

Letters

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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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I welcome the discussion on student drug testing in the UK, but the July editorial¹ 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

I am not implying that drug testing is the catch-all solution to the UK's drug problem (a problem that manifested itself in a quarter of all 15-year olds last year²). Rather, if local support for the programme exists, student drug testing can be used as a part of — not a substitute for — comprehensive drug prevention curricula and treatment availability in schools. At a time when the UK holds the dubious honour of the most drugged country in Europe, we cannot afford to write off this potential solution just yet.

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Prescribing to substance misusers

Strang *et al*'s message (*BJGP* June)¹ that between 1985 and 2001 there has been an almost threefold increase in the number of GPs seeing opiate users is indeed good news.

Sadly, however, their report on the 2001 national survey of GPs in England and Wales makes no mention of the significant improvements made in the last 4 years, thus leaving the reader with a rather negative view of what we consider to be a quantum leap forward in the field of substance misuse.

That half of the GP responders in 2001 had seen an opiate misuser in the preceding 4 weeks and half of those had prescribed opiate substitution therapies, shows how mainstream this work had already become. But in contrast to the recent RCGP's 10th Managing Drug Users Conference celebrating the distance travelled in the last 10 years, the article warns of 'rounds for concern about the

quality of prescribing'. In particular, concern was expressed that the doses of methadone prescribed were sub-optimal (mean = 37 mg).

Although there is a long and robust evidence-base to favour optimal doses between 60–120 mg of methadone, guidance to GPs before the 1999 guidelines recommended GPs should only do detoxification (hence generally using lower doses). There is inevitably a lag phase of 'catch-up' and it would be interesting to see what the current situation is regarding methadone doses. The new national study currently being undertaken in England by the NTA is clearly needed and the results will be welcomed, but anecdotally, among 184 users at the Windmill practice in Nottingham, for example, methadone doses have generally increased since 2001.

Let me suggest three further reasons why the authors should not be overly pessimistic regarding both the dose and the instalments of methadone given. Firstly there are no details given of the work/family circumstances of the users in question. What, for example, if a significant proportion of users are trying their hardest to keep down a job or study?

Secondly, that there are more and more GPs seeing drug users, inevitably means that many will just be 'dipping their toes in the water'. Do we expect GPs who are green to starting diabetics on insulin to be bold and get it right from the start? Indeed those who have just completed the first level certificate will have learned that the first 2 weeks of methadone treatment are the most dangerous with regard to lethal overdose.

And for those GPs experienced in substance misuse can we not trust them to use their clinical acumen to get it right for the individual user that they have developed a rapport with? Remember that since 2001, there is a growing body of GPs who have completed the RCGP certificate course. Four thousand e-modules have been completed, with 500 GPs finishing the part one certificate and 750 GPs in England alone having completed the (year-long) part two certificate. In keeping with both the June 2005 National Treatment Agency Plan 'Towards treatment effectiveness' and SMMGP's February

2005 *Network* we need to consider wider quality measures than just a methadone dose — for example, 'retention in treatment is fundamental to treatment effectiveness'.

In conclusion, while we applaud the intention of the authors to further mainstream this valuable work and to encourage better quality (there is always room for improvement), let's not shoot ourselves in the foot when both of these goals are already happening. Rather, let's send a message to our GP colleagues both here and abroad that this work is worthwhile to users, their families and the wider community, and that with the right support it's not only possible, but important and enjoyable work.

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Homeopathy

On the subject of homeopathic medicine, your correspondents are quick to explain its efficacy on long consultations, faith, empathy, benign deception but it is difficult to see how these features could explain the huge successes in treating animals, babies, infants and others where the charisma of the doctor is negligible.

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Corrections

Cardol M, Schellevis FG, Spreuuenberg P, van de Lisdonk EH. Changes in patients' attitudes towards the management of minor ailments. *Br J Gen Pract* 2005; 55: 516–521.

The correct footnote to Table 2 should read:

^aSignificant effect between both samples: the difference in standardised mean score was significant at the level of $P < 0.001$; the difference in effect of male sex between the two studies was significant at the level of $P < 0.01$, whereas the difference in effects of self-reported bad health and reporting more health complaints were significant at the level of $P < 0.05$. ^bSignificant effect of independent variable on patients' scores as measured with the Nijmegen Expectation Questionnaire (NEQ). ^cIn order to capture a possible non-linear relationship between age and patients' attitudes, age was modelled as a separate polynomial effect.

The correct version of Table 2 is available online at <http://www.rcgp.org.uk/journal>