Ethical commissioning in drug and alcohol services

Iriss
8th of July 2024

Table of Content

Acknowledgements

We would like to thank all of the people and organisations who agreed to be interviewed for the research, taking time out of busy schedules to reflect with us on commissioning. We would also like to thank staff from Healthcare Improvement Scotland (HIS) for providing contacts, introductions and overarching guidance on the Alcohol and Drug Partnerships (ADP) policy and operating context.

Executive Summary

Purpose and method

This is a small-scale exploratory study of ethical commissioning in alcohol and drugs partnerships (ADPs) in Scotland setting out to explore how they commission; the barriers and facilitators to commissioning; and what role the ethical commissioning principles play in their commissioning practice. The themes in ADP commissioning are strongly interrelated and the study attempts to reflect this complexity through a semi-structured emergent design formed of cross-system interviews; a rapid review of ADP delivery strategies; a review of the policy context and literature; and three case studies that take a deeper look at key themes.

Main findings

- **Context:** ADP commissioning happens in a highly challenging context. Factors include constrained finances; competing national, sectoral and local priorities; multiple visions of what treatment and recovery could and should look like. This is coupled with an ambiguous position for ADPs in terms of positional authority within their Health and Social Care Partnership (HSCP), NHS and local authority landscape.

- **Commissioning role:** There is a high degree of variation in how ADPs view themselves as commissioners; how commissioning works in practice; how collaboration and relationships work; as well as differing approaches to leadership, decision making and use of data.

- **Commissioning intent:** Common across all respondents was a deep commitment to making the system work better for people; a clear eyed understanding of the limitations of the operating context; and some creative and pragmatic attempts to embed a broadly ethical approach to commissioning.

- **Ethics and practice:** In terms of ethical commissioning practice, the respondents we interviewed shared an ethical basis for their practice that came from their personal (and sometimes lived) experience, professional background and a drive to make things better for people. This led them to work for organisations and in roles that matched their ethics. However, these roles also challenged their ethical framework pushing them to hold the tension of constrained resources and siloed systems that often worked against their drive to make things better for people.

- **Person led care and support and a human rights approach:** There was a strong positive focus on these principles both nationally (through the National Collaborative and the rights aspects of the Medication Assisted Treatment(MAT) standards) and locally to reorientate systems often experienced as disempowering and controlling towards a human rights basis.[1] However putting this into practice was constrained by insufficient and short term funding. Respondents had contested views of what a human rights approach to service provision is in practice.

- **Full involvement of people with lived experience:** Although views varied considerably on the quality and depth of engagement with people, all respondents felt progress has been made in this area. Involvement mainly took the form of creating panels or fora or the use of questionnaires, surveys and targeted research.

[1] The Clackmannanshire and Stirling and North Lanarkshire case studies discuss this in more detail.

A positive example was given of a service developed and commissioned based on direct lived experience, contrasting with organisations working with people with lived and living experience who described involvement as being 'light years away' from real engagement, influencing or co-design approaches.

- **Outcomes focussed practice:** While the overall framing of alcohol and drug services is outcomes focussed all respondents spoke at length about the real challenges, they face related to outcomes focussed commissioning, evaluation and data capture in general. Data was described as partial, lagging, incomplete and fragmented. Third sector respondents expressed frustration that outcomes information is not integrated effectively into national priority setting or local commissioning decision making.

- **High quality care and support** National drug and alcohol policies broadly frame what quality should look like with regard to outcomes for people and when support is accessed, what it should feel like (respectful, non-stigmatising and with a whole-person focus). Respondents generally agreed that the MAT standards had driven improvement in local data, but not necessarily in improvement of the services themselves, or improvement of the whole system of care and support.

- **Financial transparency, sustainable pricing, commercial viability** respondents all spoke to the level, type and method and duration of funding coming to ADPs as a major determinant of commissioning decision making and ADPs' ability to meet the ethical commissioning principles related both to finance and to fair work. Respondents across the local systems were frustrated with annual funding awards, non-recurring funding, prioritisation and fragmentation; levels of funding; lack of inflationary or living wage uplifts, problems with accurate and realistic budgets for projects.

- **Fair work**: The core objectives related to the National Drugs Mission on workforce development and workforce value map broadly on to fair work as it is articulated in the ethical commissioning principles. Respondents identified the fundamental challenge in embedding fair work practices in a system of short-term funding, that is under-resourced and does not attract uplifts to meet rising costs and salaries.

- **Shared accountability:** Designed to be a partnership, ADPs are structurally set up for shared accountability, however respondents saw accountability in practice differently. This difference reflected the range of views people hold on the role of positional and non-positional leadership within commissioning. Some respondents wanted a clearer and more structurally powerful role for ADPs, constituting them as legal entities. This is in recognition that ADP' responsibility for the complexity of substance use is not matched by their leverage in the system. Others felt the non-positional nature of the ADP is part of its' strength and it models the collaborative and distributed leadership that seeks to reduce power differentials in the system and improve practice through improved relationships.

- **Fragmentation and prioritisation:** ADP commissioning decision making is highly shaped by Scottish Government priorities and funding. Respondents understood the positive intent of this as an attempt to increase consistency and quality of supports and services. However, they noted these are based on lag data requiring translation to the ADP/local context who then need to use commissioning levers (commissioning/decommissioning) to translate this again to direct support and intervention in their area. This structure is therefore inherently inflexible and slow to respond, operating as it does on partial and historic data. Some respondents were

critical of commissioning decisions being overly shaped by what were perceived as political priority 'solutions'.

Overall, the underpinning structures, insufficient resourcing, and competing priorities mean a fundamentally ethical approach to commissioning is currently not being, and cannot be, delivered. Supporting this would require a range of inter-related changes which are explored in the recommendations below.

Recommendations

Supporting individual ADP commissioners

1. Ethical principles are hard to translate into practice, they can feel like an abstraction from the work or simply impossible to implement due to system constraints. Moving from principles to practice requires a **shared and agreed understanding of what they look like in terms of behaviours, practices and effects**. Particular attention should be paid to shared accountability, human rights and full involvement as these are the most difficult to translate into meaningful action.

2. Ethical principles need to **go beyond being stated values into being lived values, aligned with the personal ethical base of the commissioner**. Implementing the ethical commissioning principles with commissioners should focus on drawing out an individuals' practice ethics, mapping these to the principles. Individuals are more likely to take action that is aligned with their core ethical framework and how they see themselves as a person than one that is applied from the outside (Hayes, Strosahl and Wilson, 2016).

   Closely linked with recommendation 1, this requires a coaching approach to support commissioners to link and maintain their personal ethical base coupled with the creation of network/group opportunities. These would be designed to support commissioners to maintain both their ethical base and their practice by connecting with peers.

3. ADPs would benefit from '**just enough' guidance to support development of commissioning strategies to sit alongside ADP plans**. Guidance should not add to the directive funding environment by being over-prescriptive but should focus on locality needs and requirements. Guidance alone does not drive improvement so this recommendation would require comprehensive implementation support to be successful.

Funding and prioritisation

4. ADPs operate in a highly directive funding environment which intrinsically limits their ability to commission, and to commission ethically. **A co-produced approach between ADPs, Scottish Government and Ministers to service prioritisation, improvement and commissioning** (both local and national) would support the bespoke commissioning practice.

5. The balance of funding between statutory and commissioned services also intrinsically limits ADP ability to commission, and to commission ethically. At best ADPs can only commission for a very small part of the whole system of drug and alcohol services. **A review of expenditure, intervention effectiveness, individual service choice and quality on a whole system level coupled with a willingness to shift investment** would support ADPs to commission on a systems wide basis. Coupled with the development of **cross-system accountability measures** would help reduce fragmentation and focus work on the boundaries between services (e.g. ensuring wrap-around community support for those returning from residential rehab.).

6. For ADP commissioning to be fully systemic it is required to be place-based across poverty, justice, homelessness and substance use. **This would require a new structure including potentially a network of partnerships with specific focus and expertise in each area working in an aligned way, with place-based budgeting to support.** (Denham and Studdert, 2024).

7. For ADP commissioning to fully support human rights in practice **human rights based budgeting**[2], (see also, Scottish Human Rights Commission, 2023) is a potential way to shape how funding is used in ADPs. This would require a radical reset of how resources are considered as well as a more outcomes base and less segmented approach to funding.

Learning and data

8. Build a learning oriented system to ultimately replace the current target driven approach. Closely linked with recommendation 1, this would include **developing more equal relationships to underpin a live learning loop between the Scottish Government, ADPs and providers.** This would improve the whole system's responsiveness to changing needs, reducing the information lag between practice and policy and allow political priorities to be shaped by learning from practice.

9. Addressing the complexity and partial nature of the data in this area is challenging. An **increase in dedicated analytical capacity in ADPs** to improve the analysis component of the commissioning cycle would assist to do this. Coupled with recommendation 7 this capacity would improve both local and national data, providing a clear basis for decision making.

[2] Human rights budgeting is a powerful tool for change.

1. Introduction

This is a small-scale exploratory study of ethical commissioning in alcohol and drugs partnerships (ADPs) in Scotland. This study set out to explore:

- How ADPs commission services and supports in their areas and the factors that influence ADP commissioning.
- How ADPs, and in particular ADP coordinators, conceptualise themselves as commissioners.
- To what extent the ethical commissioning principles are put into practice in ADP commissioning and what the barriers and facilitators to this are.

Although structured loosely around the ethical commissioning principles the activities, outcome and themes in ADP commissioning are strongly interrelated and the study attempts to reflect this complexity.

ADPs seek to support people with problematic substance use to both recover and to live well, recognising the complexity of people's situations, needs and hopes for the future.

ADP commissioning happens in a highly challenging context. Factors include constrained finances; competing national, sectoral and local priorities; multiple visions of what treatment and recovery could and should look like; coupled with an ambiguous position in terms of positional authority within the HSCP, NHS and local authority landscape.

Our study finds a high degree of variation in how ADPs view themselves as commissioners; how commissioning works in practice; how collaboration and relationships work; as well as differing approaches to leadership, decision making and use of data.

Common across all respondents was a deep commitment to making the system work better for people; a clear eyed understanding of the limitations of the operating context; and some creative and pragmatic attempts to embed a broadly ethical approach to commissioning. However, underpinning structures, insufficient resourcing, and competing priorities mean a fundamentally ethical approach to commissioning is currently not being delivered and would require radical change to achieve.

2. Ethical commissioning principles

The ethical commissioning principles have been designed to guide and support decision making at local and national level in commissioning and procurement of adult social care and support. The nine principles have been designed to reflect the recommendations from the Independent Review of Adult Social Care (Scottish Government, 2021d) and the developing National Care Service (NCS) (Scottish Parliament, 2024).

The principles are summarised below:

1. **Person led care and support:** The person should be the priority at all levels of the commissioning and procurement process, and they should have informed choice

over the support they receive. Public services should work in an integrated and collaborative way to meet need and be transparent about unmet needs.

2. **Human rights approach:** People's ability to access their human rights should be at the forefront of the commissioning and procurement process.
3. **Full involvement of people with lived experience:** People should inform commissioning and procurement processes at every level to make sure support is designed for the people who will use it. Information should be accessible; governance should be clear and transparent.
4. **Outcomes focussed practice:** Commissioning and procurement practice should focus on supporting people to meet their outcomes and live a good life, focused on what matters to the person.
5. **High quality care and support:** Commissioned support should be of high quality and tailored to people's needs and choices. Quality monitoring should be part of contract management and there should be good complaints procedures and access to advocacy support for all**.**
6. **Fair working practices:** The workforce should be recognised and valued for the important and highly skilled work they carry out and commissioning and procurement should thus enable fair work. This includes enabling effective voice, collective bargaining, trades union representation, fair pay, fair terms and conditions, access to training and career progression opportunities.
7. **Financial transparency, sustainable pricing and commercial viability:** Providers should share financial information with procurement and commissioning to allow for sustainable pricing. Financial information should also be shared within contract monitoring to mitigate against the risk of provider withdrawal/failure.
8. **Shared accountability**: Commissioning and procurement processes should support shared accountability between providers and commissioners. These should be clear and transparent.
9. **Climate and circular economy:** Commissioning and procurement processes should support Scotland's transition to Net Zero emissions by 2045, with climate friendly approaches used wherever practical.

3. Policy context

National policy for alcohol and drug services

Commissioning is an umbrella term for the planning, delivery, resourcing and evaluation of a range and diversity of services and supports designed to meet the needs of a given area or population. The national policy framework related to substance use substantially shapes commissioning for ADPs. The National Drugs Mission (Scottish Government, 2021a), Rights, Respect and Recovery (Scottish Government, 2018a) and the Alcohol Framework (Scottish Government, 2018b) are the core policies that drive commissioning priorities in Scotland.

The National Drugs Mission (NDM) aims to reduce deaths from alcohol and drugs[3] and improve lives. This aim is underpinned by priority outcomes:

[3] https://www.gov.scot/publications/suspected-drug-deaths-scotland-april-june-2023/pages/3/

- Fewer people develop problem drug use.
- Risk is reduced for people who take harmful drugs.
- People at most risk have access to treatment and recovery.
- People receive high quality treatment and recovery service.
- Quality of life is improved for people who experience multiple disadvantages.
- Children, families and communities affected by substance use are supported.

These are then linked to cross-cutting priorities about how these outcomes should be met:

- [Putting] lived experience at the heart: people affected by substance use, including families, should be meaningfully involved in policy and decision making at national and local levels.
- Equalities and human rights.
- Tackling stigma.
- Surveillance and data informed.
- Resilient and skilled workforce.
- Psychologically informed support.

This builds on the vision of Rights, Respect and Recovery that: 'Scotland is a country where "we live long, healthy and active lives regardless of where we come from" and where individuals, families and communities:

- Have the right to health and life - free from the harms of alcohol and drugs.
- Are treated with dignity and respect.
- Are fully supported within communities to find their own type of recovery'.

The Rights, Respect and Recovery vision is underpinned by:

- Prevention and Early Intervention.
- Developing Recovery Oriented Systems of Care (ROSC).
- Getting it Right for Children and Young People and Families (GIRFEC).
- Public Health Approach in Justice.
- The Alcohol Framework 2018.

The core commitments of the Alcohol Framework centre on a preventative approach for children and young people alongside development work on guidance, legislation and licensing, intersecting with justice, health and education.

The early intervention and life course approach set out in these policies foregrounds preventative, risk reduction and recovery-focused work, including a priority focus on treatment. The outcomes of the National Drugs Mission also include broader social outcomes such as improving the quality of life for people facing multiple disadvantages, and support for children, families and communities affected by substance use, recognising the complexity of people's lives. The underpinning values and vision of these policies cut across a range of social priorities such as addressing stigma, upholding equalities and human rights and involving people with lived and living experience (LLE) of substance use.

Access to support and treatment is set out in these policies intentionally as being available through the life course and with a person-centred focus; through preventative engagement work; support for children and families affected by drug and alcohol use; harm reduction;

treatment pathways in both residential and community settings; and recovery and aftercare support.

The policies intersect health, justice, education, housing, social work and social care - setting a partnership-based approach to support as default. This necessarily includes statutory and non-statutory partners, third and independent support provider organisations, and partners who work both directly in alcohol and drug support and treatment and those who do not. The delivery of support includes both community based activity and residential (specifically residential rehabilitation) with the 'how' of operational delivery being the responsibility of individual ADP areas through a range of different partnership structures and service leads.

Together these drive expectations that commissioned services and supports should centre on relational and holistic work with people. Services should prioritise personal outcomes for recognising that interventions necessarily will need to go beyond direct alcohol and drug treatment. Workforce capacity and taking an evidence-informed approach are also priorities of the National Drugs Mission that underpin implementation expectations at local level.

At the same time, the six high level outcomes of the National Drugs Mission are also drivers for specific target focused work, such as reducing the numbers of drug deaths across Scotland and ensuring that people most at risk can access treatment and recovery. In this way treatment routes and other direct activities to reduce drug deaths are also a priority.

The way in which the commissioning of alcohol and drug services is structured will be core to how the diversity of partnerships, ways of working and service models can be managed effectively. The 'both and' nature of the National Drugs Mission, and adjacent policies, requires an approach to funding and commissioning that prioritises local responsiveness and variation as well as contribution to national targets and outcomes at the individual, local and national level.

Structure

Scotland's 31 ADPs lead the development and delivery of local, whole systems strategies aiming to reduce use of, and harms from, alcohol and drugs in their area. ADPs are multi-disciplinary, non-statutory partnerships established at local authority level composed of statutory and third sector organisations, the Police and the Scottish Prison Service.

ADPs commission, contract for, and monitor the quality of services provided by external organisations. ADPs contribute to, and must commission services that align to, the public health priorities set out in the guiding drug and alcohol policies. Commissioning is, however, not a standalone activity, it is closely related to, and influenced by, adjacent functions:

- The practice of ensuring a diverse range of sustainable providers and types of support for people to choose from (personalisation/market facilitation).
- The way that services and support are purchased and funded (procurement and grant making).
- The agreements underpinning that provision (contracts and grant making).

Funding

ADPs are typically funded through a combination of three funding streams: baseline, non-recurring, and funding from other sources.

ADP baseline funding from the Scottish Government is provided to pay for services the ADP directly commissions. From 2021, ADPs can also access part of the £250 million emergency fund for activity to reduce drug deaths (this follows a £5 million immediate action resource for ADPs in 2019). The emergency, non-recurring, funding covers a broad range of activity, both clinical and non-clinical, including treatment, residential rehabilitation, implementation of Medication Assisted Treatment (MAT) Standards and preventative community work.

ADPs may also apply for other funding to support their activity. Residential Rehabilitation (RR), for example, attracts funding for increasing capacity and improvement through the RRRCP 2 programme[4] (running from 2022/23-26). Corra Improvement (National Drugs Mission Fund)[5] monies may also be accessed for specific RR improvement activities.

Health and Social Care Partnership (HSCP) statutory services that provide drug and alcohol treatment or support are also sources of financial contribution to ADPs through the HSCP funding mechanism.

In addition to multiple funding streams that ADPs must access to fund services, **ADPs are typically not the sole commissioners of alcohol and drug services in their area.** Support and treatment services may also be funded directly by the Scottish Government (Core Funded Organisations, typically third sector with a national remit of support); indirectly by the Scottish Government through the Corra Foundation (often grassroots and third sector organisations in local areas, but also accessible by the NHS, Integrated Authorities, ADPs and HSCPs), or through other localised grant funding (Scottish Government, 2022). Any HSCP services that contribute to alcohol and drug treatment, or support may also be subject to the mainstream commissioning and procurement models as used by the HSCP. There are a number of key implications arising from this that are explored further in this report:

- Multiple funding streams and structures brings complexity to the delivery of National Drugs Mission work by introducing **different funding cycles and related procurement and contracting models within an area** (Scottish Government, 2021a).
- Restricted, short-term funding can be an enabler of new activity, channelling resources to support specific developmental work for quick impact. However, short-term funding (1-2 years) may also **limit long-term planning and development, particularly for ongoing preventative work**. Responsive action to local need may also be limited if local need is not mirrored in centralised decision making on funding direction - timely, comprehensive and relevant data is crucial to this.

[4] https://www.gov.scot/publications/residential-rehabilitation-rapid-capacity-programme-guidance/pages/strategic-context-for-rrrcp/

[5] https://www.corra.scot/grants/improvement-fund-national-drugs-mission-funds/

- Smaller ADPs, inclusive of rural and remote localities, have **smaller budgets which impact on their ability to make economies of scale** (Public Health Scotland, 2024a).
- The sustainability of services may be threatened if insufficient resources to cover on-costs are available within a multi-source funding model. This is a risk particularly for lean third sector providers, who also face problems with recruitment when only able to offer short term contracts (Coalition of Care and Support Providers, 2023, 2019; Corra Foundation, 2023).
- A fragmented commissioning structure could **limit ADP capacity to hold accountable the services** that they do not directly commission, despite other commissioned services making core contributions to local support networks and health and wellbeing outcomes.

National commissioning guidance

There is currently no national guidance or standards related to commissioning of alcohol and drug services other than the expectation that all areas have current strategic and delivery plans as stated in the national ADP Partnership Delivery Framework (Scottish Government, 2019). While the framework incorporates some of the commissioning function, there is no specific requirement for a commissioning strategy or approach. Further, the framework does not offer guidance on the role of the commissioner, leaving substantial room for interpretation across localities and a lack of clarity on governance within commissioning activity.

In contrast, both the UK and Welsh Governments have produced guidance and standards for commissioning in this area.

The UK Commissioning Quality Standard for alcohol and drug services (UK Government, 2022) set out a self-assessment tool and criteria set for commissioning practice including partnerships and governance; commissioning cycle; whole systems approaches and commissioning of high quality treatment systems. Directive in its approach, it outlines a single step-by-step approach to commissioning.

The Welsh Government guidance (2015) includes a mandate for outcomes based commissioning, placing a requirement on local areas to develop accountability measures aligned with national priorities, and aggregating data on both outcomes and cost. Although this document is nearly a decade old, it recognises that showing how local need is addressed within the broader set of national priorities is a core element of accountability. The guidance also sets out a clear definition of the role and purpose of commissioning, a set of values and a vision to inform commissioning practice, alongside practical resources to support local strategic commissioning activity.

While guidance and standards are useful in setting baseline expectations, vision and expectations within a system they are a weak lever for change where they exist in isolation. Guidance requires both comprehensive implementation support and attention to the operating context for maximum effects, particularly where a system is under significant pressure (Wales Centre for Public Policy, 2023).

4. Plans and commissioning

A review of a sample (16) of ADP strategic delivery plans demonstrates a range of perspectives on, and understanding of, commissioning.

A good commissioning strategy or plan should comprise:

- Local and national data validating the direction of the commissioning approach.
- Effective discussion of needs and projected needs, alongside areas of commissioning focus.
- A vision for commissioning, including the values and ways of working that will support this.
- Clarity on outcomes, measurement and data and how this informs decision making.
- Transparency around how procurement and contracting is undertaken to give effect to commissioning intent.
- Identification of where and how commissioning fits with the wider ADP strategic delivery plan.

The following table sets out a summary of the features of good and poor strategic delivery planning encountered in the sample of the plans. This covers the elements of commissioning, financial transparency, governance and the inclusion of lived and living experience.

Table 1: ADP Strategic Delivery Plan review

	Examples of good practice	Examples of practice that needs improvement
Commissioning purpose is included in the plan	• A whole systems approach. • A 3 year commissioning approach inclusive of quarterly reporting and annual reviews with measures. • An overview of commissioning responsibilities within the ADP. • Two ADPs reviewed had a separate commissioning strategy, and another one currently in development.	• Single statements about retendering, contract monitoring, or in one case, No reference to commissioning within strategic documents. • No information provided on procurement, contracting or contract monitoring. • Commissioning is not included in the delivery plan at all.
Financial transparency	• Transparently shows breakdown of spend from different funding streams and sets out financial ambitions. • Clearly lists ADP funded projects and initiatives. • Sets out the different funding streams available for ADP.	• Finance and contracting actions are incorporated in a plan annex but are not clearly articulated. • High level finance (e.g. budget) is presented with no contextual description or breakdown of how this is spent.
Governance, accountability and QA	• Governance structure is easy to understand showing partner roles, responsibilities and connections with the wider system. • Work being done to meet local priorities as well as national targets is demonstrated. • Equalities Impact Assessment of the strategic plan. • Impact report accompanies strategic plan discussing risks, highlights and development opportunities. • Data and analysis provided on outcomes and activity across services. • Medium term delivery plan with clear national and local outcomes accompanying longer 5 year strategic plan. • External evaluation report of ADP progress. • Incorporates learning from a learning review of the ADP and local services into strategy. • Incorporates a variety of local research findings into the plan. Recognition of improvement work to be done with planned activity alongside. • Linked to a Performance Framework.	• Visual of governance structure in the plan without, or limited, contextual discussion of how governance and accountability operate in the area. • Discussion of accountability focuses on embedding of MAT Standards.
LLE	• Some detail on approaches to incorporating LLE within planning and service design. • Clear inclusion of LLE and worker perspectives in the plan itself with relevant links of LLE perspective to different elements of the strategic plan. • Draws on participatory LLE research as part of local data gathering. • Reference to peer research or other methods of incorporating LLE within MAT Standards data gathering.	• Consultation or other engagement activity referred to but no clarity on how this was incorporated into the plan. • Single statement that community members may be involved in governance and accountability activities that include commissioning. • Minutes from LLE panel meeting to discuss service retendering - consultation discussion on service specifications. Minutes not easily accessible and available separately from the ADP strategic plan.

A strategic delivery plan is not enough for commissioning

The plans reviewed varied substantially in their presentation, content and insight into the way in which services are planned, paid for, monitored, and evaluated within areas:

- **There is a lack of locality based commissioning**: With few exceptions the strategic plans focus on how national outcomes are addressed within the local area, rather than showing a relationship between planning for local needs and meeting national targets.
- **Accountability is focussed on treatment aspects**: MAT Standards (Scottish Government, 2021b) implementation was visible as a priority activity, with attendant accountability measures, in plans that were developed after their publication. As discussed elsewhere in this report, these focus on treatment and while comprehensive in that regard, they are not applicable to a wider system of care and support around substance use.
- **Information is lacking:** Information about commissioning approaches was very limited either in inclusion to the plans or available as supporting information. Information about how services were monitored, evaluated and how that data was used to inform local planning or national policy was limited.
- **Outcomes need to be clearer:** Outcomes and associated measures (indicators) of ADP progress were typically not transparent or available, with few exceptions (e.g. retrospective external evaluation of ADP, local impact report). A standout example was a two year delivery plan - breaking down shorter term activity within a 5 year plan - showing clear national and local outcomes to guide activity.
- **Governance and inclusion is variable:** Clarity about local governance structures varied significantly. Clarity about the ways in which lived and living experience informed service design and scrutiny varied.
- **Links to the evidence base are not clear:** Few plans transparently shared insights into what works locally, or where there are gaps, to give an indication of how service planning was evidence-informed. One clear example of this done well was in the provision of a local impact report. Another ADP presents a change story of development work to meet local needs.
- **Commissioning direction is required:** Overall, the majority of plans reviewed did not provide sufficient clarity on the direction commissioning in ADP services should take as part of strategic planning. The link between commissioning role, responsibilities and contribution to planning of alcohol and drugs services was, in most cases, not well articulated. Even in examples of plans that had clearer detail around accountability, use of data, methods of learning and focus on both national and local need, approaches to commissioning could have been set out more visibly - showing how these would enable sustainable and appropriate service models to be in place to meet the need of the area.

Ethics and values in strategic delivery plans

All plans incorporated the values held by the ADPs, generally reflecting those of key national policies, and local organisational values (HSCP, local authority), with some variation.

Unsurprisingly given the time of writing of the plans there is limited direct read-across with the principles of ethical commissioning and procurement. Overlap mostly occurs around financial transparency[6]. However, detail on procurement and commercial viability was absent.

The principle of **'full involvement of people with lived and living experience'** was limited in scope. Involvement was seen to greater or lesser extents in plans where there was some detail provided on how data from people with lived and living experience informed decision making. This would be unlikely to be regarded as 'full' involvement, however this is an area that requires further definition within the ethical commissioning principles.

Shared accountability rather than 'accountability' is difficult to find within the plans, although there are some examples of good accountability practice - through publication of learning, impact and timely evaluation of services.

People-led care first and **human rights** are referred to in the majority of the reviewed plans (to differing extents). However, there is little detail of what human rights might look like in practice or how it is assessed, either by people with lived/living experience of drugs and alcohol or how it is measured within service outcomes. **Climate and circular economy** is not visible, nor are specifics about **fair work** or **commercial viability**. However, a small number of plans refer to workforce development.

Recommendation 1: Ethical principles are hard to translate into practice, they can feel like an abstraction from the work or simply impossible to implement due to system constraints. Moving from principles to practice requires a **shared and agreed understanding of what they look like in terms of behaviours, practices and effects**. Particular attention should be paid to shared accountability, human rights and full involvement as these are the most difficult to translate into meaningful action.

Reflections on ethical commissioning principles

While there are overlaps in key areas (e.g. human rights) these principles at first glance sit awkwardly with the ADP landscape, policy framing and priorities. Framed very much for the adult social care support landscape the principles focus primarily on broad functions, with the ADP in contrast shaped by targeted interventions, priorities and service areas.

[6] This is required within the ADP partnership framework.

However, these were woven throughout the discussion with respondents, expressed in different ways depending on role, professional background, organisational and personal perspectives on treatment and recovery. The majority of voices in this research saw ethical practice and ethical processes as both a personal and shared responsibility across the system.

Ethical principles in general set out to guide people to make positive decisions and actions. They are normative[7], in that they seek to justify foundational moral rules that go beyond subjective views of what it means to be 'good' or 'ethical' in a given situation. People's work, however, is highly subjective and those we interviewed as part of this study did not identify their ethics of practice as coming from the ethical commissioning principles.

In contrast, those we interviewed shared an ethical basis for their practice that came from personal (and sometimes lived) experience, professional background, and a sometimes elusive sense of hope and drive to make things better for people. This drive had led people to work for organisations that matched these values. But also, to choose roles that challenged their ethical framework, holding the tensions of constrained resources and siloed systems that seemed to work against them.

"We're not saying this because ethical commissioning tells us to, or the tender asks us to. This [person led support] is what drives us as an organisation and our approach"
(third sector organisation)

5. ADP commissioning practice

ADP commissioning differs in several ways from commissioning within broader adult social care support. The areas discussed generally saw commissioning as group led, with proposals discussed at ADP subgroup level and what was described as the technicalities of commissioning (here, generally conflated with procurement and contracting) taken forward by commissioning officers from either the local authority or NHS Board. In some areas these officers sit directly on the subgroups, in other areas, they were brought in to give effect to commissioning decisions taken within the group.

Most respondents could not identify dedicated commissioning strategies within ADPs; however, commissioning forms the core of most ADP strategic delivery plans even where it is not directly described as such.

As ADPs are not a legal entity or contracting authority under the Procurement Reform (Scotland) Act (Scottish Parliament, 2014) they are unable to directly procure services. Areas either go through an NHS or Local authority procurement team, with the majority aligned with NHS processes. This poses a challenge to ADPs looking to give effect to ethical commissioning as their ability to influence procurement and contracting practice is limited. The data doesn't indicate if this lack of influence is more pronounced for ADPs when

[7] Normative ethics is the branch of moral philosophy that is concerned with the criteria of what is morally right and wrong, the creation of rules and justifications that should shape human decision making, behaviour and actions.

compared to other commissioning functions (such as HSCPs) where these functions are also some distance from core commissioning practice.

This is mitigated where:

- ADP coordinators have a good relationship with procurement teams.
- Procurement teams and ADPs have shared purpose around service purchasing i.e. a focus on quality, personalisation and effectiveness.
- Procurement team KPIs are aligned with ADP priorities. A good example of this was given by an ADP who wished to review their contracts to procure on a longer term basis aligning this with procurement colleagues' KPIs to reduce off contract ('maverick') spend leading to a positive outcome for both the ADP, procurement teams and the providers involved.
- ADPs make effective use of grant making and direct awards as well as the relative freedom for below threshold decision making.

ADP coordinators' view of themselves as commissioners varied substantially. Some described themselves very clearly not having the skills, background or ability to commission, others described a role recognisable as that of a modern commissioner without defining it this way, with others clearly inhabiting the commissioner role - liaising with NHS/LA procurement and contracting to give effect to commissioning priorities.

Commissioning as a practice exists on a spectrum from traditional commissioning cycle based 'management' (Institute of Public Care, 2014) through to facilitative collaborative 'systems stewardship'[8] approaches. This variation in commissioning practice was noted by national providers who described a variable commissioning and procurement picture across Scotland both in terms of approach and in terms of practice (e.g. tendering frequency, balance of grants vs. procurement etc).

A number of respondents stated that there is a lack of commissioning skill and experience within ADPs as a whole. This is addressed in a number of ways including pulling in commissioning expertise from the HSCP or local authority to an ADP commissioning subgroup, through to fully outsourcing commissioning and procurement to the relevant public body.

Echoing broader debates in commissioning, respondents varied in their views of the function of commissioning and the ADP itself as a commissioner. These fell broadly into five approaches with most ADPs a mixture of one or more of these approaches. The typology overleaf has been generated by Iriss for this study.

[8] https://www.humanlearning.systems/blog/systems-stewardship-in-practice-what-it-is-and-how-to-get-started/

Table 2: A typology of ADP commissioning approaches

Traditionalist: The commissioner as running a procurement adjacent competitive selection process for service provision.	*How?* Focusses on process fairness and coherence, contract compliance and data capture.
	Key challenge: Linear service commissioning limits how holistic support can be for people.
Systemic: The commissioner as a whole systems approach based on a broadly systems stewardship role.	*How?* Focusses on relationships and structured collaboration through multiple groups.
	Key challenge: Synthesising feedback and managing conflicting priorities.
Radical: The commissioner as supporting the empowerment of people with lived and living experience to shift the balance of power in service selection, planning and design.	*How?* Focusses ADP efforts on empowerment of supported people building their influence on priorities, commissioning and service design. Reducing the harmful effects of the system on people.
	Key challenge: Power differentials and structural constraints limit full empowerment.
Innovative: The commissioner as a facilitator of innovation and experimentation within the wider system.	*How?* Encourages developmental proposals for innovative or new services. Match funding and advice and expertise 'critical friend' from the Corra Foundation support this innovative practice.
	Key challenge: Mainstreaming funding for successful innovative approaches.
Outsourced: The ADP does not commission directly or see itself as a commissioning body.	*How?* Commissioning and procurement is done by HSCP colleagues, and the ADP focuses on the delivery plan.
	Key challenge: Disconnect between vision and intent and commissioning, procurement and contracting.

ADPs, as structures with minimal positional authority within the wider HSCP and local authority system, therefore, demonstrate a range of approaches to commissioning reflective of their unique position. Respondents noted the relative importance of the ADPS within the wider pressures on the social care support system noting that ADPs were often not a priority compared to support for older people, care homes and delayed discharge.

ADP commissioning was described as 'highly relational' with it being difficult to move into a new area until those relationships and contacts were built. This was seen both as a strength and a weakness of the system. Similarly respondents had different views on commissioning and procurement practice with some seeing the use of, e.g., contract extensions as a relational approach driving continuity and stability, and others seeing it as a sign of a lack of attention to service quality and changing need.

One respondent maintained that an increased focus on governance, role clarity and building positional authority in ADPs would assist decision making in commissioning, however the majority of people we spoke to took, and valued a facilitative, collaborative approach focussed on non-positional leadership, influence and persuasion.

In the latter approach the personal and professional attributes of the ADP chair was seen as a key factor in shaping ADP commissioning and broader system influencing (such as persuading the HSCP to mainstream the funding for an innovative service). Also key to successful decision making and relationship maintenance were the skills of the ADP coordinator and team and the processes put in place to ensure structured, regular and thoughtful engagement with people, ADP members and the wider system to gather feedback, solve problems and identify commissioning priorities.

One of the challenges of this facilitative approach to commissioning is the balancing of powerful voices, particularly those with structural or professional authority. All respondents noted that **decision making in ADP commissioning is heavily shaped by the clinical voice** thus driving investment in clinical solutions to what was seen by respondents as a holistic and community contextualised problem. Respondents struggled to identify how to address this challenge with one suggestion being the provision of national specifications and guidance recommending a better mix of clinical statutory and voluntary sector supports.

6. Funding and ethical commissioning

Funding in this area comes from multiple sources and is a mixture of highly siloed/directive funding (Scottish Government) and open/innovative funding (Corra) requiring match funding from ADP resources. There is also the challenge of seeking mainstream tested services within the wider HSCP. This is particularly challenging in the current context of financial constraint and cuts.

ADP funding is allocated on the basis of Scottish Index of Multiple Deprivation (SIMD) data, meaning some areas receive comparatively small pots of siloed funding, which can often be less than the critical operating costs for the required services. Scottish Government ADP

funding does not attract the negotiated annual uplift for the payment of the living wage in social care[9], creating challenges for providers in ensuring salary parity across their organisation.

ADP funding for some interventions is short-term. From the perspective of respondents from provider organisations this poses challenges to recruitment, retention and the ability to retain a consistent and skilled workforce.

The combination of multi-source and multi-duration funding with the complex balance between directive funded priorities and local innovation means ADPs appear to be commissioning in a system that leads to tensions related to sustainability, commercial viability, and fair work.

7. Diversity of priorities

There are a wide range of voices within the ADP system, often with conflicting priorities. The commissioning function seeks to hold a series of seemingly irreconcilable tensions between different pictures of what makes for the right mix of services:

- Clinical/medical vs. psychosocial and holistic approaches.
- Community solutions vs. residential rehabilitation.
- Specific drug interventions (e.g. opioid stabilisation treatment) vs. generalised approaches.
- Grassroots recovery support vs. services that are part of the 'treatment' system.
- Ringfenced and fragmented funding for specific purposes vs. commissioning systemically to meet the complexity of people's lives.

Lived and living experience organisations identified their members want to see upstream early intervention to be the focus of ADP services. They noted that the system shouldn't wait until there is an addictions issue or someone comes through the 'addictions door', but rather have a whole systems approach that reaches people at key intervention points e.g. becoming homeless, being involved in the justice system.

This was echoed by ADP coordinators and strategic planners who, overall sought a more holistic approach to commissioning, expressing frustration at a siloed system of funding and working that doesn't serve the complexity of people's lives.

Practitioner respondents noted the unintended consequences of financial constraint and treatment-first commissioning decision making as having 'stripped out' support from the system. One respondent noted a previous role where they provided wraparound casework support for people in recovery that would now not be seen as affordable to commission. This has led to negative effects on local recovery communities with peer volunteers supporting people with acute/high and complex needs who require more in-depth support from other parts of the system.

[9] https://www.gov.scot/news/pay-uplift-commitment-for-social-care-and-childcare-staff/#:~:text=This%20uplift%2C%20announced%20in%20the,staff%20in%20ASC%20and%20ELC.

8. Decision making

Respondents from across the system noted the challenges of collecting, collating and analysing up-to-date data and information (needs assessment; feedback; outcomes data; national intelligence; local intelligence; substance use patterns; drug deaths patterns etc). This means that ADP commissioning lacks a secure foundation of data for the analysis phase of the commissioning cycle.

As a result, respondents noted commissioning decision making was often heuristic (McCaughey and Bruning, 2010); based on recency factors[10]; personal and professional background and ethos and the influence of more powerful voices within the ADP. This was highlighted particularly in discussion about the role of residential treatment where decision making, whether in favour or not, was not seen as based on 'formal' evidence.

Respondents also noted a lack of use of national and international evidence on 'what works' in service provision, echoing broader challenges related to using the evidence base in policy, commissioning and practice.

Again, there were contrasting views on the role of national and local data. Some respondents feeling local variation was overstated and there was consistency in alcohol and drug related harm across Scotland. Other respondents thought the variations in type of drugs used (for example) was less relevant to commissioning than assumed by either SG policy or some local areas. The latter view being expressed by respondents focussed on non-clinical service aspects who saw the general service response to drug and alcohol use as being more about the broad recovery and community support rather than the clinical specifics of different drugs and use patterns.

For example some respondents thought the variation in type of drug use being of less relevance in commissioning than assumed by many areas.

ADP commissioning decision making is highly shaped by Scottish Government priorities and funding. Respondents understood the positive intent of this as an attempt to increase consistency and quality of supports and services. However, they noted these are based on lag data, translated to priorities and then communicated to ADPs who then need to use commissioning levers (commissioning/decommissioning) to translate this again to direct support and intervention in their area. This structure is therefore inherently inflexible and slow to respond, operating as it does on partial and historic data. Some respondents were critical of commissioning decisions being shaped by what were perceived as political priority 'solutions'.

"Strip away community support, recovery communities, libraries and things provided by the third sector and poverty will go up, mental health problems will go up, drug deaths will go up" (LLE organisation)

[10] A cognitive bias in which those items, ideas, or examples that are most recent are remembered more clearly than those that came earlier.

All respondents expressed frustration at the siloed nature of funding in what they saw as an area characterised by interrelated and complex lives spanning homelessness, justice, poverty and education, as well as substance use that required systemic and imaginative commissioning to address. They noted that the structure of the ADP funding drives short-term commissioning decision making. When set alongside the drive for cuts and efficiencies due to financial pressures in the wider system this posed real risks to a holistic approach to service provision.

Recommendation 4: ADPs operate in a highly directive funding environment which intrinsically limits their ability to commission, and to commission ethically. **A co-produced approach between ADPs, Scottish Government and Ministers to service prioritisation, improvement and commissioning** (both local and national) would support the bespoke commissioning practice.

9. Ethical commissioning principles in practice

This section follows on from discussion of ADP practice to focus in more detail on ethical commissioning principles and where these are located within the ADP operating context.

9.1. Person led care and support and a human rights approach

All respondents noted the national work undertaken by the National Collaborative on the proposed Charter of Rights (National Collaborative, 2023a) as setting a direction and vision for embedding a human rights approach in alcohol and drugs support provision.

Reflecting the well documented gap between policy intent and putting this into practice (Wales Centre for Public Policy, 2023) more critical voices observed that the work needs to go far beyond simple statements about human rights; but rather focus on decision making, behaviour and practice:

"Just saying it's a human right doesn't mean to say it's going to happen, if you don't commission services differently to allow space within those services to ensure staff can do their work you can have all the policies in place but what you're asking ADPs to do will never be delivered in practice."
(LLE organisation)

What constitutes a human rights approach to service provision was fundamentally contested. Some respondents argued that nationally commissioned access to residential treatment is a human right, with the current funding constrained local budget approach lacking equity of access for people.

The National Collaborative Call for Evidence Analysis report (National Collaborative, 2023b) identified wider structural issues that impact on rights, such as:

- People not knowing what their rights are, therefore not knowing what support they are entitled to access.
- Short-term funding and commissioning decisions impacting on service provision - resulting in inequity of provision with a focus on crisis responses.
- Gendered and stigma related impacts on decision making, with women more likely not to access treatment due to fear of children removal to the care system.
- Power imbalances between professionals and people who might access support, as well as disparity of power between statutory and third sector partners.
- Lack of connectivity between rights to access support from different services, such as no access to Mental Health support if actively using substances.[11]

This final point is mirrored in the debate around the human right to access support and treatment for substance use, with the Right to Addiction Recovery Bill proposal (Scottish Parliament, 2021) observing that there is no statutory right to addiction treatment, and there are high levels of discrepancy in the reasons why a person may not be considered eligible for support with substance use, which is counter to human rights.

The impact of short-term funding on limiting service provision was highlighted by some interviewees. Others argued that the entire system of treatment and support runs fundamentally counter to people's human rights, with others maintaining that a treatment/clinically orientated provision ran fundamentally counter to human rights.

Human rights are explored from another angle in work by McPhee and Sheridan (2023, 2020). The authors draw on research into drug use data and trends and a wider body of work on health inequalities, (including the Independent review of Drugs, Treatment and Recovery, Black, 2021). They critique human rights in practice to scrutinise the prioritising of Scottish Government emergency funding and implementation of MAT Standards as a means of accountability. In exploring the intersection of rights, accountability, and health equalities, the authors argue for a need for nuanced understanding of the complex and multifaceted nature of addiction in policy decision making, and by extension, in commissioning. This echoes research elsewhere identifying the need for more targeted development work to address multiple inequalities that impact on substance use, such as Audit Scotland (2022) and the Hard Edges Scotland Report (2019).

The National Collaborative Draft Charter of Rights (2023a) presents a framework that incorporates PANEL principles (Participation, Accountability, Non-discrimination and equality, Empowerment and capacity-building and Legality) and the "AAAQ" framework of "availability, accessibility, acceptability and quality" as a tool that can be used to plan, develop, monitor and evaluate the right to health in the provision of alcohol and drug support. With clear outcomes and indicators attached to this framework there is scope for it to be embedded within future alcohol and drug support commissioning, although consideration would be needed as to how the monitoring of MAT Standards interacts with this to ensure monitoring and evaluation of rights is both proportionate and cohesive.

[11] In contrast clinical guidance from NHS England (2017) for case management of substance dependency observes comorbidities with mental health and sets out a rationale for a holistic approach to support and treatment of substance use.

9.2. Full involvement of people with lived experience

Although views varied on the quality and depth of engagement with people, all respondents felt progress has been made in this area over the last few years.

Several saw the MAT standards requirement for experiential evidence from people who use services, their family members and nominated person(s)[12] as a key driver across the system for increased engagement; others noting the National Collaborative work on the Charter of Rights as a factor.

Responses to this area reflected the range of perspectives held on how far involvement can, and should go, in commissioning services. Some ADP areas felt they have made progress from very tokenistic inclusion, towards creating structured and supported groups to influence service design, and to a lesser extent, have direct involvement in commissioning and procurement decisions.

However, organisations working with people with lived and living experience describe matters as **being 'light years away' from real engagement**, describing involvement as consultation only and not yet at influencing or co-design. They note that involvement is often actually simply seeking confirmation for an already agreed approach to service provision, and that decisions often go ahead without taking account of people's views.

Research into the involvement of lived and living experience of people in system change (Oertzen and others, 2022) coalesces around a range of tensions that practitioners/researchers need to hold. This involves recognising the experience of people as real and valid, and understanding that any preconceived ideas of why the involvement of people is necessary, and how this will assist in changing systems or practices, may be incorrect or partially correct. Creating physically and psychologically safe spaces and **acknowledging risk of reproduction of oppressive practices are crucial ethical considerations**, along with an awareness that **there may not be straightforward answers to emerging knowledge generated through this involvement**. Valuing relational outcomes and being able to articulate genuine partnerships are suggested as core contributors to meaningful involvement (Schehrer and Sexton,2010; Fulfilling Lives LSL Research and Learning Partnership, NPC, CRESR and Groundswell, 2021).

In the context of drugs and alcohol service redesign, living experience data generated as part of the evaluation of Residential Rehabilitation (Public Health Scotland, 2024a, 2024b) and in research by Healthcare Improvement Scotland and Scotland Excel (2023) has provided valuable information about how RR pathways should be developed to make access and experience more equitable to a wider range of people, and the implications for commissioning of RR services as a result. Living experience of MAT services has also contributed to critical analysis of MAT Standards implementation (Scottish Drugs Forum, 2021) and offered insights to making the Standards practicable.

[12] https://www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/pages/5/

A positive example was given in phase 1 interviews of a service developed and commissioned based on direct lived experience. In this example a family member with experience of living with their child while they were an active drug user shared their experience and their view that putting a service in place earlier may have prevented the resulting crisis. This was coupled with their knowledge about the evidence base for early intervention to submit a partnership bid into the Corra Foundation, match funded by the ADP.

The national ADP survey 2022-23 (Scottish Government, 2023a) indicates that ADPs find it difficult to involve lived and living experience in the scrutiny/evaluation element of the commissioning process when compared to the planning and implementation phases. It found that the most used methods of engagement were surveys and questionnaires. The survey also highlighted that a key development activity in ADPs is to improve LLE inclusion through LLE panels or fora. It is clear that there are a number of ways in which lived and living experience informs ADP commissioning with scope to do so in more depth and at different stages of the commissioning and procurement cycle. Exploring the support, capacity and skill sets required to do this ethically, meaningfully and creatively will be an important element of ongoing work at national level.

9.3. Outcomes focussed practice

The commissioning of alcohol and drug services is directed by the aim to meet the six national outcomes of the National Drugs Mission, and there are multiple channels for gathering and aggregating data - at both local and national level - about progress towards these outcomes and in the evaluation of interventions. This adds to the complexity of accountability, and planning, in this field when different data are collected, reported and analysed or aggregated through a variety of frameworks and processes.

Understanding, measuring and capturing individual outcomes, and understanding what individual organisations can and should be held to account for is a huge challenge in any form of commissioning. Recent and relevant data and information is needed throughout.

All respondents spoke at length about the real challenges they face related to data, quality and evaluation. They describe frustrations across the system that the information available is partial, lagging, incomplete and fragmented despite significant effort at local and national level to produce coherent datasets and other information to inform commissioning and service design.

"What's the point in gathering outcomes information and then not using that to say right, this is what's happening in the service, what needs to happen next?"
(third sector organisation)

Each part of the ADP gathers and analyses different data and information for different purposes, in addition to feeding in specific data to national databases such as DAISy[13].

[13] https://publichealthscotland.scot/our-areas-of-work/health-harming-commodities/substance-use/data-and-intelligence/drug-and-alcohol-information-system-daisy/about-daisy/about-the-dataset/

National data gathering on alcohol and drug services is primarily directed through:

- The monitoring and evaluation framework for Rights, Respect, Recovery (MERRR, 2019).
- The Drug and Alcohol Information System (DAISy) national database - developed to collect drug and alcohol referral, waiting times and outcome information from specialist drug and alcohol interventions.
- MAT (Medically Assisted Treatment) Standards (2021) and associated data capture.
- Evaluation of Residential Rehabilitation.
- Drug treatment targets - including focussed on increasing the number of people in protective opioid substitution therapy (National Drugs Mission Plan 2022-26)
- National drug deaths data (National Drug Related Deaths Database).
- Local service monitoring and evaluation involving lived and living experience (this also may intersect with lived and living experience as a data source within MAT Standards data gathering).
- Local service contract monitoring and evaluation for ADP commissioned services and non-ADP commissioned services.

While substantial effort goes in across the ADPs to capture and synthesise data, **this information is often siloed and difficult to synthesise into the kind of data required for fully informed commissioning decision making**.

This practice reality is reflected across evaluations and research that have been undertaken over recent years. In Residential Rehabilitation it has been observed that an inconsistent monitoring approach across ADPs resulted in insufficient data on the number of ADP/statutory funded RR places (Scottish Government, 2021e), and that there has been a lack of national outcomes data in relation to residential rehabilitation to inform planning (Public Health Scotland, 2024a). There is a need not only for standardised data, but also nuanced data analysis. One example of this is shown in the National Drugs Mission annual monitoring report 2022-23 (Scottish Government, 2023b) that states that data suggests care standards are improving but there are gaps in knowledge around why people are not accessing specialist treatment as a result.

Gaps in data collection on the progress of Rights Respect and Recovery outcomes were identified in the first Monitoring and Evaluation of Rights Respect and Recovery (MERRR) Report (Public Health Scotland, 2021). Although a national MERRR interactive portal[14] was created to make national outcomes and measures data accessible - with capacity to drill down to local area data - this does not appear to have been updated since 2019. This is indicative of the resources needed to sustain large data set availability, both in terms of having complete and coherent data sets provided in a timely way for analysis and having data processing capacity to manage that task. Together, these findings point to a structural challenge in evidence-informed decision making.

[14] https://scotland.shinyapps.io/phs-merrr/

Section 6.3 of the National Drugs Mission 2022-26 Plan (Scottish Government, 2022) acknowledges the importance of timely data and data linkage to improve holistic understanding of need. It states an intent to publish a comprehensive evaluation framework.

Through interviews respondents observed the following in relation to data:

- **Contract monitoring data:** Respondents felt that there are opportunities to make more of contract monitoring as an opportunity for learning, going beyond compliance, activity reporting and basic information.
- **Lines of enquiry:** Respondents were not clear what questions were being asked of the data collected and how (and if) it was put together at a national level to inform resulting Scottish Government priorities.
- **Feedback:** Respondents felt there could be better feedback loops between service provision and planning/commissioning. Where this worked well ADPs had open and regular conversations with providers that went beyond contract monitoring to discuss outcomes, unexpected outcomes, emerging trends and unmet need to better inform future commissioning decisions.
- **Whole system**: Respondents who were keen for a more whole system response to substance use thought better integration of data and information from justice, homelessness and other areas would help drive a more systemic approach to commissioning. Several respondents saw the development of a national patient record and better data sharing as a potential solution to this both for ADPs and the system as a whole.
- **Formal evidence:** Difficulties in using formal evidence about what works was noted by most respondents. This leads to gaps in commissioning decision making that are filled by heuristic approaches based on personal and professional preference for given approaches (e.g. harm reduction, abstinence based, treatment, support etc). It was generally felt this wasn't to do with a lack of research in this area, rather difficulties with research use.
- **Data lag:** All respondents noted the difficulty of commissioning based on out-of-date needs assessments and national data. Recognising the practical barriers to capturing live data respondents struggled to identify how this might be improved.
- **Data collection:** Services use their own, often bespoke, system for capturing activity, outcome and quality data. This then needs to be aligned with ADP reporting requirements, contract monitoring and national reporting requirements. Again, most respondents understood the practical barriers to a harmonised or single system.

Despite the challenges, some areas had undertaken thorough local mapping, building 'up' from lived experience and people's pathways through recovery, aligning with the evidence base and feedback from services to seek a 'golden thread' through a complex system from multiple perspectives.

"With scoping studies we intentionally take the position of, we start with the voice of lived experience and then what we start with looking at the evidence base. We start with the voice of lived experience and then speak to staff and practitioners and managers and then triangulate and kind of bring that information together."
(ADP coordinator)

Recommendation 9: Addressing the complexity and partial nature of the data in this area is challenging. An **increase in dedicated analytical capacity in ADPs** to improve the analysis component of the commissioning cycle would assist to do this. Coupled with recommendation 7 this capacity would improve both local and national data, providing a clear basis for decision making.

9.4. High quality care and support

National drug and alcohol policies broadly frame what quality should look like with regard to outcomes for people and when support is accessed, what it should feel like (respectful, non-stigmatising and with a whole-person focus). The Whole Family Approach (2021c) sets out a framework for providing a high quality holistic approach to including all family members including children within the provision of support for substance use. Quality Principles were developed and published by the Scottish Government in 2014, setting out guidance for standard expectations for drug and alcohol services across Scotland. In the review of literature and ADP plans for this research however it is not clear the extent to which this guidance is still used within current ADP work.

The work of substance use care and support services is also underpinned by wider care quality standards, such as the Health and Social Care Standards (2018) and the quality assessment ratings given in Care Inspectorate inspections. While Care Inspectorate inspections offer a nationally consistent quality evaluation of services, inspection reports often highlight the different tools and frameworks that individual services use to plan and evaluate the support they provide.

As explored above in sections 5.2 and 5.3, ADPs need to navigate a range of different types and sources of data (e.g. lived and living experience, national data, local service data) and guidance in order to make informed decisions and create a rounded understanding of the quality of the support provided in their area.

MAT Standards (Scottish Government, 2021b) seek to shape the longer term impact of medication assisted treatment and increase accountability on how this is available across Scotland. The standards focus on equity of access, personal choice, evidence-based harm reduction, and trauma-informed integrated care and support with the option to remain in treatment as long as requested. The phased implementation timescale for the Standards will necessarily reshape monitoring and evaluation approaches in localities, with MAT Standards 1-10 to be fully implemented in community and justice settings by April 2025, and by April 2026 sustained implementation of all the Standards is expected (Scottish Government, 2022). Support for ADPs with implementation of the Standards has been prioritised by the government through access to the MAT Implementation Support Team (MIST). Further resource has been directed to MAT implementation through Healthcare Improvement

Scotland MIST support[15]. While this is a comprehensive support package for implementation of the standards, this diverts focus towards MAT Standards where treatment is one element of the broader transformational work of the ADP.

The MAT Standards are described by Scottish Government policy respondents as a 'totemic' service improvement approach driving high quality support that is lent leverage and seriousness by a Ministerial direction in 2022, alongside central, expert support and oversight.

Respondents generally agreed that the standards had driven improvement in local intelligence and data gathering about the experience and effectiveness of services, but overall saw the MAT Standards as standards/performance targets rather than improvement per se. As with all actual or perceived target based systems, particularly those where funding is relatively prescriptive, unintended outcomes can result in some areas (Franco-Santos and Otley, 2018). ADPs could be placed in the difficult position of having to show progress against a commitment (e.g. to commission opioid stabilisation services), despite having insufficient funding to do so - resulting in seeking to redefine terms of the service to fit the need to meet the standard.

As discussed elsewhere in this report, over time the MAT Standards will necessarily intersect with other data gathering and quality assurance evaluation streams, as well as approaches to involving LLE and human rights (e.g. coherence with any future Charter of Rights for People Affected by Substance Use) within local ADP commissioning.

9.5. Financial transparency, sustainability, commercial viability and fair work

Primarily respondents in phase 1 spoke to the level, type and method of funding coming to ADPs as a major determinant of commissioning decision making and ADPs' ability to meet the ethical commissioning principles related both to finance and to fair work. These are detailed further below.

Annual cycle

All respondents noted that the annual cycle of funding makes it difficult to commission effectively, support sustainability and ensure fair work. Some areas attempt to hold this risk at ADP level, offering two and three year commitments despite this annual cycle, but most would prefer the flexibility to offer longer term contracts and funding. Late notification of Scottish Government grant funding adds both additional constraints and risk to the ADP. Annual contracting and grant making also requires additional bureaucracy. Respondents noted that one major improvement that could be made to ADP commissioning is the reinstatement of three year budgets.

[15] https://ihub.scot/improvement-programmes/housing-and-homelessness-in-healthcare/access-choice-support-medication-assisted-treatment-mat-standards

The non-recurring nature of funding can constrain the ADPs ability to commission with providers unwilling to bid for funds for staff salaries that may only last 9-12 months.

Funding prioritisation and fragmentation

Funding comes to the ADP already prioritised, with the initial National Drugs Mission funding, for example, split into six pots with spend directed centrally. This is in contrast to wider social care support commissioning where there is more freedom to prioritise locally. Respondents were evenly split on the role of prioritisation, some arguing the directed nature of the spend allowed focus on community aspects and protected the funding from being pulled into treatment with other ADP areas maintaining the need for flexible funding responsive to evolving local need.

All respondents noted that due to the SIMD based funding allocation system some smaller areas received funding that was not sufficient to establish the required services. This was noted particularly in supports that required 24/7 cover such as naloxone support. ADPs sought to mitigate this through a range of approaches, including consortium commissioning and upskilling of workers in adjacent services (justice and homelessness) to improve the wider system's response to people with problematic substance use.

Funding sufficiency

All respondents felt ADPs were under-resourced with some maintaining this is primarily due to where the money is spent, rather than the total resource per se. A clear example of funding insufficiency is illustrated by residential rehab funding. One ADP respondent received enough funding for six residential rehab places, however the Ministerial requirement for an open access model cost far more as demand for places was significantly higher, requiring the use of HSCP reserves.

This illustrates two interrelated challenges for ADP commissioning. The directive nature of the funding means only certain priorities can be resourced. Despite the funding being insufficient the requirement to meet central high level outcomes and commitments remain. Alongside this runs the difficulty of integrating political priorities with the evidence base. The evidence base shows that simply sending people to rehabilitation, without community and wraparound support is not effective, but limited funding cannot be redirected locally away from this priority. As with all priority driven approaches to improvement this leads to ADPs having to make least worst commissioning decisions and focus on managing demand through tightening criteria and access to services. This places ADPs in an irresolvable position despite this also being against the stated aims of the National Drugs Mission.

ADP and provider respondents saw national commissioning and procurement of residential rehab as a potential solution to meeting demand for residential rehabilitation but generally thought resources would still be insufficient to meet the rising demand.

Sustainable pricing and commercial viability

Provider respondents noted budgets are often too low for the cost of delivering the service, tracing this back to the sufficiency and fragmentation of Scottish Government funding. Contracts and funding were generally based on block funding rather than hourly rates giving flexibility to providers on bidding, but also allowing for unsustainably priced tenders with unrealistic staffing requirements for the funding on the table.

Positive examples of practice included ADPs that had collaborated across silos to pull money together to create a reasonable budget, and ADP areas that commissioned collaboratively. Respondents noted that where ADP coordinators had a substantial third sector background they tended to understand service costing from their professional experience.

Lack of uplifts to funding were seen as the primary challenge to commercial viability, this is due to those working in drugs and alcohol services not meeting the definition of worker within adult social care and thus not attracting the annual negotiated uplift.

ADP funding is allocated on the basis of SIMD data meaning some areas receive comparatively small pots of siloed funding, which can often be less than the critical operating costs for the required services. Scottish Government ADP funding does not attract the negotiated annual uplift for the payment of the living wage in social care[16], creating challenges for providers in ensuring salary parity across their organisation.

Fair work

Fair work as defined in the ethical commissioning principles is not fully articulated in the key policies that shape alcohol and drug services. However, core objectives related to the National Drugs Mission are "To develop a sustainable, trauma-informed, skilled workforce with the capacity to deliver a person centred, rights based approach" and "To develop a workforce which is confident, valued for the work it does and is fully empowered to prevent drug and alcohol related deaths and improve lives." (Scottish Government, 2023c).

Fair work is contextualised by objective and specific workforce interventions set out in the Drugs and Alcohol workforce action plan 2023-2026 (Scottish Government, 2023c)[17]. A range of interventions have been set out[18] in the plan that includes creating a workforce which is inclusive, diverse and reflective of the communities that it cares for and supports.

[16] https://www.gov.scot/news/pay-uplift-commitment-for-social-care-and-childcare-staff/#:~:text=This%20uplift%2C%20announced%20in%20the,staff%20in%20ASC%20and%20ELC.

[17] This plan is framed by wider objectives and interventions of the National Workforce Strategy for Health and Social Care in Scotland (2022) setting out a national framework to achieve a vision of a sustainable, skilled workforce across the entire Health and Social Care sector.

[18] Key objectives in the alcohol and drugs workforce action plan: Increasing front line health spending; Establishing a centre for workforce supply; Delivering a workforce which is inclusive, diverse and reflective of the communities that it cares for and supports; Increasing the number of medical school

The plan also states an alignment with the principles of Fair Work, and the Scottish Government's broader strategic aim to become a leading Fair Work Nation by 2025. In doing so it recognises key challenges for the alcohol and drugs workforce around recruitment, retention and service design. Key points from the plan salient to commissioning are made around:

- The impact on short term funding on recruitment and retention of workers.
- Stigma and burnout that is encountered within drug and alcohol work.
- Lack of clear career pathways.
- The impact of geography on recruitment.
- Where service redesign may be needed to make more effective use of workforce skills, abilities and interventions.

The elements listed above were not explored within the interviews but would merit investigation as part of more focused research on the intersection between commissioning and fair work within the field of alcohol and drugs support.

Respondents identified the fundamental challenge in embedding fair work practices in a system of short-term funding, that is under-resourced and does not attract uplifts to meet rising costs and salaries, unlike the wider social care support system.

Providers noted that fixed short-term funding makes it difficult to recruit staff and makes it impossible to give stability to staff as future funding is unsure. They note there is a particular challenge in the recruitment and retention of skilled staff who are not attracted by the unstable and short-term nature of this work. Again, this is a microcosm of wider recruitment and retention issues in social care support with the issues heighted by short-term/variable term funding in the sector, particularly for innovative or pilot approaches.

"Once the commissioning plan is done and ready - it will have the option of 2 + 1 years as well. Because it's not fair for staff"
(ADP coordinator)

Some ADP areas seek to mitigate this through managing the risk at ADP level and offering 2-3 year commitments. However, sustainability levers (e.g. annual inflationary uplifts) are outwith the control of ADPs and sit with the source funders.

Recommendation 7: For ADP commissioning to fully support human rights in practice **human rights based budgeting**[19], (see also, Scottish Human Rights Commission, 2023) is a potential way to shape how funding is used in ADPs. This would require a radical reset of how resources are considered as well as a more outcomes base and less segmented approach to funding.

places; Recruiting additional Primary Care staff, including GPs and pharmacists; Supporting nursing and midwifery training costs; Increasing Local Authority Social Work capacity.

[19] Human rights budgeting is a powerful tool for change.

9.6. Shared accountability

Overarching governance and accountability for alcohol and drug services sits with the National Drugs Mission Oversight group[20], with local accountability for services devolved to Integrated Authorities through ADPs working to guidelines set out in the ADP Partnership Delivery Framework (Scottish Government, 2018). Over recent years a range of evaluations and external reviews identify accountability for alcohol and drug services as requiring improvement (Audit Scotland, 2018, 2019, 2022; Public Health Scotland, 2021,2024a). Improvement has been called for in:

- Clarity of governance roles and responsibilities at strategic levels in local areas.
- Processes for information and data sharing.
- Timely availability of relevant evaluation data for performance management.
- Time lag in public reporting on progress on national outcomes.
- Transparency in the tracking and reporting of spend, and clarity on funding streams.
- Transparency on decision making prioritisation.
- Analysis and reporting linking spend and outcomes.

The National Drugs Mission 2022-2026 Plan has also referred to further development of accountability (Scottish Government, 2022). The Plan highlights a broad spread of development work to improve accountability at national and local strategic levels, with the involvement of IJBs, Public Health and Public Protection, and further inclusion of lived and living experience as an integral part of this. Support from the government with the implementation of MAT Standards was also prioritised. The range and depth of improvement areas identified sets out a need for improved overarching clarity, structure, and resourcing to support local and national accountability.

Designed to be a partnership, ADPs are structurally set up for shared accountability, however respondents saw accountability in practice differently. This difference reflected the range of views people hold on the role of positional and non-positional leadership within commissioning.

> *"they have no responsibility, there's no one in terms of governance who is your boss but you're doing your best"*
> *(Policy lead)*

One group of respondents argued that a clearer role for ADPs alongside constituting them as legal entities would improve accountability in terms of knowing 'who is in charge'. This group described the current situation as characterised by 'amateurish governance' simply relying on good people with good intentions to do the right things and that this led to diffuse accountability and people not knowing who to go to with a complaint or to challenge a commissioning decision.

More charitably this group also reflected that ADPs are given a high level of responsibility for 'fixing' the complexity of substance use, but do not have adequate leverage to do so -

[20] https://www.gov.scot/groups/national-drugs-mission-oversight-group/

creating an irresolvable tension for ADPs, and in particular the core ADP support team. They also noted national input is seen as critical in driving consistency of support for people; this does not always fit with the stated ambition to empower and encourage localities, nor does it necessarily drive consistency, particularly in access to residential treatment.

There is clearly a tension between seeking consistency across Scotland through centralised direction and encouraging local variation, expertise, creativity and best use of public funds through effective commissioning. This set of national drivers arguably creates a less independent form of commissioning than seen in other parts of the social care support system.

By contrast, other respondents saw 'good people with good intentions doing the right thing' as a very effective way of working. Explored in more detail across the three case studies, thoughtful approaches to relationship building can drive collaborative, locally responsive commissioning despite the constraints of the wider system. One area had worked in detail to rebuild relationships following the disbanding of the ADP and a period of dysfunctional relationships. Other respondents focussed on collaborative commissioning practice through seconding and co-locating staff between statutory and third sector services. Ensuring ADP subgroups were co-chaired by both statutory and voluntary sector representatives also signalled a collaborative approach to decision making.

Recommendation 3: ADPs would benefit from '**just enough' guidance to support development of commissioning strategies to sit alongside ADP plans**. Guidance should not add to the directive funding environment by being over-prescriptive but should focus on locality needs and requirements. Guidance alone does not drive improvement so this recommendation would require comprehensive implementation support to be successful.

Relationships and power

Respondents drawn from lived and living experience organisations and the third sector described ADP commissioning as characterised by power differentials and strongly shaped by cuts in funding in the wider system.

"because the system is extremely powerful and the system now thinks they can tell recovery communities, Well, you're commissioned by us, so we will tell you what you're doing. It's instructive about power, power and control."
(third sector organisation)

Recovery communities expressed concern that funding requirements that have driven them formalise have pulled them into the system they sought to critique and change, reducing their independence and drawing them into the funding/funded relationship which they saw as inherently about control.

Third sector respondents noted that partnership in some areas can feel nominal, noting that they have one or two seats at the table with the majority of seats belonging to statutory services. They described the majority of partnership working as respectful and collegiate but

noted that their influence was very limited with statutory services prioritised in terms of funding and 'what's left over is discussed with us'.

"You know we [...] we're, we're respected and stuff like that [...] but when it gets to the meetings that are further up the chain in the ADP we get one or two seats in the ADP meetings and the rest is made-up of statutory service people. So yeah the voice is there but how much an equal voice is that you know when we are talking on behalf of the whole sector"
(third sector organisation)

Other respondents saw this nominal partnership as a microcosm of the system of the whole. They drew parallels between ADPs and the unfolding development of the NCS noting that power is concentrated in large institutions driven to maintain the status quo. They noted that without substantial challenge and greater accountability these institutions will continue to struggle to actually do public sector reform and build real equity between the third and statutory sectors, reflecting on how in times of financial constraint the core purpose of public service as all parts of the system seek to protect their resources and future.

"We need public sector reform; we can't keep working at this kind do more with less in this way. It's for the local authorities as well to actually make the change. They keep talking about "how can we make the change when we haven't got enough money and cutting services: and I say well come and work for the third sector, we've been doing that for years! We can make change at the same time as get on with our core business"
(third sector organisation)

All respondents described the distinction in relationships between the ADP team, the wider ADP and the HSCP, local authority and local councillors. Relationships with the core ADP team were generally described as positive and straightforward but there was understanding that decision making on service provision did not rest with the team, but rather the larger partnership with whom relationships were less clearly defined and seen as more challenging to build and maintain.

Several respondents said there was a need to build the knowledge of councillors and local leadership about the ADP system and the complexity of the people it supports. They noted an example of good commissioning practice being undone by political decision making by elected members who found cross-ADP commissioning politically unpalatable. This example was a consortium commissioning of a service that would have been unaffordable to separately commission in each area and had been successfully commissioned and delivered in multiple areas making use of economies of scale.

Recommendation 8: Build a learning oriented system to ultimately replace the current target driven approach. Closely linked with recommendation 1 this would include **developing more equal relationships to underpin a live learning loop between the Scottish Government, ADPs and providers.** This would improve the whole system's responsiveness to changing need, reducing the information lag between practice and policy and allow political priorities to be shaped by learning from practice.

9.7. Climate and circular economy

Climate and circular economy were agreed with Healthcare Improvement Scotland to be outside the scope of this particular piece of research at the outset due to the scale and timeframes of this research piece requiring a focus of research and analytical efforts. The principles of climate and circular economy were not discussed by any respondents and there was no substantive relevant literature to explore in relation to ADP commissioning, service design or national direction.

10. Case Studies

For phase 2 of the research we spoke to three ADP areas in depth about the work they have done to improve commissioning; their view of themselves as commissioners; the barriers and facilitators to effective commissioning (locally and nationally) and their personal and practice ethics and how all of these aspects related to the ethical commissioning principles. We triangulated their perspective with those of provider and lived and living experience organisations.

Given the small number of respondents, and the limited triangulation, it is unwise to draw too many comparisons however it is important to highlight that the approach to commissioning within these ADPs goes beyond first level engagement[21] with ethics and practice. All three areas are grappling with substantial questions and tensions that form the foundation of a thoughtful approach to commissioning in a constrained system.

- Ethical practice and ethical commissioning in a system constrained by finance, notions of risk and stigma.
- Balancing the range of earnestly held, and often contested, views on the 'right' approach to treatment and recovery.
- Ethical commissioning in a siloed and linear system when many of the drivers of substance use come from exogenous factors outwith the control of the ADP.
- Ethical localised commissioning in a system where commissioning decisions are shaped nationally.

Overall it is clear that ethical practice is core to the intent of the work of ADP areas, all three areas have developed the foundations of practical ethical commissioning in their focus on relationships and involvement of people with lived and living experience. However there is not (yet) evidence of substantial changes to commissioning practice, procurement and contracting.

The case studies do not engage substantially with the mechanics of commissioning in ADPs (which are covered in the phase 1 discussion). Rather they focus on these more complex aspects, attempting to bring together the threads of commissioning role conceptualisation, personal and professional ethics, commissioning intent, commissioning practice and commissioning effects.

- Case study one focuses on the role of adaptive leadership and learning in ADP commissioning.

[21] First level responses are solutions or answers that spring immediately to mind when a person is presented with a problem or situation. For purposeful cultural innovation engagement is needed at further depth, recognising that first solutions tend to be things that are familiar/easy to do (e.g. write guidance) rather than new ideas or depth of change. (Rehn, 2019)

- Case study two focuses on human rights in ADP commissioning.
- Case study three focuses on relationships and whole systems in ADP commissioning.

Triangulation interviews

Triangulation interviews broadly supported the ADP and strategic planning perspectives on commissioning. Respondents identified the focus relationship building, human rights and lived and living experience as a positive focus.

Respondents identified, and were sympathetic to, the challenges ADPs face in terms of lack of positional authority in a system full of powerful and sometimes contradictory voices. They acknowledged the challenges that the ADP areas face in having to bring together fragmented funding and diverse priorities to form a local strategy. Overall respondents were thoughtful and nuanced about what was within the sphere of control of ADP areas and what was driven primarily by national priorities.

Respondents identified gaps between intent and commissioning practice, particularly in relationship to procurement processes and funding sufficiency. Respondents identified the structural distance of the coordinators from procurement and contracting as a key gap.

Respondents were critical of the priority given to funding statutory services across the system. They argued this leaves ADPs with little to commission and means they are attempting to optimise what is only a very small part of the overall system, which, no matter how well done, can only ever have limited success in meeting local need.

They also saw a lack of accountability within both statutory services and ADPs arguing that similar levels of contract and performance oversight should be applied across the system to drive up quality and promote consistency of services. This would mean essentially 'commissioning' statutory and external services on the same basis.

Recommendation 5: The balance of funding between statutory and commissioned services also intrinsically limits ADP ability to commission, and to commission ethically. At best ADPs can only commission for a very small part of the whole system of drug and alcohol services. **A review of expenditure, intervention effectiveness, individual service choice and quality on a whole system level coupled with a willingness to shift investment** would support ADPs to commission on a systems wide basis. Coupled with the development of **cross-system accountability measures** would help reduce fragmentation and focus work on the boundaries between services (e.g. ensuring wrap around community support for those returning from residential rehab.)

North Lanarkshire ADP

North Lanarkshire Alcohol and Drug Partnership (NLADP) was established in 2019. It is a partnership of a range of agencies that aim to understand and mitigate the effects of problematic drug and alcohol use in the area. The area has some of the highest levels of drug and alcohol related deaths in Scotland. It is notable that, when asked, the vast majority of (89%) people responding to the survey felt their community had an issue with alcohol or

drug use and that there was a comparatively low level of available support in the community (SFAD, 2020[22]).

The NLADP 2021-2024 strategy describes their work as coordinating and leading a collective response to plan and improve services and set out what needs to be put in place to support change. Their vision is for a North Lanarkshire where individuals and families experience less harm from the effects of alcohol and drug use. People are safer, healthier, treated with dignity to make informed choices around their own care, and empowered to find their own type of recovery.

The ADP is composed of an overarching Board and a range of thematic subgroups that support the five strategic aims of the partnership: Prevention & Early Intervention[23]: Treatment Care & Recovery; Whole Family Approach; Public Health Approach to Justice; and; Reducing Alcohol Harms as well as a functional subgroup dealing with financial decision making. At the time of writing they are completing their 3 year strategy and developing their next (5 year) strategy.

The ADP is supported by a small team of officers including a strategic lead, development; information and research; peer worker, and administrative support. NLADP takes a high transparency approach to their work with strategy, services, resourcing, planning and expenditure information clearly available on their website.

Lived and living experience, human rights and the workforce

A focus area for this ADP is getting beyond lived and living experience 'involvement' to deeper ways of working with people both in the support and commissioning context. Reflection from a recently appointed peer worker describes a respected and valued role, far from concerns of tokenism, where autonomy of practice and a focus on natural relationship building form the basis of effective peer work.

This raised a series of questions for the ADP including how they might in the future build a collective workforce that integrates lived and living experience into core practice without distinction between 'peer worker' and 'worker'. This commissioning intent draws together a number of key aspects including national priorities (developing a resilient and skilled workforce; reducing stigma); ethical commissioning principles (person led, full involvement of people, fair work) and an attempt to get beyond simple 'involvement' of lived and living experience to something more foundational in approach.

Sustainability, innovation and change

In this area the ADP coordinator has a clear sense of the purpose. They describe the commissioning aspect of the role as looking at what works in understanding and supporting recovery from problematic substance use and putting that in place for people in North Lanarkshire:

"My part is literally, bring the threads together, get the right people around the table and weave them together"

[22]Scottish Families Affected by Drugs (2020) "Hidden in plain sight? The experiences of families affected by substance use in North Lanarkshire" https://northlanadp.org/local-and-national-publications/

[23] The Prevention & Early Intervention and Whole Family Approach groups have now merged as the memberships were the same.

The approach to commissioning is primarily innovative and systemic. The ADP seeks to both fund and evaluate innovative services and approaches to change with successful tests being mainstreamed by the HSCP. A key facilitator to innovation at depth in this area is a commitment to persistence. This means commissioning a change for long enough to really understand its usefulness, its limitations and gather the learning. This approach exemplifies attempts to protect space and time for local experimentation and solution development within a short term, directive policy environment.

Systemic aspects of practice reflect both the background of the ADP coordinator (service provision) and the cross-HSCP interest in systemic approaches such as Human Learning Systems (HLS), as well as the coordinator's and ADP Chair's approach to leadership, accountability for learning and failure tolerance.

The ADP attempts to provide funding stability as a component of sustainability through 3 year funding commitments and transparency about expenditure on the NLADP website, strategy and update documents. Having some unrestricted budget allows a degree of leverage for the ADP in the system, giving the space noted above to commission for innovation. Although their budget is protected the respondent noted the coming cuts in funding to other services will likely have an impact on substance use services given the interrelation of this with poverty, justice and homelessness.

Outcomes, learning and evidence

An approach to continuous learning is a core part of commissioning practice in the area. A recent example is the ADPs plans to evaluate outcomes for people leaving residential rehab to understand the effectiveness of this intervention. Access to residential rehab is a national priority[24], however demand exceeds available resources, and residential rehab arguably runs counter to other policy drivers such as personalisation and community first responses.

While this will give useful data for the locality, there appears to be no immediate feedback loop to the Scottish Government for this data to inform the future national priorities that fundamentally shape ADP commissioning. This is an example of the break in the system that means long term implementation of the right system of support will remain challenging for both ADPs and Scottish Government.

This reflects the overall issue of data currency, data lag and missed opportunities for shared learning across the system. Some delays are practical e.g. it takes a minimum amount of time to run toxicology tests to determine the cause of a drug death. Other delays relate to how information is captured and a lack of a coherent learning infrastructure across the sector.

Leadership, purpose and people

As identified in phase 1, there are multiple voices, some very powerful, with multiple ideas about how best to organise and prioritise treatment and recovery. As a partnership the ADP relies heavily on adaptive leadership[25] to progress its aims but is made up of leaders and workers from a largely expertise-driven and hierarchical culture, particularly those with a clinical background.

[24] https://publichealthscotland.scot/media/25128/v5_rr-evaluation-baseline-findings.pdf

[25] Adaptive leadership is a systemic approach based on anticipation of needs, trends and patterns; building collective understanding and support for action: adapting, learning and responding to change and focussing on open accountability, maximising transparency in decision making and action selection. (Heifetz and Linsky 2002)

"Like that orchestra idea there's a bigger score, not just our different parts and yeah… I need to keep pointing to that."

This poses a challenge to collaborative decision making in commissioning, with the ADP tasked with modelling and explaining the benefits of adaptive leadership that focus on collaboration. This can be frustrating to those with expertise leadership backgrounds. The ADP coordinator is clear that is not a simple dichotomy of one approach being better than another but rather a recognition of when expertise leadership is key (for example in setting up same-day prescribing) and when adaptive leadership comes more usefully into play (making commissioning decisions that enable a system of care and support.) This tension is addressed by early and honest conversations across the partnership and building collective understanding and ownership, particularly with powerful professional groups. Despite this the ADP has struggled to get buy-in from some professional groups, particularly those who are under pressure through increasing demand and resource scarcity.

Resource scarcity works against adaptive collaborative approaches, increasing (understandably) individual partners' worries about sustainability and effectiveness of their part of the system of care and support. Coupled with worries about risk (some factual, some cultural) this creates a challenge to maintaining commissioning vision and purpose. The ADP coordinator recounts a conversation that illustrates this challenge:

"We can't put this fire out with this bucket of water because that bucket is not health and safety compliant or issued by the right department. It's like somebody pick up the bucket and just put the fire out!"

The ADP has a nuanced take on the role of the MAT Standards. They describe the standards as providing accountability across the wider system bringing substance use to the attention of senior leadership as well as bringing a previously missed focus on experiential data from people and process evidence to assist in quality. They are reflective, however, about national prioritisation where this is shaped by a small group of, albeit committed, people without an ongoing connection to the learning from providing direct support.

Ethical practice and ethical commissioning principles

The ADP coordinator described their ethical basis centred on their own values, lived experience and practice experience from working in services and support. They traced multi-layered career-spanning drivers of 'doing the right thing'; seeking to challenge injustice; work collaboratively and seeking the feeling of having done good work as their ethical practice principles. Although these differ from the ethical commissioning principles these drivers form the practice foundation on which they can be mapped.

Recommendation 2: Ethical principles need to **go beyond being stated values into being lived values, aligned with the personal ethical base of the commissioner**. Implementing the ethical commissioning principles with commissioners should focus on drawing out an individuals' practice ethics, mapping these to the principles.

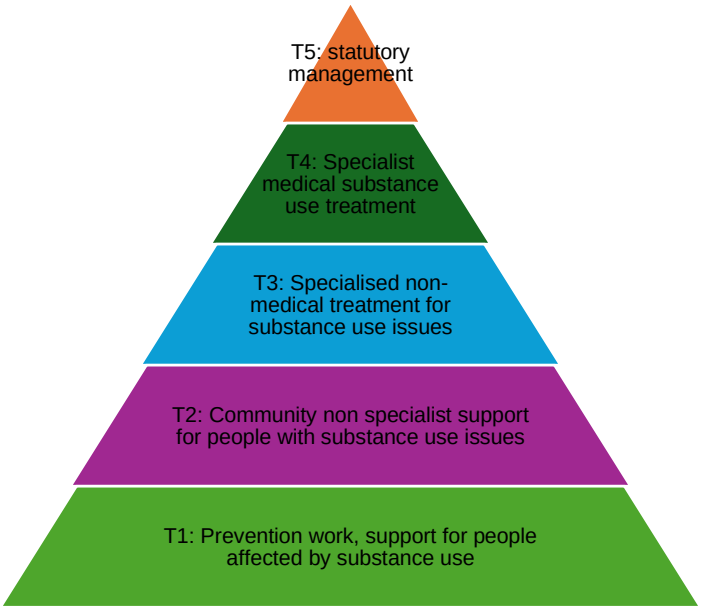
Next steps

Alongside Scottish Families Affected by Alcohol and Drugs (SFAD) and Alcohol Focus Scotland, the ADP has committed to addressing alcohol related harms, recognising high prevalence of harms and deaths in the area.

Nationally the ADP would like to see the development of a collective, a movement of people, to think through next steps following the end of the NDM in 2026. They suggest a piece of work analogous to the 2015 Partnership for Action on Drugs in Scotland which took conversations out to communities across Scotland to shape the strategy Rights, Respect and Recovery. The purpose of which being to create visible leadership for, and a collective movement behind, the next phase of national work.

Clackmannanshire and Stirling ADP

Clackmannanshire and Stirling ADP cover two local authority areas and one HSCP/IJB Partnership. The ADP has been moving towards a five-tier approach to organising services in the area.
This has involved developing a commissioning consortium for service provision of specialist psychosocial support and specialist medical substance use treatment (tiers 3 and 4) as well as developing and maintaining strong integration between the other tiers of support, allowing people to move through these as needed. The system includes a single point of access for commissioned services with the commissioning approach designed to support responsive and flexible supports around a person's changing needs.



Sustainability and relationship building

There is a presumption in the sector that in practice everything starts and ends with statutory support and treatment and in many areas the investment pattern follows this. Commissioning is a key vehicle to create an effective system of care and support around people that includes prevention and early intervention.

The ADP coordinator was clear that they are working to reset that investment pattern to follow the tiered model and rationale set out above. In this area 'technical' levers (tiering, planning, strategy, investment and commissioning approaches) are blended with an attempt to reframe the mindset of the ADP system of care and support towards a rights-aware system.

The first step was to be transparent about where funding was invested, acknowledging to partners that 5% of funding was going into specialist services. Communicating and owning honestly the reality of investment imbalance was core to building good relationships with

service providers. The ADP coordinator was clear that relationships are based on experience, not on an abstract notion of trust, and one of their roles as a commissioner was to build constructive experiences as a foundation of collaborative working:

"If you're a third sector organisation, you're used to being treated in a certain way and you're not likely to assume the best. It's a big risk for you to assume a different way of working especially when legislatively you know the power structure has not changed."

The coordinator made use of their background in service provision to understand how the proposal to change commissioning arrangements might be received by third sector partners and to recognise and highlight the third sectors' deep knowledge of the communities they serve, their understanding of structural barriers and the injustices they face.

Human rights approach

The coordinator is focussed on building a collective understanding of substance use as being around human rights and using this narrative, along with the consortium approach to commissioning, to move away from the idea of a single 'treatment entity' to the tiered system of support set out in the diagram above:

"it takes a long time for people to acknowledge that they have rights, that they are human beings. And I mean that in the most literal sense, like that they are human beings who are deserving of care and dignity and all of those things."

Looking to national policy they note there is a cross-system assumption of a human rights approach in ADP commissioning but no focus on what that means in practice and for the different partners in the ADP. For example, the loss of power for some partners that would come about were human rights to be put into practice. Some partners are powerful and thus have an interest in keeping the system as it is. ADP coordinators, who lack institutional/positional authority, can then be out on a limb, trying to reset a system without a network or movement of people to support them:

"We face a lot of resistance in pockets of the system, people perceive their power as being lost. They perceive that change is a form of [clinical] risk is probably the number one thing I hear all the time even though there's no basis for that."

In this, the coordinator highlights a core tension between the 'technocratic health management' of the MAT standards, driving optimisation of parts of the support system in treatment and recovery, and the less defined assumption of a human rights approach. The ADP coordinator is seeking to put a rights aware system into place which will make a profound change to the current system.

The change the coordinator identifies is foundational. They note that a rights-based approach highlights the paradox that the ADP is working for people whose rights have been systematically infringed by the very agencies that compose the partnership:

"So like in a very concrete way the, you know the people whose lives we're trying to improve and whose outcomes we're trying to improve [are] all the time being disenfranchised and marginalised and mistreated by what's represented on this planning partnership."

A rights-based approach in practice involves a fundamental change to the political position of people in the decision making structure. The reset of investment and commissioning approaches, they argue, takes the ADP some way towards this change but to make significant inroads would require a focus on empowering people, a liberation movement approach. Drawing on learning from the development of sexual health services, borne out of a community movement of people who did not feel they could rely on the mainstream healthcare system to support them and developing something themselves. Even now these services are substantially more community led than other types of service.

"[human rights] doesn't just happen because someone in a job comes and tells them that they have them […] we found in the starkest circumstances you know you can ask people with substance use problems and they'll recount ways where they've been treated and they're sometimes still being treated in ways nobody else would accept."

The ADP coordinator role is not a clearly defined one, this coordinator describes their role as a secretariat to a decision making body (the ADP itself) but notes that the public can view the coordinator and support team as powerful figures - attracting personal criticism of decisions and direct service and access complaints. A key facilitator for ADPs seeking to make change is senior and national leadership providing cover and validation for their work.

The coordinator views the role of commissioning primarily in structural terms: the building of an infrastructure that creates the conditions for people to recover as well as a structure around which to coalesce partners, valuing the range of individual and organisational practices while aligning these to concrete priorities.

They see values-based commissioning principles being realised with the consortium approach. and conceptualises ethical commissioning as being about how you change the way that you, and the system you work in, make decisions.

Shared accountability

The coordinator notes that even the best ADP in the world is constrained by exogenous factors. No matter how hard an ADP works it can't bring drug deaths to zero or control the flow of cocaine into their area, and sometimes it seems like ADPs are being held accountable for a change when many of the levers are outwith their control. ADPs should be accountable for and focus on radically rebalancing the delivery of care and support, reducing the way the system harms people.

"like I can make sure that from October no one's going to have to get three buses to get their methadone but that's just me stopping the healthcare system being particularly awful to a certain group of people. It doesn't actually change the material circumstances of their lives in any way."

Echoing respondents from across the research they note that people with lived and living experience often identify barriers outwith the ADP. In Clackmannanshire and Stirling transport is a key barrier, with most drug services located in Stirling, but the population is dispersed throughout the area.

Peer inquiry, hearing from people and direct support workers, can tell ADPs where the real issues are or help them to get behind a pattern to understand it. They share an example of a cluster of Hep C re-infections in an area, where knowledge from people and workers identified people injecting cocaine who were not getting a sufficient amount of equipment for

safe injection. In this example, the third sector support provider organisation had knowledge of this problem for a year but felt that partners within the commissioning structure were not taking them seriously to help address the problem.

Without a good feedback loop from people and workers' experience, and respect and value for that information, they spoke of how it would be easy for the ADP to go with local or national drug use patterns (which are predominantly opioids). As a result this information could be missed, and therefore so would be the answer of how to respond to it.

The coordinator also identified siloed working more generally as a key barrier to recovery and treatment, noting real progress will not be made until siloed working between the substance use and mental health fields is addressed. Here their point links to the broader challenge for ADPs in lacking positional or institutional leadership and not having, or not perceiving they have, the levers to address this type of wider issue.

"where we've been able to hear people who are, sorry I hate this phrase, but like on the front line of this, saying actually the problems you think you're dealing with are not the real problems."

Full involvement of lived and living experience and person led care first

The commissioning consortium involves the views of people with lived and living experience (LLE) much more than previous structures. The coordinator's background in academic research brings a useful perspective and skillset to capturing views though focus group work. Coupled with MAT experiential data the data from this LLE engagement brings a stronger and clearer voice to decision making.

The coordinator plans to do more participatory work like peer inquiry so people can put across what isn't working from their perspective. The overall theme of developing a rights-based system is put into practice through commissioning an unusual local organisation (Resilience Learning Partnership) to assist the capture and use of lived and living experience. RLP describe themselves as a trauma network, rather than a substance use organisation. They are seen in the ADP as bringing lived experience of the oppression that follows from substance use and wider determinants of inequality and distress such as poverty, homelessness, justice and the experience of being part of a minority group.

A strong foundational value in this ADP is the idea that the primary outcome in ADP support is, and should be, the development of relationships and the absence of an undercurrent of transaction. Broader public, and some clinical, opinion can frame substance use support as transactional, linear and to some degree moral - where a person is "deciding to be a better person". This idea of a trajectory or a linear pathway through a service system is seen by the coordinator as counter to a human rights-based approach. The ADP coordinator reflected that the human rights approach is something that can be driven by both commissioning and by proactive change.

Commissioning can change the structure of how people interact with the system; and centre people with lived and living experience in its analytical and decision making phases. However direct practice needs to be human rights-focussed to ensure people are treated the way they should be treated, and know how to claim their human rights, seek remedy and navigate the system to best effect.

Outcomes focussed practice

The ADP coordinator centred on transparency in this aspect of commissioning. They noted that it is important for public bodies to be accountable for the right outcomes and also be clear on factors they can't influence, the outcomes they can't deliver on, and things that prevent them achieving those outcomes. This again is a call for realism in what alcohol and drug partnerships can do, and for making sure that a commissioning vision does not pull too sharply away from resourcing and decision making realities. This means that commissioning can put things in place to mitigate or work around barriers but may not be able to directly resolve them.

"[Good practice is] being able to acknowledge, from a commissioning perspective, large elements of your own powerlessness."

In contrast, in relation to working with people the ADP coordinator had a different view. Here outcomes could be used to communicate hope and to show that recovery is possible, especially where the journey to those outcomes is clearly and tangibly described in a way that people who are struggling can hold on to. This tangible description is critical.

"Nobody wants to hear a lofty commitment to ending poverty and ending addiction - it's too far away from people's lived reality."

Learning

Aligning with their perspective that substance use services should be not just about delivery but rather be a movement and a change in mindset, they view the commissioning consortium as not simply transactional but a way to collectively reflect and make sense of circumstances. It provided a space where the third sector and others can challenge the ADP on whether its approaches benefit the people they support.

Returning to the idea of a rights-aware system they see the ADP role as about empowering both people and workers to make their own points on their own behalf, and then listening to and acting on these. This can and has led to uncomfortable discussions and risks raising "an army of annoyed people". But the ADP coordinator is clear on the importance of having uncomfortable discussions, raising problems in common (e.g. recruitment and retention) and working through complexity. This approach is more challenging to navigate and describe than a traditionalist/transaction-based commissioning approach, but over the longer term they believe it is fundamental to a rights-based and systemic approach to commissioning.

Next steps

Locally the ADP coordinator is focussing on strengthening the influence of people with lived and living experience, particularly ensuring it is the core part of all decision making in commissioning. They are also focussed on continuing and strengthening open commissioning discussions within the consortium - as part of building people's skills and capacity to advocate for themselves across the ADP and at all levels.

Nationally the ADP coordinator suggests some interesting next steps for substance use policy these include:

- Using the last two years of the drug mission funding to fund innovation that can bridge to a totally new system - a system that's fully rebalanced towards early intervention and prevention.
- Getting underneath why, with our strong technical response to reducing drug deaths, we still see these rising, and work on new approaches from there.

- Thoughtfully consider the political framing of substance use as being about reducing drug deaths. What might a mindset, or a political response, to substance use that is focussed on life look like? Where might that take us?

Perth and Kinross ADP

At the time of interviewing Perth and Kinross ADP were at a transition point, closing and reviewing their 2021-2023 strategy and working together to develop their next one. The ADP area sets out the 'how' of their delivery strategy as follows:

- Engaging with people with lived experience.
- Taking a whole system/whole family approach.
- Working with national drivers and priorities.
- Supporting a 'level playing field' between statutory and third sector services.
- Ensuring consistency of practice with public protection.
- Working to the recommendations of the independent inquiry into mental health services in Tayside.

The 2021-2023 strategy demonstrates an outcome and impact orientated approach across the partnership based on a recovery oriented system of care (ROSC) model.[26]

Improving commissioning

The ADP coordinator describes the commissioning task over the last few years as recovery from the impact of COVID-19 and the returning of services to in-person contact where possible. The ADP has retained some of the virtual/online options recognising the geographical challenge of the area and the location of the majority of services in Perth.

A core challenge for this area is that of supporting people in outlying areas to access support. This is a mixture of practical challenges outwith the ADP sphere of control (poor transport links, poor broadband) and people's preference to access services outwith their area for fear of stigma in small communities.

Person-led care first

It is clear that local variation in need, geography and substance use patterns is critical to effective commissioning in this area and is a space where an innovation approach to commissioning is useful. The ADP coordinator reflects on this, noting the challenge of resourcing (staffing and funding) outlying rural areas. The ADP is exploring the possibility of tagging their support on to existing services and spaces such as community meet ups and walking groups. This seeks to address the resourcing challenge alongside the potentially stigmatising experience of attending a substance use group in a small village; while conversely balancing some people's strong identification with their area that means they wouldn't attend support somewhere else.

[26] A recovery oriented system of care (ROSC) is a coordinated network of community based supports that is person centred, strengths and resilience based, wrapping round the person with, or at risk of, problematic substance use and their family/loved ones to support their recovery. Some definitions of ROSC have the aim of abstinence; others of harm reduction.

In terms of person led commissioning they explain that one size doesn't fit all, but that the degree of resources required for full individualised personalisation would exceed the resources available.

Shared accountability

The coordinator reflects that the relatively small size of Perth and Kinross brings both strengths and challenges in establishing relationships and shared accountability in the ADP. A small area means relationships can develop across the partnership with people known as individuals as well as through their organisational identity. Conversely there is the risk common to small communities, of avoiding challenge, groupthink and trying to keep things 'nice'.

"Everybody is really nice and that's a really good thing and clearly we don't want to be nasty but sometimes you have to challenge, and you have to say no."

One of the focal points of the ADP delivery plan is to set a 'level playing field' across the sector. The ADP coordinator feels that relationships have improved substantially but that the underlying power imbalance in the commissioning (funder-funded) relationship is a factor in the extent of constructive challenge from the sector. The dominance of the statutory sector in terms of resourcing and perceived power/importance is still a factor.

In an echo of the Clackmannanshire and Stirling ADP (CLSADP) case study interview, the ADP coordinator reflects on a system that prioritises the statutory functions in substance use with the third sector "doing the rest of the bits'', and how the system should be reset to acknowledge that the third sector has the flexibility to meet people where they are and have broader and preventative conversations and interaction. They are keen not to dismiss the definite statutory functions in substance use (e.g. medication, social work) but rather to place this as part of a ROSC rather than the focus.

Sustainability

Drawing on their own experience across different services they think through what makes it difficult to level the playing field and increase collaboration and transparency in ADPs. They note that we can work to make it better but that the way we work is not set up to do this; from the practical, e.g. they had easy access to statutory partner emails and calendar availability for arranging meetings, to the cultural, and lack of trust between sectors. They see this lack of trust as exacerbated by the differences in funding and accountability with short term, monitored funding for the third sector contrasting with longer term funding to the statutory - a sector that historically attracts less oversight.

"I remember saying when our ADP funding was kind of up in the air and I was saying that we don't know what we can do, we don't know if we can fund things and one of our third sector partners kind of jokingly said now you know how we feel all the time."

One of the interventions planned to address this is a harmonising of oversight/monitoring between statutory and third sectors. This both seeks to level the different expectations of the sectors and also to provide better data for future commissioning.

Attention to the basics

Building a ROSC can sound like a 'technical' service planning and commissioning task, but the ADP coordinator argues that persistent attention to the basics is key to ethical commissioning in ADPs and this is often overlooked. They note that the foundation of good collaborative practice is getting people to speak to each other, to have lots of conversations and to develop a clear understanding of what each organisation does and how it contributes to treatment and recovery.

ADP as a whole system

The ADP is structured on a multi-agency process, where referrals into substance use services are considered at a regular meeting of key services, and the person is matched to the service that best fits. While this is a positive structure there is still a 'statutory first' power imbalance: the default model being that the statutory Integrated Drugs and Alcohol Recovery Team (IDART) considers whether they accept or reject the referral first and then 'the rest' goes to the third sector.

The challenge then is twofold:

- Capturing people's outcomes and follow up after accessing a service. This is a particular challenge with third sector partners who have different data capture and processes.
- People's recovery journey isn't linear; they don't often follow the trajectory of referral - treatment - recovery but the system has a linear internal logic to it that is reflected in how referrals are handled.

These challenges are the focus for the new delivery plan where the ADP coordinator is keen to collaboratively (re)map the ROSC as it currently is to highlight where it is working well and where there are gaps. This will assist with considering how to reset the system from a linear end to end process to an ecosystem of support. The ADP coordinator conceptualises this as a 'village of supports' that would better reflect the complexity of people's actual recovery experience.

The ADP coordinator notes that activities such as system mapping and process walkthroughs have a dual purpose in commissioning; they help to build relationships and make spaces for conversations in addition to their practical purpose. They note that the MAT Standards have provided this focus to the system by forcing people to come together and work through a request or a problem collaboratively, giving them much needed space to think and plan in roles that are otherwise focussed on immediate delivery of support.

As in other ADP case studies in this series, the coordinator brings their professional background and skills to the role of ADP as commissioner. In this case study the coordinator is an analyst, bringing a strong focus on the first stage of commissioning (analysis) and an impact and outcomes oriented approach.

The coordinator identifies the core challenge in creating a balanced whole-system approach in substance use is that the system cannot be redesigned from scratch. Rather the focus has to be about the difficult work of changing existing offers by using commissioning as one of a range of levers to do so. Decommissioning is an integral and difficult part of this, particularly in the current resource constrained system, which again reduces the available funding for investing to reorientate the ROSC. The coordinator describes the pace of changing the

available support landscape as gradual, work requiring buy-in from all partners. They observe that this can never be a ‘quick win’.

They reflect on an underpinning tension of the ADP, of trying to create a prevention and recovery orientated system against the urgency and national priorities of reducing drug deaths. They identify that this demands very strong positional leadership; absolute clarity of vision; ‘stickability’ and persistence for success. The key barrier to this is decision making and resource scarcity.

“In the current climate you know, sometimes people are making decisions on finance and so on that are very short term for reasons that I understand. But this makes it so difficult to try and implement something longer term even if you have a clear vision.”

Recommendation 6: For ADP commissioning to be fully systemic it is required to be place based across poverty, justice, homelessness and substance use. **This would require a new structure including potentially a network of partnerships with specific focus and expertise in each area working in an aligned way, with place-based budgeting to support.** (Denham and Studdert, 2024).

Ethical commissioning and personal ethics

When asked about the ethics underpinning their approach to commissioning the ADP coordinator identified that his key driver, across their career, as simply wanting things to be radically better for people. They speak of discomfort with “sitting back and just saying things are good enough” and demonstrate a changemaker mindset that resists “doing things just because we’ve always done it that way”.

“If you’re doing something that doesn’t work, make it better for people, don’t just keep […] operating a failing system. Try and make it better, as good as possible, that’s my motivation for doing this work.”

Next steps

Locally the ADP is concluding the development of its new strategic delivery plan drawing together 30-40 organisations and people and their perspectives on what needs to come next so their focus for the future is putting the plan into practice. Emerging priorities include:

- Developing a pathway to address other substance use patterns (in Perth & Kinross they are seeing a shift away from opiate use to alcohol, crack (cocaine) and benzodiazepines.
- Focussing on how to commission for recovery as a whole, not simply what happens after treatment. This includes the ADP coordinators concept of a recovery village where people might access multiple types of support simultaneously and move in and out of different supports as required.

Nationally the ADP coordinator would like to see a focus on new patterns of substance use and a move away from the opioid based aspect of the MAT Standards. Echoing the ask from other ADP areas, this is a call for future policy that focuses on what's actually going on in communities and taking a ground-up approach to priority selection.

Like the CLSADP case study the ADP coordinator raises the question of the system focussing on reducing deaths and considers the role of hope in substance use policy and practice.

"Just keeping people alive isn't enough, the [next] strategy needs to be ambitious enough to make sure that it does focus on recovery […] this would be my big thing for a new Mission"

Annex A: Methodology

The research comprised the following methodology:

Interviews with key stakeholders

Researchers conducted semi-structured interviews (phase 1) with:

- A selection of ADP coordinators and other ADP roles from across Scotland (six areas). The areas were identified to offer a range of perspectives from alcohol and drugs services in different geographical and demographic contexts.
- Representatives from national support provider organisations.
- Representatives from Healthcare Improvement Scotland (HIS) teams working in the field of alcohol and drugs.
- Representatives from the Scottish Government working in this policy area.

Interviews with ADP coordinators and providers focused on exploring:

- Their role, in particular how it relates to commissioning.
- The extent to which they see the ethical commissioning principles in practice and the barriers and facilitators to this.
- The role of collaboration and relationships in effective commissioning.
- How commissioning intent is given effect through procurement, grant making and contracting.
- Contextual factors that influence commissioning - funding, national policy, evidence and data.

Interviews with policy colleagues/HIS focused on exploring:

- Their role, in particular how it relates to commissioning.
- Contextual factors that influence ADPs and commissioning - funding, national policy, evidence, data and national improvement efforts.
- The barriers and facilitators to ethical commissioning.

Interviews were recorded with a thematic analysis of transcripts undertaken following a semi-emergent process to allow for unexpected themes and topics to be recognised. Respondents in this phase have been anonymised and are not identified in the document to allow them to give their views freely.

Desk review of key policy and literature

Key policy documents and related literature: This included policy updates, reviews, external evaluations of alcohol and drug interventions or services and ADP strategic plans. The desk review used a set of keywords related to commissioning, procurement and contracting, and alcohol and drugs services, to search online for publicly available documents from local areas. Policy and related literature were cross checked through engagement with HIS and Scottish Government colleagues. All interviewees were invited to provide examples of relevant literature, including local strategy, commissioning and procurement documents, frameworks or model/ example contracts.

Commissioning plans: The desk review focused on a sample of plans from ADPs across Scotland. This involved a light touch review of 16 ADP strategic plans sourced through an internet search.
Search terms used: *ADP + commissioning + framework + plan + strategy + 2021 + 2020 + 2022 + 2023 + 'area name'.*

Plans were then analysed with a focus on three areas:

- The extent to which commissioning and procurement form part of delivery plans, including the presence, or absence of, dedicated commissioning or procurement strategies.
- The extent to which ethical commissioning principles could be evidenced within the strategic documents. Given that the majority of these plans were produced either prior to the introduction of the principles, or immediately after, there was no expectation of a direct representation, but rather a read across within the plans to some or all of the principles.
- The requirements of the ADP Partnership Delivery Framework (Scottish Government, 2019)
    - A strategy and clear plans to achieve local outcomes to reduce the use of and harms from alcohol and drugs.
    - Transparent financial arrangements.
    - Clear arrangements for quality assurance and quality improvement.
    - Effective governance and oversight of delivery.

Case studies

A second round (phase 2) of semi-structured interviews with ADP coordinators, strategic planning, provider organisations and lived and living experience organisations formed the basis of three case studies along with relevant supporting documentation.

Case study areas were selected on the basis of emergent information from the first round of interviews and researchers' wider knowledge of commissioning in Scotland.

Research ethics

All interviews took place on MS Teams, with calls recorded and securely stored in the Iriss cloud server. Interviewees were provided with research information and a consent form to sign prior to the interviews. Anonymity of interviewees is protected within this research, apart from in case studies where local areas are named.

Limitations of the research

- The remit of this research was not to undertake a full scale review of all ADP activity or commissioning of alcohol and drugs services across Scotland, but to provide a 'point in time' snapshot of the current policy and practice context, with the intention of highlighting areas for further research and consideration.
- Fieldwork had short lead times that coincided with end of financial year activity. This placed some limits on the capacity of invited participants to be involved in both phase

1 and phase 2 interviews. The research team mitigated this as much as possible, offering flexible engagement to respondents. However, findings should be treated with the appropriate caution based on the small sample and incomplete triangulation of the case studies.

- Researchers were unable to gain access to examples of contracts or procurement documents. This was due primarily to short lead times for fieldwork and lack of direct access to the teams that would hold these documents.

Presentation of findings

To reduce repetition, we have integrated the desk research, phase 1 (interview) findings and researcher interpretation against a set of core themes. Recommendations are presented in-text as well as at the close of the report. Case studies are presented separately.

Annex B: Strategic Plans and ADP documentation

Aberdeenshire
Aberdeenshire Draft ADP Strategic Delivery Plan 2023-26 https://www.hi-netgrampian.scot.nhs.uk/wp-content/uploads/2023/09/3d-i-Draft-Strategic-Delivery-Plan.pdf

Argyll and Bute
Argyll & Bute ADP 2023 Strategy refresh (2023) Argyll & Bute Alcohol and Drug Partnership

Dundee
Dundee ADP 2023-28 Strategic Framework:
https://www.dundeeprotects.co.uk/ADPFramework23.pdf
Dundee ADP 2023-28 Strategic Plan: https://www.dundeeprotects.co.uk/adpstrategy.htm
MAT Standards Implementation Plan:
https://www.dundeeprotects.co.uk/MATStandards_Implementation_Plan.pdf
2 year delivery plan - with outcomes: https://www.dundeeprotects.co.uk/adpstrategy.htm

Clackmannanshire and Stirling ADP (2023)
CSADP Commissioning High Level Plan (internal)
Substance Use and Mental Health and Wellbeing (internal presentation)
Commissioning Consortium update (internal presentation)
Joint ADP Commissioning Consortium – Model of Care Briefing (internal report)

Dumfries & Galloway
Draft Alcohol and Drugs Strategy 2023-26
https://dghscp.co.uk/wp-content/uploads/2023/02/Final-DG-Draft-Strategy-14.pdf

Edinburgh
Edinburgh ADP Strategic Plan 2021-24: https://www.edinburghadp.co.uk/wp-content/uploads/2022/06/EADP-Strategic-Plan-2021-2024-1.pdf

Falkirk
ADP Delivery Plan 2020-23
https://falkirkhscp.org/wp-content/uploads/sites/9/2023/05/Falkirk-ADP-Delivery-Plan-Final.pdf

Fife
ADP Strategy 2020-23 https://www.fifeadp.org.uk/__data/assets/pdf_file/0021/243714/Fife-ADP-Strategy-2020-23-v2.pdf
MAT Standards Implementation Plan:
https://www.fifeadp.org.uk/__data/assets/pdf_file/0020/423335/Fife-ADP-Implementation-Plan-2022-2023.pdf

Glasgow
Glasgow City Alcohol and Drug Strategy (2020-23):
https://www.glasgow.gov.uk/CHttpHandler.ashx?id=50921&p=0

Highland
ADP Strategy (2020-23)
https://www.highland-adp.org.uk/userfiles/file/hadp_general/HADP-Strategy-2020-2023-Nov-2020-FINAL.pdf

North Lanarkshire
North Lanarkshire ADP Strategy 2021-24

North Lanarkshire ADP Highlight Report 2022-23
North Lanarkshire ADP and Scottish Families Affected By Drugs (2020) “Hidden in Plain Sight: The experience of families affected by substance use in North Lanarkshire”
Supporting documents such as impact report and other local documents available from https://northlanadp.org/local-and-national-publications/

Orkney
ADP Strategy 2021-26
https://www.orkney.gov.uk/Files/OHAC/Reports/ADP_Strategy_%202021_2026.pdf

Perth and Kinross Perth and Kinross ADP Strategic Delivery Plan 2020-23
Perth and Kinross ADP Annual Report 2019/20

Scottish Borders
ADP Strategy 2020-23: https://www.nhsborders.scot.nhs.uk/media/750626/ADP-Borders-Strategy-2020-23.pdf
ADP evaluation 2021: https://www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/general-services/alcohol-and-drugs-partnership-(adp)-support-team/drug-alcohol-services/drug-and-alcohol-services-evaluation-2021

South Ayrshire
South Ayrshire ADP Strategy 2023- 26 https://south-ayrshire-adp.scot/about/our-strategy/

West Dunbartonshire
West Dunbartonshire (2011-21)
http://www.wdhscp.org.uk/media/1052/wd-chcp-commissioning-strategy-for-alcohol-and-drugs-services-2011_2021-p57h.pdf

West Lothian
ADP Strategic Commissioning Plan 2020-23
https://westlothianhscp.org.uk/media/45976/Alcohol-and-Drug-Services-Commissioning-Plan-2020-23/pdf/Alcohol_and_Drugs_Services_Commissioning_Plan_2020-23.pdf?m=637408725418230000

Annex C: References

Audit Scotland (2022) Drug and alcohol services: An update. https://audit.scot/uploads/docs/report/2022/briefing_220308_drugs_alcohol.pdf

Audit Scotland (2019) Drug and alcohol services: An update. https://audit.scot/uploads/docs/report/2019/briefing_190521_drugs_alcohol.pdf

Audit Scotland (2018) Health and social care integration: update on progress. https://audit.scot/uploads/docs/report/2018/nr_181115_health_socialcare_update.pdf

Black, C. (2021) Independent review of drugs phase two report https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

Bramley, G.,Fitzpatrick, S.,Wood, J.,Sosenko, F., Blenkinsopp,J.,Littlewood, M.,Frew, C., Bashar, T.,McIntyre, J., and Johnsen, S. (2019) Hard Edges Scotland Report. https://www.therobertsontrust.org.uk/publications/hard-edges-scotland/

Coalition of Care and Support Providers (2023) "It's out of whack!" Expert voices on ethical commissioning and procurement in not-for-profit social care. https://www.ccpscotland.org/wp-content/uploads/2023/11/Its-Out-Of-Whack-Interviews-CCPS-_Final.pdf

Coalition of Care and Support Providers (2019) Handing Back Contracts: Exploring the rising trend in third sector provider withdrawal from the social care market. https://decentworkgoodcare.com/wp-content/uploads/2019/07/Handing_Back_report_CCPS-0022019-cunningham.pdf

Corra Foundation (2023) National Drugs Mission Funds Progress Report. https://www.corra.scot/wp-content/uploads/2023/09/National-Drugs-Mission-Funds_Progress-Report-2023.pdf

Davidson,L.,Rowe,L.,Di Leo., Bellamy., C., and Delphon-Rittmon,M., (2021) "Recovery-Oriented Systems of Care: A Perspective on the Past, Present and Future" Alcohol Research Current Reviews

Denham,J.,and Studdart,J.(2024) Place-based public service budgets: making public money work better for communities. New Local: Future Governance Forum https://www.newlocal.org.uk/wp-content/uploads/2024/01/Place-Based-Public-Service-Budgets_New-Thinking.pdf

Fulfilling Lives LSL Research and Learning Partnership, NPC, Groundswell, and CRESR (2021) Re-thinking Outcomes: A guide for commissioners of services designed for people experiencing multiple disadvantage. https://groundswell.org.uk/wp-content/uploads/2021/12/Re-thinking-Outcomes-Guide-for-Commissioners.pdf

Franco-Santos,M., and Otley, D.(2019) Reviewing and Theorizing the Unintended Consequences of Performance Management Systems International Journal of Management Reviews https://onlinelibrary.wiley.com/doi/10.1111/ijmr.12183

Hayes, S.C.,Strosahl, K.D., and Wilson, K.G (2016) Acceptance and Commitment Therapy: the process and practice of mindful change (2nd Edition) Guilford Press: New York

Healthcare Improvement Scotland and Scotland Excel (2023) Pathways to Recovery: Redesigning Residential Rehabilitation Pathways Embedding Lived Experience in the Commissioning and Contracting of Residential Rehabilitation Services in Scotland. https://ihub.scot/media/10119/20230608-pathways-to-recovery-his-se-engagement-analysis-and-findings-v10.pdf\

Heifetz.R., and Linsky, M. (2002) A Survival Guide for Leaders. Harvard Business Review https://hbr.org/2002/06/a-survival-guide-for-leaders

Institute of Public Care, Oxford Brookes University (2014) Commissioning for Health and Social Care. SAGE:London

McCaughey, D., and Bruning, N.S.,(2010) Rationality versus reality: the challenges of evidence-based decision making for health policy makers. *Implementation Science* 5:39 https://link.springer.com/article/10.1186/1748-5908-5-39

McPhee, I., and Sheridan,B. (2023) Policy traps and policy placebos: assessing drug policy network responses to drug related deaths. *Drugs, Habits and Social Policy* 24:1 (39-52) https://www.emerald.com/insight/content/doi/10.1108/DHS-06-2022-0023/full/html

McPhee, I., and Sheridan,B. (2020) AUDIT Scotland 10 years on: explaining how funding decisions link to increased risk for drug related deaths among the poor. *Drugs and Alcohol Today* 20:4 (313-322) https://www.emerald.com/insight/content/doi/10.1108/DAT-05-2020-0024/full/html

National Collaborative (2023a) A draft outline of a Charter of Rights for People Affected by Substance Use. https://www.alliance-scotland.org.uk/blog/resources/draft-charter-of-rights-national-collaborative/

National Collaborative (2023b) National Collaborative Call for Evidence – Analysis Report Summary. https://www.alliance-scotland.org.uk/wp-content/uploads/2023/10/National-Collaborative-Call-for-evidence-Analysis-Report-01.11.23-digital_r2.pdf

North Lanarkshire ADP and Scottish Families Affected By Drugs (2020) “Hidden in Plain Sight: The experience of families affected by substance use in North Lanarkshire” https://northlanadp.org/wp-admin/admin-ajax.php?juwpfisadmin=false&action=wpfd&task=file.download&wpfd_category_id=16&wpfd_file_id=281065&token=&preview=1

Oertzen,A.S., Vink, J., Odekerken-Schröder, G., Mager, N., and Azevedo, S. (2022) Navigating the tensions of integrating lived experience in participatory healthcare design, *The Design Journa*l, 25:6 (997-1018) https://www.tandfonline.com/doi/full/10.1080/14606925.2022.2113223

Public Health Scotland (2024a) Evaluation of the Scottish Government Residential Rehabilitation programme – baseline report.

https://publichealthscotland.scot/publications/evaluation-of-the-scottish-government-residential-rehabilitation-programme/evaluation-of-the-scottish-government-residential-rehabilitation-programme-13-february-2024/#section-2-1

Public Health Scotland (2024b) Exploring the experience of accessing residential rehabilitation for substance use: Baseline survey of residential rehab clients. https://publichealthscotland.scot/media/25132/v22_baseline-rr-client-survey.pdf

Public Health Scotland (2021) Monitoring and Evaluating Rights Respect and Recovery - first monitoring report. https://www.publichealthscotland.scot/publications/monitoring-and-evaluating-rights-respect-and-recovery-merrr/

Rehn, A. (2019) Innovation for the Fatigued: How to Build a Culture of Deep Creativity. Kogan Page: London

Schehrer, S., and Sexton, S. (2010) Involving users in commissioning local services. Joseph Rowntree Foundation. https://www.jrf.org.uk/involving-users-in-commissioning-local-services

Scottish Drugs Forum (2021) Medication Assisted Treatment: Service Evaluation of People's Experience of Accessing MAT in 6 Health Board Areas Across Scotland. https://www.sdf.org.uk/wp-content/uploads/2021/11/Updated-MAT-Report-Oct-2021-Final-Version.pdf

Scottish Government (2023a) Alcohol and Drug Partnerships Annual Survey 2022-23. https://www.gov.scot/publications/alcohol-drug-partnerships-adp-2022-23-annual-survey/pages/3/

Scottish Government (2023b) National Drugs Mission Annual Monitoring Report 2022-23. https://www.gov.scot/publications/national-mission-drugs-annual-monitoring-report-2022-2023/pages/1/

Scottish Government (2023c) Drugs and alcohol workforce action plan 2023-2026. https://www.gov.scot/publications/drugs-alcohol-workforce-action-plan-2023-2026/

Scottish Government (2022) National Drugs Mission Plan 2022-26. https://www.gov.scot/publications/national-drugs-mission-plan-2022-2026/

Scottish Government (2021a) National Drugs Mission. https://www.gov.scot/policies/alcohol-and-drugs/national-mission/

Scottish Government (2021b) Medication Assisted Treatment (MAT) Standards: access, choice, support. https://www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/pages/3/

Scottish Government (2021c) Families Affected by Drug and Alcohol Use in Scotland: A Framework for Holistic Whole Family Approaches and Family Inclusive Practice https://www.gov.scot/publications/improving-holistic-family-support-towards-whole-family-approach-family-inclusive-practice-drug-alcohol-services/documents/

Scottish Government (2021d) Independent Review of Adult Social Care. https://www.gov.scot/publications/independent-review-adult-social-care-scotland

Scottish Government (2021e) Pathways into, through, and out of, residential rehabilitation. https://www.gov.scot/publications/pathways-through-out-residential-rehabilitation-scotland/pages/1/

Scottish Government (2019) Alcohol and Drug Partnerships: delivery framework. https://www.gov.scot/publications/partnership-delivery-framework-reduce-use-harm-alcohol-drugs/pages/1/

Scottish Government (2018a) Rights, Respect and Recovery: Alcohol and Drug treatment strategy. https://www.gov.scot/publications/rights-respect-recovery/

Scottish Government (2018b) Alcohol Framework: Preventing Harm. https://www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/

Scottish Government (2017) Health and Social Care Standards: My support, my life. https://www.gov.scot/publications/health-social-care-standards-support-life/

Scottish Government (2014) The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services. https://www.gov.scot/publications/quality-principles-standard-expectations-care-support-drug-alcohol-services/pages/12/

Scottish Human Rights Commission (2023) Collected briefing papers on human rights budgeting https://www.scottishhumanrights.com/media/2546/hrbw-collected-briefing-papers-vfinal.pdf

Scottish Parliament (2024) National Care Service (Scotland) Bill. https://www.parliament.scot/bills-and-laws/bills/national-care-service-scotland-bill/overview

Scottish Parliament (2021) Proposed Right to Addiction Recovery (Scotland) Bill. https://www.parliament.scot/bills-and-laws/proposals-for-bills/proposed-right-to-addiction-recovery-scotland-bill

Scottish Parliament (2014) Procurement Reform (Scotland) Act. https://www.legislation.gov.uk/asp/2014/12/schedule

UK Government (2022) Commissioning Quality Standard: alcohol and drug services. https://www.gov.uk/government/publications/commissioning-quality-standard-alcohol-and-drug-services

Wales Centre for Public Policy (2023) Implementation-Minded Policy Making. https://www.wcpp.org.uk/wp-content/uploads/2023/11/Implementation-Minded-Policy-Making.pdf

Welsh Government (2015) Revised Guidance for Commissioning Substance Misuse Services. https://www.gov.wales/sites/default/files/publications/2019-02/revised-guidance-for-commissioning-substance-misuse-services.pdf