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 year[2]). 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.

KEVIN SABET
Research student, University of Oxford, Department of Social Policy and Social Work, Oxford.
E-mail: kevinsabet@hotmail.com

REFERENCES

1. Gerada C, Gilvarry E. Random drug testing in schools. *Br J Gen Pract* 2005; **55**: 499–501.
2. National Centre for Social Research/National Foundation for Educational Research. *Smoking, drinking and drug use among young people in England in 2004*. London: Department of Health, 2005.
3. Brady L. Drug testing is a strong weapon in the war on drugs in schools. *Student Assistance Journal* 2003; **15:** 3.
4. Goldberg L, Elliot DL, MacKinnon DP, *et al.* Drug testing athletes to prevent substance abuse: background and pilot study results of the SATURN (student athlete testing using random notification) study. *J Adolesc Health* 2003; **32:** 16–25.

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.

STEPHEN WILLOTT
Drugs lead for and on behalf of the RCGP Sex, Drugs and HIV Task Group
E-mail: stephen.willott@gp-c84683.nhs.uk

REFERENCE

1. Strang J, Sheridan J, Hunt C, *et al.* The prescribing of methadone and other opioids to addicts: national survey of GPs in England and Wales. *BJGP* 2005; **55:** 444–451.

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.

IVOR E DONEY
3 Wallcroft, Durdham Park, Bristol BS6 6XJ.

Corrections

Cardol M, Schellevis FG, Spreeuwenberg 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:

[a]Significant 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. [b]Significant effect of independent variable on patients' scores as measured with the Nijmegen Expectation Questionnaire (NEQ). [c]In 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