FIGURE 8
CONSULTANCY SERVICES LTD

# Evaluation of the Digital Lifelines Scotland (DLS) Programme

# EVALUATION SUMMARY

## Prepared for the Digital Health & Care Innovation Centre

May
2025

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## Acknowledgements

There are many people that we would like to thank for their help with this project. Without their support we would not have been able to gather so much valuable data.

Most importantly, we would like to thank those people who gave up their time to offer their views and experiences, whether through completion of a survey, participation in an interview, or one of the evaluation working groups.

We would also like to thank the DLS programme team and the core members of the key delivery partners from SCVO and the Simon Community Scotland for their constant help and support throughout the evaluation process. Without their timely assistance in providing access to staff, volunteers, digital champions, as well as providing access to the extensive set of evidence documents gathered by themselves and all delivery services, the evaluation would have been much more challenging.

Finally, we would also like to express our gratitude to our Project Advisory Group for their support and advice throughout the evaluation.

## Who this report is for, and other supplementary reports

This version of our report is a **summary** of our full and **Final Report** of the evaluation of Phase 2 of the DLS programme. The Final Report is supplemented by our **Supporting Evidence Report** which provides all our supporting evidence for the main report in a series of appendices.

Additionally, we have written a shorter **Supplementary Briefing Report** which is aimed at policymakers, commissioners, and funders at both local and national levels. This report will be made available via the DLS website in due course.

## Language considerations

The world of drug use treatment is full of jargon and abbreviations. We have chosen to use ‘people-first’ language which emphasises the individuality, equality, and dignity of people rather than defining people primarily by a problem or issue. We want to emphasise the importance of language in helping to challenge and reduce the pervasive stigma that is still attached to being a person who uses drugs.

## Citation

This report should be cited as: Perkins A, Dumbrell J, Livingston W, McCluskey S, and Steele S. *Evaluation of the Digital Lifelines Scotland (DLS) programme – evaluation summary.* Dundee: Figure 8 Consultancy Services Limited; 2025.

# Evaluation of the Digital Lifelines Scotland (DLS) programme – Phase 2 [2023 – 2025]

## Evaluation Summary

Digital Lifelines Scotland (DLS) began in 2021. It supports people who are at high risk of drug-related harm by helping them get better access to digital technology and services. Since 2021, the Scottish Government has given £3.2 million to fund the programme.

In Phase 1 (2021-2023), DLS provided internet-enabled devices (like smartphones and tablets), data packages, and digital skills training to people with multiple and complex needs, reaching over **965 individuals**. Each service also appointed "digital champions" (staff or volunteers trained to help others use the devices), to keep people engaged. DLS also funded research into addressing acute risk of overdose. This included studies like ODART (Overdose Detection and Alert Response Technologies). It also looked at whether new apps, such as Here4U and By My Side, could work in practice. These apps use real-time monitoring and digital peer support to help prevent overdoses and respond to crises more quickly. The Phase 1 evaluation found that getting online helped people connect with harm reduction services and peer support, strengthening relationships that keep them safer. However, it also highlighted challenges, such as the **ongoing cost of data and devices**, which made it hard to maintain those benefits in the long run.

Phase 2 of the DLS programme ran from April 2023-March 2025) where the focus was on **embedding digital support into everyday services** – making digital inclusion a normal part of how third sector harm reduction and recovery services work .

The Phase 2 evaluation was carried out to understand what difference the DLS programme has made when it was integrated more fully into health, social care, and community services. It looked at how DLS affected people's **digital inclusion** (ability to get online and use technology), their **access to services** (like health care, counselling, and support groups), their **wellbeing** (including confidence and social connection), and **harm reduction** outcomes (such as safety from overdose or crisis).

Overall, the evaluation found that the DLS programme has **had a positive impact** – it has helped **more people get online and develop digital skills**, made it **easier for them to engage with support services**, **improved their wellbeing by reducing isolation**, and **provided new ways to stay safe and reduce immediate risks** of harm. These changes show how digital inclusion can be a powerful tool to support people with problem drug use, complementing Scotland's National Mission to reduce drug-related harms.

## What we did

Our evaluation used a mixed-methods approach, gathering both numbers (quantitative data) and personal experiences (qualitative data). We worked closely with people who have lived or living experience of drug use to shape the evaluation. For example, we held **co-production workshops** to decide what questions to ask and how to measure outcomes, ensuring the evaluation focused on what really matters to individuals in need of support. We then collected information through:

- **Document review:** We reviewed all DLS programme reports and monitoring data. This helped us understand how the programme was implemented and track outputs like the number of devices given out.
- **Interviews with stakeholders:** We conducted interviews with key DLS team members, partner organisations, and senior staff from services involved in DLS. These interviews provided insights into how DLS was delivered and how organisations adapted their practices.
- **Surveys:** We carried out surveys with different groups – **DLS participants (clients)**, **digital champions/early adopters**, and **staff/practitioners** – to gather feedback on all the main outcomes DLS hoped to achieve. The surveys included questions on digital skill levels, service access, wellbeing, and experiences of stigma or risk. We even ran a **"real-time" weekly text message survey** with a small group of participants (texting them two questions each week for a month) to get immediate feedback on how they were doing and if they were encountering any issues.
- **Focus groups:** We hosted focus group discussions with people who received devices/support and with the digital champions in services. In total, five focus groups with 37 individuals were conducted, allowing participants to share their stories and validate findings from the surveys in their own words. These group conversations revealed nuances about how DLS affected day-to-day life.
- **Working groups:** Together with DLS staff and partners, we developed an **evaluation logic model** (a roadmap of how DLS activities should lead to outcomes) and used a **"performance story"** approach to link evidence to that model. In practice, this means we carefully examined whether the intended short-term and medium-term outcomes of DLS were coming true, by piecing together evidence from all the sources above. We looked at **programme inputs** (what was put in, like funding, devices, training), **outputs** (what was delivered, like number of people trained, new digital services created), and **outcomes** (the changes for people and services). By gathering data from multiple angles, we strengthened confidence in our findings – if surveys, interviews, and focus groups all pointed to the same change, we could have confidence that DLS has had a real effect.

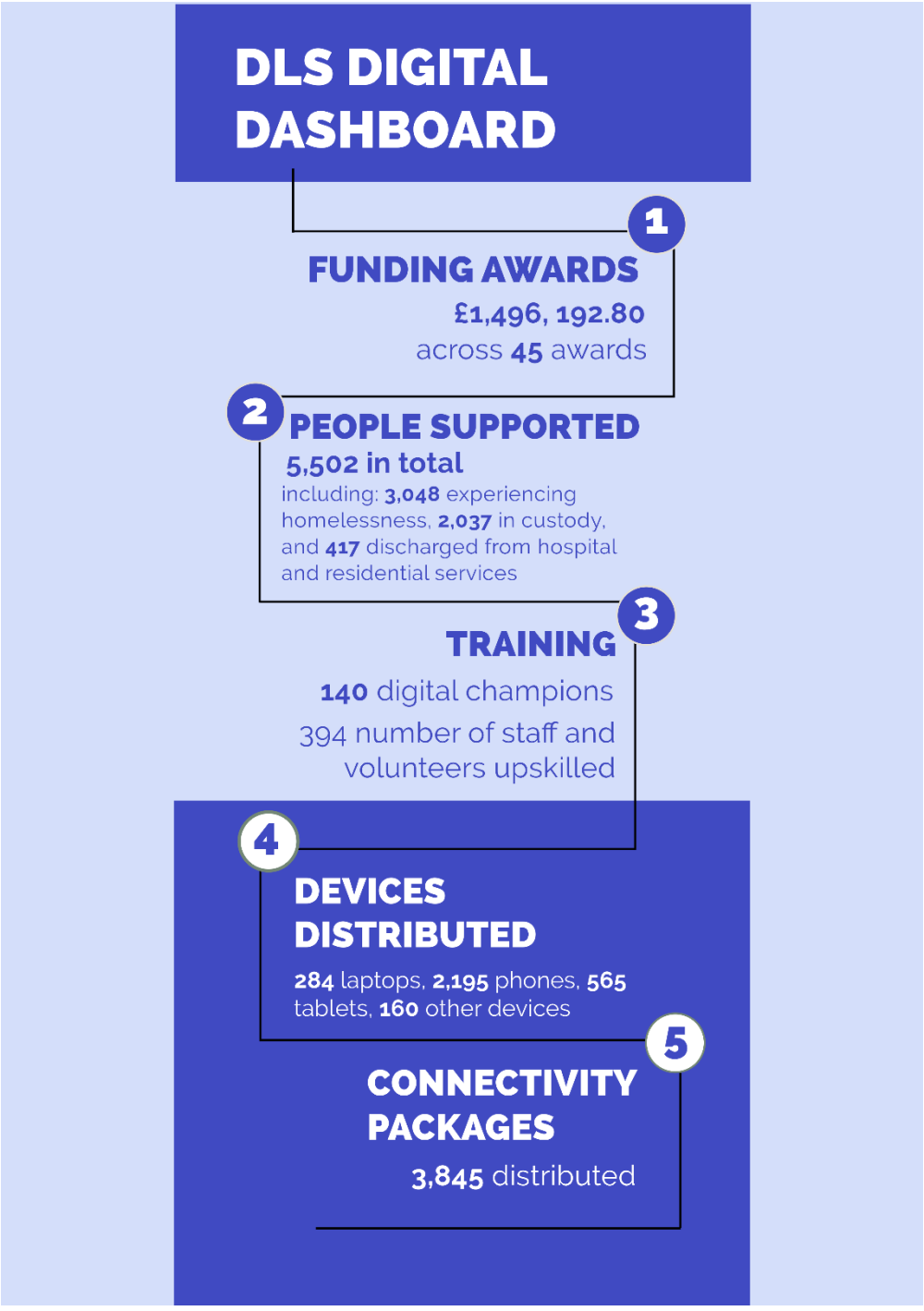
# Our key findings

DLS Phase 2 produced a range of important findings. The most significant results show improvements in **digital inclusion**, **access to services**, **wellbeing**, and **harm reduction** for the people and communities involved. Below, we highlight these key outcomes, using real examples from the evaluation to illustrate what changed.

## *Digital inclusion and skills*

The programme greatly expanded access to digital technology for people who use drug services, as indicated in the following infographic:

**Figure 1.** DLS programme outputs infographic



Across its projects, DLS **distributed thousands of devices** and connectivity packages to those in need. Each device came with a simple quick start guide or tutorial to help new users get online easily. Importantly, DLS didn't just hand out devices; it also invested in **training and support** so people could actually use them. Services trained **digital champions** who worked one-on-one or in groups with participants to teach **basic digital skills** – from creating an email account to using health apps. This supportive approach paid off: **participants' digital skills and confidence improved significantly**. For instance, surveys showed a **nearly 40% increase in confidence using a smartphone** for everyday tasks. People reported that with **personalised support** from staff or volunteers, they felt able to do things online that they couldn't before – like accessing online health services or managing their finances via mobile apps. One person noted how this new skillset increased their independence:

> *"I didn't have a bank account for years, and it was causing tensions in the family. Now, I've got my own, and I don't need to rely on anyone else.". Another participant said, "I had no idea how to use a laptop before. Now I'm online every day doing my SVQ coursework and helping out with digital admin at* [service name]*."*

These examples show how DLS opened up opportunities by giving people the tools and confidence to participate in the digital world.

### *Access to services*

By removing digital barriers, DLS made health and support services **far more accessible**, especially for individuals who had difficulty engaging through traditional in-person routes. People who were previously **excluded due to geography or personal circumstances** could now connect with vital services online. For example, someone living in a rural area noted that public transport was virtually non-existent for them; without online access, they simply *"wouldn't have been able to engage at all"*. DLS devices and connectivity allowed this individual to attend video appointments and communicate with support workers despite the distance. Another example comes from the justice context:

> *"When I got out of prison, I had no idea what to do. Having a phone meant I could call my worker, find housing, and get to my appointments."*

This person's phone (provided through DLS) became a lifeline that helped them reintegrate into the community – they could immediately reach out to a key worker, contact housing services, and keep up with medical or support appointments, rather than falling through the cracks after release.

These stories are backed up by broader evidence with services reporting that **attendance and engagement rates improved** as they offered more flexible, digital

options. People could choose to **text, call, or video-chat** with staff when they couldn't attend in person, leading to fewer missed contacts. Online service delivery (such as tele-health consultations for medication-assisted treatment) also **extended the reach** of interventions to new groups. For instance, university-led pilot projects demonstrated that remote prescribing and virtual recovery groups could effectively support people in areas where services were previously hard to reach.

In short, DLS helped **bridge gaps** in the support system. **Location, mobility issues, or social anxiety** became less of a barrier when services went digital. One participant described how a gentle approach to digital engagement built their trust. At first, they only **joined online group sessions with the camera off**, just listening; then as they grew more comfortable, they began to speak up; eventually, they gained the confidence to **attend in-person groups every week**. This progression shows how digital access can be a stepping stone to wider community engagement.

### *Wellbeing and social connection*

Greater digital inclusion translated into tangible **wellbeing benefits** for individuals. **Isolation was reduced** as people were able to stay in touch with family, friends, and peer support networks through their phones or computers. Many participants commented that having the means to call or message someone when they felt low made a huge difference – it gave them a sense of belonging and support, even if they were physically alone. By engaging in online social activities or simply being able to watch videos, read news, or pursue hobbies online, people experienced **less boredom and loneliness**, which are factors that can contribute to relapse or increased drug use.

Additionally, being able to manage daily tasks online (like renewing benefits or scheduling appointments) boosted individuals' **sense of autonomy and control**, thereby improving mental wellbeing. One service provider noted that **digital engagement became a form of therapy** for some individuals. For example, joining a recovery forum or attending an online skills class provided structure and hope.

The programme also saw indications of **reduced stigma** and improved self-esteem. As people learned digital skills, they often took on new roles (like helping a friend set up a phone, or contributing to an online group), which made them feel valued and capable. In some cases, **family relationships improved** because participants could reconnect via video calls or social media after long periods of disconnection.

Overall, the data showed a clear trend, that **improved digital access led to better emotional wellbeing**, by empowering people, connecting them to communities, and making everyday life a bit easier. One participant's journey captures this well:

> *"At first, I just listened with my camera off. Then I started talking. Now, I go to in-person groups every week."*

DLS provided the initial safe space (online) for this individual to engage at their own pace, ultimately helping them build confidence to participate fully in society.

### *Harm reduction and safety*

Perhaps most importantly, DLS contributed to **reducing immediate risks of harm** for people who use drugs. By equipping individuals with digital tools, the programme created new channels for **real-time support during crises**. For instance, several services set up systems for sending **overdose alerts or urgent messages** to individuals' phones – such as warnings about particularly dangerous batches of drugs circulating locally, or reminders to carry naloxone (the opioid overdose reversal medication).

People also had quicker access to emergency helplines and online crisis counselling. The evaluation's monitoring data suggests that this **instant access to information and help** likely **prevented overdoses and other harms**.

Both DLS participants and professionals gave examples where a digital connection made a critical difference. In numerous cases, **individuals at high risk maintained regular contact with their support workers, or peers, via phone during mental health crises**, which prevented further harm. Instead of facing the crisis alone (which might have led to self-harm or relapse), individuals could reach out immediately and receive help because they had a working phone and data. Frontline staff noted that having a direct line to the individuals that they work with through digital means often served as an **early warning system** – they could tell if someone was in trouble (for example, unusual online behaviour or messages) and intervene sooner.

Additionally, DLS fostered the development of innovative **digital harm reduction tools**. In Phase 1, the programme explored ODART (overdose detection and alert technologies), and in Phase 2 there were pilots like **mobile supervised drug consumption apps and online telemedicine for addiction treatment**. These innovations showed promise in providing life-saving support. For example, callers using drugs in isolation could receive peer supervision, and in the event of no response to vocal prompts, emergency contacts could be automatically alerted.

While such technologies are still being refined and new partnerships are formed in this space, DLS's on-the-ground work proved the concept that **digital interventions can save lives**. By the end of Phase 2, many participants described feeling **safer and less anxious** knowing they could call for help or access online support at any time. Professionals also observed a cultural shift, with harm reduction no longer being limited to physical interactions (like visiting a needle exchange or counselling session).

# Our conclusions

We have concluded that the DLS programme has made a **meaningful and positive contribution to people's lives and to service delivery**. Phase 2 has demonstrated that when digital inclusion is properly supported, it becomes an **integral part of harm reduction and recovery efforts**. The findings show that DLS has helped individuals achieve better outcomes (engagement, wellbeing, safety) and also prompted changes in organisations and communities that could lead to **long-term improvements**.

## *Lasting change for individuals*

For many, DLS was more than a temporary boost – it helped build lasting capabilities. Participants gained not only devices, but also **skills and confidence that stay with them**. This means they are better equipped for the future. They can continue using digital tools to access services, find information, pursue education or jobs, and keep in contact with support networks. In the long run, these capabilities contribute to more stable recovery journeys. Someone who can, for example, manage an online benefits account or set up reminders on a phone for medication is someone who has a bit more control over their life. The evaluation noted that while digital support alone cannot resolve all underlying issues, it **arms people with opportunities and connections** that can help tackle those issues. By successfully bridging gaps in access, DLS has nudged services closer to treating **digital access as a basic right for all**, which helps reduce the stigma of "technology handouts" – people are not judged for receiving a device; instead, digital inclusion is seen as a **normal part of modern life and recovery**.

## *Lasting change for services and systems*

DLS Phase 2 also influenced the way organisations operate. Many partner services realised that digital inclusion needs to be **embedded in routine practice, not just added on as a one-time project**. During the programme, some organisations updated their **policies and procedures** – for example, changing intake forms or case management systems to **ask about digital needs for every individual**. This ensures that even after DLS funding ends, staff will continue to check if someone has a phone or internet access and provide support accordingly, so nobody is left offline without help. A clear takeaway was that **digital support should be budgeted as a core expense** (like rent or utilities for a service) rather than relying on special grants. Indeed, a number of services found creative ways to sustain digital inclusion after initial funds ran out – such as using refurbished or donated devices to keep supplying phones or training a wider pool of staff as digital champions, so the knowledge remains even if individual staff leave. This reflects a broader **culture shift**, with organisations moving towards viewing digital access as **essential to support**, aligning with the ethos that helping people online is part of helping people, period.

The programme's influence also spread beyond the immediate funded projects. Through regular meetings, knowledge exchange events, and sharing of results, DLS **encouraged other drug and alcohol services across Scotland to take up digital inclusion initiatives**. Partners involved in DLS championed the successes and learned lessons, which sparked interest in replication. We heard that some service providers now talk about digital inclusion in terms of **rights and equity**, noting that providing a phone or Wi-Fi to someone can **reduce stigma** (by allowing them to engage like anyone else, without having to beg for access) and promote **fair access to resources**. While not every service in Scotland has adopted these practices yet, the conversation has started, and there's momentum toward a more digitally inclusive support system. In this way, **DLS has contributed to systemic change**. It has showed what's possible and set examples that others are beginning to follow.

### *Sustainability and moving forward*

The evaluation highlighted that to **secure these gains long-term**, a shift in funding and strategy is needed. DLS has benefited from short-term funding streams – quick grants that helped get it off the ground, especially during COVID-19 when digital inclusion became urgent. However, relying on one-off funds can lead to uncertainty and **stop-start support**, which is hard on both services and those who need to use services. Encouragingly, some organisations have started to **allocate resources in their core budgets** for digital inclusion (for example, setting aside money to buy data vouchers each year) and those organisations are in a stronger position to maintain and even expand digital support. The evaluation's findings reinforce this point, that making digital inclusion part of normal funding and planning (rather than an optional extra) is critical for **sustained impact**. The DLS programme has shown policymakers and funders that investing in digital inclusion yields real benefits in engagement and harm reduction. Going forward, the hope is that digital inclusion will be woven into the fabric of harm reduction and recovery services nationwide – helping to close the digital divide for people with problem drug use as a matter of course.

In conclusion, **Digital Lifelines Scotland Phase 2 achieved its core aims**. It has improved digital access and skills for a vulnerable population, which in turn has improved service engagement, wellbeing, and safety outcomes. It has also provided valuable lessons on how to integrate digital support into the health and social care system. The programme's contribution to long-term change is evident in the new practices and attitudes adopted by organisations and the empowerment of individuals who were part of it. By treating connectivity and digital skills as a fundamental need, DLS has laid groundwork for a future where **being digitally connected is part of the recovery journey**.

# Our recommendations

The evaluation's final report provides a set of practical recommendations to build on the progress of DLS Phase 2. Our recommendations are provided in the set of four tables below. The recommendations are directed at different groups – **organisations**, **practitioners**, **individuals with lived experience, and strategic leads** (across Digital Health & Care Innovation Centre, TEC Programme, ADPs, NHS Boards and industry partners) – reflecting the idea that everyone has a role in sustaining digital inclusion and its benefits.

## ORGANISATIONS: Embedding digital inclusion into systems and policy

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|---|
| **Vision**: Organisations in the health, social care, housing, and justice sectors, working alongside people with experience of problematic drug use, fully integrate digital inclusion into their service models, ensuring that it is a core component of strategic planning, funding, and delivery. |
| **Recommendation #1: Consolidation of Board-level commitment and leadership**<br>○ Ensure organisational board members and/or senior leadership teams understand the strategic importance of digital inclusion for meeting the needs of people at risk of drug harms.<br>○ Provide digital inclusion training for governance boards to support informed decision-making. |
| **Recommendation #2: Integration of digital inclusion into staff roles and training for all those who work alongside people with experience of problematic drug use.**<br>○ Ensure consistency of digital inclusion responsibilities within job roles across health, social care, and justice services.<br>○ Ensure all forward-facing staff receive ongoing digital literacy training, so they can effectively support individuals who access services. |
| **Recommendation #3: Improvement of data-sharing and digital rights**<br>○ Develop transparent, secure, and user-controlled data-sharing systems, enabling individuals who experience problems with drugs to manage their own information across services.<br>○ Focus on removing bureaucratic barriers that prevent effective collaboration between organisations and services. |

## PRACTITIONERS: Supporting digital inclusion in service delivery

**Vision**: Practitioners across health, social care, and justice services, working alongside individuals with experience of problem drug use, confidently support them to use digital tools, ensuring that digital inclusion becomes an everyday aspect of forward-facing care.

**Recommendation #4: Strengthen, and build the capacity of, the DLS digital champions' network**

- Provide practical support to digital champions to develop their digital skills, tailored to their personal circumstances.
- Encourage digital champions to engage with a community of learning to support their ongoing development and digital competencies.

**Recommendation #5: Embedding of inclusive and supportive digital inclusion for people with experience of problematic drug use**

- Recognise that past difficult experiences may affect individuals' confidence in using digital tools. Ensure early conversations focus on digital access and textual literacy needs, providing practical, tailored support to build confidence in a safe and supportive environment.
- Ensure digital training is delivered in a safe, supportive, and non-judgemental environment.

**Recommendation #6: Delivery of digital access is equitable and meets individuals where they are at**

- Advocate for flexible digital provision, recognising that people at risk of drug harms have diverse experience of technologies and digital access – one-size-fits-all approaches do not work.
- Adapt digital inclusion strategies to meet the diverse needs of people with complex challenges (e.g., homelessness, drug use, mental health issues).
- Ensure digital access is available at service points, including drop-in centres, recovery hubs, and supported housing services, with public or guest Wi-Fi and charging facilities to remove economic barriers to participation. Encourage agencies to support individuals with connectivity costs where possible, recognising financial impact of digital exclusion.

**Recommendation #7: Establishment of digital inclusion as part of core practice within services supporting people with experience of problematic drug use, in line with wider health and social care provision**

- Ensure all forward-facing staff have the confidence, skills, and responsibility to support digital inclusion within their service, embedding digital literacy support into all care plans, keyworking sessions, and routine interventions.
- Strengthen collaboration across health, social care, and justice services to ensure digital inclusion is a shared responsibility, reducing reliance on external referrals and making it an integral part of everyday practice.
- Embed digital literacy support into existing interventions, such as harm reduction, drug treatment, mental health services, and rehabilitation programmes.

## INDIVIDUALS: Empowering individuals to take control of their digital future

**Vision**: Individuals affected by homelessness, drug use, criminal justice involvement, or mental health challenges have the confidence, skills, and access needed to fully participate in the digital world, enabling them to improve their quality of life.

**Recommendation #8: Development of digital confidence and independence**

- Support individuals to develop essential digital skills for everyday life, including accessing benefits, online banking, and health services.
- Promote accessible digital training, a sharing of such resources amongst organisations, and encouraging all to consider different literacy levels and abilities.

**Recommendation #9: Promotion of personal data control and rights**

- Make digital access, privacy, and data control rights transparent and routine, ensuring individuals are regularly informed and supported to understand and exercise their digital rights.
- Enable individuals to manage their own records, prescriptions, and appointments digitally, reducing reliance on third parties. Where exceptions apply, such as issues of capacity, alternative support should be a last resort rather than a default approach.

**Recommendation #10: Consistent delivery of access to devices and connectivity**

- Advocate for affordable internet access and provide on-premises connectivity, across health, drug treatment and recovery, homelessness, and justice settings, ensuring individuals do not face financial barriers to digital participation.
- Work with service providers to ensure individuals receive devices that meet their needs (e.g., larger screens, or screen reader software, for those with disabilities or brain injuries).

**Recommendation #11: Adoption of digital tools for personal growth and recovery**

- Promote digital tools that support mental wellbeing, recovery, and community engagement amongst individuals with experience of problematic drug use.
- Encourage online peer support networks to help individuals learn digital skills together in a supportive environment.

**Recommendation #12: Genuine collaboration of individuals with lived/living experience of problematic drug use in co-designing digital services (through an equal and reciprocal partnership)**

- Involve individuals in shaping digital inclusion initiatives, ensuring responses reflect real needs and lived experiences.
- Create feedback loops so individuals can share their experiences and influence future improvements.

## STRATEGIC LEADS: Accelerating digital products and platforms

**Vision**: People affected by drug use can seamlessly access both proven national digital-health platforms and cutting-edge, co-designed innovations. Health, social-care, housing, and justice services, working alongside industry and lived-experience partners, embed these tools as routine practice, accelerate their continuous improvement, and scale successful solutions quickly across Scotland. All commissioned services treat digital inclusion as part of their job and not as an optional extra.

**Recommendation #13: Require services to address digital needs in commissioning contracts**

When commissioning treatment, support, or recovery services, include requirements or incentives for providers to supply digital access support. For example, tender specifications could state that the service must provide or facilitate devices and data for individuals who lack them, and train staff as digital champions. This will help in mainstreaming the practice. It will also help to spread the cost, as providers can build it into their service delivery plans (which commissioners fund).

**Recommendation #14: Embed national digital health platforms and mainstream consumer apps**

- Map where digital tools and services such as Near Me, Connect Me and national digital-mental-health services can support people at risk of drug harm to access services and support
- Upskill staff and Digital Champions to onboard individuals and promote everyday wellbeing apps (diet, activity, mindfulness)
- Track uptake and outcomes and then feed learning into wider health and social care programmes to refine national offers

**Recommendation #15: Grow the innovation pipeline for digital solutions aimed at those who experience problems with drug use**

- Co-design, test and evaluate new apps/wearables for harm-reduction and recovery (building on By My Side)
- Create lived-experience insight panels and clear data-governance guides to speed development and relevance
- Lobby for agile procurement routes so that proven pilots can scale rapidly across health, social-care and justice settings

**Recommendation #16: Create local device and data solutions via partnerships**

- ADPs should convene local partners (telecom companies, charities, libraries) to set up schemes like device donation drives or bulk data purchase at discounted rates for their client base. For instance, partnership with a telecom could yield community SIM cards with cheaper rates for vulnerable people. Local innovation can reduce the cost burden and engage community goodwill. Some DLS areas did this informally; formalising it can secure a steady flow of resources. It also fosters community involvement in solutions.

**Recommendation #17: Allocate small flexible funds for emergency top-ups and replacements**

- Commissioners should set aside a discretionary fund that front-line services can tap quickly to replace a lost phone or buy a data top-up in emergencies (i.e. simplifying the admin so that support isn't delayed). Having a safety net fund means a person won't be cut off for weeks due to bureaucratic delays, thus maintaining continuity of care.

**Recommendation #18: Facilitate training and support for the workforce**

- Ensure that all commissioned services have access to training on digital inclusion (perhaps funded or arranged by the ADP centrally). This could involve workshops for staff on basic IT troubleshooting, using online tools with individuals, and trauma-informed digital engagement. Building staff capacity will make services more effective in delivering digital support. Confident staff can pass skills to those individuals they support and integrate tech in support plans. It also standardises quality – everyone working in the sector should have at least baseline digital helper skills.

## Concluding thought

Our recommendations call for a collective effort to **embed digital inclusion into the fabric of support for people who use drugs**. Organisations need to lead with strategy and resources, practitioners need to implement with compassion and creativity, and individuals should be empowered and involved. The DLS Phase 2 evaluation shows that when these pieces come together, digital lifelines can truly help save lives and build brighter futures. The task now is to maintain and expand on these gains – making sure that digital lifelines remain strong long after the initial programme, so that everyone in Scotland, regardless of their circumstances, can benefit from the opportunities of the digital age.