Glasgow Caledonian University

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Public Health Scotland

Evaluation of the Scottish Government National Drug Deaths Mission

Incorporating a Financial and Economic Perspective

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Abbreviations

ADRS	Alcohol and Drugs Recovery Services
BBV	Blood-borne virus
DRD	Drug-related death
GCU	Glasgow Caledonian University
GIRFEC	Getting It Right For Every Child
HSCP	Health and Social Care Partnership
JBI	Joanna Briggs Institute
LLE	Lived and Living Experience
MAT	Medication Assisted Treatment
NESI	Needle Exchange Surveillance Initiative
NIHR	National Institute for Health and Care Research
OAT	Opioid agonist treatment
PHS	Public Health Scotland
PICO	Population – Intervention – Comparator – Outcome
PWID	People who inject drugs
QALY	Quality adjusted life year
REA	Rapid evidence assessment
RO	Research objective
RRRCP	Residential Rehabilitation Rapid Capacity Programme
SDCF	Safer drug consumption facility
SDF	Scottish Drugs Forum
SG	Scottish Government
SHIeLD	Substance Use and Health Intelligence Linked Dataset
THN	Take-home naloxone

Executive Summary

The level of harm from drugs in Scotland is high relative to the rest of the UK and Europe. Drug-related death (DRD) rates have been increasing over the last two decades before stabilising in recent years, but Scotland still has among the highest rates globally. In response, the Scottish Parliament declared DRDs a "public health emergency" in 2019 and, in 2021, the Scottish Government introduced a 5-year National Mission to reduce DRDs and improve the lives of those impacted by drugs supported by a commitment to invest an additional £250m in drug and alcohol services over the 5-year period.

Public Health Scotland (PHS) have been tasked by the Scottish Government to evaluate the National Mission, covering the period 2021 to 2026. The evaluation framework includes six work packages, one of which is the economic evaluation of the National Mission described in this report. The work was commissioned and funded by PHS and undertaken by Glasgow Caledonian University.

The work focuses primarily on the new funding made available to the National Mission (referred to as National Mission funding in the remainder of the report), but PHS were also interested in how these resources relate to the wider, ongoing investment in drug and alcohol services that aims to meet the goals of the National Mission.

Research aims and objectives

The overall purpose of the study was to inform discussion about the likelihood that the National Mission funding has delivered value for money and how to allocate limited resources across the following in-scope treatment options: take-home naloxone, safer drug consumption facilities, opioid agonist treatment (OAT), psychosocial interventions, detoxification services, stabilisation facilities and residential rehabilitation.

The study aims were to explore, first, how National Mission funds have been allocated and spent and, second, the benefits which that expenditure has (or is likely to have) delivered, based on existing evidence of the effectiveness and cost-effectiveness of services funded. The study had five research objectives (ROs):

RO1: To map how National Mission funds have been (i) allocated and (ii) spent across the in-scope treatment services.

RO2: To explore to what extent the National Mission expenditure related directly to the in-scope services has been additional to what would have been funded anyway through other sources (e.g. NHS Board funding).

RO3: To identify and briefly summarise, for the specific treatment services that are in scope, whether there is a recent systematic review, review of reviews or other robust summary evidence relating to effectiveness and cost-effectiveness, identifying any evidence gaps.

RO4: To identify and summarise available evidence on whether the National Mission has contributed to improving access to, and quality of, the in-scope treatment services.

RO5: To synthesise, being clear about limitations, the information collected in relation to the following two questions: (i) to what extent have National Mission funds been spent on effective and cost-effective drug treatments and (ii) to what extent has the National Mission funding contributed to improving access to, and quality of, different treatment services.

Research Objectives RO1 and RO2: Financial analysis

The financial analysis comprised two stages. Stage 1 involved desk-based work to collate information on the National Mission funding and wider expenditure on in-scope services from published sources. Stage 2 involved semi-structured interviews with a purposive sample of six ADPs (urban, rural and mixed urban/rural) to understand local governance arrangements, how they had used the National Mission funding across the in-scope services, additionality and the challenges faced in using those funds. Interviews were conducted between October and November 2025.

Ethical approval for the study was granted by Glasgow Caledonian University (GCU) School of Health and Life Sciences Research Ethics Committee.

Stage 1 illustrated that over the 5-year period, funding of between £140 and £160m per annum for drug and alcohol services supported a wide range of services and initiatives to meet the aims of the National Mission. Around £56m of this was baseline funding transferred via NHS Territorial Boards for onward delegation to Integration Authorities to be invested through ADPs, increasing to nearly £79m in 2025/26 as a greater proportion of the funding was put into Boards' baseline funding. The remainder comprised Alcohol and Drugs policy funding, of which £50m per annum was the National Mission funding, rising to around £60m by the end of the period.

Funding was allocated via multiple channels. For example, in 2024/25, £50.3m was allocated by the Scottish Government in direct funding to ADPs. Together with the baseline funding, this meant approximately 70% of all alcohol and drug funding was channelled through ADPs. Sixty per cent (£30m) of the direct funding to ADPs came from the National Mission funding. The remaining National Mission funding (approximately £20m) is distributed by the CORRA Foundation or directly managed by the Scottish Government. Overall, around a third of the total funding for drug and

alcohol services comes from the National Mission and around a fifth of the total funding for drug and alcohol services is National Mission funding spent by ADPs.

Stage 2 provided a more granular picture of how these funding streams are used by ADPs. Sixteen themes were identified that revealed a complex and fragmented funding landscape, substantial additionality but also challenges in mapping resource use in detail across the in-scope services and in assessing what difference funding was making to outcomes.

Research Objectives RO3 and RO4 – Reviews of evidence on effectiveness, cost-effectiveness, quality and access.

To address RO3, we conducted rapid evidence assessments of the effectiveness and cost-effectiveness evidence for the in-scope treatment services in relation to three outcomes: problem drug use, non-fatal overdose and drug-related deaths.

We searched multiple research databases and conducted a quality assessment of key reviews using a modified version of the Joanna Briggs Institute (JBI) critical appraisal tool for appraising the quality of systematic reviews and research syntheses. Review-level evidence was assessed as moderate to high quality for take-home naloxone (THN), safer drug consumption facilities (SDCFs), OAT, and detoxification services across each outcome, where evidence existed. We did not identify review-level evidence for a number of the outcomes for psychosocial interventions, residential rehabilitation, or any of the outcomes for stabilisation facilities. The evidence from economic studies comprised both cost-effectiveness analyses, including analyses of cost per quality adjusted life year (QALY), and cost-benefit analyses.

Review-level evidence supported the effectiveness of OAT in reducing and preventing drug-related mortality. THN is effective at reversing opioid overdoses and preventing drug-related mortality, but evidence is limited at a population level. Review-level evidence did not indicate that THN is associated with increased risk of non-fatal overdose or problem drug use. Furthermore, OAT was associated with reductions in drug use. Both OAT and THN were considered cost-effective within review-level literature. Review-level evidence showed that SDCFs are associated with reductions in mortality and overdose risk factors, and appear cost-effective, although there is a lack of evidence of their impact on drug use. Relating to psychosocial interventions (particularly contingency management) and detoxification services, review-level evidence highlighted short-term reductions in drug use, but there is a lack of or no review-level evidence demonstrating sustained impacts on overdose or mortality, and limited cost-effectiveness evidence. There is limited review-level evidence for residential rehabilitation reducing drug use, and a lack of evidence for overdose and mortality outcomes and for cost-effectiveness.

Furthermore, there is currently no review-level evidence on the effectiveness or cost-effectiveness of stabilisation facilities.

To address RO4, we assessed reports published by national bodies (including PHS, Scottish Public Health Observatory, Glasgow City Health and Social Care Partnership, and the Scottish Government) covering periods before and after the implementation of the National Mission to ascertain the impact on access to in-scope treatment services. To assess whether the quality of services had improved, we synthesised existing experiential evidence published by the Scottish Drugs Forum and PHS from people with lived and living experience (where available) since the start of the National Mission.

The evidence suggests that there have been improvements in access to take-home naloxone (with caveats about the extent to which naloxone is carried by those provided with it) and publicly funded residential rehabilitation places. A safer drug consumption facility (SDCF) – "The Thistle" – has been opened in Glasgow. The number of people accessing OAT remains relatively high and stable. Furthermore, the Medication Assisted Treatment (MAT) standards were increasingly met, suggesting that the quality of drug treatment services has improved. However, information on access remains limited, particularly relating to detoxification services, stabilisation facilities, and psychosocial interventions (where there was no publicly available data).

Experiential information on quality of services highlighted improvements particularly to OAT delivery, but improvements remain inconsistent across Scotland. Lack of support for and a desire to access services to address mental health were consistently highlighted as an unmet need.

Research Objective RO5 – Synthesis and Conclusions

The study found that substantial allocations were made to and spent on services shown by the review-level evidence to be effective and either cost-effective or having benefits in excess of costs. Substantial funds were also allocated to service areas where there is an absence of review-level evidence on effectiveness and cost-effectiveness, but this reflects the state of the evidence base rather than indicating poor value for money. This should not be seen as an argument not to invest in, or to move resources away from, areas where evidence is currently absent. Rather, it points to the need for improved monitoring, evaluation and research. Specific recommendations are made below.

The study also found that progress is being made in preventing DRDs and improving access and quality, albeit with a lot still to do to address need and achieve the aims of the Mission.

However, it is not possible to give a definitive answer to questions of value for money and where funds should be allocated in the future for two reasons: first, the financial analysis showed that a precise assessment of where individual funding streams have been allocated is not possible; second, the review-level evidence identified does not give a clear indication of what the most effective and cost-effective treatments (or combination of treatments) are across all the in-scope services.

Enhanced monitoring and evaluation are needed to improve our understanding of whether the aims of the National Mission are increasingly being achieved, to fill the evidence gaps so that we are better able to judge the relative value for money offered by current and future approaches to reducing drug-related harms, and to guide future investment decisions. More precise data on whether and how National Mission funding has been spent on the in-scope services would be difficult to achieve given the nature of the services and the funding streams involved. Furthermore, it may not reflect local priorities, and interpretation would remain challenging due to the gaps in evidence on the effectiveness and cost-effectiveness or cost-benefit of many of the in-scope services. Therefore, we recommend prioritising further development of information on the outcomes of drug and alcohol services, further research on the effectiveness and cost-effectiveness or cost-benefit of those services and consideration of how best to hold organisations to account for the use and impact of the funding for drug and alcohol services.

1. Background

The level of harm from drugs in Scotland is high relative to the rest of the UK and Europe. DRDs have increased over the last two decades to a peak of 1339 in 2020 (National Records of Scotland, 2025). They have stabilised since then to 1017 in 2024 but after adjusting for age, there were 19.1 DRDs per 100,000 people in 2024, still 3.6 times as high as they were in 2000. In 2024, people in the most deprived areas of Scotland were 12 times as likely to die of a DRD compared to people in the least deprived areas. The Scottish Parliament declared DRDs a “public health emergency” in 2019 (Iacobucci, 2019).

To address this issue, on 20 January 2021, the Scottish Government introduced a National Mission to reduce DRDs and improve the lives of those impacted by drugs. It published the National Mission on Drug Deaths: Plan 2022-2026 in August 2022 setting out six key outcomes to achieve the overall aims of the Mission (Scottish Government, 2022a). It also made a commitment to invest an additional £250m in drug and alcohol services over the lifetime of the current Parliament (2021 to 2026) to help achieve these outcomes, through a range of initiatives such as:

- Standards to improve Medication-Assisted Treatment (MAT)
- A programme to improve access to residential rehabilitation
- A pilot programme to introduce a Safer Drug Consumption Room in Glasgow
- Expansion of the Take Home Naloxone programme.

Many of these initiatives continued programmes of work that had begun before 2021 and had been recommended by the Drug Deaths Task Force (Scottish Drug Deaths Taskforce, 2022).

Public Health Scotland (PHS) have been tasked by the Scottish Government to evaluate the National Mission, covering the period 2021 to 2026 (Public Health Scotland, 2024a). The primary focus of the national evaluation is programme impact in terms of increased access to treatment and increased quality (effectiveness) of treatments. The evaluation framework includes six work packages, one of which is the economic evaluation of the National Mission.

This report relates to the economic evaluation work package. The work was commissioned and funded by PHS. The brief for the work focused primarily on the National Mission funding i.e. the new funding (£50m per annum) made available over the five years of the Mission. PHS were also interested in a broader cost mapping exercise to help understand how these resources relate to the wider, ongoing funding of drug and alcohol services that aims to meet goals of the National Mission. Therefore, this report describes work to map how the £250 million (£50 million per

year) commitment of National Mission funding was spent and where that funding fits within total funding for drug and alcohol services that contribute to the Mission's objectives, including pre-existing baseline and policy-related funds.

Research aims and objectives

The overall purpose of the study was to inform discussion among relevant stakeholders in Scotland about:

- the likelihood that the National Mission funding has delivered value for money.
- how to allocate limited resources across different treatment options going forward.

The study aims were to explore, first, how National Mission funds have been allocated and spent and, second, the benefits which that expenditure has (or is likely to have) delivered, based on existing evidence of the effectiveness and cost-effectiveness of services funded.

The scope of this study was limited to investment in treatment services specified by Public Health Scotland and discussed with the National Mission Evaluation Advisory Group. This included investment in frontline alcohol and drug services overall. The following drug treatment services were in scope: take-home naloxone, safer drug consumption facilities, opioid agonist treatment (OAT), psychosocial interventions, detoxification services, stabilisation facilities and residential rehabilitation. An additional intervention highlighted by the Advisory Group that was outside the scope of this project was peer recovery services. Work to address this gap is being undertaken by PHS.

The study had five research objectives (ROs):

- RO1: To map how National Mission funds have been (i) allocated and (ii) spent across the in-scope treatment services.
- RO2: To explore to what extent the National Mission expenditure related directly to the in-scope services has been additional to what would have been funded anyway through other sources (e.g. Health Board funding).
- RO3: To identify and briefly summarise, for the specific treatment services that are in scope, whether there is a recent systematic review, review of reviews or other robust summary evidence relating to treatment effectiveness and cost-effectiveness, identifying any evidence gaps.

- RO4: To identify and summarise available evidence on whether the National Mission has contributed to improving access to, and quality of, the different in-scope services.
- RO5: To synthesise, being clear about limitations, the information collected in relation to the following two questions: (i) to what extent have National Mission funds been spent on effective and cost-effective drug treatments and (ii) to what extent has the National Mission funding contributed to improving access to, and quality of, different treatment services.

2. Research Objectives RO1 and RO2: Financial analysis

2.1. Methods

The financial analysis comprised two stages. Stage 1 involved desk-based work to collate information on National Mission funding and wider expenditure on in-scope services from published sources. These included the National Mission Annual Reports (2021/22-2024/25) (Scottish Government, 2022b, 2023, 2024a, 2025a), data on allocations made to NHS Boards and Alcohol and Drugs Partnerships (Scottish Government, 2025b), the funding letter to Alcohol and Drug Partnerships (ADPs) from the Scottish Government for 2025/26 (Scottish Government, 2025c) and the Audit Scotland report on Alcohol and Drug Services published in October 2024 (Audit Scotland, 2024). These sources were supplemented with discussions with relevant personnel in the Scottish Government, NHS, ADPs and the third sector to discuss data availability and the most effective means for gathering the data required.

The aim of these analyses was to provide a high-level national picture from published sources of how National Mission funds have been used within the wider context of spending on drug and alcohol services.

The aim in Stage 2 was to conduct a Scotland-wide survey across all 30 ADPs. ADPs are partnerships that bring together local statutory and non-statutory organisations. They are responsible for developing and supporting implementation of a local strategic plan aimed at reducing the use of and harms from alcohol and drugs. They are not statutory bodies in their own right, but they operate alongside Integration Authorities, which are public bodies responsible for overseeing delivery of local integrated health and social care services, including adult alcohol and drug services.

The original aim of the survey was to gather data on spending across the in-scope treatment services using standardised self-completion tools developed from information gathered in Stage 1. These data would be supplemented with detailed case studies of a purposive sample of 3-4 ADPs to create a detailed overall picture of spending patterns and funding flows, enabling us to explore how funding was used, additionality, challenges faced and lessons learned.

In practice, in response to the complexity of the funding streams identified in Stage 1 and following discussions with Scottish Government and PHS about challenges faced in previous attempts to map spend, we agreed with PHS to adapt the approach by replacing the survey with an increased number of case studies.

We:

- identified a purposive sample of six ADPs (large, medium-sized and small; urban, rural and mixed urban/rural) covering over a third of the general population and approximately 45% of drug-related deaths.
- collated and shared with the ADP leads the published data on the additional allocations going to their Health and Social Care Partnerships.
- used these figures as the basis for semi-structured qualitative interviews with ADP leads to understand local governance arrangements, how they had used those allocations across the in-scope services, explore additionality and consider the challenges faced in using those funds.

Interviews were conducted with the six ADP leads between October and November 2025, focusing on the in-scope treatment services. The transcripts were checked and analysed by two researchers independently to identify key themes emerging from the interviews.

Interim findings were shared with the National Mission Evaluation Advisory Group and Scottish Government colleagues to sense-check the findings, discuss the emerging themes and reflect on their implications for governance and policy in relation to the National Mission. (For membership of the Evaluation Advisory Group, see (Public Health Scotland, 2024a), Appendix 4).

Ethical approval for the study was sought from Glasgow Caledonian University (GCU) School of Health and Life Sciences Research Ethics Committee (REC) and granted on 20 July 2025, reference HLS/PSY/24/248.

2.2. Results – Financial analysis – National Mission Funding Allocations

The total funding allocated to drug and alcohol services over the five-year period, increased from £140.7m in 2021/22 to approximately £162m in 2025/26 The total budget is composed of several distinct sources (Table 1):

• **NHS Baseline Funding**: This funding is transferred via NHS Territorial Boards for onward delegation to Integration Authorities to be invested through ADPs based on local needs and priorities in tackling drug and alcohol issues. In summer 2023-24, the pay deal for healthcare staff under the Agenda for Change (AfC) agreement was approved. For drug and alcohol services this totalled an additional £5 million each year from 2023-24.

• **Alcohol and Drugs Policy Funding**: This funding is designated for the improvement of frontline care delivery. It incorporates £17 million from the 2017 Programme for Government (PfG), which is allocated directly to NHS territorial boards. In 2025/26, this was rolled into NHS Boards' baseline allocations, which accounts for a large proportion of the increase in this category of spending in the final year of the National Mission. Alcohol and Drugs Policy Funding also includes the core operational budget of the Scottish Government's Alcohol and Drugs Policy division.

• **National Mission Funding**: This funding represents the additional £50 million per year pledged by the First Minister in January 2021 specifically for the National Mission. In 2023/24 and 2024/25, an additional £12 million was allocated to support a cross-Government plan aimed at a broader range of initiatives for people who use drugs and for prevention programmes, falling slightly to £60m in 2025/26 as more of the funding was rolled into NHS Board baselines.

Table 1: Drug and alcohol funding sources (2021/22-2025/2026)

Funding Source	2021/22 (£m)	2022/23 (£m)	2023/24 (£m)	2024/25 (£m)	2025/26 (£m)
NHS baseline funding	56.5	56.5	57.6	57.6	78.9[2]
Agenda for Change	-	-	5.0	5.0	3.0[3]
Alcohol and Drugs Policy	34.2	35.4	37.0	32.1[1]	20.4
National Mission Funding	50.0	50.0	62.0	62.0	60.0

Funding Source	2021/22 (£m)	2022/23 (£m)	2023/24 (£m)	2024/25 (£m)	2025/26 (£m)
TOTAL	**140.7**	**141.9**	**161.6**	**156.7**	**162.3**

Sources: SG National Mission Annual Reports: 2021/22 (Table 1, p.46), 2022/23 (Table 1, p.44), 2023/24 (Table 1, p.37), 2024/25 (Table 1, p.40), Scottish Budget 2025 to 2026 Supporting Documents, Alcohol and Drug Services delivery support 2025-2026: letter to Alcohol and Drug Partnerships.

Notes:

1 The figure for Alcohol and Drugs policy of £32.1m is reported as £37.1m in the 2024/25 National Mission Annual Report Table 1 due to the inclusion of the funding for Agenda for Change, excluded in earlier versions.

2 In 2025/26, the NHS baseline increased significantly from £57.6m to £78.9m due to the addition of the £17m Programme for Government (PfG) allocation into baseline funds, approximately £2m of associated Agenda for Change uplift, plus a 3% baseline increase (see Alcohol and Drug Services delivery support 2025-2026: letter to Alcohol and Drug Partnerships).

3 The 2025/26 Agenda for Change figure (£3.0m) represents the remaining AfC uplift, as the PfG-related AfC (approximately £2m) has been incorporated into the Board baseline.

Table 2 illustrates the channels through which these funds have been allocated. ADPs received additional funding of around £50m over the first 4 years of the National Mission, 2021/22 to 2024/25. In 2025/26, the 'additional ADP funding' line reduced from £50.3m to £36.3m mainly because, as noted previously, the £17m from the Programme for Government and approximately £2m of associated Agenda for Change funds from the £5m mentioned above, were incorporated into the Health Board baseline funds allocated to ADPs.

Around 70-75% of all alcohol and drug funding (from the NHS Board Baseline and the Additional ADP funding) is channelled through ADPs. These partnerships commission services from statutory health and social care partners and from third sector providers.

The remaining funds are distributed through:

- the **Corra Foundation**, which serves as an intermediary for distributing funds to grassroots and third sector organisations;

- **Scottish Government**, which administers a proportion of the funding for drug and alcohol services, including some of the £50m National Mission funding itemised in Table 1;
- **Core Funded Organisations (CFOs)/Key Third Sector Partners (KTSP)**: This channel supports key third sector organisations integral to the Mission: Crew Scotland, the Scottish Drugs Forum, the Scottish Recovery Consortium, Scottish Families Affected by Alcohol and Drugs, and With You.

Table 2: Funding Distribution (2021/22-2025/2026)

Funding Channel	2021/22 (£m)	%	2022/23 (£m)	%	2023/24 (£m)	%	2024/25 (£m)	%	2025/26 (£m)[1]	%
Health Board baseline funds for ADPs	56.5	40	56.5	40	57.6	36	57.6	37	78.9[2]	49
Additional ADP funding[3]	50.4	36	50.3	35	50.3	31	50.3	32	33.3[2]	21
Agenda for Change	-	-	-	-	5.0	3	5.0	3	3.0	2
Grants via Corra	16.2	11	13.0	9	13.0	8	13.0	8	13.0	8
SG Managed	13.9	10	18.9	13	31.9[4]	20	26.9	17	NA	
CFOs /KTSPs [5]	3.7	3	3.2	2	3.7	2	3.8[6]	2	NA	
TOTAL	**140.7**	**100**	**141.9**	**99**	**161.6**	**100**	**156.7**	**99**	**162.3**	**100**

Sources: Scottish Government National Mission Annual Reports: 2021/22 (Table 2, p.46), 2022/23 (Table 2, p.44 & Fig 5, p.45 & Table 3, p.46), 2023/24 (Table 2, p.38), 2023/24 (Table 2, p.38). Figures may not add to 100% due to rounding. SG refers to Scottish Government.

Notes:

1 2025/26 figures for funding distributed directly through ADPs via NHS Boards (rows 1–3) are drawn from the Scottish Government's 2025/26 funding allocation letter and appendices. Final figures for SG managed and KTSPs for 2025/26 were not available at the time of writing, pending publication of the National Mission Annual Report for 2025/26.

2 Programme for Government funding was added to Board baselines in 2025/26, previously accounted for under Additional ADP funding, which explains the large increase and decrease in these figures.

3 Additional ADP funding includes £3m allocated from Drug Deaths Taskforce funding in 2021/22.

4 Figures from 2023/24 include the additional National Mission funds made available under the Cross-Government Plan managed by the Scottish Government.

5 Terminology changed from "Core Funded Organisations" (CFOs) in the 2021/22 and 2022/23 SG National Mission Annual Reports to "Key Third Sector Partners" (KTSPs) in the 2023/24 and 2024/25 reports.

6 Table 3 in the SG National Mission: Annual Report 2024-25 includes an additional £1.25m for Scottish Families Affected by Alcohol and Drugs funded from the Getting it Right for Every Child (GIRFEC) programme.

Drug and alcohol services funding to ADPs was broken down into allocations earmarked for specific 'funding themes' by SG. Table 3 provides a breakdown of these allocations between 2021/22 and 2024/25. These data are based on the National Mission Annual Reports. As noted earlier, the report for 2025/26 had not been published at the time of writing. The four largest categories within the National Mission commitments are residential rehabilitation, Medication Assisted Treatment (MAT) Standards, funding for local and national initiatives and, in the last two years covered by Table 3, the Cross Government Action Plan.

Funding for **Residential Rehabilitation** saw a marked increase over the period, peaking in 2023/24 before falling back slightly in 2024/25. In 2021/22 and 2022/23, funding comprised three sources: CORRA Foundation's Service Improvement Fund ring-fenced for residential rehabilitation (£3m), direct funding to ADPs of £5m from National Mission funds, and the Scottish Government's Recovery Fund (£5m), administered directly by the Scottish Government to support access and capacity. From 2023/24, the Recovery Fund was succeeded by the Residential Rehabilitation Rapid Capacity Programme (RRRCP), funded from the Alcohol and Drugs Policy budget, which provided £11.1m in 2023/24 and £9.2m in 2024/25. This expansion in RRRCP funding accounts for the majority of the increase in total residential rehabilitation spending over the period.

Funding for the implementation of **MAT Standards** remained relatively stable throughout the period covered by the National Mission at slightly above £10m. Funding from the National Mission for **Local and National Initiatives** saw an increase in funding from £13.8m in 2021/22 to £18m over the remaining three years due primarily to the consolidation of funding for outreach and near-fatal overdose pathways itemised separately at £3m each in 2021/22. This change reflects a strategic decision to consolidate these funds into broader "National Mission priorities" allocated to ADPs to provide greater flexibility at a local level to tailor responses to specific needs.

The **Cross Government Action Plan** was initiated in 2023/24 with a budgeted allocation of £12m to support initiatives addressing the complex needs of people who

use drugs and to support prevention and early intervention. The 2023/24 Annual Report noted that this initiative was partly funded through ADP underspends from previous years. A footnote to the 2023/24 thematic funding table records that actual expenditure against this allocation was £5.3m, due to delays in some planned initiatives. In 2024/25, £12m was again allocated and recorded in the Annual Report's funding sources table but spend against this allocation reported in the thematic breakdown table was £7m, again reflecting delays in some planned initiatives.

Funding of £6.5m was committed annually to initiatives supporting **children and families**. Annual funding of £1m to support initiatives promoting the use of **lived and living experience** to inform policy and practice was typically split between ADPs to support local engagement panels and the National Collaborative to embed a human rights-based approach in the delivery of drug and alcohol services.

Table 3: Funding Breakdown by Theme and Source (2021/22-2024/25)

Funding Theme	2021/22 (£m)	2022/23 (£m)	2023/24 (£m)	2024/25 (£m)
National Mission Commitments				
Children & Families	6.5	6.5	6.5	6.5
Residential Rehabilitation	13.0	14.5	19.1	17.2
Lived & Living Experience	1.0	1.0	1.0	1.0
MAT Standards	10.4	10.3	10.3	10.3
Surveillance	1.5	0.5	0.6	0.7
Local & National initiatives	13.8	18.0	18.0	18.0
Outreach	3.0	-	-	-
Near-Fatal Overdose Pathways	3.0	-	-	-
Cross Government Action Plan	-	-	12.0	7.0[1]
National Mission Commitments Subtotal	**52.2**	**50.8**	**67.5**	**60.6**

Funding Theme	2021/22 (£m)	2022/23 (£m)	2023/24 (£m)	2024/25 (£m)
Alcohol & Drugs Policy Commitments				
ADP PfG delivery	17.0	17.0	17.0	17.0
Drugs Policy delivery	-	13.1	10.7	12.6
Drug Deaths Taskforce	7.4	-	-	-
Nationally Funded projects	4.8	-	-	-
Operational costs	1.7	2.3	2.6	2.6
Agenda for Change	-	-	5.0	5.0
Alcohol Policy Commitments	1.0	2.3	1.3	1.3
Alcohol & Drugs Policy Commitments Subtotal	**31.9**	**34.7**	**36.6**	**38.5**
ADP Baseline	56.5	56.5	57.6	57.6
TOTAL	**140.7**	**141.9**	**161.6**	**156.7**

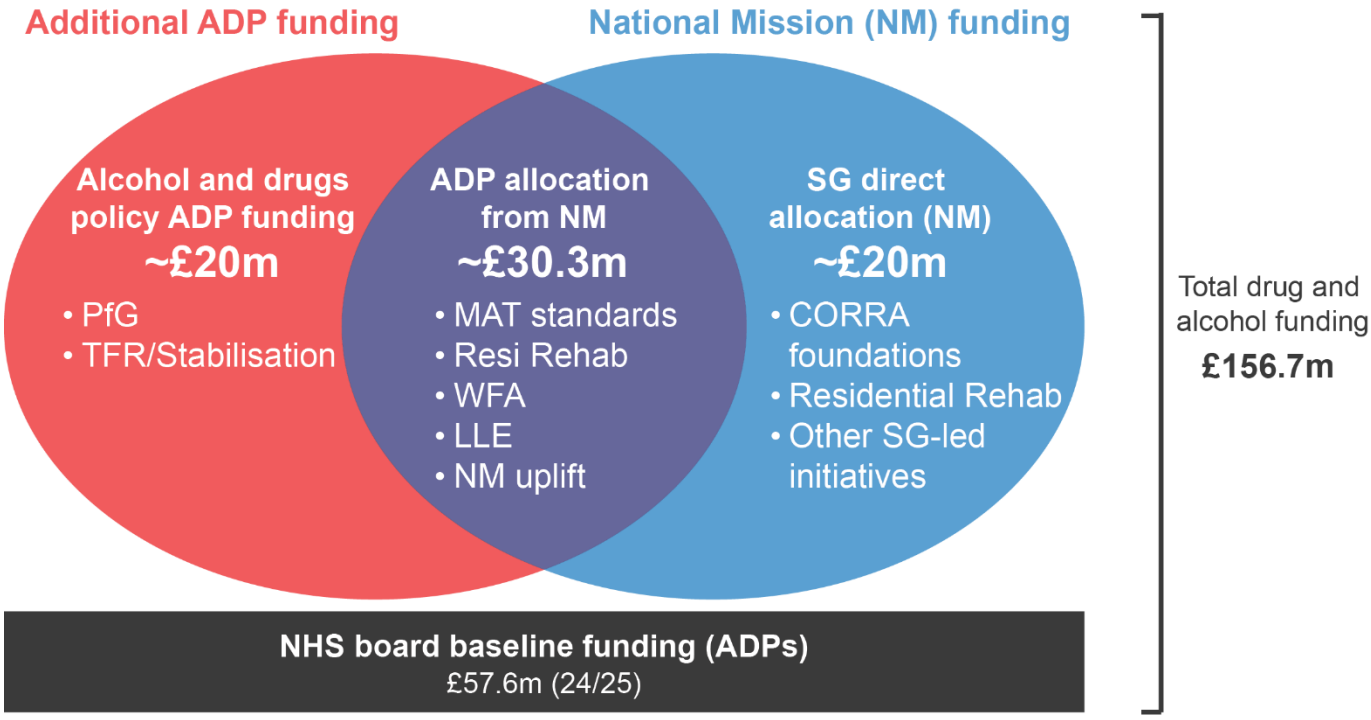
Sources: SG National Mission Annual Reports: 2021/22 (Table 6, p.49), 2022/23 (Table 6, p.47), 2023/24 (Table 5, p.41), 2024/25 (Table 5, p.41). 2025/26 Report not published at the time of writing.

Note:

1 For 2023/24, actual expenditure on the Cross Government Action Plan was £5.3m against a budgeted allocation of £12m (see Annual Report 2023/24, Table 5, footnote 15). For 2024/25, actual expenditure on the Cross Government Action Plan was £7m against a budgeted allocation of £12m (see Annual Report 2024/25, Table 5, footnote 8).

In summary, funding from various sources allocated via multiple channels supports a wide range of services and initiatives to meet the aims of the National Mission. This project is focused primarily on the commitment of £50m per year National Mission funding but it is important to put this in context. Not all the funds allocated to ADPs come from the National Mission funding, and some of the National Mission funding does not go to ADPs. This is illustrated in Figure 1, based on allocations for 2024/25, the latest year for which the National Mission Annual Report is available.

Figure 1: Relationship between Additional ADP Funding and National Mission Funding (2024/25)



Notes:

PfG: Programme for Government; TFR: Task Force Response Fund which became the Stabilisation Fund; WFA: Whole Family Approaches; LLE: Lived and Living Experience.

Total drug and alcohol funding available in 2024/25 was £156.7m. Of this, additional ADP Funding and National Mission funding amounted to approximately £70.3m. Board baseline funding to ADPs represented another £57.6m. The remainder of the total funding available mainly comprised Scottish Government-managed funds for a range of activities including additional residential rehabilitation; monitoring, surveillance, evaluation and research; and the Cross-Government Action Plan.

A proportion (approximately £30m, or 60%) of the £50m annual National Mission funding was allocated via ADPs. Most of the remaining £20m of National Mission funding was allocated through CORRA Foundation grants (£13m) and the Scottish Government-managed Residential Rehabilitation Rapid Capacity Programme (£5m of the £9.2m total value of the programme in 2024/25).

Conversely, of the additional funding received by ADPs (approximately £50.3m in 2024/25), only around £30m comes from the additional National Mission funding. The balance is from the existing Drugs Policy budget, primarily the Programme for Government, and was available prior to the launch of the National Mission.

When combined with the NHS Board baseline funding (£57.6m in 2024/25, rising to £78.9m in 2025/26), around 70% of the total funding for drug and alcohol services flows through Alcohol and Drug Partnerships, but the bulk of that is not National Mission funding. This has implications for:

- accountability mechanisms for tracking how National Mission resources translate into services given how intertwined they are with wider funding streams;
- understanding local autonomy in spending decisions over the totality of resources available to support the National Mission;
- the potential for National Mission funding to make a difference to service delivery given it is part of a much bigger whole.

These issues are explored further in the results of the semi-structured qualitative interviews in the next section.

2.3. Results – Financial Analysis – Themes from interviews with ADP leads

The analysis identified sixteen major themes characterising the implementation of National Mission funding. These themes have been organised into five broad groupings: an overarching theme reflecting the wider funding landscape within which ADPs operate; a first set of themes (2–7) addressing strategic dimensions of funding implementation; a second set (8–12) examining specific areas of spending, service gaps, and questions of additionality; a third set (13–14) concerned with the limitations of available cost and outcome data for evaluating the impact of National Mission; and a final set (15–16) exploring issues of service delivery and viability. The following sections present these themes, supported by verbatim quotations presented anonymously to ensure respondents cannot be identified.

Theme 1: National Mission Funding Within Broader Funding Landscape

The first theme relates back to and reflects the findings in Section 2.2. National Mission funding sits within a broader landscape of funding sources including Programme for Government, NHS baseline, spending by local authorities, and CORRA Foundation grants. Respondents described many different ways in which

this played out across services locally. Many services are supported by multiple funding streams, with National Mission funding supplementing existing resources.

> ″We have a stabilisation service which costs an awful lot more than that [the additional ADP allocation].″
>
> "Our spend plan for this year is almost doubled [our allocation for that area of spend]."
>
> "All of the whole family approach money goes on whole family approach, but it's not the totality of our spend. [The] rest [comes] from core ADP budget."

This creates opportunities to increase capacity but also means it is challenging to identify the specific contribution of National Mission funding. Many of the remaining themes reflect the ways in which this funding context influences service design and delivery and the implications this has for understanding how funding is used and the impact it has.

The first set of themes relate to strategic issues raised by the respondents.

Theme 2: Funding Fungibility[1] and the Aggregation of Funds

ADPs combine funding from the National Mission with NHS baseline, Programme for Government, and sometimes local authority funds. This fungibility facilitates integrated services but renders granular financial tracking of the use to which specific allocations are put very difficult. The analogy of a bath into which multiple funding streams flow and from which funding for a wide range of services is drawn, was endorsed by several interviewees as an accurate description of operational reality.

> "It's all in one pot now apart from the stuff that we absolutely keep [separate] residential rehab, MAT standards, etcetera... I treat most of those things as basically fungible. ... the baseline funding plus the PFG

[1] Fungibility is a concept commonly used in finance and commerce. It means that a currency or financial instrument can easily be substituted for another without altering its value. A plain English synonym would be interchangeability. In this report, it means that different funding streams are combined and used interchangeably.

plus, the National Mission funding where it's not ring- fenced it’s conjoined... confused with all the other funding lines."

"Into our ADP budget comes the PfG money, the National Mission money and all the other categories we've talked about today."

"It's all one pot but we don't get to see all of the pot."

The third quote speaks to the information challenges some ADPs feel they have faced in understanding how the resources allocated to drug and alcohol services are used, referred to in Theme 14, and the sharing of information, referred to in Theme 3.

Theme 3: Governance Structures and Local Decision-Making

Governance structures varied between ADPs and this was reflected in varying perceptions of the influence ADPs have over how funds are spent and services delivered, relative to partner organisations (HSCP/NHS). Some ADPs spoke of their strong influence over the delivery of drug and alcohol services:

"I think it's a real strength of our ADP to be right in the heart of things because it means that our chairs have authority and they have teeth."

“In [XXX], the ADP is completely in charge.”

Others expressed frustration over the degree of influence they had over the wider budget, the proportion still managed by statutory or specialist services, and the degree of sharing of information about spending. A related concern was the risk of money being diverted to purposes other than those intended, with ADPs often lacking visibility over how statutory partners deploy resources nominally allocated for drug and alcohol services.

“ADP allocation shouldn't be being used to bolster the board's service and yet it sounds like it is in all places."

“"No clarity around how much has been spent [by drug and alcohol services in the NHS board] ... So it's a work in progress to try and understand all the money that comes into the Board for drug and alcohol support."

The allocations "have predominantly gone straight to the NHS... I suspect from my discussions with colleagues this is probably true across the board."

"I know exactly what happens to every penny that we allocate to them [ADP contracted services]... From the public sector, I get nothing... I really have no idea what happens to the money [that goes to statutory partners] and I suspect that is probably quite the same across the country."

Theme 4: Central Direction and Ring-Fencing

Respondents spoke of the balance between central direction by the Scottish Government of the uses to which funding should be put and the freedom to decide locally how funds should be used and the way in which services should be delivered. Respondents acknowledged that explicit direction through ring-fencing, targets and reporting requirements could be used as leverage to drive local change, whilst highlighting the risk that such arrangements can create inflexibility that prevents resources being deployed where they are most needed locally. Views on the appropriate balance between central direction and local autonomy varied considerably between ADPs. Some welcomed direction as a way of encouraging action and protecting against the use of funds for other purposes. Others sought greater autonomy.

"It's much easier if somebody above me is saying you have to spend it on this and I can tell everybody else [there is] no choice about this, it's completely out of our control... If they think you've got flexibility, nothing happened, the money just vanishes."

"The bottleneck [for residential rehab] was detox and not abstinence-based rehab placements, we asked if we could use it to deal with that capacity and we were told no."

"It's both. I'm quite split there... The non-fatal overdose and the outreach allocations were really helpful in getting the conversation started... However, I would also say there've been real frustrations at some of the allocations, thinking we know this is not the right place to put this."

"Would very much welcome less direction from the Scottish Government."

Theme 5: Whole System Challenges and Legacy Services

ADPs spoke of the challenges in furthering the National Mission's emphasis on new capacity and service innovation alongside existing statutory services. Changing current services in a whole-system way was described as a huge task. Some ADPs felt that the National Mission money created a dynamic of cross-sector collaboration that supports whole-system thinking. Echoing the earlier theme about scope to influence service change, others referred to high percentages of spend still sitting with statutory services with limited information on how resources were being used and constraints on how money could be spent that can thwart change. Legacy funding arrangements and historical precedent continued to shape how resources flow.

> "We're just looking at a purely clinical model where I think we're missing the kind of whole systems, the whole person stuff."
>
> "The challenge of tendering a service or all that contract management for all these pre-2020 agreements, all of that is just massive workload and I don't do it justice."
>
> "There is barely a plan [for the National Mission]... a lot of it is ... whatever people were doing pre-National Mission... Services... really struggling to think about this in any kind of whole systems way."
>
> "Moving funding from the statutory to the third sector is extremely unpopular in pretty empowered parts of the system."

Theme 6: ADPs and CORRA Funding

The financial analysis in Section 2.2 highlighted the funding from the National Mission that is channelled through the CORRA Foundation and supports significant third sector activity supporting the aims of the Mission. The funding sits outside ADP budgets, but ADP leads reported strong collaborative relationships with CORRA and highlighted service developments this funding has enabled locally. By operating through a dedicated grants mechanism, CORRA has been able to direct National Mission resources rapidly into grassroots and third sector organisations, funding services and approaches that ADPs could not easily commission through standard procurement routes.

> "We have a very specific additional resource that we get from CORRA... which allowed us to develop a specific team dedicated to supporting

> people along the pathway for residential rehab... that system has proved very, very good."
>
> "We work really closely with CORRA. We've got great relationships with them... and all the third sector partners that received those grants. So locally I think it's been very, very positive."

The concern was raised, in particular where ADPs felt they had not been involved in funding decisions taken by CORRA, that ADPs faced pressure to sustain those services if and when CORRA funding came to an end, either planning for their potential discontinuation or making provision for them to continue, which put pressure on remaining funding. This speaks to the following theme raised by several respondents regarding the impact of uncertainty of future National Mission funding.

Theme 7: Sustainability and Future Uncertainty

Concerns about the sustainability of services beyond the National Mission's funding period (2025/26) emerged as a significant and distinct theme. This uncertainty was affecting current decision-making, with ADPs reluctant to develop services or commit to permanent staffing arrangements without confidence in future funding. The risk that withdrawing National Mission funding will increase health inequalities was explicitly raised. Respondents suggested third sector services were likely to bear the brunt of any funding reduction.

> "What happens beyond the National Mission and where does that financial burden and risk associated with that sit?"
>
> "Without defined outcomes for these pots of funding and without a clear plan of exit from all of this funding, there's a huge question mark about what any of this can really look like."

In relation to themes 6 and 7, it should be noted that after the interviews were undertaken, the final tranche of National Mission funding for 2025/26 administered by the Corra Foundation was announced and the Strategic Plan for alcohol and drugs covering 2026 to 2035 was published in March 2026. The plan includes a commitment to establish a refreshed Alcohol and Drugs fund to support local and community organisations, providing multi-year funding. The levels and distribution of funding for this and the Strategic Plan as a whole are still to be finalised at the time of writing.

The second set of themes refers to specific areas to which funding was allocated, additionality of funding and areas where respondents felt there were gaps in funding.

Theme 8: MAT Standards – Positive Impact as Part of Much Wider Funding

National Mission funding for MAT standards made positive impacts on delivery and focused minds, through investment in a wide range of resources, including new clinical posts and MAT coordinator posts. Total MAT spending is substantially greater than the National Mission allocation, with large contributions also coming from the NHS/HSCP baseline funding allocated to ADPs. The wide range of services involved in meeting the standards funded as part of core business means attributing additionality to individual National Mission-related investments is hard. Echoing the earlier theme about the role of central direction, one respondent also suggested that MAT standards were implemented because they came with money and explicit direction and reporting requirements.

> "We spend considerably more than that [the National Mission allocation]... It's a drop, but it's been significant, ..., it's had a really positive impact on our delivery of the MAT standards...That's what the money went into very explicitly within the statutory services. "
>
> "Although [MAT standards] money comes into the ADP, it then gets transferred for spending by our drug and alcohol [services]... with no clarity on how much has been spent or what [they] are spending it on."
>
> "The entire allocation ... we have for MAT standards is spent on MAT standards. But .... [some] MAT [standards] ...we fund from local funding."

The respondent who made the point in the last quote agreed with the suggestion that multiple funding sources and the importance of existing services in meeting MAT standards made it very difficult to say how much was spent in total on meeting the standards.

Theme 9: Residential Rehabilitation

ADP leads described how National Mission funding had been used to secure additional residential rehabilitation placements. As with the MAT standards, they described how multiple funding sources support residential rehabilitation in addition to National Mission funding, such that linking increases in capacity to specific funding sources was challenging. Concerns were also voiced about the onus on additional placements through National Mission funding when the challenge for some was lack of funding for the whole pathway, particularly community detox, stabilisation, pre-rehab preparation and post-rehab support, rather than residential rehabilitation placements specifically. There was concern that some of the National Mission-

funded additional placements were provided in establishments that were far away for many service users and didn't address the needs or bottlenecks locally.

> "...inpatient detox beds ... are incredibly expensive but absolutely essential. That's our bottleneck. That's the pinch point in the city."
>
> "We should be providing what people need locally without having to send them out of their communities... A lot of work needs to be done to support people before they get to residential rehab... I don't know if the outcomes are as effective as the amount of investment and if that were put into local capacity... I think we might be able to do more with it... I don't think the additional placement fund was helpful."
>
> "A lot of people from [our area] are sent to residential rehab and they don't complete it because it's really difficult... sending people too soon does them no favours, they really do need to be well prepared... originally we actually struggled to spend the money that was given to us by the Scottish Government for the residential rehab element of it."

Theme 10: Lived and Living Experience – Small Funds, Transformational Impact

While the financial allocations for Lived and Living Experience (LLE) are relatively small (typically £13k-£40k), the interviews suggest this funding may be delivering disproportionately high additionality and strategic value. The embedding of lived experience voices in strategic decision-making was described as one of the most significant shifts enabled by the National Mission.

> "Employed a senior officer with lived experience – absolutely transformational."
>
> "One of the big shifts I would say over the National Drugs Mission has been the involvement of lived and living experience."

Respondents described using this funding to commission independent third sector organisations to facilitate LLE panels and reported spending substantially more on LLE-related activities than covered by the allocations they received for this. Other sources of funding were also used, including Programme for Government funding.

> "We over-resource that because there's a need for recovery activities and lived experience engagement. "

Theme 11: Additionality of National Mission Funding

National Mission funding was simultaneously described as a 'drop in the ocean' compared to existing baseline budgets, yet also 'transformational' and 'critical' and many examples were given of additional services or specific staff resources that had been funded with the National Mission funding, including, as noted earlier, resources within the statutory services to help meet MAT standards.

> "Our whole drug service really, which is a huge spend, most of [the funding for MAT standards and residential rehab] is a drop in the ocean... but there's absolutely added value [from the National Mission funding] that we can see and we can feel the impact of it. "

Several respondents highlighted that the additional value added by the National Mission funding lay not only in increasing quality, access or capacity, but also as a strategic catalyst for innovation and cross-sector collaboration.

> "The National Mission ethos and actually having money on the table has allowed relationships to grow and build."
>
> "We wouldn't have [that] team without the National Mission funds [and it's also] driving collaboration... it's allowed us to function as a partnership."

National Mission funding was also used to reach groups that ADPs identified as being underserved by existing services:

> "Some unmet needs from communities that were maybe not needing a specific support. That was people with disabilities, LGBT people from minority background and communities."

The tension between the level of funding and the impact it was having was a consistent theme:

> "I mean [National Mission funding] made a big difference in our ability to comply and report to the Scottish Government... But does it really make the difference that ministers were hoping funding would make to very vulnerable individuals? I'm not sure."

Theme 12: Strategic Service Gaps

Several respondents felt that the National Mission had a narrow, opiate-centric focus, which had created gaps in service delivery. ADP leads identified a lack of focus on alcohol and emerging consumption trends such as stimulants. They underlined the importance of funding being flexible enough to respond to emerging consumption patterns or issues of particular concern locally.

> "There's almost no direction for what we do with our alcohol money. There's no requirements, there's no standards. And there's no data... We poured money into OAT and we've got no idea what happens around alcohol."
>
> "The focus on the National Drugs Mission has been narrower on opiates and opioids... What we're seeing now is a huge rise in the use of cocaine and other stimulants and... I guess we've struggled sometimes within the financial restraints that we're in to be able to move that money more effectively."

The next two themes relate to the challenges in getting good information on the costs and outcomes of services.

Theme 13: Outcomes Monitoring

Several respondents highlighted limitations in the information available to monitor whether National Mission funding made a difference and the appropriateness of different ways in which that might be measured. All the ADPs highlighted the aim of improving outcomes and the lack of information available to ADPs on the ways outcomes had improved for service users as a result of the National Mission funding.

Some also emphasised that because outcomes are ultimately the result of much more than drug and alcohol services, collecting and interpreting outcome data that reflect the impact of services is challenging. One respondent referred back to the 'bath analogy', suggesting it makes outcomes and performance reporting more important, but also more challenging.

> "I don't think... I'm being asked the questions that would force me to show what additionality I'm locally achieving... Only metric is the number of people dying. I can show that it's all been spent in the right places but for many metrics I can't show you the way it's reducing harm."
>
> "The 'bath analogy' makes outcomes, performance reporting more important and we've all struggled with that... need for us to really think

about what outcomes we are looking for... what do we genuinely have control over?"

"What I feel is lacking across the whole thing is the outcomes of it all... it's very hard to either disinvest or to be reassured that the service needs to continue or be reassured that the service does need more money."

Theme 14: Costing Approximations and Attribution Challenges

A corollary of pooling funds is that interviewees described difficulties in accurately costing the in-scope services or attributing expenditure to specific funding streams.

"It's almost impossible to separate it [funding for residential rehab as a whole] all out...you could get [information on the National Mission funding for residential rehab placements], but that would misunderstand actually what the whole package looks like... your inpatient beds which is huge and it's never included, the community preparatory work that goes into getting somebody ready for residential rehab, which is essential."

This interviewee made a similar point about funding for whole family approaches and other respondents made similar points.

“It's integrated... So I can't give you a figure for [psychological support spending] because that's part of the core service."

"Quantifying that would be a little bit difficult because it's not always 100% clear how much of somebody's time is devoted to specific pieces of work."

These challenges appeared in some cases to lead to a degree of discretion in the allocation of costs when meeting reporting requirements rather than reflecting a precise attribution of costs associated with service delivery. Services frequently meet multiple needs simultaneously, making separation of costs conceptually problematic as well as practically difficult.

"I couldn't really tell you [what sources are used where] and we do sometimes put in numbers against them when we have to report back... 'stick a label against them'... I cram everything into one of those spends, that's the only way we can pretend it makes sense."

> "We have funded the national placements on the national traineeship... but I think I reallocated that for this year to National Mission. I just thought it was maybe a bit of a better fit."

The final two themes relate to service delivery and viability issues in some ADP areas, leading to potential underspend.

Theme 15: Underspend Risks

Some respondents referred to the risk of underspends arising from the speed with which ADPs were expected to deploy funding, which was challenging where services and/or staff needed to be developed. The risk of 'quick fixes' rather than sustainable solutions was noted.

> "The first year they gave us £XXX,000 and it was about 3/4 of the way through the year and they think we can just whistle and make dozens [of changes]."

> "ADPs had got no money basically and then got an awful lot of money very quickly but no additional support to process those monies."

Non-recurrent funding created reluctance to offer permanent contracts, whilst competition for scarce specialist staff (particularly advanced nurse practitioners and psychologists) created the risk that posts remained unfilled.

> "Unless you actively have people in posts, you can't claim the money for them... it's a market shortage and we don't have the ability to cover the posts."

Theme 16: Urban/Rural and Service Viability Challenges

Respondents explained how geography created implementation challenges. Rural ADPs and smaller ADPs receiving smaller allocations face particular difficulties around service viability, with allocations often insufficient to fund viable standalone services within their area. Urban areas face different challenges around the scale of need and complexity of service systems. Some ADPs cannot carry forward funding, creating additional pressure to spend within financial years.

> "We want to do it [set up a stabilisation service]. There is a need there, but we don't have a model that could fit that budget."

"We're not providing an equitable service... but we don't have enough money to scale it up across the whole of the [area]."

ADP Lead interviews – summary of themes

In summary, the sixteen themes identified in this analysis reveal a complex and fragmented funding landscape: the funding comes from many different sources, goes through several funding channels and is put to a very wide range of uses.

In many instances it makes sense for ADPs, often in collaboration with NHS Boards, to pool funding from the National Mission with resources from other sources to enhance existing provision or to create a sustainable and viable service. However, the pooling of multiple funding streams in this way makes it difficult to account for how specific funding streams have been used which, in turn, makes it more difficult to demonstrate additionality. Financial reporting against specific budget lines sometimes involves arbitrary attribution rather than genuine cost allocation, reflecting the integrated nature of service delivery.

Respondents acknowledged that ring-fencing of spending is useful in protecting specific priorities, they also described how it can prevent resources being deployed where bottlenecks actually exist. Some respondents suggested the focus of the National Mission on opioids may have left gaps in responding to alcohol harms and emerging patterns of stimulant use.

Respondents voiced concerns about the sustainability of services due to uncertainty about funding beyond 2025/26 leading to challenges in developing services or offering permanent contracts, with significant implications for workforce development and service continuity. Respondents highlighted challenges in measuring outcomes to help inform future policy and service delivery, which makes accountability for delivering outcomes harder to achieve and limits evidence-based resource allocation decisions.

National Mission funding, although substantial, is only around a third of the total funding for drug and alcohol services that contribute to the goals of the National Mission. The proportion of National Mission funding that goes to ADPs is only around a fifth of the total funding for addressing the aims of the National Mission. Several respondents referred to the funding being helpful but limited. In some instances, funding for individual ADPs was insufficient to put in place viable services locally, underlining the need in some instances to ‘pool’ funding geographically or between service areas. ADPs also described how HSCP/IJB structures can significantly affect their ability to direct resources, carry forward underspends, and hold statutory partners accountable for outcomes.

Despite these limitations, many of the ADPs spoke of the additionality enabled by the National Mission funding. There were many examples of how National Mission

funding had increased capacity, for example, in outreach services, in supporting the implementation of MAT standards, and in encouraging and facilitating collaboration between partners to further the aims of the National Mission. Respondents reported how Lived and Living Experience funding, despite modest allocations, has driven significant strategic change in how services engage with people who use them.

Further information on the impact of the National Mission on access and quality is summarised in Section 4 below. We return to the implications of these findings in the discussion section.

3. Research Objective RO3 – Rapid Evidence Assessment of Effectiveness and Cost-effectiveness literature

3.1. Aim

The aim of the rapid evidence assessment (REA) was to identify and briefly summarise, for the specific treatment services that are in scope, whether there is a recent systematic review, review of reviews or other robust summary evidence relating to treatment effectiveness and cost-effectiveness, identifying any evidence gaps.

3.2. Methods

We conducted REA of the effectiveness and cost-effectiveness evidence for the in-scope treatment services (also referred to as interventions) on three outcomes on the same causal pathway (problem drug use, non-fatal overdose and drug-related deaths) agreed in consultation with PHS and the National Mission Evaluation Advisory Group (Table 4). Our objective was to provide an overview of recent review-level evidence rather than cover the entirety of the evidence base on the effectiveness and cost-effectiveness of the stated interventions in relation to the outcomes of interest.

The following databases were searched: Medline (EBSCO), CINAHL (EBSCO), and PsycINFO (see Appendix 1 for the search terms used across each database). We also considered grey literature reviews that covered the impact of each treatment service on reducing the pre-agreed outcomes. For each review, we extracted the information outlined in Appendix 2.

Table 4: Population-Intervention-Comparator-Outcome (PICO) framework

Population(s)	People who use drugs
Intervention(s)	Naloxone, safe drug consumption facilities, opioid agonist treatment, psychosocial interventions, detoxification services, stabilisation facilities and residential rehabilitation.
Comparator(s)	Individual reviews to specify; other interventions, treatment as usual and no intervention.
Outcome(s)	Problem drug use, non-fatal overdose and drug-related deaths.

In the first instance our search strategy assessed review-level evidence, published between January 2020 – May 2025. We identified and summarised the most recent review for each of our outcomes (Table 4). We extended our search backwards if sufficient review-level evidence was not available for an intervention and/or outcome. When more than one review was drawn on for a given outcome, this was done to ensure comprehensive coverage of the available evidence and to reflect differences in review scope (e.g. inclusion criteria or methodology). If there was limited evidence for a stated outcome, we used identified reviews to describe the impact of the intervention on risk factors known to be associated with the outcome. We did not conduct an additional search of primary literature. We considered literature that related to adults (>18 years old), was conducted in high income countries, and was published in English. We did not consider reviews that only considered specific risk groups (e.g. homeless or incarcerated populations). Relating to cost-effectiveness, we considered all reviews that related to the stated interventions and outcomes. The evidence base is very heterogeneous in terms of the methodology and setting of the studies included in the reviews. Therefore, the conclusions drawn in the reviews relate to a range of comparator groups and comparator interventions.

We conducted a quality assessment of key reviews using a modified version of the Joanna Briggs Institute (JBI) critical appraisal tool for appraising systematic reviews and research syntheses (**https://jbi.global/critical-appraisal-tools**), which assesses the quality of studies across 11 key domains (Appendix 3). Utilising guidance provided by the Evidence for Action team at PHS, we assessed the review level evidence to be of ‘high quality’, ‘moderate quality’ or ‘low quality’ based on the criteria outlined in Appendix 4. Furthermore, we did not conduct our own assessment of the quality of primary literature included in the reviews. Rather, we drew on the assessment of quality reported within those reviews (if available).

3.3. Findings – effectiveness and cost-effectiveness

This section provides a high-level overview of the findings of the REA. Detailed findings can be viewed in Appendix 5, with references detailed in Appendix 6.

Table 5 summarises the findings from the JBI assessment, appraising the quality of review level evidence used to assess the effectiveness and cost-effectiveness of in-scope treatment services. The table refers only to the quality assessment of recent reviews undertaken and doesn't indicate whether there was evidence of effectiveness or not. Review level evidence generally was of moderate to high quality for take-home naloxone (THN), safer drug consumption facilities (SDCFs), OAT, and detoxification services across each outcome. We did not identify review- level evidence for a number of the outcomes for psychosocial interventions, residential rehabilitation, or any of the outcomes for stabilisation facilities.

Table 5. Summary of rapid evidence assessment (REA) findings: quality rating of reviews based on Joanna Briggs Institute quality assessment tool

In-scope treatment service	Drug use	Non-fatal overdose	Drug-related deaths	Cost-effectiveness
Take-home naloxone	**	**	***	**
Safer drug consumption facilities	N/A	***	***	**
Opioid agonist treatment	**	**	***	**
Psychosocial interventions	***	N/A	N/A	N/A
Detoxification services	***	**	N/A	**
Stabilisation facilities	N/A	N/A	N/A	N/A
Residential rehabilitation	*	N/A	N/A	N/A

*** = High quality; ** = Moderate quality; * = Low quality; N/A = No review-level evidence available

Table 6 summarises the key findings from the REA for each outcome. Detailed REA findings can be viewed in Appendix 5, with references detailed in Appendix 6. Briefly, review-level evidence supports the effectiveness of OAT and THN in reducing and preventing drug-related mortality. Review-level evidence did not indicate that THN is associated with increased risk of non-fatal overdose or problem drug use. Furthermore, OAT was associated with reductions in drug use. Both OAT and THN were reported as cost-effective. Review level evidence outlined that

SDCFs are associated with reductions in mortality and overdose risk factors and appear either cost-effective or have favourable cost-benefit ratios, although there is a lack of evidence of their impact on drug use. Relating to psychosocial interventions (particularly contingency management) and detoxification services, review-level evidence highlighted short-term reductions in drug use, but there is a lack of review-level evidence demonstrating sustained impacts on overdose or mortality, and limited cost-effectiveness or cost-benefit evidence. There is limited evidence (meaning some evidence is available but is limited in scope or quality) relating to residential rehabilitation reducing drug use but a lack of evidence for overdose and mortality outcomes and for cost-effectiveness/cost-benefit. Furthermore, there is currently no review-level evidence on the effectiveness or cost-effectiveness/cost-benefit of stabilisation facilities.

Table 6. Summary of findings from each rapid evidence assessment (REA) on each in-scope treatment service.

Intervention	Summary	Review reference(s) for each outcome (and quality of review(s) based on JBI assessment)
Take-home naloxone (THN)	Findings from a moderate quality review indicate that naloxone provision is not associated with increased drug use or overdose risk, but there is limited evidence relating to reductions in both outcomes. Findings from a high-quality review highlights that THN is effective in reversing opioid-related overdoses and preventing drug-related deaths, but there is limited evidence of effectiveness relating to impacts on mortality at a population level. Findings from two moderate quality reviews indicate that the provision of THN is cost-effective.	Problem drug use: Tse et al, 2022 (Moderate) Non-fatal overdose: Tse et al, 2022 (Moderate) Drug-related mortality: Fischer et al, 2025 (High) Cost-effectiveness: Cherrier et al, 2022; Beaulieu et al, 2021 (Moderate)
Safer drug consumption facilities (SDCF)	There is a lack of evidence relating to drug use among people who use safer drug consumption facilities, but findings from a high-quality review	Problem drug use: Levengood et al., 2021 (High)

Intervention	Summary	Review reference(s) for each outcome (and quality of review(s) based on JBI assessment)
	indicate that they can improve uptake and access to drug treatment programmes which are associated with reduced drug use. There is limited evidence of their effectiveness in reducing non-fatal overdose, however, there is high quality review level evidence showing that they are associated with reducing risk factors associated with non-fatal overdose (e.g. public injecting). Based on a high-quality review, SDCFs are associated with reductions in drug-related mortality but evidence is limited. Conclusions from a moderate quality review suggest that SDCFs are cost-effective and/or have benefits in excess of costs.	Non-fatal overdose: Levengood et al., 2021 (High) Drug-related mortality: Levengood et al., 2021 (High) Cost-effectiveness: Behrends et al., 2024 (Moderate)
Opioid agonist treatment (OAT)	There is moderate quality evidence highlighting that OAT is consistently associated with reduced opioid use. Moderate-quality review-level evidence also suggests that engagement in OAT is protective against non-fatal overdose and is cost effective or has benefits in excess of costs. There is high-quality review-level evidence that shows the provision of OAT is associated with reductions in drug-related mortality.	Problem drug use: Patnode et al., 2020 (Moderate) Non-fatal overdose: Dunne et al., 2025 (Moderate) Drug-related mortality: Santo et al., 2021 (High) Cost-effectiveness: Fardone et al., 2023; Beaulieu et al., 2021 (Moderate)
Psychosocial interventions	There is limited evidence of effectiveness of psychosocial	Problem drug use: Bolivar et al 2021; Ginley et al

Intervention	Summary	Review reference(s) for each outcome (and quality of review(s) based on JBI assessment)
	interventions reducing drug use. However, high-quality review-level evidence highlighted that some psychosocial interventions – particularly contingency management – are associated with short term reductions in drug use. There is a lack of review-level evidence that psychosocial interventions reduce drug-related deaths or prevent non-fatal overdose. However, there is limited review level evidence that some psychosocial interventions (contingency management) can improve engagement with other interventions (OAT), that are associated with reductions in drug-related mortality and non-fatal overdose. There is a lack of cost-effectiveness or cost-benefit evidence for substance use-focused psychosocial interventions.	2021; Darker et al, 2015; Schwenker et al., 2023 (High); Dellazizzo et al 2023; Ronsley et al, 2020; Ray et al 2020 (Moderate); Benztley et al, 2021 (Low) Non-fatal overdose: Bolivar et al 2021 (High) Drug-related mortality: Bolivar et al 2021 (High) Cost-effectiveness: Shearer at al 2015 (Moderate)
Detoxification services	There is limited evidence of effectiveness of detoxification services in reducing drug use. High-quality review-level evidence suggests that detoxification can achieve short term reductions in drug use, but there is a lack of evidence on the impact of detoxification alone in sustaining reductions in drug use. There is also limited evidence relating to non-fatal overdose, findings from moderate quality reviews indicate that the period post-detoxification is	Problem drug use: Amato et al., 2013; Amato et al., 2011 (High) Non-fatal overdose: Dunne et al., 2025; Armoon et al., 2023 (Moderate) Drug-related mortality: N/A Cost-effectiveness: Fardone et al., 2023;

Intervention	Summary	Review reference(s) for each outcome (and quality of review(s) based on JBI assessment)
	associated with an increased risk of non-fatal overdose. There is a lack of review-level evidence examining the impact of detoxification on drug-related mortality. There is limited evidence on the cost-effectiveness or cost-benefit of detoxification.	Beaulieu et al., 2021 (Moderate)
Stabilisation services	There is a lack of review-level evidence to date on the effectiveness and cost-effectiveness of stabilisation facilities.	N/A
Residential rehabilitation	Limited, moderate quality review-level evidence indicates residential rehabilitation is effective in reducing drug use. There is a lack of review-level evidence to date on the effectiveness of residential rehabilitation in reducing risk of overdose and drug-related deaths, and on the cost-effectiveness or cost-benefit of residential rehabilitation programmes.	Problem drug use: De Andrade et al 2019 (Moderate); Scottish Government, 2022 (Low) Non-fatal overdose: N/A Drug-related mortality: De Andrade et al 2019 (Moderate); Scottish Government, 2022 (Low) Cost-effectiveness: Fardone et al., 2023 (Moderate)

4. Research Objective RO4 - Review of Literature on Quality and Access to Services

4.1. Aim

The aim of the review was to summarise the available evidence on whether the National Mission has improved access to, and quality of, the different in-scope treatment services.

4.2. Methods

Using available data from reports published by national bodies (including PHS, Scottish Public Health Observatory, Glasgow City Health and Social Care Partnership, and the Scottish Government), we summarised access to in-scope treatment services (also described as interventions) across Scotland as a whole from 2019 and up to the latest data available (covering periods before and after the implementation of the National Mission). We referred to national data throughout apart from when reporting on SDCFs; Health Board-specific data relate to NHS Greater Glasgow and Clyde only as the only board currently operating a SDCF.

To assess the quality of stated interventions in Scotland, we synthesised existing experiential evidence from people with lived and living experience (where available) since the start of the National Mission including reports published by the Scottish Drugs Forum and PHS.

The evidence identified and summarised is listed in the References Section. We conducted a rapid assessment and overview of available published data. We have not critically appraised the routine evidence or directly attributed changes in access or quality to the National Mission. Rather, we have summarised trends in access covering the period of the National Mission and summarised available experiential evidence from people accessing services. We did not conduct an additional search of the peer-reviewed scientific literature. There may also be unpublished or locally held data on service access/quality that was not considered given the timescales of this project. The scope and definition of access and quality was set by PHS during the commissioning of this work.

4.3. Findings - Access, and quality

The findings from the review of evidence on access are summarised in Table 7 (at the end of Section 4.3).

4.3.1 Take-home naloxone (THN)

Access

PHS publishes annual and quarterly monitoring reports of THN distribution. The latest annual report (at time of writing) relates to data published up until financial years 2022/23 (published in Feb 2024) (Public Health Scotland, 2024b). The latest quarterly report was published in September 2025 and relates to data published between January and March 2025 (Public Health Scotland, 2025a). PHS summarises data from the Naloxone Monitoring Database, which contains a record of THN distributed in the community (this includes through harm reduction services, including community pharmacies, and third sector organisations), prisons and the Scottish Ambulance Service (Public Health Scotland, 2024b, 2025a).

The total annual number of THN kits distributed nationally in Scotland has increased from approximately 13,000 in 2019/20 to approximately 32,000 in 2024/25 (Public Health Scotland, 2024b, 2025a). The 'reach' of the National Naloxone Programme is also quantified, defined as the percentage of people at risk of opioid overdose who have been supplied with THN. Within the Naloxone Monitoring Database, information is collected on who each THN kit is supplied to (e.g. person at risk, member of the public or professional). Reach is reported as the number of THN kits issued as a 'first supply' to 'person at risk'. Reach has increased from an estimated 50.2% in 2019/20 to 82.2% in 2024/25 (Public Health Scotland, 2025a), based on available data at the population level on the distribution of the number of kits.

The Needle Exchange Surveillance Initiative (NESI) is a national, biennial, bio-behavioural survey of people who inject drugs (PWID) recruited at pharmacies and other services providing injecting equipment in Scotland. NESI was implemented in 2008-09, with latest published data relating to 2022-23 (eight surveys in total). NESI aims to measure the prevalence of blood-borne viruses (BBVs) among people who inject drugs, but also collates information on demographics, risk factors and uptake of harm reduction services (including THN). The proportion of NESI participants who were prescribed THN in the last year has increased from 65% in 2019-20 to 69% in 2022-23. NESI also records information on naloxone carriage (i.e. the proportion of people in possession of naloxone at the time of their NESI interview) among those who have been prescribed THN. Carriage is used internationally as a proxy indicator for availability of naloxone in the event of an overdose. In contrast to uptake, carriage of naloxone fell from 21% in 2019-20 to 9% in 2022-23 among people who had been prescribed THN (Public Health Scotland, 2024c).

Quality

PHS undertook a survey in the latter half of 2024 of individuals with current or past experience of using drugs, as part of their evaluation of the National Mission (Public Health Scotland, 2025b). They collected data on their views on the support currently available to them from Alcohol and Drugs Recovery Services (ADRS) and whether

the support offered from services had improved or got worse over the last two years. Respondents were presented with a list of treatment and care options they had received in the last 12 months (classed as ‘support received’), and what services they would have liked to receive but were unable to access (classed as ‘unmet need’). The responses to both questions were combined to give a proxy indicator of ‘total demand’. The ‘total demand’ can be lower than the sum of ‘support received’ and ‘unmet need’ as respondents could report that they had accessed a treatment option but still report it as unmet need. The authors reported that the main limitation of the survey was that it was likely not based on a representative sample although representativeness is challenging to assess given the lack of detailed data on the demographics of people who use drugs in Scotland. Therefore, they heavily caveated the results based on the characteristics/demographics of respondents. Key groups underrepresented in the survey were people younger than 25, people in prison, and ethnic minorities. Those in contact with peer support groups or with their local ADRS were likely overrepresented. Female respondents, homeless respondents, those living in rural areas, and respondents in recovery were more likely to report unmet needs.

They received 494 responses, from across 27/29 Alcohol and Drug Partnerships (ADPs). In relation to naloxone: 58% of respondents reported a demand for naloxone; 56% reported receiving naloxone and 3% reported an ‘unmet need’. Naloxone was one of the most reported treatment and care options received (Public Health Scotland, 2025b). A higher proportion of respondents from rural areas (11%), compared to urban areas (2%) reported an unmet need with regards to naloxone.

4.3.2 Safer drug consumption facilities (SDCF)

Access

The UK’s first sanctioned SDCF in Glasgow (“The Thistle”) opened on the 13th of January 2025, after initially being proposed in 2016 in response to an HIV outbreak among PWID in the city (Tweed et al., 2018). Glasgow City Health and Social Care Partnership publish monthly monitoring reports of Thistle service activity data. The latest monthly report relates to data published up until the end of December 2025 (Glasgow City Health and Social Care Partnership, 2025). By the end of December 2025, The Thistle had been accessed 10,819 times in total, increasing from 336 in January to 1,468 in December. Overall, it has supervised 7,460 injecting episodes relating to 560 unique individual service users, increasing from 268 episodes in January to 1,094 in December. There have been 88 medical emergencies recorded to date (an average of seven per month) and no fatalities.

Quality

We did not identify any published evidence relating to people's experiences of accessing or using SDCFs in Scotland.

4.3.3 Opioid agonist therapy (OAT)

Access

The Medication Assisted Treatment (MAT) standards were published in May 2021. They are evidence-based standards aimed at promoting the consistent delivery of safe, accessible and high-quality drug treatment for people who use drugs across Scotland (Scottish Government, 2021). They consist of 10 standards, including measures to improve access to OAT (including accessing OAT on the day of presentation). See Appendix 7 for a summary of all the MAT standards. The Scottish Government also set a target of increasing the number of people who are prescribed OAT to 32,000 by 2024 (Scottish Government, 2022a).

Alcohol and Drug Partnerships (ADPs) submit information on their progress towards implementing MAT Standards, that is collated and reported annually by the MAT Standards Implementation Support Team (MIST) at PHS (Public Health Scotland, 2025c). The most recent benchmarking report stated that in 2024/25, for MAT standards 1–5 (relating to same day access to OAT, choice of medication and appropriate dose, increased access among those at risk, provision of harm reduction services alongside OAT, and retention in treatment), 91% have been assessed as fully implemented. This represents an increase from 17% in 2021/22, 66% in 2022/23 and 90% in 2023/24. For MAT Standards 6–10 (relating to psychologically informed treatment, access to OAT within primary care, access to social and mental health services that are trauma informed), 75% were assessed as fully implemented and 16% as partially implemented in 2024/25, an improvement from 2023/24 when 91% of standards 6–10 were partially implemented. The authors also reported limitations with these assessments: 'fully implemented' means that the criteria agreed have been met for the year of assessment but does not mean that all people who request care receive it to the agreed standard at the time. Furthermore, the assessment may not reflect experiential feedback (described below in the quality section) as the assessment uses evidence on whether care is in place, not feedback from people using services.

The Scottish Public Health Observatory (ScotPHO) publishes annual figures by financial year on the prescription of OAT in Scotland (Scottish Public Health Observatory, 2025). They describe the minimum number of individuals prescribed OAT drugs (including methadone, buprenorphine, buprenorphine/naloxone, and long-acting buprenorphine (LAIB)). They also report on the number of prescriptions which have a Community Health Index (CHI) number (the unique patient identifier that individuals receive when accessing healthcare in Scotland) to estimate the

number of people receiving OAT. CHI capture on OAT prescription forms nationally is generally around 80%, so the number of people receiving OAT will potentially be an underestimate as records without a CHI are not captured.

ScotPHO collate data from Prescribing Information System (PIS) and Hospital Medicines Utilisation Database (HMUD). PIS contains a record of all drugs which are dispensed and prescribed in the community in Scotland, with specific records relating to OAT drugs (listed above) extracted (Alvarez-Madrazo et al., 2016). The prescription of LAIB started in March 2020. Although administered in community settings, it can also be ordered and prescribed via hospital stock order forms and is captured in HMUD which does not include CHI numbers. Estimates of the numbers of patients receiving LAIB on HMUD is estimated using prescription length. The number of people prescribed specific drugs (methadone, buprenorphine and LAIB) is also captured, however, these figures are not mutually exclusive and individuals can be counted twice if prescribed more than one drug (e.g. the sum of the methadone and buprenorphine patient figures may be greater than the OAT patient count for the same period) (Scottish Public Health Observatory, 2025).

By financial year, in 2019/20, the minimum number of people prescribed OAT was 29,253. The number of people prescribed initially increased and peaked in 2021/22 (30,058). In 2024/25, an estimated 28,015 people were receiving OAT in Scotland, falling short of the Scottish Government target of 32,000. This is against a backdrop of a small reduction in the prevalence of opioid dependence in Scotland between 2014/15 and 2022/23 (Public Health Scotland, 2025d). In terms of specific drug types, the number of people prescribed methadone decreased from 24,721 to 18,006 from 2019/20 to 2024/25. For the same period, the number of people prescribed buprenorphine (including buprenorphine/naloxone) increased from 5,820 to 6,916, respectively. Estimates on the number of people receiving LAIB are only available quarterly from 2021/2022. Patient numbers increased from 834 in Q1 2021/22 to 4,270 in Q4 2024/25 (Scottish Public Health Observatory, 2025).

NESI also reports on access to OAT, and publishes data in relation to methadone, buprenorphine and LAIB access separately. In 2019-20, 79% and 4% of NESI participants who had injected in the last six months reported receiving methadone and buprenorphine in the last six months, respectively. In 2022-23, the equivalent proportions were 68% and 8%, respectively, while 11% also reported receiving LAIB. When restricted to participants who were visiting the service to obtain injecting equipment, the proportion who had received prescribed methadone in the last six months was 63% and 75% had received either methadone or buprenorphine, which is broadly comparable to 2019/20 for methadone prescribing (Public Health Scotland, 2024c).

Quality

Scottish Drugs Forum (SDF) conducted an evaluation of people's experience of accessing MAT before and after the implementation of the MAT standards. In 2021, they conducted semi-structured interviews facilitated by peer researchers across six Health Boards in Scotland (Ayrshire and Arran, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian and Tayside) which included 95 participants (Scottish Drugs Forum, 2021). The majority of people (86%) interviewed felt that the process of starting MAT could be improved. Key qualitative findings included: delays in accessing treatment; inconsistent experiences in terms of achieving a therapeutic dose; lack of choice and agency in decision making surrounding type of medication and dose; lack of engagement with prescribers; increased need for mental health support; and variation across Health Board areas.

A subsequent qualitative study led by SDF conducted post-National Mission and MAT Standards implementation (Scottish Drugs Forum, 2024), sought to build on earlier baseline findings by examining which MAT standards are currently being implemented and identifying ongoing gaps, barriers and facilitators to access. The study involved 65 participants across the same health board areas as the baseline evaluation, with the addition of Highland and Borders, and included people currently accessing MAT, those seeking to access treatment, and individuals not currently engaged in treatment. Data were collected by peer researchers. Key findings indicated persistent barriers to access, including experiences of stigma from providers, inconsistent application of same-day access, and communication difficulties with services. Participants expressed a preference for direct and responsive communication (e.g. phone calls or text messages), while travel costs and distance were reported as practical barriers to attending appointments.

In relation to choice and support, participants frequently reported limited choice when initiating MAT, challenges in changing medications, and inconsistent experiences in achieving a therapeutic dose. The quality of relationships with key workers was reported as a key factor in sustaining engagement. However, experiences of supportive and therapeutic relationships were inconsistent. Participants highlighted gaps in support during transitions into and out of the criminal justice system, limited access to harm reduction services, and insufficient mental health support. While examples of good practice were identified, the findings point to a continued lack of consistency within and across Health Board areas. The study concludes that successful implementation of all ten MAT Standards, alongside consistent and person-centred support, is essential to improve engagement and retention. Recommendations emphasise reducing stigma, improving communication, increasing awareness of MAT Standards and treatment options, and prioritising therapeutic relationships within services.

SDF also conducted a qualitative study of people's experience in accessing LAIB across four Health Boards (Lothian, Forth Valley, Dumfries and Galloway, and

Highland), with data collected by peer researchers (Scottish Drugs Forum, 2025). They conducted interviews with 46 people accessing LAIB and 9 people receiving LAIB in prison. Furthermore, they conducted a staff survey to understand their experiences of supporting people to access LAIB which was completed by 53 staff members. The study stated that the provision of LAIB has shown promising outcomes for people receiving LAB, including: greater stability, increased autonomy and improved quality of life. However, consistent with SDFs wider MAT evaluation, participants reported inconsistent experiences in terms of access, choice and support. Key areas identified for development included the provision of information through peer education and support, so that individuals can make informed decisions about their treatment. Psychosocial support, and access to mental health services were identified as particularly important to support individuals as LAIB can increase mental clarity compared to other OAT medications. Furthermore, participants highlighted the need for increased communication and contact in between appointments, led by the individual accessing treatment. The report concluded that "LAIB was widely recommended by participants and seen as a valuable treatment by staff, the findings outline its effectiveness depends on how it is delivered and supported by services throughout the individual's treatment journey."

Relating to the PHS survey of people with current or past experience of using drugs (described above) (Public Health Scotland, 2025b), of the 494 responses, 57% had accessed OAT, 13% reported an unmet need for OAT, with total demand for OAT being 62%. Among respondents who had received OAT in the last 12 months, 41% had received their first dose on the same day or the next day. The report stated, "The 41% percentage is lower than may have been expected based on the assessment of compliance with the same-day prescribing MAT standard in the 2025 PHS MIST benchmarking report". Furthermore, 63% of respondents reported that they had received their choice of OAT medication. The report also stated that in terms of general experience overall, "seven in ten respondents felt the support they were receiving from services now was better than two years ago. Two in ten felt the support was now worse than two years ago". The report also stated that those reporting a problem with opioids were more likely to feel that the support was better. Furthermore, a higher proportion of respondents from rural areas (12%), compared to urban areas (5%) reported an unmet need with regards to OAT.

4.3.4 Psychosocial interventions

Access

No routine data for Scotland are currently published on the number of people accessing psychosocial interventions, and the delivery of psychosocial interventions are not captured in national monitoring datasets.

Quality

Findings from the PHS survey of people with current or past experience of using drugs (described above) (Public Health Scotland, 2025b) indicated that counselling and mental health support had the highest levels of unmet need (47%) and total demand across those surveyed (met and unmet need – 81%). Furthermore, mental health support emerged as the most prominent unmet need within the free text responses of the survey.

4.3.5 Stabilisation facilities

Access

A scoping survey was developed in consultation with the Stabilisation and Crisis Care Working Group (SCCWG) and the Residential Rehabilitation Development Working Group (RRDWG) to identify potential providers of services (including detoxification and stabilisation) for people who use alcohol and/or drugs in Scotland as of June 2023. We did not identify any information on access to stabilisation services pre-National Mission for comparison.

They conducted a single mapping survey of capacity of stabilisation, detoxification and other crisis support services and identified a total of 38 providers of stabilisation services in Scotland, based on their reporting of offering OAT or benzodiazepines and/or OAT optimisation (Scottish Government, 2024b). The majority (over 70%) of providers identified were statutory organisations (e.g. NHS hospitals). Around half (53%) of services operated in a community-based or outpatient model and the other half (47%) in a residential or in-patient setting.

Of the 29 stabilisation providers that provided information, there was a total of 1,875 people receiving treatment for drug use as of June 2023. This included 272 people attending residential or in-patient services and 1,603 people attending community or out-patient. There is a wide range in the types of substances for which treatment and support is offered, level of treatment and support, and the length of the treatment. However, most services also offered detoxification services (95%) and psychosocial interventions (92%) (Scottish Government, 2024b).

The survey also reported on detoxification/stabilisation within the prison service. Of the prisons who responded (12/15), all offered some form of stabilisation for a range of substances alongside other treatment and support (Scottish Government, 2024b).

Quality

We did not identify any published evidence relating to people’s experiences of accessing stabilisation services in Scotland.

4.3.6 Detoxification services

Access

A Scottish Government mapping survey conducted in June 2023 identified a total of 41 services that provided detoxification in Scotland (the majority – 36 – also offer some form of stabilisation, discussed above) (Scottish Government, 2024b). The survey documented the number of detoxification providers, but not the number of individuals accessing detoxification, or detoxification services prior to June 2023.

Quality

We did not identify any published qualitative evidence relating to people's experiences of accessing detoxification services in Scotland.

Relating to the PHS survey of people with current or past experience of using drugs (described above) (Public Health Scotland, 2025b), the total demand for detoxification services among respondents (494) was 31%, and the unmet need was 15%. Over half of respondents (56%) who had accessed detoxification services (73) reported that it was easy to access, with 36% reporting that it was difficult to access.

4.3.7 Residential rehabilitation

Access

Through the National Mission, the Scottish Government set a target of increasing the number of statutory funded residential rehabilitation placements by three-fold, stating that "at least 1,000 people every year would be publicly funded" for their residential rehabilitation placement (Scottish Government, 2022a).

As part of the evaluation of residential rehabilitation in Scotland, and progress towards these targets, PHS has been publishing figures annually on the number of people accessing residential rehabilitation (including private and statutory funded places) (Public Health Scotland, 2025e). They compared the number of people who were accessing residential rehabilitation between 2019/20 and 2024/25. However, comparisons between these periods are heavily caveated due to differences in how the data were collected and recorded during these periods. In 2024/25, the number of providers who submitted information was 16 (covering 24 different residential rehabilitation centres). In 2019/20, data were submitted to the Scottish Government from 14 providers (across 17 residential rehabilitation centres).

The report stated that "overall access to residential rehabilitation (publicly or privately funded) has increased slightly in Scotland between 2019/20 and 2024/25". In 2019/20, there were approximately 1,600 individuals accessing rehab compared to 1,773 in 2024/25. However, access to publicly funded rehabilitation places has more

than doubled over the same period (~542 to ~1,135) (Public Health Scotland, 2025e) and now meets the Scottish Government target.

Quality

Relating to the PHS survey of people with current or past experience of using drugs (described above) (Public Health Scotland, 2025b), residential rehabilitation had the second highest level of reported unmet (29%) need among those who were surveyed (494). Fewer than half (47%) of those who had accessed rehab (55) reported it was easy to access, with 45% reporting it difficult to access. The free text responses also reflected positive and negative experiences of accessing residential rehab services across Scotland.

Table 7. Summary of access to in-scope treatment services before and after the National Mission

Intervention	Data source(s)	Pre-National Mission (2019)	Post-National Mission (post-2019, latest available)
Take-home naloxone (THN)	PHS National Naloxone Programme Scotland monitoring report (annual and quarterly) (Public Health Scotland, 2025a, 2024a)	13,000 THN kits distributed nationally in 2019-20. Estimated programme reach was 50.2% of people at risk of opioid overdose.	Approximately 32,000 THN kits distributed in 2024-25. Estimated programme reach to people at risk of opioid overdose increased to 82.2%.
Take-home naloxone (THN)	Needle Exchange Surveillance Initiative (Public Health Scotland, 2024b)	2019-20: 65% prescribed THN in the last year; 21% carrying naloxone on day of interview.	2022-23: 69% prescribed THN in the last year; naloxone carriage on day of interview decreased to 9%.
Safer drug consumption facilities (SDCFs)	Glasgow City Council Health and Social Care Partnership Thistle Service Data (Glasgow City Health and Social Care Partnership, 2025)	Not available, the Thistle opened in January 2025.	From January to December 2025: Accessed 10,819 times Supervised 7,460 injecting episodes Used by 560 people Responded to 88 medical emergencies (no fatalities).
Opioid agonist therapy (OAT)	PHS, National benchmarking report on the	Not available, MAT standards	MAT standards 1-5 (access and prescribing): full

Intervention	Data source(s)	Pre-National Mission (2019)	Post-National Mission (post-2019, latest available)
	implementation of the medication assisted treatment (MAT) standards (Public Health Scotland, 2025c)	were implemented in 2021.	implementation increased from 17% in 2021/22 to 91% in 2024/2025. MAT Standards 6–10 (psychosocial, primary care and trauma informed care): 91% provisionally implemented in 2023/24, which increased to 75% fully implemented in 2024/25 and 16% partially implemented.
Opioid agonist therapy (OAT)	Scottish Public Health Observatory (ScotPHO) (Scottish Public Health Observatory, 2025)	An estimated 29,253 people prescribed OAT in 2019-20[1]: Methadone: 24,721 people Buprenorphine: 5,820 people Long-acting injectable buprenorphine: not available (prescribing started in March 2020).	In 2024/25, an estimated 28,015 people were receiving OAT in Scotland: Methadone: 18,006 Buprenorphine: 6,916 Long-acting injectable buprenorphine: 4,270 in Q4 2024/25.
Opioid agonist therapy (OAT)	Needle Exchange Surveillance Initiative (NESI)	2019-20: 79% reported receiving methadone and	2022-23: 68% received methadone, 8% buprenorphine,

Intervention	Data source(s)	Pre-National Mission (2019)	Post-National Mission (post-2019, latest available)
		4% buprenorphine in the last six months.	11% long-acting injectable buprenorphine in the last six months.
Psychosocial interventions	Not available.	Not available.	Not available.
Stabilisation facilities	Scottish Government mapping survey (Scottish Government, 2024)	Not available.	In 2023, there were 38 services that provided stabilisation services in Scotland. Of the 29 that provided information, there were a total 1,875 receiving treatment (including 272 people attending residential/in patient) and 1,603 people attending community or outpatient.
Detoxification services	Scottish Government mapping survey (Scottish Government, 2024)	Not available.	41 detoxification providers identified nationally (38 providing stabilisation services). No national data available on the number of individuals accessing detoxification.
Residential rehabilitation	PHS: Evaluation of the Scottish Government Residential	Approximately 1,600 people accessed residential	Approximately 1,773 people accessed residential rehabilitation in

Intervention	Data source(s)	Pre-National Mission (2019)	Post-National Mission (post-2019, latest available)
	Rehabilitation programme (Public Health Scotland, 2025d)	rehabilitation in 2019/20, including ~542 publicly funded placements.[2]	2024/25. Publicly funded placements more than doubled to around 1,135.[2]

1Number of people receiving different drug types is not mutually exclusive; people can be prescribed more than one drug per year.

2Comparisons are caveated due to differences in data collection methods and provider coverage.

5. Research Objective R05 – Synthesis and Discussion

The purpose of this work was to inform discussion about the likelihood that the National Mission funding has delivered value for money and how to allocate limited resources across the in-scope services. It sought to do this by answering the questions (i) to what extent have National Mission funds been spent on effective and cost-effective drug treatments and (ii) to what extent has the National Mission funding contributed to improving access to, and quality of, different treatment services.

5.1. To what extent have National Mission funds been spend on effective and cost-effective drug treatments?

It is only possible to give a partial answer to this question, for two reasons. First, as documented in the financial analysis, a precise and comprehensive assessment of how much funding has been spent on each of the in-scope services is not possible. The financial analyses and interviews identified a number of challenges in identifying expenditure in specific areas, including: services being funded by multiple sources; additional funding sitting alongside existing funding of established services making it difficult to separate the two and identify the additional impact of new funding; the importance of all the elements of care packages being in place for services to work effectively, with examples provided of where 'bottlenecks' were not addressed by funding allocations; and uncertainties around the definition of some in-scope services and what should be provided as part of such a service. These challenges mean that mapping spend can only provide a very blurred and partial picture of the totality of the investment, what it has been spent on, what the sources of funding have been and therefore what the additional benefits of the National Mission funding specifically have been.

Second, the review has shown that there is a mixed picture regarding the availability of evidence. There is review-level evidence that OAT, safer drug consumption facilities and take-home naloxone are effective and cost-effective/cost-beneficial, but more limited evidence across the other in-scope services. There is limited review-level evidence on the effectiveness of residential rehabilitation in reducing overdose or drug-related mortality and limited evidence on the cost-effectiveness/cost-benefit of residential rehabilitation. There is currently no review-level evidence on the effectiveness or cost-effectiveness/cost-benefit of stabilisation services. Evidence of the impacts of SDCFs on drug use is limited and there is little or no review-level evidence demonstrating sustained impacts of psychosocial interventions on overdose or mortality. Cost-effectiveness and cost-benefit evidence is limited. There

is also evidence that detoxification is ineffective in reducing non-fatal overdoses as the period post-detoxification without linkage to other appropriate interventions is a time of elevated overdose risk.

Therefore, even if we knew precisely how much of the National Mission funding had been spent on each of the in-scope services, in some instances the evidence is not available to judge whether that spending represents an effective and cost-effective use of resources. Review-level evidence from economic evaluations such as cost-effectiveness, cost-utility or cost-benefit analyses, is particularly limited in many areas. Most studies are from North America and, for particular interventions, studies vary in terms of comparator (i.e. what the intervention is compared to), comparison groups, outcomes measured and/or the type of economic evaluation undertaken. Cost-utility analyses (sometimes called cost per QALY studies) usually use different cost-effectiveness thresholds to those recommended in the UK, reflecting the appropriate benchmark for the countries where they were carried out but limiting their generalisability to Scotland. Cost-benefit analyses are often partial in terms of the benefits estimated. Many exclude monetary values of reduced morbidity or death. Many compare costs of interventions to cost ‘offsets’, in terms of reduced use of other services such as healthcare, social work or criminal justice services, and to productivity gains from service users better able to work post-intervention. However, this implies that cost-saving and productivity are the criteria by which the economic case for an intervention should be judged, rather than the health benefit they generate relative to the cost. It is important to bear these issues in mind when assessing the economic evidence base in this area.

It is important to be clear about the nature of these gaps in the effectiveness and economic evidence. First, the effectiveness of any intervention can be judged against a range of outcomes. The evidence review looked at the evidence in relation to three outcomes on the same causal pathway (drug use; non-fatal overdose; drug-related death), plus cost-effectiveness/cost-benefit evidence. It highlights that for some interventions, evidence is available on some outcomes and not others. Where evidence is available, it sometimes suggests that services are effective in relation to some outcomes and not others. Where this is the case, it is important not to draw general conclusions regarding effectiveness and cost-effectiveness/cost-benefit across all the potential outcomes.

Second, for some of the services, there is an absence of evidence that the service is effective (in relation to one or more outcomes), rather than evidence that it is ineffective. This is an important distinction. Statements about limited evidence do not mean that services are unlikely to generate beneficial outcomes, it means there is more uncertainty about whether they will do so or not.

Third, the variable quality of the available evidence across different interventions should not be seen as an argument to move resources away from areas where evidence is currently absent. Rather, it points to the need for improved monitoring,

evaluation and research to fill the evidence gaps so that in future we are in a better position to judge the relative value for money offered by different approaches to reducing drug-related harms.

Combining the results of the financial analyses and the evidence reviews gives some indication of how National Mission funds have been used and whether they have been spent on the services identified in the review-level evidence as being effective and cost-effective. Substantial resource has been invested into some of the in-scope services supported by the evidence, although precise quantification of spend in these and the other in-scope services is difficult for reasons discussed in Section 2. Substantial allocations were made, from both the National Mission funding and the wider budget available to support the National Mission's objectives, to medication assisted treatment (which incorporates OAT and psychosocial treatment) and residential rehabilitation. Respondents reported that this funding had been used to support these services and they also highlighted that substantial additional resources were invested in them from a variety of sources. Substantial funds are also allocated to service areas where there is an absence of review-level evidence on effectiveness and cost-effectiveness, but this reflects the state of the evidence base rather than indicating poor value for money.

Overall, this study suggests that a substantial proportion of the National Mission and wider funding to reduce drugs deaths and improve other outcomes has been spent on effective and cost-effective interventions with some improvements in access and quality. However, it also highlights there is a pressing need to improve the information available to fully answer the study questions and inform overall judgements regarding value for money and how to allocate resources across treatment programmes.

5.2. To what extent has the National Mission funding contributed to improving access to, and quality of, different treatment services?

The evidence reviewed to address RO4 suggests that there have been some increases in access and quality in a range of treatment services since the introduction of the National Mission. The MAT standards are increasingly being met, although the Benchmarking Report notes that direct comparisons between years need to be made with caution. It also points out that reporting on adherence to the standards does not provide an assessment of the outcomes of implementation of the MAT standards, in terms of whether implementation has been effective and benefitted people.

There has been an increase in the number of naloxone kits distributed and an increase in the reach of the programme but a fall in the number of people carrying kits, reducing the potential impact of the programme. Parallel to a small drop in

prevalence of opioid dependence, OAT prescribing has declined slightly but still comfortably meets global coverage targets (World Health Organization, 2023). Access to residential rehabilitation has increased by around 11% with a more than doubling of publicly-funded places, offset in part by a decline in provision in other sectors.

Available data were more limited for detoxification services and stabilisation services, particularly on the number of people receiving these services. There were no data available on psychosocial interventions.

Experiential information on quality of services highlighted improvements particularly to OAT delivery, but improvements remain inconsistent across Scotland particularly across rural areas. Lack of support for people who use drugs in need of mental health services and a desire to improve access to mental health services were consistently highlighted as an unmet need.

The evidence from this report suggests that ADPs regard positively the National Mission emphasis on, and funding for, engaging people with lived and living experience in collaborative work to improve the quality and availability of drug and alcohol services.

5.3. Recommendations

To inform discussion about whether the National Mission funding has delivered value for money and how to allocate limited resources across the in-scope services, information is required on how resources have been used, the outcomes of current services and the effectiveness and cost-effectiveness/cost-benefit of services (current and planned). The study has found that there are major challenges in getting information on spend across the in-scope services that is reliable, valid and consistent between areas. Tightening up the monitoring of particular categories of spend would be difficult, costly and time consuming to do well and the value of doing so would be limited for many services if: 1. it remains unclear what we should be spending the money on, nationally or locally, given our gaps in understanding of effectiveness and cost-effectiveness both internationally and in Scotland; 2. information on the impact of services on outcomes for service users remains limited; 3. there are differing priorities locally; 4. some services remain ill-defined; and 5. the effectiveness of particular interventions depends on how they are delivered in combination with other services.

Therefore, we recommend that priority should be given to improved monitoring of outcomes and more evaluation to fill the gaps that have been identified in the evidence on the effectiveness and cost-effectiveness of the different service options to 1. provide better information on the outcomes of current services and 2. to provide a stronger basis for judging whether the most effective and cost-effective types of services are being implemented. In parallel, recognising the challenges in monitoring

how National Mission funding or other funding sources have been spent, we recommend policy and delivery stakeholders work together to develop approaches for stronger financial monitoring of the most important areas of spend (in terms of costs, activity and outcomes).

Specifically, we would recommend the following as priority areas for additional monitoring and research:

There is a need for larger prospective studies, including natural experiment studies that assess community-level as well as individual-level outcomes. Studies should place an emphasis on rigorous baseline, follow-up measures, comparator groups, and assessment of potential confounders (such as other interventions, drug use patterns or demographics). Emphasis should be placed on long-term outcomes.

The evidence base for some interventions needs to be updated (e.g. Residential Rehabilitation) or established (e.g. Stabilisation Services) within the Scottish context, particularly given the resources committed through the National Mission. Specific research priorities in these areas are highlighted below. Furthermore, the evidence base is also focused on interventions to address opioid dependence, and further research is needed to address changes in drug trends (including cocaine use) (Public Health Scotland, 2025f).

Interventions are rarely delivered in isolation, so there is a need to assess the combined impact of interventions (e.g. detoxification, psychosocial interventions, residential rehabilitation and OAT).

There is a need for more evidence of the cost-effectiveness or cost-benefit of services delivered in the UK, and of the population groups they serve. As noted, much of the existing economic evidence is from North America, based on different cost-effectiveness thresholds and methods to those recommended in the UK. Key parameters such as the cost of services and the costs avoided elsewhere in the system, such as criminal justice costs, are also likely to differ in the UK. Studies should examine overall cost-effectiveness, and any variation in cost-effectiveness according to the different population groups accessing services.

Scottish Government, HSCPs, ADPs and other policy and delivery stakeholders should work together to explore the potential of approaches such as programme budgeting or cost and activity mapping as a basis for better understanding how resources are being used across local areas, taking account of change over time and variation in local priorities.

Some of these gaps in the international evidence base are being addressed by current research using real world data from Scotland and funded by the National Institute for Health and Care Research (NIHR). ‘Evaluating the Public Health Impact of Interventions for the Prevention of Drug-related Deaths in the Population: in Scotland’ (EPHeSUS) is estimating the effectiveness and cost-effectiveness of THN

and other interventions (National Institute for Health and Care Research, 2024). A second NIHR-funded study is evaluating the impact of The Thistle SDCF in Glasgow (National Institute for Health and Care Research, 2025).

There is also a need for more research in the following specific service areas:

Residential rehabilitation

To strengthen the evidence base on outcomes considered in this study, improvements are required in access to and use of individual-level service data that facilitates linkage with other administrative datasets (e.g. through SHIeLD). This would help address issues around comparability of risk profiles between people accessing different treatments, as well as allowing evaluators to account for a range of risk, modifying and confounding factors that influence outcomes, including type of treatment, length of treatment, comorbidity, and demographics. It will also allow consideration of a broader range of outcomes including those where core effectiveness evidence is lacking e.g. mortality, cost-effectiveness/cost-benefit, and to assess the impact of residential rehabilitation over longer term follow-up. The recent acquisition of individual-level data by PHS for publicly funded residential rehabilitation placements as part of the National Mission represents an opportunity for Scotland to lead the way in this area. Quantitative approaches to understanding the impact of residential rehabilitation should be complemented by qualitative work with an experiential focus which has yielded important insights into other interventions such as OAT.

Stabilisation facilities

Individual-level data on stabilisation services is lacking, limiting our understanding of outcomes associated with this key element of the National Mission. Like residential rehabilitation, development work is required in the short term to create a data flow from stabilisation services into PHS to facilitate better understanding of individual-level outcomes.

5.4. Conclusions

In summary, substantial resource has been invested into some of the in-scope services supported by the evidence, although precise quantification of spend on these services was not possible. Substantial funds have also been allocated to service areas where there is an absence of review-level evidence. Progress is being made in improving quality and access but with a lot still to do to address need, to achieve the aims of the Mission – reducing deaths, improving access and quality – and to understand whether these aims are increasingly being achieved with the funding being invested. We recommend prioritising further development of information on the outcomes of drug and alcohol services, further research on the effectiveness and cost-effectiveness or cost-benefit of those services and

consideration of how best to hold organisations to account for the use and impact of the funding for drug and alcohol services.

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