RHD0002

Written evidence submitted by Dr Fay Dennis

(Goldsmiths, University of London)

1. I am Senior Lecturer in Sociology at Goldsmiths, University of London. I have researched and written extensively on drug and alcohol treatment and recovery in the UK.

2. I am recipient of a prestigious Wellcome Trust University Award (2022-2027). This Award funds my current research on the effects of the COVID-19 pandemic on UK drug and alcohol services and support.

3. I have received three previous substantial research grants from the Economic & Social Research Council (2012-2016), Foundation for the Sociology of Health and Illness (2017-2018) and the Wellcome Trust (2018-2022), which have supported my research in this area of drug and alcohol treatment over the last ten years.

4. In 2020, my monograph on injection drug use and treatment was shortlisted for the Foundation for the Sociology of Health and Illness book prize for the book considered to be making the most significant contribution to the global field of sociology of health and illness.

5. In 2021, I won the New Writer's Prize for the best article published in the *Sociology of Health and Illness* journal as voted for by the Editorial Board. The article in question scrutinised the UK's high levels of drug-related deaths and how our treatment systems may be inadvertently contributing to these harms (see Dennis 2021).

6. In recognition of my expertise in the field, I am Associate Editor at the *International Journal of Drug Policy* and editorial board member for *Contemporary Drug Problems.*

Executive summary

7. Treatment is a key protective factor against drug-related death and harm. Identifying barriers and how to overcome them is vital in driving harm down and saving lives.

8. From my embedded position as a researcher in the field for fifteen years, I can confidently assert that many people who use illegal drugs are not benefiting fully from this life-saving and enhancing treatment because of the stringent and goal-driven ways in which it is delivered.

9. Treatment is often perceived and experienced by people who use drugs as a means for controlling and steering their behaviour (to be drug free) rather than supporting them where they are in their dependency journey.

10. If we want to improve the attractiveness and run low-threshold services that are easy to access and retain people, we have to accept that not everyone is ready or willing to stop using illegal drugs. With this fact accepted, we can start to be bolder in our attempts to keep people safe. We need to

improve treatment options and flexibility in adapting treatment to the individual, with an awareness to the unequal ways people who use drugs are marginalised.

11. This includes thinking and working across, to unite, a historically divided sector.

The focus of my response

12. In this Committee's call for evidence on 'Reducing the harm from illegal drugs', I address the particular question of 'barriers to accessing treatment and supporting recovery'.

13. Within this, I focus on opioid agonist treatment (OAT) for heroin and opioid dependency.

14. I focus on this because this is where my expertise lies but also because this is the most common reason people seek drug treatment in the UK, with 140,000 people accessing OAT in England alone, which is 75% of the treatment population (OHID 2023).

15. OAT is also widely evidenced to reduce harms and deaths (e.g., Pierce et al 2015; White et al 2015), which makes its attractiveness, accessibility, and engagement key to this Committee's Inquiry.

16. My response refers to my own and others' research. I welcome the Committee to contact me if they would like to know more or receive copies of the referenced work.

What are the barriers to treatment and how to overcome them?

17. The main reasons people discontinue treatment, and specifically, opioid agonist treatment, or do not access treatment in the first place are because of the singular, inflexible, and often punitive and stigmatising ways in which it is delivered. These are frequently unintentional systemic effects rather than individual or service driven. Below I unpick these barriers and how to overcome them.

Supervised consumption as a 'default'

18. As a head commissioner of drug and alcohol services told me recently, the supervision of people in pharmacies to take their opioid agonist treatment (OAT) remains the 'default' position of prescribers (unpublished interview, 13-09-23).

19. Taking place at busy pharmacies with other members of the public present, we have long known that supervised consumption is experienced as stigmatising and unduly controlling (e.g., Bourgois 2000; Fraser & valentine 2008).

20. During the COVID-19 outbreak, emergency guidelines (e.g., to reduce face-to-face contact) enabled a more individualised approach to risk, meaning many people no longer had to be supervised and could take their opioid agonist medication home (PHE 2020).

21. OAT recipients report many positive effects of this change, including feeling more trusted and in control of their treatment, and having the freedom and flexibility to work and care for loved ones (DDN 2021; Durjava nd; Holloway et al 2022; Kesten et al 2021; MEAM 2020). It also had the added benefit of disrupting contact with other people who use/sell drugs (Scott et al 2023). And, to state the obvious, it meant people could avoid the stigmatising process of supervised consumption, improving self-worth and confidence (Schofield et al 2022; Welch & Barnes 2020).

22. More people joined treatment during this time, supporting the notion that supervised consumption is a barrier to treatment (OHID 2021). The national drug charity Release also saw a reduction in calls to their helpline regarding OAT, suggesting greater satisfaction (Dennis 2023).

- *Overcoming the barrier*

23. If this Inquiry is serious about reducing stigma and improving people's access and engagement with treatment and recovery, a more individualised approach to OAT is vital (like that enabled by the COVID-19 emergency guidelines).

24. Commissioners, service providers and service users broadly agree that supervised consumption should not be the default position of services. This is supported by the clinical guidelines: '[S]upervision should be dependent on assessed clinical need and should not be applied in an arbitrary way' (DoH 2017, p. 101).

25. When I have drilled down into why supervised consumption has returned to the 'default' after the COVID-19 emergency guidelines (PHE 2020) and its many successes for service users, stakeholders point to how services are regulated (Dennis 2023).

26. The perception, and indeed, reality (from my interviews with service providers), is that the regulatory body bares down harshly on service managers and prescribers where a service user tragically dies. This drives an approach to prescribing that can overlook the good that comes from more flexibility and dynamism in favour of control and caution. The outcome is that many people continue to be constrained and stigmatised by a strict dosing regimen.

27. Overcoming this barrier to treatment will involve rethinking the role of the regulatory body and how services are held accountable when tragedy occurs.

'Carrot and stick' prescribing

28. Prescribing practices are often experienced as infantilising and an expression of power imbalance where patients are rewarded for 'good' behaviour through, for example, less frequent pick-ups (the carrot) and punished for 'bad' behaviour through, for example, having to attend the pharmacy more frequently or even having to start opioid agonist treatment again on a lower dose, enduring the inevitable withdrawal symptoms this will produce (the stick). This is summarised by one service user as a feeling of being 'played with' (Dennis & Pienaar 2023).

29. The feeling of being manipulated by a reward-and-punishment prescribing system is a common reason people leave treatment or fail to re/engage (Dennis & Pienaar, 2023; Dennis 2021; 2019; Frank et al 2021).

30. Moreover, the perceived threat of punishment often leads to a dishonest relationship between the keyworker/doctor and service user. Service users feel they must hide their illegal drug use and 'can't really be open' (Dennis 2021, p. 1182).

31. This has a silencing effect, enhancing stigma, and, worryingly, produces a paradoxical situation in which people are unable to talk about their drug use at a drug service, meaning they cannot get the help and support they need.

- *Overcoming the barrier*

32. While there are often clinical reasons for changing prescription regimes, more care needs to be taken in making decisions based on the risk and communicating this carefully, which includes scrutinising these aforementioned unintended consequences.

33. OAT is a vital, life-saving medication, which must not be prescribed in a way that can be perceived and experienced as a reward/punishment for certain behaviours.

34. We need to foster respectful, honest relationships between service users and prescribers/keyworkers/services where service users can be honest, feel heard and not have to hide their illicit drug use.

35. This requires a more tailored risk assessment, where people can enter into meaningful conversations with prescribers and know their individual situations and feelings will be heard and included.

36. We need to prioritise making OAT as low-threshold and user-friendly as possible, even if we know people are still using illicit drugs, rather than something that can be used as a bargaining chip to steer behaviour.

The 'recovery agenda' and pressure to 'move through' treatment

37. Following what became known as the recovery agenda emerging out of the 2010 Drug Strategy and its accompanying guidance (Home Office 2012; NHS 2012), there has been an emphasis on moving people through treatment rather than retention: 'Now it's about the movement, the through-puts' (recovery worker); 'From the onset, you're looking at a client and saying how do you want to plan your recovery?' (project manager, Dennis et al 2020).

38. This stress on movement is reinforced by payment structures built on a definition of success as becoming 'drug free'. This gets summed-up by one service user:

> Say somebody comes into the service, they're self-harming and they're using loads of drugs. Then they cut out the self-harm and they drastically reduce their drug use. The services are not rewarded for that in any way, shape, or form. They're only rewarded for this cold business of successful completion. (Dennis 2021, p. 1184)

39. As a result, opioid users have been a less attractive group to treat because of the long-term nature of OAT: 'one of the things I'm trying to do here now is offer services to a wider range of drug users [other than opioid users] because I know that I'll get better completions for those drug users' (service manager, Dennis 2019, p. 176). This practice has been condemned as 'cherry picking' (see Floodgate, 2017, p65).

40. A similar mentality for movement and 'full recovery' has resulted in a denigration of OAT medications in the sector and stigma towards those who are prescribed them. For example, a commissioner of community drug services once told me 'you're just giving them another thing that ensnares and traps them in addiction' (Dennis et al 2020).

41. With the recovery agenda's ongoing legacy, clinicians, workers, and service users all talk about a continuing expectation to reduce OAT dosing after titration rather than maintain optimum dosing. This can result in recipients finding themselves in withdrawal and using illegal drugs to compensate, or simply feeling alienated by a treatment system that values this one marker of success (Boyt 2014).

42. Even the word ‘recovery’ can be off-putting for some people reaching out for support. It has become synonymous with abstinence and a legacy of treatment people may have had poor experiences with. Moreover, it is associated with the divisive twelve-step programmes.

Overcoming the barrier

43. If we are serious about reducing harm, it is vital that treatment systems are welcoming of people where they are in their dependency journey and are not applying undue pressure to reduce their OAT, or even their illegal drug use until they are ready.

44. We need payment structures that reflect the importance of getting people into and retaining them in treatment rather than just getting them out the other side. We need this dual focus so people can be supported by treatment structures for as long as they need.

45. We need to value and reward services for engaging people in different forms and measures of success.

46. There was a time when the word ‘recovery’ was used to supplant all things ‘drugs’, for example, drug workers became recovery workers and drug services became recovery services. I would urge the sector to return to a plainer use of language given the legacy of recovery and its divisive and morally charged nature.

Lack of treatment options and new thinking

47. A key problem facing the substance use sector as outlined by Dame Carol Black in her report is a lack of diversity and new thinking when it comes to treatment options.

48. For example, the old two-option system of OAT is simply not working for many people, especially those who have been in-and-out of treatment for many years. The service users I speak to want to try something new (Dennis 2021).

49. Stakeholders point to more money being injected into the sector but, with limited new thinking, they fear it will simply be ‘more of the same’. Like in many other sectors, the COVID-19 pandemic forced innovation, showing that new ways of working are possible. We need to harness where these experiments have worked rather than simply returning to what we know (Adams et al 2022; Chang et al 2020; Finch 2020; Wisse et al 2021).

50. The ongoing criminalisation of people who use drugs is a clear barrier to new thinking and the reach of a whole systems approach promised by the 2021 Drug Strategy. Treatment systems can only go so far to make themselves attractive and caring while operating within an environment of criminalisation and the stigma it carries.

- *Overcoming the barrier*

51. We need a more varied approach including a broader range of opioid agonist medications beyond methadone and buprenorphine.

52. Those fortunate enough to have experienced different options such as morphine and diamorphine through successful trials (e.g., Metrebian et al 2015; Poulet et al 2022; Riley et al 2023; Strang et al 2015) feel resentful and disregarded in not being allowed them again:

> I'm resentful because I'm fifty-six, I know what works for me. I know that heroin [diamorphine] or morphine is not in itself harmful, what is harmful is using stupid street drugs so please […] I'm not going to die of morphine, just work with me, give me what I need.

53. Long-acting buprenorphine has recently entered the treatment offer with positive results (e.g., Melichar et al 2022; Neale et al 2019). We now need more options for diamorphine and morphine prescribing, which actually has a celebrated history in this country, known as the British System (Strang & Gossop 1994).

54. We need spaces and forums to think collaboratively across the sector and try out new ways of working. The COVID-19 pandemic showed us that a 'new normal' is possible and governmental bodies, service providers and commissioners can all engage in joined-up thinking united by a principle of care. With the immediate COVID crisis lifted, we need to continue pushing on this spirit of collective thinking and working to engender more attractive, accessible, and engaging treatment.

55. Because criminalisation gets in the way of this new thinking/working, we need to seriously reconsider our legislative approach, like thirty other countries (TalkingDrugs 2023) and now Scotland have already done (Scottish Government 2023).

Gender, sexuality, race, and class

56. Due to the social nature of drug stigma and discrimination, barriers to treatment are often magnified for those marginalised by gender, sexuality, class, and race.

57. Drug and alcohol services tend to be heterosexual, cis-male dominated spaces which can be unwelcoming and even intimidating and predatory for women and other gender and sexual minorities (WithYou 2021).

58. They also tend to be overwhelmingly white spaces which can further exclude those marginalised by race.

Overcoming the barrier

59. There needs to be greater recognition of the unequal ways drug use, policy and stigma affect different groups, including how this impacts people's access and experience of treatment.

60. We need dedicated treatment spaces for marginalised groups and specialist training to improve diversity and inclusion.

61. We need to foster approaches and systems that are overtly anti-racist and anti-sexist. This means not only recognising the way race and gender unequally affects treatment access and outcomes but is actively part of disrupting this harm.

A divided system

62. Divisions cut across all levels of the substance use sector from our governing bodies and policies to research and activism, through to how services are organised and how workers align themselves and the practices they employ. These are unhelpfully based on two schools of thought: harm reduction and recovery. Unfortunately, these foci are frequently pitted against each other, getting in

the way of the joined-up thinking and whole system approach Dame Carol Black advocates for in her report.

63. By pitting safety against recovery you get left with attitudes such as this one from a service manager: 'if you start from "is this safe" then you'll never reduce [OAT], because it's always safe not to reduce' (Dennis et al 2020). Here, the safety of a maintenance dose of OAT is being put at odds with a reduction/recovery-oriented dose. The manager goes on to explain how safety is no longer the organising principle of the service. With our tragically high opioid-related death rates, we cannot afford such attitudes and ethos. The safety of service users must be prioritised alongside their aspirations for change which may indeed be simply for more safety. People should not be rushed into reduction and recovery at the expense of safety.

Overcoming the barrier

64. We need to stop thinking about treatment as either harm reduction or recovery, or even treatment as different to recovery (present in the Black Review, 2021 Drug Strategy, and this Inquiry's call for evidence).

65. We should adopt a plainer use of language along the lines of treatment and support (rather than harm reduction/recovery) which covers all levels of service provision. Language matters and can help breakdown divides and facilitate cross-sector conversation and collaboration.

66. We also need to stop organising services using these terms, which only serves to reinforce these divides (e.g., services and teams as harm reduction/recovery, clinical/psychosocial).

67. Living through the COVID-19 outbreak, we have seen how the substance use sector can unite in a time of crisis on a principle of care and I urge the sector to hold onto this spirit in tackling harm now and in the future.

References

Adams, E.A., Parker, J., Jablonski, T., Kennedy, J., Tasker, F., Hunter, D., Denham, K., Smiles, C., Muir, C., O'Donnell, A., Widnall, E., Dotsikas, K., Kaner, E. and Ramsay, S.E. (2022) A qualitative study exploring access to mental health and substance use support among individuals experiencing homelessness during COVID-19. *International Journal of Environmental Research and Public Health* 19:3459.

Bourgois, P. (2000) Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry* 24(2): 165-195.

Boyt, A. (2014). Staying alive. *Drug and Drink News,* 7. https://www.drinkanddrugsnews.com/staying-alive/ (accessed Oct 2023).

Chang, J., Agliata, J. and Guarinieri, M. (2020) COVID-19 - Enacting a 'new normal' for people who use drugs. *International Journal of Drug Policy* 83 102832.

DDN (Drink and Drugs News) (2021). It's my script. https://www.drinkanddrugsnews.com/its-my-script/ (accessed Oct 2023).

Dennis, F. (2019) *Injecting bodies in more-than-human worlds*. London: Routledge.

Dennis, F. (2021) Drug fatalities and treatment fatalism: Complicating the ageing cohort theory. *Sociology of Health & Illness* 43(5): 1175-1190.

Dennis, F. (2023) Ripping up the rulebook? Doing 'a little bit of digging' with Niamh Eastwood and Shayla Schlossenberg (blog). https://rippinguptherulebook.org/blog/ (accessed Oct 2023).

Dennis, F. and Pienaar, K. (2023) Refusing recovery, living a 'wayward life': A feminist analysis of women's drug use. *The Sociological Review* 71(4): 781-800.

Dennis, F., Rhodes, T and Harris, M. (2020) More-than-harm reduction: Engaging with alternative ontologies of 'movement' in UK drug services. *International Journal of Drug Policy* 82: 102771.

DoH (Department of Health and Social Care) (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health.

Durjava (nd) OAT situational assessment before, during, and after Covid-19. (unpublished report shared by EuroNPud).

Finch, E. (2020). Supervised dispensing after COVID-19. *NHS The NHS Substance Misuse Provider Alliance*. https://www.nhsapa.org/post/supervised-dispensing-after-covid-19 (accessed Oct 2023).

Floodgate, W. (2017). *From maintenance to recovery: Exploring the reorientation towards recovery in British drug policy during a time of reform and economic austerity*. Unpublished PhD Thesis.

Frank, D., Mateu-Gelabert, P., Perlman, D.C., Walters, S., Curran, L. and Guarino, H. (2021) 'It's like 'liquid handcuffs': The effects of take-home dosing policies on Methadone Maintenance Treatment (MMT) patients' lives. *Harm Reduction Journal* 18: 88.

Fraser, S. and K. valentine (2008) *Substance and substitution: Methadone subjects in liberal societies*. Basingstoke: Palgrave Macmillan.

Home Office (2012). *Putting full recovery first*. London: Home Office.

Holloway, K., Murray, S., Buhociu, M., Arthur., Molinaro., Chicken, S., Thomas., Courtney, S., Spencer, A., Wood, R., Rees, R., Walder, S. and Stait, J. (2022) Lessons from the COVID-19 pandemic for substance misuse services: Findings from a peer-led study. *Harm Reduction Journal* 19: 140.

Kesten, J.M., Holland, A., Linton, M.J., Family, H., Scott, J., Horwood, J., Hickman, M., Telfer, M., Ayres, R., Hussey, D., Wilkinson, J., Hines, L.A. (2021) Living under coronavirus and injecting drugs in Bristol (LUCID-B): A qualitative study of experiences of COVID-19 among people who inject drugs. *International Journal of Drug Policy* 98: 103391.

MEAM (Making Every Adult Matter) (2020) Flexible responses during the Coronavirus crisis: Rapid evidence gathering June 2020. http://meam.org.uk/2020/06/11/flexible-responses-during-the-coronavirus-crisis/ (accessed Oct 2023).

Melichar, J., Pearson, L., Richards, E., Lindsay, A. and Greenwood, R. (2022) Significantly improved outcomes – both in retention and CGI scores - using Long Acting Buprenorphine (LAB-Buvidal) versus treatment as usual for Opioid Dependence in Wales during the Pandemic. *European Psychiatry* 1;65(Suppl 1):S814.

Metrebian, N., Groshkova, T., Hellier, J., Charles, V., Martin, A., Forzisi, L., Lintzeris, N., Zador, D., Williams, H., Carnwath, T. and Mayet, S. (2015) Drug use, health and social outcomes of hard-to-treat heroin addicts receiving supervised injectable opiate treatment: Secondary outcomes from the Randomized Injectable Opioid Treatment Trial (RIOTT). *Addiction*. 110(3): 479–90.

National Health Service (NHS) (National Treatment Agency for Substance Misuse) (2012) *Medications in recovery: Re-orientating drug dependence treatment*. www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf (accessed Oct 2023).

Neale, J., Tompkins, C.N.E. and Strang, J. (2019) Prolonged-release opioid agonist therapy: Qualitative study exploring patients' views of 1-week, 1-month, and 6-month buprenorphine formulations. *Harm Reduction Journal* 16(1): 25.

OHID (2021) National statistics: Adult substance misuse treatment statistics 2020 to 2021. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report (accessed Oct 2023).

OHID (2023) National statistics: Adult substance misuse treatment statistics 2021 to 2022: Report. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2021-to-2022/adult-substance-misuse-treatment-statistics-2021-to-2022-report (accessed Oct 2023).

PHE (2020) COVID-19: Guidance for commissioners and providers of services for people who use drugs or alcohol. London: Public Health England.

Pierce, M, Bird, S.M., Hickman, M., Marsden, J., Dunn, G., Jones, A. and Millar, T. (2016) Impact of treatment for opioid dependence on fatal drug-related poisoning: A national cohort study in England. *Addiction* 111(2): 298-308.

Schofield, J., Dumbrell, J., Matheson, C., Parkes, T. and Bancroft, A. (2022) The impact of COVID-19 on access to harm reduction, substance use treatment and recovery services in Scotland: A qualitative study. *BMC Public Health* 22: 500.

Scott, G., Turner, S., Lowry, N., Hodge, A., Ashraf, W., McClean, K., Kelleher, M., Mitcheson, L. and Marsden, J. (2023) Patients' perceptions of self-administered dosing to opioid agonist treatment and other changes during the COVID-19 pandemic: A qualitative study. *BMJ Open* 13(3): e069857.

Scottish Government (2023). A caring, compassionate and human rights informed drug policy for Scotland. Edinburgh: APS Group Scotland.

Strang, J. and Gossop, M. (Eds.). (1994). *Heroin addiction and drug policy: The British system* (Vol. 1). Oxford: Oxford University Press.

Strang, J., Groshkova, T., Uchtenhagen, A., van den Brink, W., Haasen, C., Schechter, M.T., Lintzeris, N., Bell, J., Pirona, A., Oviedo-Joekes, E., Simon, R., Metrebian, N. (2015) Heroin on trial: Systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction. *British Journal of Psychiatry* 207(1):5-14.

Strang, J., Metrebian, N., Lintzeris, N., Potts, L., Carnwath, T., Mayet, S., Williams, H., Zador, D., Evers, R., Groshkova, T. and Charles, V. (2010). Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): A randomised trial. *Lancet* 375(9729):1885–95.

TalkingDrugs (2023) Drug decriminalisation across the world. https://www.talkingdrugs.org/drug-decriminalisation/ (accessed March 2023).

Welch, Z. and Barnes, C. (2020) We changed our services because of coronavirus – this is what we've learned. https://www.changegrowlive.org/about-us/news-views/changes-what-we-learned (accessed Oct 2023).

White, M., Burton, R., Darke, S., Eastwood, B., Knight, J., Millar, T., Musto, V. and Marsden, J. (2015) Fatal opioid poisoning: A counterfactual model to estimate the preventive effect of treatment for opioid use disorder in England. *Addiction* 110: 1321–1329.

Wisse, E., Burke-Shyne, N., Chang, J. and Southwell, M. (2021) COVID-19 and people who use drugs; seizing opportunity in times of chaos. *International Journal of Drug Policy* 90: 103097.

WithYou (2021) A system designed for women? Understanding the barriers women face in accessing drug treatment and support services. https://www.wearewithyou.org.uk/who-we-are/research/ (accessed Oct 2023).

October 2023