c weight loss
d depression
e paranoid psychosis.

3. Features of a dependence syndrome are:
a an evidence of tolerance
b progressive pleasure from the drug
c persistence with the drug despite harmful consequences
d a strong desire to take the substance
e a need to inject.

4. Areas causing relapse are:
a positive life events
b affective/mood status
c the service user's coping resources
d a loss of belief in the possibility of change
e sexual experiences.

5. If prescribing dexamphetamine, then:
a the tablet form is preferred to the elixir
b dosage should not be above 20 mg
c dispensing arrangements are typically weekly
d if goals of treatment are not met, prescribing should stop
e severe mental illness is not a contraindication.

MCQ answers

1	2	3	4	5
a F	a T	a T	a F	a F
b T	b T	b F	b T	b F
c T	c T	c T	c T	c F
d F	d T	d T	d T	d T
e F	e T	e F	e F	e F

Commentary

Roch Cantwell

In the sometimes sensational world of illicit drug reportage, there is one unsung villain. While heroin misuse remains the *bête noir* of tabloid journalism, ecstasy the demon of the dance floors and cocaine caricatured as the choice of the rich and famous, amphetamine misuse has lurked the shadows. Its use defies such simple categorisation and spans several groups in society. Bruce has provided a timely reminder of this neglected area in substance misuse literature and, in the process, has highlighted the relevance of basic information gathering as the most important tool in the armamentorium of drug misuse workers. The lack of prominence given to what they describe as a "hidden epidemic" is striking. Could this be because amphetamine misuse is a less prevalent problem than that of other illicit drugs? Evidence suggests otherwise. Amphetamine is the second most common illicit drug seized in the UK (after cannabis). It is easily produced and used in a variety of modes, and recent research confirms a high prevalence of misuse in this country reflecting that found in North American and Australian literature.

What other explanation can there be for its neglect by the Government and health service? In some circles, amphetamine is viewed as at the 'softer' end of the range of illicit substances, identified as part of dance culture or as a substance taken in similar contexts to cannabis. However, the evidence for harm associated with amphetamine is mounting. It is frequently injected and those injecting have high levels of associated risk-taking behaviour. A recent Edinburgh study revealed that amphetamine was injected by more subjects (44% of their sample of injecting drug users) than any other drug (Peters *et al*, 1997). Results from the ongoing National Treatment Outcome Research Study (NTORS) project also suggest high rates among those attending

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specialist treatment units (Gossop *et al*, 1998). Practices such as needle-sharing are just as common among amphetamine users as in those who use heroin (Klee, 1992; Hando & Hall, 1994). Furthermore, in Klee's population of injecting women in the north-east of England, amphetamine users had a greater interest in sex and frequency of intercourse than their heroin using comparators, despite perceiving their risk of infection as negligible. For those working with psychiatric populations the risks of amphetamines are well recognised. Overactivity, mood change and paranoid beliefs, all features of amphetamine intoxication, are particularly detrimental to patients with psychotic and affective disorders.

Reasons have perhaps more to do with the perceived lack of specific interventions for amphetamine misuse and the consequent reluctance of clinicians to involve themselves with this population. An article specifically devoted to treatment issues may go some way to redressing this deficiency. Bruce's approach to management tailored to the wishes of the patient emphasises the need to recognise that motivation is not static and that engagement must be the first priority for what is often a chaotic population. Even in those wishing to continue use, harm reduction strategies can have a significantly beneficial effect on long-term outcome. Ultimately, interventions may require targeting at more specific groups. Klee (1997) has suggested a typology based on a series of drug-users' lifestyles, which includes such classifications as 'recreational users', 'controlled and uncontrolled users, 'criminal users' and 'self-medicators'. She regards these as having heuristic value for further research but could also point to more specific interventions, most probably of an educative nature.

The series of papers emerging from the NTORS study provides further encouragement (Gossop *et al*, 1997, 1998). This is perhaps the most comprehensive and ambitious UK project ever undertaken into outcome for severe drug and alcohol misusers in routine clinical care. Although only preliminary data are available for amphetamine users, there is clear evidence that, at one-year follow-up there was a reduction in amphetamine use for those treated either in residential programmes or in the community. There was also a reduction in overall injecting and sharing behaviour. The importance of this study lies in its demonstration of the effectiveness of current clinical practice, and it provides encouragement for clinicians in the face of ongoing threats to specialist addiction services.

The provision of substitute prescribing is the author's most controversial suggestion, yet one that has been made by several acknowledged experts within the addiction field. Experience of prescribed amphetamines finding their way onto the black market in the UK in the 1960s, coupled with early trials showing a lack of benefit in those receiving substitute amphetamines, dampened enthusiasm for such an approach. The inability of amphetamine to mirror the rapid change in attitude toward substitute opiate prescribing following the advent of HIV perhaps relates to the misperception of low rates of injecting behaviour among amphetamine users and the absence of a 'socially acceptable' substitute such as methadone. Yet evidence from Fleming and Roberts (Fleming & Roberts, 1994; Fleming, 1998) demonstrates the effectiveness of this approach and the relative lack of risk in vulnerable populations, such as those with pre-existing psychosis. It is clear, however, that any move toward greater prescribing could only follow a change in attitude at governmental level. The most recent report on management of drug misuse and dependence from the Department of Health (1999) is a significant improvement on previous versions. While commenting on the lack of a body of research to guide practice, it acknowledges that substitute prescribing is widespread and offers guidelines for practitioners with regard to those groups who may be most suited to this approach. There is a great need, however, for any change in practice to be informed by further research into its effectiveness. Improved recognition of the prevalence and widespread harm associated with amphetamine use remains an important first step in the development of a clearer public health policy toward misuse.

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