Written evidence from Build on Belief

1. Summary

Build on Belief (BoB) is a small charity run by people with lived experience of drug and alcohol dependency for people with similar experience across seven London boroughs. BoB works with those not in treatment, those going through treatment and, importantly, supporting them once they have completed their treatment.

We focus our submission on how those with such life experiences can be supported to sustain long term improvements to their health and wellbeing and how national and local drugs strategy can be enhanced.

Sound critical analysis of the governments drug strategy and drug policies, with recommendations for improvement, has been undertaken in the past few years by authoritative bodies such as the ACMD and the UK Drug Policy Commission. The UKDPC also, uniquely, examined areas where adopting new processes or structures could help to increase the effectiveness of drug policy.\(^1\) We commend these to the Committee.

These analyses identified profound problems with the funding, commissioning and integration of treatment and services to support long term recovery and prevent relapse. Nothing has changed substantially since they were published. If anything, the challenges have worsened.

All of these pressures, coupled with the dynamics of local commissioning and the use of competitively based commercial contracts favouring large providers, has meant funding to enable and support small peer-led organisations is very limited.

1.1 We recommend:

- PHE develop a new set of performance expectation measures to better reflect the long-term recovery health and wellbeing progress of those completing treatment, whether in the community or in prison;
- PHE should produce updated guidance about the value of co-production, including mutual-aid, recovery community organisations including how active involvement of service users in planning and delivering services could be improved;
- Alongside the large drug and alcohol treatment provider system, PHE should seek to enable and support a national support network for service user and peer-led bodies.
- Commissioning practices need to be developed that enable and incubate small peer run services providing longer term recovery support. This could be achieved by parceling independently provided peer-based recovery activities separate from major ‘whole-system’ drug treatment and harm-reduction services;
- Local commissioners should look at using three-year grant funding as the vehicle to enable community-based peer-led services provide complementary recovery and wellbeing activities;

\(^1\) UK Drug Policy Commission, ‘How to make drug policy better’.  
https://www.ukdpc.org.uk/publication/how-to-make-drug-policy-better/
Local commissioners should be encouraged to adopt additional impact measures to gauge the contribution that peer-led organisation make to the long-term recovery, health and wellbeing of participants.

The government must find a funding mechanism that stabilises and protects funding for local drug and alcohol treatment, recovery and harm-reduction services if it is serious about delivering its drug strategy;

A central grants programme should be established by PHE for supporting the organisational infrastructure of peer-led recovery organisations. This could be done by PHE in collaboration with the National Community Lottery Fund and its purpose would be to enable capacity building and service development of peer-led social activity charities.

2. What is Build on Belief (BoB)?

Build on Belief delivers peer-led, social-activity based services across seven London boroughs for people who have, or have had, substance use problems. We work with more than 2500 individuals each year. In essence, we provide a ‘social tonic’ as part of a social prescribing approach to improve vulnerable peoples health and wellbeing and their ability to sustain recovery.

The charity was born from a group of service users who, with access to funding, decided to create a weekend service for individuals with addiction problems. The charity was seen as ‘filling in the gaps’ in the drug treatment system (ie. weekend and evening services; socially based activities; peer-led volunteering) rather than replicating existing service provision. From its conception its service delivery, training, choice of activities and operations have been decided by its staff and volunteers.

All of the eighteen staff, including the Chief Executive have lived experience of dependency and addiction, as have several members of the Board of Trustees. We have a volunteer team of more than 200 people, almost all of whom, have or have had substance use issues. A significant number also have mental health problems.

We use our personal lived experience of dependency, treatment and recovery to support and improve the health and well-being of those seeking social support and contact. We follow a model of recovery that is predicated on engagement in meaningful activities which has a positive effect on self-perception and identity, and generates self-esteem, self- efficacy and feelings of wellbeing. Involvement in a diverse range of pro-social activities, such as volunteering, art and cultural activities, sport, fitness and wellbeing activities can provide an impetus towards and sustaining positive change.

We encourage service users and volunteers to use our collective knowledge and experience to improve their own lives. All of our paid staff were recruited from the volunteer team. Many of the volunteer team have progressed from being service users. This progression acts as positive role modelling. Our services are designed to create safe and constructive social networks, supporting peoples’ aspiration to re integrate into wider society at their own pace. Our own lived experience, from trustees and managers to volunteers is used to shape the design and implementation of services.

https://www.buildonbelief.org.uk/what-do-we-do
Crucially, all our services operate at weekends, a time when the main treatment services provided by our partners are closed. Increasingly we are also operating during weekdays as well, with especially Ealing and Hillingdon being able to provide a comprehensive menu of social activities in ‘discrete’ premises for at least five days of the week. Unlike structured treatment services there is no planned exit, and the services are available to use for as long as an individual requires support. We recognise that for an individual with a long substance use history and complex needs, a successful recovery journey takes many years.

All of our projects model their activity and service provision around the five ways to wellbeing (keep active; learn; give back; take notice; connect) with the aim to improve the health and well-being of everyone using them, volunteers and service users alike.

It is always challenging to demonstrate ‘impact’ especially when delivering low threshold, open access services where data recording is, of necessity kept fairly minimal. During 2017 we undertook a survey of the service users and volunteers at our longest standing services in the boroughs of Kensington & Chelsea and Hammersmith & Fulham. ³

- 83% either strongly agreed (24%) or agreed that the local BoB service aided their recovery;
- 93% agreed or strongly agreed (24%) that the local BoB service met their needs;
- 95% agreed or strongly agreed (34%) that they were satisfied, overall with the service.

3. Our experience of the treatment system and recovery

Drug users and dependent users are not a homogeneous group. The ACMD in its report on Vulnerability & Drug Use has examined how risk and vulnerability are understood and used in relation to substance use and has presented a relevant framework that places risk within the broad determinants of health and wellbeing. The ACMD found Inequalities in health and social outcomes are higher in substance using groups compared to the general population. Social exclusion is one determinant of inequality that affects people who use substances. This is a broader concept than just poverty, and also includes the inability of individuals and communities to participate effectively in mainstream social, cultural, and political life.⁴

Leaving aside those people who go through ‘natural recovery’ without input from professionals or mutual-aid groups, BoB’s experience is that many people going through structured drug treatment, especially those with enhanced ‘social capital’, will successfully re-engage with wider society and move on. Crucially however, from a public policy and services provision perspective, a significant cohort will not. The funded treatment care pathway can realistically only signpost people to subsequent social or health support, such as mutual aid 12 step programmes or to the small number of recovery-oriented bodies like BoB.

In the 2017 survey of service users and volunteers, we found a catalogue of distressing social and health conditions:

- I in 3 of those claiming benefits had been sanctioned;
- Only 8% were in employment;
- 70% were currently still using drugs or alcohol;
- About 1 in 10 were not accessing formal treatment services;
- 25% were being prescribed medication for a physical health problem;
- 40% said they had a mental health problem and were receiving medication;
- 53% smoked tobacco;
- Over 60% had been accessing BoB services for over 1 year of which approximately 40% had been for 2 years or more.
- No one owned a house. No one lived in private rented accommodation. Everyone lived in social housing, hostels or was NFA.

Anecdotally we believe such experiences are replicated across our other five services. Basically, there is a cohort of extremely damaged and vulnerable people who face a really tough, lonely and isolated time in trying to improve their health and wellbeing as part of their recovery journey.

We believe we can say with some confidence:

- People who had had lived experience of drug and alcohol problems need somewhere and something to belong to;
- People need more than structured treatment, especially as they travel through the relatively short treatment system;
- People need extensive help and support to address all their wider health, social and economic needs;
- Recovery is an on-going process, not a destination with a single outcome such as abstinence;
- There is a significant cohort of people who are fragile, at high risk of relapse and who represent a potential high cost to the NHS and criminal justice system;
- People need to engage with peers in a constructive social environment;
- Not everyone has the necessary ‘social capital’ or social skills to reintegrate easily with wider society;
- Peer support utilising the assets of those with lived experience can be a powerful and complementary tool to treatment;
- Peer support and co-production is a ‘social tonic’ founded on social prescribing for better health and wellbeing;
- A modest investment to support longer term recovery and integration goes a long way.

4. Evidence Base for Peer-led recovery social activities

The evidence to support the value of peer-led mutual support services in recovery from drug and alcohol addiction has been examined by the Government’s official advisors on drug policy, the [Advisory Council on the Misuse of Drugs](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/262629/Second_report_of_the_Recovery_Committee.pdf) as well as by the EU drugs agency, the [EMCDDA](https://www.emcdda.europa.eu). Both conclude that there is good evidence internationally to support mutual-aid and peer run services. It is encouraging that BoB is often cited as an example of good-practice and as a vehicle to sustain the initial benefits that formal treatment for substance use generates.  

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PHE has also reviewed the evidence for mutual aid and recommended its support by local commissioners and treatment providers. However, it is worth noting that the evidence was largely restricted to the 12 step programmes or SMART recovery rather than more peer-led, social activity-based services.

William White, a key US academic and commentator on addictions has looked at the evidence for peer-based addiction recovery support. He concludes in this extensive review:

Peer-based models of care can have a transforming effect on larger systems of care and on our society,….But peer models of recovery support can also be corrupted and devoured by larger systems of care. As peer-based services are integrated into the existing treatment system or offered by free-standing independent organizations, there will be pressure to emulate the ethos of the existing treatment system, including the professional roles of counsellors and others.

Care must be taken not to over-professionalize… the very conditions out of which these peer-models were spawned. It will be very important to achieve a delicate balance between peer-based and professional service models, to retain the strengths of each and manage the vulnerabilities inherent in each model…it is more helpful to view these approaches as complementary…Peer-based recovery support services can help shift the larger treatment system from a focus on brief biopsychosocial stabilization to a focus on the long-term recovery process. Peer-based models can inject a recovery focus—a source of renewal—into treatment institutions whose fear of the current climate of financial scarcity has driven them into excessive preoccupation with paper, profit, and professional prestige”.

5. Barriers to peer-led sustained recovery & recommendations for change

In 2017 the ACMD thought “that biggest threat to achieving recovery outcomes, and maintaining the quality and capacity in current drug treatment systems in England is the loss of financial resources and loss of prioritisation of the highly marginalised group of drug users who require treatment and recovery interventions…”.

While this critique largely addresses the concerns about the ‘defenestration’ of the drug treatment system, crafted over the past thirty years, it does not readily address the opportunity of how to move forward and build an infrastructure of peer-led support services to optimise and complement structured treatment provision.

Build on Belief believes there are three ‘structural’ barriers which if addressed, could energise more and better socially based, peer-led drug (and alcohol) recovery services which can improve health and wellbeing:


(a) National strategy and leadership

PHE has published guidance about the value of Mutual Aid. Referring to Recovery Community Organisations, they claim, “Although they are not mutual aid groups they share many important characteristics and can contribute substantially to supporting people in recovery”. The guidance is directed at local commissioners, service providers, prisons and drugs practitioners. Welcome as this guidance is there are three ways in which it falls short in ambition:

- Its vision of ‘mutual-aid’ is limited, focussing largely on the 12 Step networks. A broader vision of mutual-aid, based on co-production in service delivery across the diverse range of public services (including treatment) and community activities, is necessary to bring about long-term recovery;
- The outcomes framework adopted by PHE, with its impetus being successful treatment completions, does not chime with a vision of long-term recovery and health and wellbeing;
- There needs to be a re-energised momentum in the national ‘championing’ of recovery community organisations, traditional mutual-aid and service user involvement networks.

We recommend:

- PHE develop a new set of performance expectation measures to better reflect the long-term recovery health and wellbeing progress of those completing treatment, whether in the community or in prison;
- PHE should produce updated guidance about the value of co-production, including mutual-aid, recovery community organisations including how active involvement of service users in planning and delivering services could be improved;
- Alongside the large drug & alcohol treatment provider system, PHE should seek to enable and support a national support network for service user and peer-led bodies.

(b) Local commissioning

Many, but not all local commissioners now include and promote the involvement of peer-led recovery support organisations in their local drug treatment, recovery and harm-reduction programmes. Where they do this, it is usually done in one of two ways. First is the inclusion of a peer-led recovery component when they invite competitive bids for a ‘whole treatment system’ provision. BoB has found that this is the most common approach. The other way, much rarer, is for the local council to grant-fund or commission an independent peer-led organisation to deliver a service or peer-led community activities. This does not preclude the much larger treatment programmes from also embracing peer recovery initiatives. The Royal Borough of Kensington & Chelsea has adopted this approach for some years and it has been instrumental in enabling and sustaining a high level of peer activity in the area, principally through the independent Build on Belief. Red Rose Recovery in Lancashire is another good example.

Our experience suggests there are some important local commissioning barriers to progressing more and better peer-based recovery initiatives:

• The pressure on local financial and staffing resources has resulted in the adoption of a competitive ‘whole system’ treatment and recovery approach to commissioning where the onus of responsibility to deliver peer-recovery support is left with the lead-provider organisation. This can work against smaller, independent organisations.

• Some lead-provider organisations, for example Change, Grow, Live (CGL), WDP and CNWL have a track-record of working in collaboration with and enabling independent peer-led organisations such as BoB. But perhaps inevitably, some large treatment service providers seek to operate in-house peer-based recovery activities themselves. Our view is that this undermines the very essence of the empowerment of people to take more responsibility for their health and wellbeing and to help others.

• Grant funding for peer-based recovery organisations has largely disappeared, apart from some limited support from charitable trusts and foundations. This is an obstacle to the nurturing of co-production for long-term recovery and enhanced health and wellbeing.

• The outcome measurement frameworks adopted at the local level do not adequately embrace longer-term recovery and health and wellbeing improvements especially when structured treatment is completed. This works against peer-based social activity to sustain recovery. In short, “what isn’t measured isn’t funded. And what is not funded doesn’t get done”. The ACMD has examined in detail the impact of austerity on drug treatment and the commissioning of drug treatment services. It found in a survey that when asked what process measures are prioritised locally:
  ▪ 95 per cent said Public Health Outcomes Framework measures;
  ▪ 87 per cent said treatment completion;
  ▪ 60 per cent said numbers in treatment;
  ▪ 54 per cent said retention in treatment;
  ▪ just over a third said drug (36%) or alcohol (38%) misuse treatment penetration.

We recommend:

  o Commissioning practices need to be developed that enable and incubate small peer run services providing longer term recovery support. This could be achieved by parcelling independently provided peer-based recovery activities separate from major ‘whole-system’ drug treatment and harm-reduction services;
  o Local commissioners should look at using three-year grant funding as the vehicle to enable community-based peer-led services provide complementary recovery and wellbeing activities;

11 ACMD, Commissioning impact on drug treatment, 2017
Local commissioners should be encouraged to adopt additional impact measures to gauge the contribution that peer-led organisation make to the long-term recovery, health and wellbeing of participants.

(c) Funding and resources

Not only has the funding for drug treatment been spread more thinly over the past few years, as the original ring-fenced drug treatment budget has been broadened to include alcohol treatment. It has been diluted also, as funding for drug and alcohol treatment has had to compete with other pressing public health priorities. Compounding this has been the impact of austerity and cuts to local councils and their public health budgets. In effect this has been a ‘triple-whammy’ on the help available to support a very marginalised and vulnerable group.

The analysis by ACMD already mentioned has highlighted the damage being done to the structured drug (and alcohol) treatment system. Collective Voice which speaks on behalf of drug and alcohol treatment providers, has said funding for drug and alcohol treatment in communities and prisons has fallen by about 25-30% in real terms since 2013/14. A range of authoritative organisations has added their weight recently to the crisis facing public health funding. The loss of drug and alcohol treatment ring-fenced funding as it has had to compete locally with other pressing priorities has been a regressive step. This has not only had a deleterious impact on structured treatment provision including its availability but also its quality. Crucially it has inhibited the development of peer-led recovery community organisations across England and acted as a serious obstacle to achieving longer-term recovery and improvements to health and wellbeing. Funding for stimulating and supporting peer-led community recovery organisations is profoundly inadequate.

We recommend:

- The government must find a funding mechanism that stabilises and protects funding for local drug and alcohol treatment, recovery and harm-reduction services if it is serious about delivering its drug strategy;
- A central grants programme should be established by PHE for supporting the organisational infrastructure of peer-led recovery organisations. This could be done by PHE in collaboration with the National Community Lottery Fund and its purpose would be to enable capacity building and service development of peer-led social activity charities.

Build on Belief

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