

THE BLACK MARKET IN METHADONE – SOME REFLECTIONS

The “issue” of the black market in methadone presents itself in a number of different stances, and with a number of (often covert) motivations attached. Such stances range from the “objectively” scientific through to full moral panic. Prescribers and prescribing services may respond in a threatened manner, for example by clinging to the most restrictive interpretation of “guidelines”, which effectively become “rules”. These “guidelines” were often informed by the same stances and motivations by which we feel threatened. Our actions, then, may become irrational responses to agendas that are themselves irrational. This study sets out to create a space for thinking about the fact of a black market in methadone, without a threat of ethical censure, or a fearful conformity to the criminal justice agenda, straight-jacketing the debate into a restricted and narrowly defined region.

I take as a starting point my own professional experience of working as a doctor within the field of methadone prescribing. When, in 1991, I began a new post as a salaried GP in a central London NHS practice working with Dr John Cohen (deceased), I was a bit startled to find that the practice was prescribing to scores of drug-addicted patients. There was very little monitoring, no structured care, many patients were getting at least a weeks medication at a time, physeptone tablets and ampoules were given to some, requests for benzodiazepines were often agreed to, and so on. We were aware of the fact that patients could, and occasionally would, share their medication with others. We published a descriptive account of the service (Cohen et al, British Medical Journal, 1992, 004, pp 1158-60), one of the first pieces of research on GP treatment of drugs misusers.

John Cohen sat on the Advisory Council on the Misuse of Drugs (**ACMD** – of which more later), and kept me informed of the discussions there. One that often cropped up was, of course, the black market in methadone. John’s attitude was one of questioning whether the existence of such a black market was necessarily a bad thing; as he saw it, the black market had negative *and* positive aspects.

Eighteen months further along a steep learning curve found me working at a local CDT. Here there was more structure and monitoring, but in many ways the attitude was similar. We wanted to get patients into treatment. We did our best to create attractive and accessible services, and managed to recruit the sort of patients that more traditional DDU’s had found hard to reach - women with children, working people, stimulant users, and the severely socially marginalized. We tailored our approach to the needs of our patients wherever possible. For example if you were working, or had onerous childcare responsibilities, you could be considered for a weekly pick up of your medication.

Some things have, of course, got better since those days. For instance, there is now an acceptance that therapeutic doses of methadone should be used (although this seems to be more accepted in theory than actually put into practice – and *we* gave therapeutic doses back then). Budgets have been hugely expanded and many more patients are now able to benefit. But there have been losses too - an ethos of innovation and openness, and the confidence to use our clinical judgement without looking over our shoulders and answering to people who’ve never treated a drug addicted person in their life. We wished to create programmes that did not give the

message to potential clients “we inherently do not trust you”. We thought we were putting behind us those kinds of “traditional” attitudes to drugs users. But here we are, a decade later, confronting them all over again. For how else can a system that automatically puts you on a daily-observed consumption (**DOC**) regime, one that is increasingly funded and driven by the criminal justice system, be described?

How and why has this reversal occurred? No doubt there are a number of reasons, but without doubt one of the key ones has been the black market in methadone. It is this that provides the main justification for the enforcement of daily-observed consumption. And the obsessive preoccupation with the black market has played an important role in the process of (re-)defining drug addiction as a law and order rather than a health care issue.

But surely curtailing the black market is all about harm reduction? Doesn't the black market bring harm reduction into disrepute? Undoubtedly these questions need answering, so let's go back and think about what Dr John Cohen had said. He expressed a view few practitioners today would venture - that the existence of a black market in methadone was either much nothing to worry about, or even something that might be at least partially positive. How could he think such a thing? Obviously he was not arguing that a black market was a good thing *absolutely*. I assume he meant that in *context* it is a good thing (or at least, not a bad thing). In a perfect world, there would be no black market in methadone. But then neither would there be a black market in heroin. The central point to grasp is that the methadone market is inextricably interconnected with, and dependent upon, the wider, larger, and more dangerous market in heroin. And the argument that (one imagines) John Cohen would have elaborated from here is one that I'm confident the reader can construct for herself. Any attack upon such an argument must rest upon an important plank: that of undermining something in the claim above concerning the methadone market's relationship to the heroin market. There is only one credible place where it can be attacked; that is in the claim that the methadone market is less dangerous than the heroin market. And if we look at the history of such attacks, this is exactly what we find, and I shall shortly analyse a particular example.

First I want to take a deeper look at the methadone market itself. I'm interested to see what alternative interpretations might be available to us, were we not intent on merely showing it to be a “bad thing” in need of urgent rectification. Any market, in order to function effectively, needs two things - supply and demand. Almost all of the attention around the black market focuses on supply. The story goes that Doctors supply methadone to patients in ways that allows (or even encourages) patients to supply the methadone to third parties. But what about demand? Who are these third parties? Well, we do know something about that, and it turns out that the vast majority of the buyers are other drug addicts (see the excellent work by Jane Sheridan). Few who are not addicted to opiates desire methadone; as a drug it's not much fun and it has a very negative image. It might have some appeal if there's nothing else around, but when you've got a choice of alcohol, heroin, cocaine and MDMA all widely available and relatively cheap, demand for methadone is going to be very low outside of the addict population. So allowing opiate addicts to get hold of methadone legally with a minimum of fuss, inconvenience, and cost would be one highly effective way of curtailing the black market. It tells us something important that we've opted for another approach entirely, one that focuses solely on supply, thereby making access to

methadone more inconvenient than before. We seem to like making a lot of fuss about methadone in other ways too, for example by insisting that its legal recipients must in all cases have access to such intensive support that the cost of treatment rises, creating waiting lists and ongoing demand for black market methadone.

Of course, all this theorising notwithstanding, there is no denying that if you could successfully cut off all supply to the market, there would be no market – I’ve already employed that argument myself on the demand side of the equation. Lots of demand plus no supply is no more viable than lots of supply and no demand. But there’s a difference; if you’ve soaked up all the demand, then it’s going to take a lot of effort to create some more (that’s why corporations pay huge fees to advertisers). But if demand is high and you’ve cut off the major avenue of supply, people will move to fill the gap in the market. The more supply is cut, the higher the price will rise, and the higher will be the rewards to any potential black marketeers. The inevitable result is that organised crime moves in to fill the gap, sourcing the methadone either from burglary of pharmacies, or illicit manufacture. We might also note the recent advent of internet pharmacies. It recently took me just 5 minutes to locate a Mexico based online retailer offering methadone 10 mg tablets at a cost of about 50 pence per tablet.

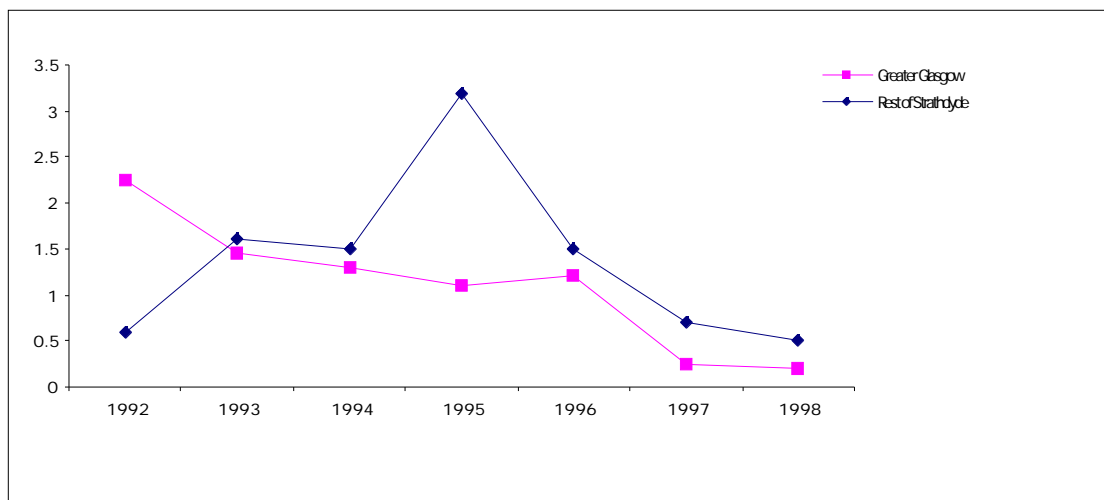
So now let’s see about the effects of the black market in methadone. Since the major adverse effect is death from over dosage, we will look at that, and specifically those claims I mentioned earlier. They appeared in a report entitled “Reducing Drug Related Deaths” produced by the Advisory Council on the Misuse of Drugs – that self same body that Dr John Cohen used to sit on. It devotes the entirety of Chapter 7 to Methadone. It starts off (7.1) by claiming that in 1997 there were **647** deaths with which methadone “was associated” in England and Wales. In chapter 8.4, the equivalent figure for all opioids - including heroin and methadone- is given as **963** for that year- thus their figure is considerably higher for methadone than heroin. Below is a copy of the table they provide where the figures are broken down into: (A) methadone in combination with other drugs – **152**: (B) methadone in combination with alcohol – **102**: (C) All mentions – **421**.

	Methadone (all mentions)	Methadone in combination with other drugs	Methadone in combination with alcohol
1993 (provisional*)	230	92	49
1994	269	110	57
1995	310	130	58
1996	368	141	87
1997	421	152	102

Presumably “all mentions” means *all* mentions, yet the authors appear to have added that figure (C) to both (A) and (B), then subtracted 1, to get their total of **674** (A+B+C = **675!**). I can’t be sure that’s what they have done, because it is quite simply *not clear*

what they've done. And it gets worse. The data has been culled from death certificates, and we are not told *where* the "mention" is. Death certificates have places where medical information that may not be directly causing death can be entered. In how many of these cases was the methadone thought to be a significant cause of death? We are not told. The data is a complete muddle yet the authors seem confident they can draw meaningful conclusions. The more one looks at what they present, the more one suspects that they have reached their conclusion first, then (rather ineptly) tried to make the evidence fit it. The authors of the report also fail to inform us of something important which they must, or should, have known about, which is that the methadone concentrations taken as indicating fatal overdose may be quite incorrect for persons who are on regular methadone treatment (Merrill, Garvey, Rosson, BMJ, 1996;313:1481). This remains an area of uncertainty at the present time, and it may in fact be that inter-person variation is so high as to make it impossible to give any definite levels.

Further methodological inadequacies are to be found in section 7.20, where an attempt is made to show that observed consumption cuts methadone deaths. This is supposedly shown by comparing methadone deaths for "Rest of Strathclyde"(which did not have widespread DOC) with "Greater Glasgow"(which did). If you look at the graphs there seems to be no evidence for this contention, except for the year 1995 when something anomalous appear to have occurred in "Rest of Strathclyde", for which there might be any number of reasons. In any case we are not told whether the difference achieves statistical significance. It is impossible to reach any conclusions other than the extremely tenuous on the basis of this data. This however does not stop the authors commenting, "These data *strongly suggest* that the supervised consumption of methadone can prevent methadone- related deaths (my emphasis)".



8.13 states "Deaths would be reduced if agencies and GPs ceased to prescribe...controlled drugs in tablet or ampoule form. In our view...disciplinary sanctions should be deployed to curtail irresponsible prescribing". No evidence at all

is offered in support of this contention. We are by now firmly into the medieval worldview, when something could be decreed true on the basis that someone important, Aristotle usually, had held it to be so. It should be noted that Aristotle himself would have been alarmed at the poor reasoning and lack of science involved.

The findings of the **ACMD** report caused consternation amongst many prescribers and agencies, and were used by enemies of methadone and harm reduction to further their own agendas. That is incredibly sad when one considers how seriously flawed were some of its findings. When a properly conducted scientific survey was made of methadone deaths (Drug Related deaths as reported by Coroners in England and Wales annual review 2001 National Programme on Substance Abuse deaths, Centre for Addiction Studies, St George's Hospital Medical School), it showed that for 2001 there were **571** deaths in which heroin was implicated compared with **164** for methadone. Of these cases, **314** were due to heroin alone and only **61** to methadone alone. Some other findings are of interest for comparison purposes. Alcohol was implicated in **392** cases, always in combination with other substances, Antidepressants in **221** cases, alone in **83**. Compared to 2000, the level of methadone deaths was stable, but the level of deaths from other opiate/opioids (dihydrocodeine, dextropropoxyphene etc) had increased 55% to **405, 174** alone. We should note that these drugs are widely prescribed as non-controlled prescription-only medicines for a whole range of non life-threatening conditions such as back-ache. Stimulants as a class (amphetamine, cocaine, and Ecstasy) were implicated in **171** cases, **43** alone. Of the methadone deaths, "43% were known to be prescribed methadone prior to their death, so 57% may have obtained it illegally."

So actually there are less than **100** deaths per year that might be attributed to the black market in methadone, and much less than that where it was the sole cause of death. This relatively small-scale problem could be tackled in any number of ways other than enforced supervised consumption. Patients can for instance be asked to return their empty containers: this is especially effective for ampoules, but even for oral medication the street price is higher if it's in its original container. A national publicity campaign to warn naïve drug users of the dangers of casual use of methadone could be backed up by local initiatives where there seems to be a particular problem. Prescribing programmes that users actually value are, I'd contend, less likely to give rise to diversion than uncaring, anonymous and overly bureaucratic ones. Getting users involved in the running of their own services would give them a vested interest in the service not being discredited by widespread diversion. And as I've already argued, rapid access to programmes providing meaningful doses in a manner that is convenient for all users that wish to be treated would massively reduce demand, thereby lowering the street price of methadone to a level where it would scarcely be worth diverting.

The response so far to the demands for observed consumption in the **Department of Health Guidelines (2000)** and the **ACMD** document has, for a number of reasons, been patchy. Research conducted by a postal survey (Telfer and Bernard, SMMGP, March 2001) showed that only **23** of **99** CDTs started all their clients on supervised consumption, and that at **36** of the CDTs supervision was not available at all. The findings of this study into the black market in methadone would support this "pragmatic" response, and hopefully provide some confidence to clinicians to follow their clinical judgement in assessing each case on its merits. There would seem to be

no need or justification for giving diversion and its prevention the priority it has been accorded of late, and it would appear that some people who advised on the **ACMD** report should have been a great deal more careful with their use of figures. Our priority should be creating convenient access to methadone for all who might benefit. This will help solve the “problem” of the black market, and produce the maximal quantity of the many well-documented health benefits associated with methadone prescribing.

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