available:

And the waiting time for that [the youth counselling service] isn't that long. They can literally walk in and have the assessment pretty soon in a couple of weeks and have some form of treatment of help pretty soon after that.

I would actually take the problem to a local paediatric counsellor who I think probably could respond quite quickly.... And she happens to be in the building at least once a week. So it's the sort of problem I would actually physically walk along to her and discuss and say can you really help me with this.

As noted above, GPs particularly valued services that were in close proximity to them and which offered them easy informal means of both discussing cases prior to referral and of receiving feedback on treatment and its outcomes:

...we have settings with our counsellor that, like in a practice meeting, where we can talk about people and sort of share things. Particularly if there were concerns about somebody who was suicidal or something like that, then you would be able to come to the meeting and talk about that. So we can support her as well and what she's doing....it's a much better situation than if you refer to the psychology services at the hospital where, you know, you get a summary letter at the end of their six or 12

weeks of CBT or whatever. Like about four weeks after they're finished....

In the next section, we examine the GPs' awareness of and level of contact with university support services.

5.3 The University Service World

As noted earlier, the GPs who volunteered to participate in our study were likely to have had an established interest or relevant experience in young people's mental health problems and therefore this group might be expected to be more aware than most GPs of the support services offered by universities. Several GPs considered that university counselling services might have a role to play in Ben's treatment. Such services were characterised as easier for patients to access than other forms of counselling:

.... since there's horrendous waiting times for NHS or voluntary counselling, then if they can get it through the university that's quite handy.

A few of those interviewed suggested that universities might be able to offer other relevant forms of support such as guidance from personal tutors or careers advice.

Earlier studies (Stanley and Manthorpe, 1999; Jacobson, 2002) have found communication and co-ordination between community health services and campus based student support services to be limited. Six of the GPs expressed a readiness to instigate contact with university health services in order to develop a fuller picture of the students' needs and history:

Sometimes I've actually contacted the university doctors with their permission to find out what's going on and what's happening....

One GP suggested contacting Ben's 'moral advisers' or personal tutors.

The other feature described as characteristic of cases involving university students was the lack of continuity and coordination between their care when at university and their care when back at their parental home. Students who were living away at university are no longer registered with their previous home or family GP and there are

likely to be difficulties in accessing records. A number of those who were prepared to engage in such communication with university health services noted that it could prove difficult and demanding in practice:

And quite long periods can go past where the patient's at University for two or three months and then back at home perhaps for two months over the summer holiday and they may need regular reviews during all of those periods which means that the care may have to be shared effectively between the home GP and the University health centre, and possibly a home mental health unit and maybe even referral to a mental health unit more local to the University. And that can certainly cause logistical problems and you know it becomes a bit protracted trying to involve lots of people....

Although a proportion of the GPs evinced an awareness of university support services and were prepared to engage with them, it was clear that the effort and time required to negotiate with university systems and staff in addition to contacting local services might well be a deterrent for some busy practitioners. However, one GP provided an example of good practice in communication, instigated by university support staff:

I had a chap who was about to finish at University and various people from University Counselling and possibly even the University Chaplain or both, wrote to me to say that they were concerned about him – a young man who had developed an obsessive compulsive disorder.

6. Conclusions

6.1 Good Practice

In discussing the findings of this research, it is important to acknowledge that the GPs who participated did not constitute a representative sample but rather opted in to the study. Their willingness to do so may be attributed to a commitment to research or to a particular interest in work with mental health problems and/or young people. The experiences and views elicited should be regarded as

representing the practice of an informed and motivated group of practitioners. In commenting on the scenario, our interviewees were removed from the many other pressures and demands which beset and distract GPs in their day-to-day practice. While they were asked to describe their usual approach to such a case, their accounts may have encompassed more of the ideal than is generally available to the busy GP in such cases.

In view of these limitations on the study, it may be wise to consider the practice and approaches identified as examples of good practice in this field rather than as representative practice. This needs to be born in mind when considering the following conclusions and we will draw attention to areas where it may be particularly relevant to recognise the possibility of lower standards of practice.

6.2 Suicide Prevention in General Practice

Community mental health services have increasingly acknowledged the need for a proactive approach in engaging with individuals in the early stages of their contact with services. Assertive outreach services (Department of Health, 2000) are the recent embodiment of this approach. This study found that the degree to which GPs were prepared to be proactive in their attempts to engage with a young person who might be at risk varied considerably. At one end of the spectrum, some GPs felt unable to take any action in response to the parent's anxieties; at the other extreme, a small number of GPs were prepared to visit Ben without warning or to arrange to have him brought to the health centre without prior discussion. In between these two points, the GPs identified a range of strategies which might prove valuable to practitioners who were similarly keen to make contact with a young person who might be at risk but also wanted to establish a respectful and trusting relationship which would provide a basis for further intervention.

We noted in the introduction to this report Michel's (2000) emphasis on actively seeking contact with an individual at risk, availability at times of crisis and continuity of care as key features of effective suicide prevention in general practice. We have identified the range of approaches displayed along the dimension of proactivity. In relation to availability in a crisis,

the study identified a readiness to reassure relatives by encouraging them to make contact at times of crisis and GPs were also aware of the procedures and criteria for calling on fast-response specialist mental health services in a crisis. Although some GPs were clearly prepared to provide counselling or listening services on an on-going basis themselves and so ensure continuity for a young person at risk, continuity of care was not otherwise identified and may be hard to offer in large group practices. Continuity of care may be particularly difficult to achieve for university students who change address frequently and oscillate between home and university-based services.

6.3 Confidentiality

The GPs interviewed were clear about their duty of confidentiality with regard to young people and clear about the boundaries of that duty. They viewed confidentiality as a right which all patients were equally entitled unless risks were judged to be high and severe. They also saw confidentiality as providing the foundation for a confidential therapeutic relationship in which individuals might be able to disclose suicidal thoughts and receive appropriate support. There was evidence that some practitioners were able to balance their duty of confidentiality with parents' needs for information and these GPs provided examples of how they might facilitate communication between a young person and his/her family without breaching confidentiality.

However, while the rationale and applications of the duty of confidentiality might be clear to GPs, they are not always so easily apparent and explicable to young people or their families. The toolkit on confidentiality produced by the Royal College of General Practitioners and Brook (2000) notes the need for health services to display information assuring young people of their right to a confidential service. For parents, the arguments for protecting the confidentiality of a young person about whom they are concerned need to be carefully elucidated and the GPs in our study again provided some examples of how this might be done.

Conflicts appear most likely to arise in situations when risks are judged to be high. In such situations, GPs are empowered to pass information on to other practitioners but not to

relatives or parents. Non-professional carers are currently not included within the 'need to know' community wherein confidentiality can be breached and various commentators (Harbour, 2001; Szmuckler and Holloway, 2001) have questioned this position. Of course, GPs and parents may differ in their assessments of risk so that what parents experience as a high-risk situation may not be judged as such by professionals. However, as GPs in our study acknowledged, it is parents who may be left to manage such situations with little external support. Unless parents are known to be abusive or unsupportive towards a young person at risk, there seems little justification for excluding them from the 'need to know circle' when risks are perceived to be high.

6.4 The Service Picture

While the accessibility and opportunities for feedback afforded by primary care counselling services made them attractive to GPs seeking to offer support to young people in distress, it was clear that these services were often overloaded and unable to offer a swift response. Other NHS counselling and therapeutic services were also regarded as difficult to access unless there were immediate risks to individuals' or others' safety. Those GPs who had directed young people to counselling or mental health services specifically directed at young people had found them useful and easier to access, but not all GPs had access to or were aware of such services locally.

Mental health or counselling services for young people may be provided by the voluntary sector or by youth services. Such organisations need to ensure that health centres and GPs are aware of their services, as the GPs in our study, although a relatively well informed and interested group, had limited knowledge of such services. The cut-off age for Child and Adolescent Mental Health Services (CAMHS) currently varies considerably across the country – such discrepancies look likely to be addressed by the forthcoming *National Service Framework for Children* which will fix the service's age range at 0-18 (Department of Health, 2003). Service structures need to acknowledge the extent to which young people's transition to adulthood may be prolonged by a range of social and economic factors.

University-based student support services were identified as offering young people the prospect of a rapid response that was sensitive to young people's needs. Only a proportion of the GPs interviewed suggested contacting such services and a number of those who had done so had found communication and liaison difficult. A number of commentators (Stanley and Manthorpe, 2001b; Royal College of Psychiatrists, 2003) have pointed to the need to strengthen communication between university and community mental health services; GPs serving university populations need to be included these networks. Universities are increasingly appointing mental health co-ordinators who are in an ideal position to inform local primary care services of university services and facilitate communication over high risk cases.

There was evidence that some GPs responded to service shortfalls by assuming an active therapeutic function themselves. Ability and capacity to take on such a role will vary enormously between individual practitioners and not all GPs will be able to take on such a role. While mental health specialists have emerged among GPs, the skills needed for working with older people with mental health problems vary considerably from those needed with younger people and there may be arguments for further specialisation. Some of the GPs in our study appeared to have developed their interest in young people's needs on the back of their own parenting experiences and personal experiences may provide a useful foundation for GP training and education in this area.

6.5 Identifying and Responding to Young People in Distress

Like the parents included in our earlier study (Stanley and Manthorpe, 2001a), the GPs conveyed some sense of difficulty in distinguishing between what was 'normal' behaviour in young people and what constituted indicators of high risk or mental health problems. This issue reflects the reality that many of the indicators of high risk, such as drug and alcohol use or relationship breakdown, are extremely common in young people, whilst the high risk outcomes which professionals seek to predict from those same indicators are relatively rare

(Hider, 1998). The confusion around distinguishing indicators of risk from 'normal' behaviour in young people is matched by uncertainty regarding the status of young people. A muddled status is particularly evident in relation to university students who have not yet entered the world of full-time employment and may still be financially dependent on their parents. Some of the GPs' messages for parents, particularly the suggestion that parents should simultaneously 'back off' yet stay involved, reflected the ambivalence which surrounds the status of young people. In responding to the scenario presented to them, some practitioners also seemed keen to retain the possibility that Ben's problems were not beyond the bounds of 'normal' developmental problems susceptible to non-medical interventions.

Practitioners often have an aversion to labelling young people as mentally ill since they fear that such labels may act as self-fulfilling prophecies (McGorry, 1995). However, the danger is that without such a label a young person may not be perceived as eligible to receive services. If inappropriate labels of high risk are to be avoided, preventive services directed at young people in distress need to be further developed. Such services need to have the capacity to engage with young people and monitor their behaviour over time to identify what is acceptable behaviour in a young person and what constitutes evidence of significant mental health needs requiring treatment. Hider's (1998) review of youth suicide prevention by primary healthcare professionals finds some evidence for the effectiveness of regular long-term contact with suicidal young people. Early Interventions in Psychosis services aimed at the 14 to 35 age group are currently developing in England and Wales and such services incorporate a commitment to referring for assessment on the basis of 'diagnostic uncertainty' (Spencer et al, 2001, p.136). These services aim to achieve a sustained engagement with service users and to make effective links with a range of services for young people (Department of Health, 2001). In the future, Early Interventions Services may be able to make a significant contribution to both preventive and support services for young people in distress. In some areas, such services have identified university students as a particular target group.

7. Recommendations

1. The GPs in this study provided some valuable examples of approaches that could be used both to engage a young person and to work with dilemmas of confidentiality which occur when working with young people and their parents. These examples could be used to develop information and training for GPs on working with young people and their families.
2. The exclusion of carers from 'need to know' communities when risks are judged to be high requires further consideration by professional organisations such as the BMA, the Royal College of Psychiatrists and carers' organisations as well as service user groups.
3. GPs' awareness of counselling and support services for young people in the voluntary and education sectors needs to be developed and maintained. Such organisations need to ensure that primary care services receive information identifying eligibility criteria and referral procedures in accessible formats.
4. University support services also need to ensure that local GPs working with the student population are aware of their services and are familiar with procedures for contacting university staff. Mental Health Co-ordinators in universities are ideally placed to undertake this liaison role.
5. The development of specialist GPs in the area of young people's mental health should be considered by primary care trusts.
6. CAMHS services need to clarify the age group which they are serving. Gaps in local mental health services for young people can then be identified.
7. Early Interventions in Psychosis services need to maintain their broad approach to assessing and treating mental health needs in order to be able to undertake preventive work with a range of young people. Young people who are actively suicidal should not be excluded from their services.
8. Mental health services focused on young people need to be further developed. Young people are likely to find services which are exclusive to their age group more accessible and sensitive to their needs.

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Appendix 1

Vignette presented to GPs participating in the study

Stage 1

Mrs Smith attends surgery to talk to you about her son, Ben. You know the family fairly well as they have been registered with your practice for many years. Ben is 20 and has been at university for the last two years. However, Mrs Smith tells you that he has decided to take a year out from his studies as he feels that Engineering is not right for him. He has been back at home for a month now and he is concerned about him as he is underweight, spends a lot of time in this room and rarely talks to his parents. He does not seem to have made any plans for the coming year. She and her husband are currently supporting him and she is concerned that he does not seem interested in any of the suggestions for work or voluntary activities that they have suggested.

Stage 2

Ben is persuaded by his parents to make an appointment with you. He is initially reluctant to talk but, when encouraged, reveals that he has been feeling very low at university following the break-up of a relationship. He has been seen by the GP at the university health centre and was prescribed anti-depressants which, he says, didn't help, although he took them for four months. He also reveals that he feels very uncertain about the future and, on one occasion at university, seriously considered ending his life. He assures you that this was only after a heavy drinking bout and that he no longer feels like this. He says that he is sleeping normally and eating properly now that he is back home. Despite these assurances, you would like to try a different anti-depressant. Ben is less enthusiastic but agrees to go away and think about it.

The next day you receive a telephone call from Mrs Smith who says that Ben won't tell her anything about his appointment with you and she needs to know that Ben is going to get some help.