Speed on prescription

Prescribing amphetamine may help Britain cope with one of its biggest drug problems

PRESCRIBING a substitute drug is a widely accepted intervention for dependent opiate users but not yet for amphetamine users. My aim is to challenge that orthodoxy and to suggest that amphetamine prescribing has a role as one of several potential interventions. This challenge is also being played out in practice by projects in Wales, the South West and elsewhere, often in response to the overwhelmingly stimulant-based drug problem in their areas.

In many parts of the country amphetamine use is widespread and much more common than opiate use. The drug is injected, sometimes in large quantities (in South Wales up to three quarters of an ounce per day) and used widely in the sex industry.

Most disturbing is the potential for amphetamine misuse to spread HIV, hepatitis B and C, and other blood-borne infections. In her ground-breaking research on amphetamine misusers, Hilary Klee found them at least as likely to share needles as opiate users. Amphetamine is a socially used stimulant with a reputation for enhancing sex. Disinhibition can also lead to increased risk of unsafe sexual practices.[1]

These are powerful arguments for anti-HIV initiatives aimed at amphetamine users at least as vigorous as those aimed at opiate users – but the case for prescribing is less clear cut. Unlike opiates, amphetamines are not generally associated with marked physical dependence (although this has been questioned[2]) and excessive amphetamine use – prescribed or not – can lead to psychological problems such as paranoia and psychosis. Set against this risk is the fact that amphetamines rarely cause death from overdose; opioids do, either as street drugs alone or street drugs in combinations with methadone.

A bad press

In recent years policy makers have consistently argued against stimulant prescribing – but today their reasons seem less then overwhelming. In 1988 *Aids and Drug Misuse Part 1* from the Advisory Council on the Misuse of Drugs (ACMD) cautioned:

> "Many misusers of amphetamine and other non-opioids are not heavy, regular users and there is a serious danger that prescribing for them will increase their drug use leading in turn to greater instability. There is also a particular problem with prescribing drugs in tablet or capsule form which may ... be injected causing serious harm. We recommend that in general, publicity and outreach combined with syringe exchange and advice and counselling services are the best means of reaching and influencing the behaviour of non-opioid misusers. There may however be very exceptional cases in which short-term prescribing of non-opioids might be helpful."[3]

by
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> In many parts of the country amphetamine use is widespread and much more common than opiate use. The drug is injected and used widely in the sex industry. Risks of injecting-related damage and of HIV and hepatitis spread are considerable but uptake of services is poor. Despite official discouragement, several projects have reacted to this situation by offering a prescribing service. Evidence is accumulating that this helps attract stimulant users to the service and leads to positive behaviour change.

Many amphetamine users are not heavy users – but many *are* already heavy, regular users leading unstable and chaotic lives, enmeshed in crime and prostitution. Outreach and needle exchange are important, but still leave too many amphetamine users unattracted to services which they feel have nothing to offer them or which they see as being for opiate users.[4]

In their second *Aids and Drug Misuse* report the ACMD reiterated their opposition, citing "previous experience in this country of prescribing stimulants regularly to drug misusers which is generally acknowledged to have been disastrous, resulting in an increase in chaotic behaviour."[5] The experience referred to presumably dates from the late 1960s when the attempt to treat methylamphetamine abuse by prescribing the same drug was not a success.[6]

Then street supplies of amphetamines derived from legitimately produced pharmaceutical stocks. The drugs were pure and clean. Today's illicitly produced amphetamine sulphate is of very low purity – in South Wales, as low as 5 per cent. Lower purity probably means less risk of psychological problems, but adulterants increase the health risks of injecting.

The major difference from the 1960s, however, is today's concern about the spread of HIV and hepatitis C infections among drug injectors. So new physical health reasons to consider a prescribing response have emerged, while the risk that this might aggravate psychological illness may have decreased.

Official guidelines issued to doctors in 1991 also counselled against prescribing amphetamines "as the risk of them being misused is very high."[7] A valid concern, but one that could be minimised by safeguards against misuse and diversion (see *Guidelines for prescribing* panel).

In 1993 the latest ACMD report, *Aids and Drug Misuse: Update*, endorsed earlier warnings but was slightly more open-minded. The report acknowledged that "injecting of cocaine and amphetamines is a particular concern in some parts of the country" and drew "attention to the need for research into strategies for risk reduction." Still, the bottom line was that there "may be very exceptional cases in which short-term prescribing of non-opioids might be helpful but we urge that such prescribing practices should be exercised with caution."[8]

In some parts of the country where projects are already prescribing dexamphetamine as a substitute for street amphetamine, this advice has a distinctly 'stable door' ring. Given the enormous potential for harm from amphetamine use, their actions should be recognised as a service-led response to what is often the major local drug problem.

Evidence accumulates

Research evaluating amphetamine prescribing is rarely published, partly because the difficulty in recruiting control groups makes what little there is unacceptable to academic journals (though progress is being made).[9] The problem arises precisely because amphetamine users will generally not attend medical services unless offered a prescription. This means there may not be enough non-prescribed clients against whom to compare the progress of those receiving a prescription – Catch 22.

Despite this there is enough published and unpublished evidence to justify more widespread trial of prescribing interventions. In Portsmouth a prescribing programme for amphetamine users has reported large reductions in injecting.[10] Fifty per cent of clients had stopped injecting and others had moved towards oral drug use. Clients' lifestyles stabilised; street drug use and criminal behaviour had declined; and many had started to seek employment. Similarly promising results have been reported from Exeter.[11]

Official advice is out of date. New health risks have emerged

A conference on substitute prescribing of amphetamines held in Bristol in October 1993 was oversubscribed and attended by delegates from across the UK, indicating great interest in the issue. Four projects engaged in amphetamine prescribing reported positive behaviour change in respect of injecting, use of street drugs and general health. Philip Fleming updated findings from the Portsmouth study already referred to.[12] Andrew McBride and Judy Miles presented findings from large samples being treated in Mid Glamorgan and Exeter respectively. I reported from a project in Cardiff, where amphetamine prescribing was the major part of a package that included group work.

Our first ten clients showed reduced injecting, better health, less illicit drug use, reduced prostitution and crime, and a distinct improvement in the stability of their lives. Comparison with baseline measures taken before prescribing started showed that the changes were concurrent with the prescribing. It was also clear that the prescribing element was the one that had attracted clients to the service.

From participants at the conference it was obvious that the prescribing of amphetamines is taking place quite widely and is seen as an appropriate harm reduction measure with promising outcomes. Evidence for its effectiveness is accumulating but it will take publication of good clinical research in a major journal for this to gain respectability.

GUIDELINES FOR PRESCRIBING

❶ Most projects screen potential candidates for amphetamine precribing by looking at psychiatric history, current mental state, evidence of current amphetamine use (urinanalysis), evidence of long-term use, and evidence of injecting. A physical examination for general health status is desirable.

❷ Dispensing should be daily, as with many methadone projects. This permits checks to be made on mental state and general health.

❸ Dexamphetamine sulphate either in tablet form or in suspension can be used. Using the suspension helps ensure the client swallows the drug on the premises. Tablets are easier to secrete.

❹ Throughout the country doses tend to centre around about 30mg of dexamphetamine a day. As with opiates, it is difficult to estimate equivalence with street drugs because of variation in purity levels.

❺ The contract with the client should incorporate regular checks of psychiatric condition and monitoring of non-prescribed drug use. Prescribing can be altered if problems occur.

❻ Evidence of psychotic problems should be grounds for at least temporarily stopping the prescription, perhaps with a review when symptoms remit.

Time to try

Except for cannabis, amphetamine is the most widely used drug in some parts of the UK, possibly in the UK as a whole. Services are generally poor at attracting amphetamine users and poor at changing their risk behaviour. Evidence has been presented that prescribing can help attract clients into service and act as a vehicle for positive behaviour change.

Prescribing is no panacea. It should be part of a package including services such as counselling, and is not suitable for all amphetamine users, particularly those using small amounts and not injecting. That still leaves many heavy, chaotic users for whom prescribing could be the one thing which might provide the opportunity for change.

Fears that prescribing amphetamines might lead to an increase in psychotic episodes have yet to be borne out. The evidence being gathered about the efficacy of prescribing should not be ignored. It's time to give it a try. ❍

1. Klee H. "A new target for behavioural research – amphetamine misuse." *British Journal of Addiction*: 1992, *87*, p. 439-446 and presentation to Amphetamine Prescribing conference. Bristol, 1993.
2 Littlewood P. *Amphetamines and crime*. Unpublished conference paper, Northampton, December 1992.
3. Advisory Council on the Misuse of Drugs. *AIDS and drug misuse. Part 1*. HMSO, 1988.
4. Klee H. op cit.
5. Advisory Council on the Misuse of Drugs. *AIDS and drug misuse. Part 2*. HMSO, 1988.
6. Hawks D., Mitcheson M. *et al*. "Abuse of methylamphetamine.", *British Medical Journal*: 1969, *21*(2), p. 715-721.
7. Department of Health. *Drug misuse and dependence: guidelines on clinical management*. HMSO, 1991.
8. Advisory Council on the Misuse of Drugs. *AIDS and drug misuse: update*. HMSO, 1993.
9. Dr McBride and Dr Miles commented on this difficulty at the Amphetamine Prescribing conference, Bristol, 1993.
10. Roberts D. "Amphetamine prescribing." *SCODA Newsletter*: June/July 1991, p. 6-8.
11. Willoughby S., Hager K. *et al*. *Prescribing for amphetamine users in Exeter: interim report*. Paper presented to SCODA Conference on Working with Stimulant Users, 1989.
12. Roberts D. op cit.

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