FIGURE 8
CONSULTANCY SERVICES LTD

Evaluation of the Digital Lifelines Scotland (DLS) Programme

SUMMARY REPORT FOR POLICYMAKERS

Prepared for the Digital Health & Care Innovation Centre

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1. Introduction

This summary report has been prepared for national and local policymakers and strategists to outline the full implications of the Phase 2 evaluation (April 2023 – March 2025) of the Digital Lifelines Scotland [DLS] programme, and to identify a bespoke set of resulting recommendations.

The Phase 2 final evaluation report (May 2025) sets out the difference that the DLS programme has made once it was integrated more fully into health, social care, and community services. It explores how DLS has 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.

The main evaluation report, which sets out the detailed findings and full set of recommendations, can be accessed via the following link:

DLS Evaluation 2025 | Digital Lifelines

This report seeks to place the findings within the context of global and national digital inclusion policy and practice. It provides a headline summary of the reach of the DLS programme, followed by two sections outlining the strategic implications and resulting recommendations for national and local policymakers and strategists.

2. Contextualising Digital Lifelines Scotland within global and national digital inclusion practice

Introduction

The following rapid literature review sets out how the DLS programme fits into wider work on digital inclusion. It provides an overview of how other countries and UK nations have supported people to get online and use digital technology. It then shows how DLS builds on this work and seeks to break new ground by focusing on people most at risk of drug-related harm.

Why digital inclusion matters

Being digitally included means having access to the internet, devices, and the skills and confidence to use them. This can help people stay healthy, connected, and involved in society. Around the world, governments, statutory providers, and civic society organisations have tried to improve digital access. These efforts often target people affected by poverty, poor education, or isolation.

Global examples of digital inclusion

- **Uruguay**: In 2007, Uruguay launched Plan Ceibal to give laptops and internet access to all children and teachers in public schools. It also added digital skills to the school curriculum. This helped close the digital gap between city and rural pupils and improved learning and life chances.
- **Spain (Basque Country)**: The KZgunea programme provides free digital training to older adults, unemployed people, and those with low education levels. It has helped people feel more confident online, find work, and use public services.
- **Denmark and other Nordic countries**: Denmark set up the Network for Digital Inclusion in 2015. Over 90 public and charity organisations work together to help excluded groups go online. The government also changed laws to make it easier for people to use digital public services.
- **Estonia**: Often called a world leader in digital services, Estonia has invested in broadband, online identity, and e-government tools. However, older and disabled people still face digital barriers. This shows that giving people access is not enough, support must be tailored.
- **Australia**: In Australia, charities lead most digital inclusion work. For example, Infoxchange supports low-income, indigenous, and remote communities with devices, training, and support. These projects are shaped with local people and often use trauma-informed and culturally appropriate approaches. But without a national strategy, access is patchy and uneven.

UK comparisons

- **Wales**: Wales has put digital inclusion at the heart of its work to build a fair and sustainable future. The Welsh Government s 2021 digital strategy focuses on people, skills, and inclusion. It supports digital skills for all ages and works with community groups to reach those at risk of exclusion.
- **England**: The UK Government s 2022 digital strategy mainly focuses on the economy. It supports digital start-ups and investment. It mentions inclusion but does not make it a main goal.
- **UK Government**: Digital inclusion action plan published in Feb 2025 [Online].

Scotland's approach

Scotland s digital inclusion work has included four key national programmes:

- **Connecting Scotland**: Launched during the COVID-19 pandemic, this programme provided devices, internet access, and training to people at risk of exclusion. This included people on low incomes, care leavers, older adults, and those shielding for health reasons. Support was delivered locally through trusted organisations.
- The Connecting Scotland programme also included the **Technology Enabled Care 'Connecting Residents in Scotland's Care Homes programme'**, again launched during the COVID-19 pandemic.

- **Digital Inclusion Programme (Digital Health and Care) 2023-2025**: Launched in March 2023 focusing initially on the areas of Mental Health and Housing, the programme developed, tested, and implemented a range of digital inclusion models to enable people to access services and supports and experience improved wellbeing. The programme has produced a range of models, tools, and resources for embedding digital inclusion as an integrated part of health and social care. This programme has now closed.
- **Digital Lifelines Scotland (DLS) 2021-present day**

Despite this progress, few programmes in Scotland or elsewhere have focused on people who use drugs, yet we know that this group faces major barriers to digital access. These include stigma, homelessness, poor mental health, and lack of trust in services. Most inclusion efforts are not designed with these challenges in mind.

The role of Digital Lifelines Scotland

DLS fills this gap. It supports people at high risk of drug-related harm by helping them get online and use technology safely. The programme is based on harm reduction, trauma-informed care, and co-design with people who have lived and living experience. It works through frontline services and is built around trusted relationships.

DLS shows how digital inclusion can be part of wider support for recovery and wellbeing. It treats digital access not just as a benefit, but as a basic need that can help save lives. This unique needs-based focus makes it different from most other programmes in the UK and beyond.

3. Who DLS has reached

DLS specifically targeted **people at highest risk of drug-related harm and digital exclusion**. The profile of people supported includes:

- **People experiencing homelessness:** Over half of the individuals supported (**around 3,000 people**) were reached via homelessness and housing support services. Many had unstable living situations, limited access to technology, and were at acute risk of overdose or health crises. DLS has worked with outreach programmes, hostels, and day centres to identify these individuals and get them online.
- **Individuals in custody or leaving prison:** About **2,000 people** in prison settings or recently liberated have been supported. Transitions from custody back into the community are known to be high-risk periods for drug-related death and relapse, often compounded by social isolation. DLS partnered with the Scottish Prison Service and throughcare (post-release support) teams to provide digital access as part of prison release planning. In practice, this meant people leaving prison were given a basic smartphone (often pre-loaded with important contacts and apps) and a data package so that they could immediately connect with community services, or support groups upon release. Frontline workers noted that something as simple as having a phone on the day of release could make the difference between a stable transition and someone

falling into crisis (for example, being able to arrange housing and attend health appointments right away).

- **People in hospitals due to drug-related issues:** Around **417 individuals** were engaged through hospital-based initiatives. These were often people who had been admitted for drug overdoses, infections, or other related health emergencies. Hospitals used DLS resources to ensure that when people were discharged, they did not go back out disconnected . For instance, a person revived from an overdose might be given a DLS device and linked with a digital recovery network or online naloxone training before leaving the hospital.
- **Geographic and demographic reach:** DLS projects operated across urban and rural areas of Scotland, including remote communities where services are sparse. Many supported individuals who lived in rural localities with poor public transport or limited local support groups. By providing internet access, DLS effectively brought services to them. One participant living in a rural area shared that without online access, *I wouldn t have been able to engage at all* because there were no nearby services and no transport. The programme also reached a wide age range of adults, including some older individuals with long-term drug problems who had never used smartphones before, as well as younger people who might be more tech-savvy but lacked resources or safe online spaces.
- **Multiple and complex needs:** Virtually everyone reached by DLS had multiple disadvantages – such as mental health issues, trauma histories, or disability – alongside their substance use challenges. These factors often intersect with digital exclusion. DLS took an inclusive approach, aiming to reach those who were often *hardest to reach* by traditional means. By working through trusted local services (like third sector drug and homelessness services, recovery cafés, shelters, and justice social work), the programme identified people who were not engaging with mainstream digital inclusion schemes. This intentional targeting ensured DLS resources went to people at acute risk – including those with recent overdose experiences, those living in extreme poverty, or those facing stigma that kept them isolated.

DLS has reached people at the margins – those with the greatest need and least access to digital tools. By focusing on individuals experiencing homelessness, imprisonment, and health crises, DLS has plugged a critical gap. It has given these high-risk groups the means to connect with life-saving information and support. Notably, many of these individuals were not benefiting from any other digital inclusion initiatives (like general community broadband projects) because of their circumstances. DLS has tailored its approach to make sure digital help was delivered through familiar support channels and at key moments (for example, at prison release or hospital discharge) when it could have maximum impact on a person s safety and recovery.

4. Strategic implications for policy

The results of DLS have important strategic implications for policy and future planning in Scotland. The success of DLS Phase 2 signals that digital inclusion should become a cornerstone of strategies addressing drug harms and social inequalities. Here are the key implications and considerations for policymakers.

1. Make digital inclusion a standard part of drug prevention and recovery policy: DLS demonstrates that providing digital access and skills is not an optional frill, but a necessary component of effective support for people who use drugs. Policymakers should explicitly incorporate digital inclusion in (and beyond) the current National Mission on Drugs and related frameworks. This means, for example, when developing guidelines or outcomes for Alcohol and Drug Partnerships, they should include measures of digital connectivity and literacy for those who use services. National quality standards for harm reduction services could be updated to say that every individual s digital needs should be assessed and addressed (just as physical health or housing needs are). By mainstreaming digital inclusion into policy, the government ensures that it is no longer a time-limited project but part of the fabric of care. The cultural shift is already underway with many stakeholders now seeing connectivity as indispensable for full citizenship. Policy needs to cement that, declaring that no one in recovery should be left offline.

2. Ensure sustainable funding and scale-up: The government and funders must plan for long-term investment in digital inclusion initiatives. Rather than relying on ad-hoc grants, core funding should be allocated to maintain devices, data, and digital support staff within services. This could involve dedicated budget lines in health and social care funding for *digital inclusion support*. The scale of Phase 2 (supporting 5,500 people) is still just a fraction of those in need across Scotland. To scale up, policymakers could consider a national programme (or integration with the existing Connecting Scotland programme) specifically targeting people at risk of drug harm, learning from DLS. The evaluation suggests that making such funding ongoing and predictable would greatly enhance impact. In practice, this might look like each Alcohol and Drug Partnership getting an annual allocation to fund devices/data for 'X' number of people or expanding initiatives like providing a phone upon prison release as a standard procedure nationwide. Economies of scale could be achieved by central procurement of data packages or devices (reducing per-unit costs) if digital inclusion is adopted on a larger scale. The cost-effectiveness argument from DLS provides some leverage. So, investing upfront in connectivity can save money later by preventing crises. Strategic policy should secure funding streams that allow these programmes not only to continue but to grow to meet demand in all regions.

3. Cross-sector collaboration and co-ownership: DLS cut across various sectors (health, mental health, justice, housing, social care). One implication is that no single agency can do this alone. A cooperative approach is needed where different departments and sectors co-own the digital inclusion agenda. For example, the Justice Directorate should work with Health to ensure people leaving prison have digital support in place (combining throughcare

efforts with digital aid). Housing and homelessness services should coordinate with Alcohol and Drug Partnerships so that when someone gets housed, they also get online. To facilitate this, policy could encourage or mandate partnership frameworks (such as multi-agency protocols or shared funding pots) that specifically focus on digital inclusion for vulnerable groups. The evaluation noted how multi-agency Memorandums of Understanding and knowledge sharing benefited DLS. Scaling that up could mean regional *digital inclusion committees* that bring together Councils, the National Health Service, the Department for Work and Pensions, and charities to streamline efforts. A strategic implication is the need to break down silos. For instance, if the National Health Service is rolling out online appointment systems, they must coordinate with community groups to ensure patients have internet access to use them. Policy can drive this by tasking relevant bodies to include digital inclusion in their joint planning. For example, Community Planning Partnerships could have a digital inclusion workstream for vulnerable populations.

4. Integration with broader social agendas (housing, health, justice): The outcomes of DLS (improved stability, engagement, safety) directly support goals in other policy areas:

- *Housing:* Keeping someone digitally connected can help them sustain a tenancy (by managing bills, applying for benefits online, connecting with landlord portals). Thus, housing policy should see digital access as part of tenancy sustainment. For instance, housing support services could ensure new tenants coming out of homelessness have Wi-Fi or a device included in their resettlement package. Some housing associations might integrate free communal Wi-Fi in hostels or provide tablets for residents' use. Policy could incentivise this by including digital connectivity in housing quality standards or funding criteria for homelessness programmes.
- *Health and care:* As health services increasingly offer digital routes (like e-consultations, telepsychiatry), health policy must ensure digital equity that vulnerable groups can also benefit from. The learning from DLS can feed into the Digital Health and Care Strategy, emphasising outreach and support for those not naturally online. Health boards might fund liaison roles or partner with community organisations to deliver digital training as part of public health initiatives. Additionally, through the Scottish Government's National Digital Mental Health Programme, mental health and drug services can formally incorporate digital peer support options, given DLS has evidenced their effectiveness. The policy implication is that healthcare innovation should always include an inclusion plan; rolling out an app is pointless if the target individuals cannot access it. DLS provides a template for how to bridge that gap.
- *Justice and community safety:* The justice system could formally adopt digital support as part of throughcare for offenders. For example, prison release protocols might include assessing digital needs, providing a phone and a contact list of support. Community justice partners could use digital monitoring not in a punitive way, but to keep people safe. Digital literacy can also be part of rehabilitation and skills training in prisons, preparing individuals for the online world that they will re-enter. Policymakers in justice should view connectivity as crucial for reducing re-offending: it helps people

connect with jobs, positive communities, and comply with requirements (like attending appointments virtually if needed). A strategic idea could be a *digital throughcare* policy, ensuring continuity of digital access from custody to community.

- *Education and employment (skills agenda):* Although not the primary focus, DLS outcomes in confidence and skills feed into employability. The government s employability and adult education strategies should note that basic digital skills gained through programmes like DLS can be a stepping stone to further learning or work readiness for a marginalised group. So, linking those strategies would be beneficial. For instance, ensuring people in recovery can progress to digital skills courses or vocational training online.

5. Digital rights and reducing inequalities: On a high level, DLS highlights that digital exclusion is a facet of social inequality. People who use drugs often are some of the most digitally excluded, exacerbating their marginalisation. The strategic implication is that Scotland s digital programmes (like Connecting Scotland) must cater to those with complex needs, not just general low-income households. There may be a need for a targeted digital inclusion initiative under the National Mission on Drugs, or at least priority access for this group in existing schemes. Policymakers should consider digital access as a right. If services are *digital by default*, then failing to provide access is effectively denying services. To that end, government might explore legislative or regulatory measures, such as ensuring all prisoners have access to basic digital resources upon release or requiring that public services maintain non-digital alternatives until inclusion gaps are closed.

6. Sustainability through mainstreaming: A crucial implication is that pilots and short-term projects, whilst useful to prove concepts, should transition into mainstream services if successful. DLS Phase 2 has shown that the model works; now the focus should be on embedding it into business-as-usual for Alcohol and Drug Partnerships and Health Boards. Sustainability will come from institutionalising these practices. For example, making *digital champions* a standard role in job descriptions for support workers, or having the National Health Service fund device libraries for people who are marginalised by services. Policymakers should be asking: how do we permanently embed this into the system? One route would be through commissioning. When Health Boards or Councils commission services (like a contract for a recovery service), they could include requirements and provide the additional resource for digital inclusion. For example, the service must provide or facilitate digital access for individuals. This would support providers to continue the work as part of their operations, funded by those contracts. Commissioners need to be clear that this digital inclusion element cannot just be tagged onto contracts with an expectation that providers should absorb the costs into their delivery plans. Appropriate consideration needs to be given to resourcing to make this happen. Another route would be through guidance and training. By incorporating digital inclusion training into core training for drug workers, social workers, etc., new practitioners would enter the field ready to address this.

7. Evidence and evaluation for continuous improvement: Strategically, the DLS evaluation provides a rich evidence base. Going forward, policies should encourage ongoing evaluation

of digital inclusion efforts. Setting up systems to track outcomes (like engagement rates, health outcomes, cost offsets) would allow refinement and strengthening of the approach. The government might invest in a longitudinal study to follow DLS participants over time to see long-term impacts on health and wellbeing – data that could further inform cost-benefit arguments and fine-tune delivery. Also, sharing evidence nationally (through conferences, publications, and practitioner networks), would help all areas to implement best practices. This would tie into policy support for knowledge exchange. For example, the government could fund an annual *Digital Inclusion and Recovery* forum to keep momentum and innovation alive.

5. Recommendations

Building on the evaluation findings and the above strategic analysis, here are practical **recommendations** targeted to policymakers – to sustain and amplify the impact of DLS. Each recommendation is accompanied by a note on expected benefit or rationale:

1. **Embed digital inclusion in core funding and strategy for drug services:** Make connectivity and devices a standard budget item in funding allocations to Alcohol and Drug Partnerships and related programmes. For example, include a per-capita allowance for digital access in any new funding packages. *Impact:* This would provide sustained resources so that people remain connected beyond pilot phases, preventing the *cliff edge* when short-term funds end. In the long run, it would likely reduce costly emergencies by keeping people engaged in support.

2. **Launch a national *Digital Lifelines* initiative as part of the new (post-National Mission on Drugs) strategy on Drugs and Alcohol:** Scale up and embed the DLS model across all regions, ensuring every high-risk individual (for example, upon prison release, hospital discharge for overdose, entry into treatment) is offered digital support. *Impact:* Nationwide coverage would level up access, so no matter where someone lives, they can benefit. It also signals high-level commitment, encouraging local services to prioritise digital inclusion.

3. **Promote cross-departmental collaboration with dedicated oversight:** Establish a working group or task force that brings together health, justice, housing, and digital policymakers to coordinate actions on digital inclusion for vulnerable groups. Assign clear ownership to ensure actions (like providing devices at prison liberation or Wi-Fi in temporary accommodations) are implemented jointly. *Impact:* This would help break down silos and ensure that initiatives (prison programmes, telehealth, housing support) are synced, creating a seamless digital safety net around individuals. This coordination was key to DLS success and should be formalised.

4. **Incorporate digital access metrics into national monitoring and outcomes:** Begin tracking metrics such as *% of people in drug services with access to an internet-enabled device* or *digital skill confidence levels of those who use services* as part of

routine data returns from Alcohol and Drug Partnerships. *Impact:* What gets measured gets done. Including these metrics will incentivise services to pay attention to digital inclusion. It would also allow government to evaluate progress and pinpoint gaps. Over time, improvements in these metrics would correlate with better engagement and outcomes, strengthening the evidence base.

6. Closing statement

The Digital Lifelines Scotland programme has shown conclusively that **digital inclusion can be a life-changing and life-saving intervention** for people at risk of drug-related harm. By providing the means to connect, DLS has helped individuals regain dignity, support, and hope. It has strengthened engagement with services, fostered personal growth, and created new safety nets in previously unreachable moments of crisis. Perhaps most importantly, it has demonstrated that no one is *too hard to reach* if we are willing to meet them where they are – even if that is online.

For policymakers, the message is clear: **investing in digital inclusion is an investment in better health, greater equality, and human potential**. What was once seen as experimental is now proven practical. The successes of Phase 2 of the DLS programme present an opportunity (and indeed an imperative) to scale up and embed these approaches so that every person in Scotland struggling with problem drug use or exclusion can benefit. This means committing to the long haul by making digital lifelines a permanent part of our health and social support landscape.

There is still much work to do. Bridging the digital divide will require continued collaboration across sectors, sustained funding, and adaptation as technology and needs evolve. Challenges like affordability, infrastructure, and skills gaps must be continually addressed. But the trajectory is set – each tablet distributed, each video call answered, each text message of encouragement sent. These are steps toward a more inclusive and compassionate system.

In moving forward, Scotland has the chance to **lead by example**. By fully integrating digital inclusion into its National Mission on Drugs and wider social policies, it can show how a modern nation leaves no one behind in the digital age. The DLS programme s legacy will be not only the lives it touched over 2021–2025, but also the blueprint it has provided for lasting change.

Digital inclusion should no longer an optional add-on because it is a real lifeline. The human stories and hard data from DLS reinforce the importance of continuing this work.