Letters

Random drug testing in schools

Once upon a time in an address to the South East Region, which includes Kent, Al Aynsley-Green (now the Children's Commissioner) warned against persistent attempts by the popular media to 'demonise' teenagers. The *BJGP* has performed a useful service in summarising our limited understanding of the long-term consequences of screening school children randomly for traces of illicit drugs.[1] The economic and workforce costs are high and there is no evidence of health gain. I was consulted (*pro bono*) about some aspects of the unilateral initiative in Kent. That felt to me much more relevant to symbolism about discipline and public relations (especially for the private sector participants) than related to the health of young people. This high-profile exercise took place at a time when many in the NHS were coming together, unsung, in a major effort to improve the care of young people at risk of harm from substance use (including alcohol) and to develop better treatment and rehabilitation services for dependent users.[2]

At the time when the tabloid papers were enthused, my main concern was the lack of public health perspective about this drug screening. We have failed to provide the target of 'one school nurse per secondary school', we have failed to recruit enough doctors 'with a special interest' in child protection, and in the poorest neighbourhoods we have failed to stem the spread of TB among young people. Rolling out indiscriminate drug screening of high cost and no benefit seemed like a white elephant that could trample more needed work in school health. However, on reflection it became clear that the worst outcome of screening might be a major increase in school exclusions and truancy (both associated with harmful substance use and other health hazards). Such young people are likely to get no primary health care at all (as our 'Right Fit' project with

Barnardo's demonstrated). The context of substance use is critical. For example, there was no insight in the screening exercise that the population of 11–12 year olds who regularly misuse substances, and who may be at the greatest risk of self-harm, overlaps considerably with the population who have experienced abuse or exploitation by adults.[3]

It is many years since I taught adolescents (rather poorly). However, I recall that good education thrives in an environment of respect and trust. Any process that causes humiliation and alienation to teenagers is risking their long-term wellbeing. Too many teenagers now feel demonised. Thankfully, the Royal College of General Practitioners has launched an initiative on adolescent health. At Primary Care 2005 in Birmingham, there was a packed house for the College session, eager to learn how better to help young people at school.

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3. Booth KJ, Caan W. Poverty and mental health. *BMJ* 2005; **330**: 307.

I welcome the discussion on student drug testing in the UK, but the July editorial[1] arguing that random drug testing in schools is a poor method of identifying and supporting children who use illicit drugs overlooks some major points on the potential efficacy of this practice.

Gerada and Gilvarry argue that drug testing would detract us from overall drug prevention and make finding out about student drug use difficult. Quite the opposite, however, is likely to happen. The point of student drug testing is to 'deter and refer' — deter drug use from

happening in the first place and refer troubled children to help.

Counter to media images, drug use among children does not start with a dodgy character on a street corner offering young people drugs. On the contrary, drug use and addiction is spread from peer-to-peer, friend-to-friend. Drug testing therefore gives children a legitimate reason to say no to drugs when they are offered them. Last year that could have helped the 62% of 15-year olds who said they were offered drugs in the UK.[2]

Additionally, drug testing is not meant to catch the child who 'everyone knows' is using drugs. We all know who those children are — they're the ones who are not involved in school activities, who arrive at school with dilated pupils and frequently suffer major academic difficulties. Those children need our immediate help. However, student drug testing targets the children that are often much more difficult to detect. Thus, a main purpose of random testing is to get those who have yet to show symptoms of their drug use the help they need before their 'recreational fun' turns into dependence or addiction. 'Help' does not entail prison or jail time. Instead, the family's privacy is respected and the child is referred to, for example, a counsellor or doctor. Consequences entail being denied involvement in sports or other extra curricular activities during the treatment period and until the child tests negative for drugs.

Research and experiences has shown that this 'carrot and stick' method works: After 2 years of a drug-testing programme, Hunterdon Central High School in New Jersey, US, saw significant reductions in 20 out of 28 drug-use categories, including a drop in cocaine use by 18-year olds from 13% to 4%.[3] Researchers in the state of Oregon found that '… a policy of random drug testing surveillance appears to have significantly reduced recent drug use among adolescent athletes' at a large secondary school.[4]