PRACTICE OBSERVED

Innovations in London

London Youth Advisory Centre

FAITH SPICER

The London Youth Advisory Centre is an independent "open door" service for young people that offers information and counselling and provides contraception. It was established to try to help them to cope with adolescent confusion in a society that has become increasingly complex and bewildering.

In the 1950s child guidance clinics catered for adolescents, but they were not very much used by this age group. School medical officers, teachers, and psychologists dealt mostly with health and study problems and youth clubs with activities. Young people did not find it easy to turn to family doctors, believing perhaps that their confidences would be betrayed to parents. The behaviour patterns of young people changed rapidly: sexual activity before marriage was widespread, yet the Family Planning Association was not able to provide contraception for them. Young people were experimenting with drugs and with alternative ways of living—by "dropping out" of society, for instance. The rise in venereal disease, unwanted pregnancies, breakdowns, suicides, drug abuse, anorexia, accidents on the road, delinquency, and the increase in the breakdown of families made it clear that something should be done to help young people at this critical time to prevent catastrophes. At the same time doctors, health workers, and teachers were becoming interested in the psychodynamics of human behaviour. Some received further training, which included child guidance clinics for health personnel, training in psychosexual medicine for family planning doctors, and courses for general practitioners.

In the early 1960s various groups started up to help young people, some begun by the young people themselves—Release and BIT Information Service, for example—and the Soho and Blenheim projects were set up to help those who were drifting helplessly. Youth leaders also set up experimental projects in coffee bars to contact alienated young people who did not use the conventional clubs. The Brook Advisory Centre was one of the first organisations set up specifically to help young people. It offered a much needed contraceptive service for young unmarried girls. At least 30% of the clientele did not come to the Brook for contraception but for other problems and even among those who did, a high proportion needed considerable support and counselling.

As a result of my experience as medical director of the Brook Advisory Centre, I decided to establish a unit that would provide contraception, counselling, and an information service. I had been asked by Westminster Health Department to do something of the kind for them, and with funds from a charitable source the London Youth Advisory Centre was established, running side by side with the Westminster service, which eventually obtained separate premises and is now supervised by social services in Westminster. I obtained charitable status for the London Youth Advisory Centre by joining, as a trustee, the Community Development Trust, the members acting as advisors to LYAC. LYAC is seeking independent status as a charity and has its own management committee. It is funded partly by charitable gifts and partly by the Camden and Westminster Area Health Authorities and Camden Borough. It has received financial support from the Inner London Education Authority, social services, and from the Department of Health for special investigations and experimental work.

Its work

Much time is spent forging links with other professionals in the area, and over the years good liaison has been achieved with schools, family practitioners, hospitals, social workers, and other organisations in the community. All the doctors and counsellors at LYAC, except for the administrative secretary, are part-time. They have all had training and experience in dealing with the problems of adolescence. On the whole, the doctors deal with the contraceptive requests, with pregnancy, and with psychosexual disorders, though each has a small case-load of young people with other difficulties. The counsellors see cases that are not quasimedical. Staff meet weekly for case discussions with a consultant psychotherapist.

The main work at LYAC is counselling young people, who may come without referral from other agencies if they wish. Most come on the advice of friends, and more and more through the recommendation of local doctors, teachers, education welfare officers, health visitors, social workers, and other organisations in the community; some come as a result of contact with radio or magazine "help lines." Young people and adults can also telephone or call in about law, housing, education, employment, etc.

Last year over 500 people saw a doctor or counsellor, making about 2000 visits. Most of them were between the ages of 16 and 21, though those under 16 were well represented and parents consult the staff more and more. More girls attended than boys, which is understandable in view of the contraceptive and pregnancy service offered here, but when these cases were excluded we found that the young men who came were slightly older and had more deeply entrenched problems.

There is a wide range of symptoms, including quasiphysical and gynaecological, sexual, drugs, anorexia, depression, anxiety, loneliness, and difficulties with study, with relationships, and with parents. Understandably, few young people present with behaviour problems, though parents often seek advice for this reason. We do not take on long-term psychotherapy, though each worker may have a few cases who come once a week for some months. It is impossible to work with people who need more support than can be given in sessions once a week, and no prescribing is done, except for contraceptives, so that liaison with general practitioners is often essential.

Once a week a social worker from the hospital drug clinic visits the centre to work with young clients who are not yet addicted to opiate drugs. A school nurse holds meetings fortnightly for parents who are anxious about their children. Two support groups are held, which are attended by health visitors who work in the area. Members of staff visit schools, and talk to students and offer support to teachers. Much advisory work is thus undertaken in the community.

It is difficult to assess the value of LYAC. If we can prevent unwanted pregnancy or repeated pregnancies, prevent admission to hospitals due to overdose and adolescent breakdown, hold families intact, assist a depressed young person to return to work or to study, then LYAC can count as being of use. Certainly to judge by the response of general practitioners, school doctors, hospital physicians, psychiatrists, and other professionals—and of the young people themselves—the service is fulfilling a useful role. The centre is informal and comfortable and provides information leaflets. It is independent and therefore the staff have no statutory function, as do social service social workers. The staff are highly trained, have the time to listen, and preserve confidentiality with their clients. They also work as consultants to other workers.

"Open door" counselling centres for adolescents have proliferated throughout Britain and Europe. The LYAC is perhaps unique in offering the combined skills of doctors and counsellors. Young people do use a service such as LYAC provides and therefore can negotiate more skilfully the difficulties of adolescence in this complex society.

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Safer Prescribing

Four traps for the prescribing doctor

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Most experienced doctors develop their own favourite drugs for common problems. But rare problems also require prescriptions occasionally and sometimes raise safety issues not yet considered in these articles.

Controlled drugs

You may not write many prescriptions for controlled drugs, for example, but when you do safety should be an important factor. Which of these drugs, for instance, is a controlled drug?

lidoflazine (Clinium)	diflunisal (Dolobid)
dipipanone (Diconal)	levorphanol (Dromoran)
diritramide (Dipodolor)	phenazocine (Narphen)
pextropropoxyphene (Distalgesic)	dextromoramide (Palfium)
	mefenamic acid (Ponstan)

And what are the rules for writing prescriptions for controlled drugs? For those who do not know or who have forgotten, they were covered recently in an article by Dr Stuart Carne.[1]

Adverse reactions

The opportunities for unsafe prescribing lurk round every corner. Not all the hazards of prescribing result from negligence or ignorance. Every new drug or combination introduces the possibility that a few patients may have an adverse reaction. And this reaction may present as just another of those symptoms or signs that are so frequent in a Monday morning's surgery. Conjunctivitis and rashes, for example, are not particularly rare, and it was only when they occurred at a higher rate than normal in patients on practolol that a major problem was identified with the drug. It took four years for this connection to be made, and once it was adverse reaction reports flooded in, confirming the genuineness of the effect. Yellow cards, however, often gather dust in doctors' desks. About 700 a month are received from general practitioners by the Committee on Safety of Medicines—a tiny proportion of reactions that must occur.

If you filled in a yellow card every time a patient on drug X presented with symptom Y the Committee on Safety of Medicines might be inundated. But if you wait until the manifestation is evident and obviously linked to a drug many people might well suffer unnecessarily. What is needed is constant suspicion; that is, in any case, a useful asset for a general practitioner. Somewhere during the history-taking there is probably time for a quick glance at the record card—almost as a reflex—to see whether the sign or symptom *might* be linked to a drug, particularly a new one.

Repeat prescribing

About 45% of the drugs prescribed in Britain are issued without direct contact between doctor and patient. It has been calculated that the repeat prescriptions signed each day in a four-man practice would provide enough work for a fifth partner if all patients were to be seen by a doctor before receiving repeat medication.

There seem to be two opposing views of the importance of repeat prescriptions. One general practitioner might say: "I used to get patients wanting to see me, and all they wanted was a repeat prescription and the occasional 'by the way, doctor.' Now I've sorted out a system that gives them their prescriptions without them having to see me at all."[2] Another might say: "I see the repeat prescription as a diagnosis in its own right, and I ask whether the patient's need for this minimal but regular contact with the practice is actually an expression of some underlying problem in our relationship which needs further analysis. Because of that I keep a close eye on my own repeat prescriptions and occasionally see what happens when I try to disturb the relationship."[3]

However you analyse the elements of a repeat prescription you must remember that safety is always an important consideration. Giving any drug long-term may become unsafe if circumstances change. The patient's condition could become better or worse. The patient's circumstances could change—he or she may start driving or drinking or taking other drugs. The rate of consumption may change and go unnoticed. For all these reasons some form of regular monitoring of patients on repeat prescriptions is necessary.

One way of doing this is by using repeat prescription cards. A criticism that is often made of repeat prescription cards to be carried by the patient is that they perpetuate unbridled prescribing without the patient seeing the doctor. Many practices have such cards, often designed by and for the practice.[4] The card that I use in my practice is shown. Their advantages include rapid identification for hospitals and other doctors of the exact treatment a patient is receiving: they provide all the information a secretary or receptionist needs to prepare the prescription; such prescriptions are usually more legible to the pharmacist: and patients can obtain repeat prescriptions without waiting or by post.

There is another type of medical record that is useful for monitoring repeat prescribing—the drug sheet, a card that stays with the patient's other medical records. Because this is not carried around by the patient some doctors consider it to be safer than the first type: it cannot be lost and abused by someone else, and it creates a need for the patient to see the doctor more often.

Potential errors in repeat prescriptions

Four repeat prescriptions that you might be asked to sign are shown. We suggest that you look at them and consider any questions that come into your mind before reading on.

Considering Samantha Grunter: Has she been adequately followed up? Could her nausea be an adverse reaction? For Muriel Pougher: Could her asthma have started due to aspirin? While with Gilbert Rock: What about the absorption of tetracyclines? And for Ernest Preston: Is a potassium supplement necessary?

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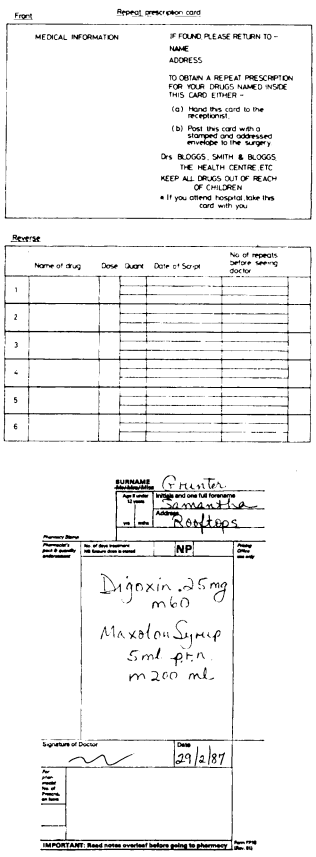

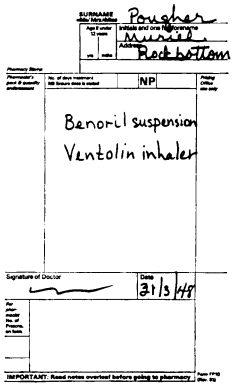

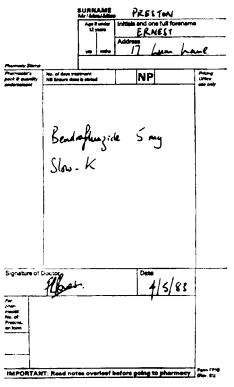

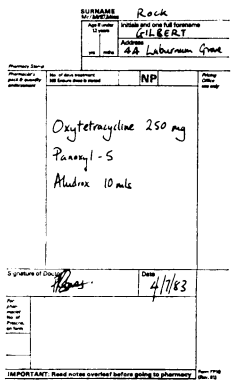

Non-pharmacological prescribing

Most of these articles have been about prescribing with some pharmacological justification—that is, you prescribe something because you believe that the patient will feel better if he takes what you prescribe in the way you suggest because of the chemical effects of the substance. It is worth considering, however, whether there are occasions when drugs—active pharmacological substances—should be prescribed with no pharmacological justification at all. We must remember that: "Most active preparations are capable of causing death, however rarely."[5] Yet one general practitioner[6] has identified four types of occasion on which he prescribes without pharmacological justification: (*i*) As a way of maintaining a relationship; (*ii*) as a gift—a symbol of a wish to do something when you cannot think of anything better; (*iii*) to fulfil socially motivated patient demands, such as weight reduction; (*iv*) as a way of getting rid of a patient.

Do you think that such attempts to justify non-pharmacological prescribing are valid? Do they apply in your practice?

This is the last of four articles on prescribing.

References

1 Carne S. Prescription medicines. *Br Med J* 1981;**282**:1517-20.
2 Jolles KE. *Update* 1973;**8**:277-83.
3 Marinker M. *Patient centred medicine*. Hopkins P, ed. London: The Balint Society and Regional Doctor Publications, 1972.
4 Drury VWM. Repeat prescribing. *J R Coll Gen Pract* 1982;**32**:42-5.
5 Taylor RJ. Toward better prescribing. *J R Coll Gen Pract* 1978;**28**:263-70.
6 Harris CM. Personal view. *Br Med J* 1980;**281**:57.

This article is based on an audiovisual presentation made for vocational trainees in general practice by the MSD Foundation. Further information about the tape-slide programmes on which this series is based is available from the MSD Foundation, Tavistock House, Tavistock Square, London WC1H 9LG.