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“You’re not informed unless you make it your business”: Insights from a Scottish national study exploring attitudes towards residential rehabilitation

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ABSTRACT

Background
Despite Scotland’s commitment to patient-centred substance use care, little is known about how individuals learn of residential rehabilitation. This study explores whether national policy goals of informed decision-making translate into on-the-ground practice.

Methods
This paper presents a secondary analysis of data generated during a larger mixed-methods evaluation of residential rehabilitation. Participants (n=197 people who reported a drug problem in the previous 12 months) were recruited from 29 Scottish Local Authority areas and completed structured face-to-face interviews. Peer researchers with lived experience conducted interviews. Qualitative data were thematically examined according to macro-level (systemic), meso-level (community), and micro-level (individual) influences.

Results
Many participants reported never being informed of residential rehabilitation by healthcare providers. In response, peers, family, and community support groups filled information gaps, though their accounts were inconsistent or contradictory. Consequently, individuals resorted to micro-level strategies, such as internet searches and repeated questioning of key workers, to piece together essential details. Participants frequently expressed frustration with missed opportunities to explore alternative treatment pathways, compounding a sense of systemic neglect and disempowerment. This dynamic interplay between macro, meso, and micro factors often hindered genuinely informed decision-making and undermined policy ambitions for accessible, rights-based care.

Conclusions
Findings highlight pervasive communication gaps, echoing other contexts where new or less-familiar treatment options remain poorly signposted. Mandated communication protocols, formal peer collaboration, and reduced burdens on individuals could strengthen the alignment between practice and Scotland’s National Mission. By closing these knowledge gaps, services can better support people

with problem substance use to make truly informed decisions about residential rehabilitation and broader treatment pathways.

Keywords
Residential rehabilitation, informed decision-making, problem drug use, medication-assisted treatment, patient-centred care, peer-led networks, Scotland drug policy.

Abbreviations
ADP: Alcohol and Drug Partnership
MAT: Medication Assisted Treatment
RR: Residential Rehabilitation
PHS: Public Health Scotland
GP: General Practitioner
CPN: Community Psychiatric Nurse

BACKGROUND

Globally, drug use prevalence, harms, and deaths continue to escalate, straining public health and social-economic systems (1). In the UK, these challenges are pronounced (2), with Scotland experiencing the highest drug death rates in Europe (3,4). In response, the Scottish Government has enacted a range of policy initiatives following the 2018 drug strategy 'Rights, Respect and Recovery' (5), including a Ministerial Drug Deaths Taskforce (DDTF) in 2019 (6) and the 'National Mission' to reduce drug deaths (7). Alongside extensive harm reduction measures and medication-assisted treatment (MAT) standards developed to increase access to, and choice in, drug treatment (8), the Scottish Government have ring-fenced five million pounds annually to Alcohol and Drug Partnerships (ADPs) to improve access to residential rehabilitation (RR), while the total Scottish Government commitment is £100 million over five years, covering increased bed capacity, prison-to-rehab pathways, and other national initiatives (9). This funding was designed to enhance treatment choice and align with a growing emphasis on ensuring that people who use drugs can make informed decisions regarding their care.

The policy environment in Scotland, reflecting broader Western health and social care trends, advocates individual choice and informed decision-making, grounded in a rights-based approach (means putting human dignity, equality, and legal rights at the heart of policies and services) (10). The 'Orange Book' which provides UK-wide guidance to treatment services states the primary role of clinicians is to "assist patients in making their own, informed, choices about their treatment goals and priorities, and to agree the actions to try to best achieve them" (11). Going further, the guidance also recognises that while treatment goals tend first to focus on reducing harm, as treatment progresses, these goals can shift toward recovery and building resilience (11). The MAT Standards and forthcoming human rights legislation, which will enshrine the right to the highest attainable standard of health in Scots law (8,10), underline the importance of inclusive, respectful, and choice-oriented drug treatment services. By centring individual autonomy and involvement, these reforms aspire to improve treatment engagement and outcomes. However, the literature on how effectively these ideals are realised in practice, particularly in relation to drug treatment services, remains limited (12). Moreover, evidence of the effectiveness of shared decision-making in addiction contexts is mixed (13–15), prompting further exploration of how information is conveyed and how patients engage with that information in real-world settings.

The notion of the ‘informed patient’ originated in late 20th-century healthcare, highlighting patient empowerment, autonomy, and engagement in managing chronic conditions (16,17). Research shows well-informed patients often achieve better adherence (18,19), yet scholars question how far information access can genuinely enhance self-determination (20,21). Shared decision-making aims to incorporate both clinical evidence and patient preferences (16,22), but substance use treatment brings unique complexities, such as stigma, varying motivation levels, and structural disadvantages, that can hinder effective patient participation (23,24).

Understanding informed decision-making in the context of drug treatment requires considering multiple layers of influence. Indeed, such multi-level analyses permit a better understanding of how risks are shaped across structural social and individual levels (25), whilst explorations of layered influences on health care (21), and substance use treatment decision-making (23,26,27) are also common. Macro-level factors (policy, funding, service configuration, messaging from statutory services) can either foster or inhibit open communication about treatment options. Meso-level influences (peer networks, family relationships, community resources) shape the informal spread of information. Micro-level dynamics (individual readiness, personal research, and agency) further determine how people seek, interpret, and act on available information about treatment options. Where one level fails, e.g., service providers not proactively offering information, people who use drugs may resort to community networks or self-guided research, with variable results (28).

Recent policy changes in Scotland have explicitly sought to expand the range of drug treatment choices, including greater access to RR. In Scotland, RR is provided by public and private services via Alcohol and Drug Partnerships, though access remains uneven despite recent investment. Effectiveness evidence is mixed, but monitoring shows benefits for some, and newer stabilisation centres now support MAT stability alongside abstinence in line with national standards. Yet, a mixed methods evaluation, by Perkins and colleagues, of Scotland’s government-funded RR programme revealed pervasive gaps in awareness and knowledge of the treatment option (28). Almost half of their 367 respondents (47%) reported low-to-no awareness, and the primary route of information was informal and community-derived. Only a minority (19%) rated their knowledge between seven and ten out of ten and/or described receiving structured information from health or social care professionals, reflecting significant macro-level communication failings. Moreover, many participants had to undertake personal research or rely on social circles (meso-level routes) to gain even a basic understanding of RR’s availability and processes for accessing it.

Perkins et al. (28) observed an inverse relationship between RR awareness and the intention to pursue it, suggesting that higher awareness, when it originates from supportive, credible sources, might moderate demand by clarifying who is eligible for, might benefit from, and how to access RR. Notably, some respondents already had prior experience of RR, were in long-term recovery, or were established in community services, factors which may also have shaped both their awareness and interest in RR. However, the reliance on personal or community-based knowledge pathways indicates that those without robust social networks or resources may be less likely to learn about, let alone access, RR. These findings conflict with the spirit of the Scottish MAT standards (8), which aim to support informed patient choice, yet also highlight, consistent with review level evidence on patient centred care (29,30), how macro-level goals for patient autonomy can be undermined by inadequate micro- and meso-level infrastructures of information-sharing.

Drawing solely on the open-text responses from the work package (WP) 2 survey (n=198) data from Perkins et al.'s evaluation, the present paper explores the processes by which individuals experiencing problem drug use seek and acquire information regarding RR and other treatment options. Alongside structured survey items, participants could elaborate in free-text boxes—for example, explaining their awareness rating of RR (0–10), commenting on the accuracy of a provided definition, or describing reasons, barriers, and motivations for past or no RR experience. These open-text responses formed the qualitative dataset analysed thematically in this paper. Specifically, this paper investigates how macro, meso, and micro routes to 'informedness' shape participants' knowledge, preferences, and decisions. By applying this multi-layered lens, the aim is to reveal where failures and successes occur in providing accessible, consistent, and context-specific information. A further aim is to address the gap in critical literature on how people with problem drug use become (or fail to become) informed patients in a rapidly changing policy environment. The resulting insights may inform ongoing efforts to embed shared decision-making principles in substance use care, improve communication practices, and ensure that individuals have a genuine, informed choice in shaping their treatment journeys.

METHODS

Study design and setting

This paper presents a secondary analysis of WP2 from a larger three-work-package independent evaluation conducted by Perkins et al. (28) of Scotland's government-funded RR expansion programme. The evaluation was commissioned and funded by the Scottish Government but delivered by external researchers, and while government funding may shape priorities, the study was designed and conducted independently under Public Health Scotland oversight (31). Perkins and colleagues' evaluation employed a mixed-methods approach to investigate perceptions of, and demand for RR, among individuals using drugs in Scotland. The other work packages were a short questionnaire, distributed online via non-NHS harm reduction, treatment and recovery services (WP1), and in-depth qualitative interviews (WP3). This paper specifically examines how individuals with problem drug use seek and acquire information regarding RR and other treatment options, addressing a critical aspect of the wider evaluation. Full methodological details are available in Perkins et al. (28), the comprehensive report submitted to funders.

Peer research methodology

A partial peer research methodology was utilised, involving individuals with lived experience of problem substance use at all stages of the research process. Peers supported tool design, collected all data, contributed to analysis and sense-making, and were co-authors on both the original report and this article. This was not a fully peer-led study but a partnership model, where peers worked alongside academic researchers to shape decisions without assuming sole ownership. Such an approach reflects a collaborative rung on Arnstein's ladder of participation (32), moving beyond tokenism towards shared influence, while still falling short of full citizen control. This balance supported high participant engagement and ensured the research was grounded in the real-world experiences of those directly affected by drug use.

Participants and recruitment

Participants were individuals who self-identified as having a current or previous drug problem within the past twelve months. The fieldwork for WP2 was conducted between June and December 2023, encompassing 197 participants from 29 of Scotland's 32 Local Authority (councils/municipalities)

areas. Recruitment strategies included collaborations with alcohol and drug partnership leads, professional stakeholders, and direct engagement with non-NHS substance use and recovery settings. Additional recruitment methods involved distributing posters with QR codes and targeted advertising on platforms such as Facebook and Reddit.

Data collection

WP2 utilised a detailed structured questionnaire administered through face-to-face interviews to gather comprehensive data on participants' perceptions and experiences of RR. These surveys included both quantitative and qualitative questions, with a particular emphasis on open-text responses that provided deeper insights into participants' information needs and decision-making processes regarding treatment options.

Data analysis

The analysis for this paper employed a two-stage approach. Initially, inductive coding of free text box responses was conducted to allow themes to emerge organically from the qualitative data. Subsequently, a deductive analytic process was applied, organising the identified themes according to the macro-level (systemic and institutional factors), meso-level (community and social networks), and micro-level (individual initiative and personal responsibility) routes to informedness. This multi-layered framework, commonly used across related literature (21,23,25–27) facilitated a comprehensive understanding of how different levels of influence shape participants' knowledge, and perceptions regarding RR. To enhance rigour, the qualitative framework incorporated reliability checks: coding was conducted by multiple researchers, with peer review of coding outputs and consensus meetings held to resolve discrepancies. This strengthened analytic validity and ensured consistency in the application of codes across the dataset.

Ethics

Ethics approval for the broader project was obtained from the Wrexham University Research Ethics Committee (ID540, dated 18/01/2023). All procedures followed the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments. All participants provided informed consent prior to participation and were offered a £20 bank payment as a token of appreciation for their time.

RESULTS

Routes to informedness: Macro, meso, and micro dimensions

While some participants said that they received minimal information and guidance, others explained how they actively forged their own paths, seeking clarity through non-traditional channels. Their accounts revealed how they struggled, adapted, and persevered to become informed within a complex and often inadequate information landscape.

Macro-level (systemic) factors influencing informedness (‘never offered’)

A prominent macro level theme was the systemic absence or inadequacy of structured information about RR. Many participants reported having extensive contact with health or social care providers but reported never being proactively informed of their rehabilitation options. Terms such as ‘never offered’ and ‘not informed’ were commonly used, as respondents frequently emphasised that professionals and institutions failed to communicate potential treatment pathways beyond standard maintenance therapies, such as methadone programmes.

> *'Never really heard of any places, never mentioned by GP, mental health nurse etc'.* (Male, 30-34)

> *'Doctors don't inform you. If you said it to them, they say 'we have to have a meeting about it' but nothing happens'*. (Male, < 20)

Participants described scenarios where they attended appointments and engaged with services over extended periods without a single mention of RR. This lack of proactive information often led them to believe that RR simply did not exist, was not available in their area, or was beyond their reach. The result was a widespread lack of basic factual knowledge regarding what RR entailed, how to access it, or who was eligible. Some individuals reported going decades without discovering that more intensive, supportive treatment options might be available:

> *'I have never been given the chance of rehab or been spoken to about it and that's over 30 years'.* (Male, 50-54)

> *'I was at death's door before anyone offered me any help'.* (Female, 45-49)

Where participants did receive some indication of RR's existence, the details were often vague, inconsistent, or discouraging. Several respondents described being told there was no funding, or that waiting lists were excessively long, which may or not have been accurate, rendering a perception that RR is an unattainable option. Others felt that healthcare workers knew little about the realities of problem drug use or were unwilling to engage in meaningful discussions:

> *'I was told for years there was no funding for me, and I would not get rehab (...) they don't offer rehab (...) for people like me'.* (Male, 40-44)

> *'I think there's workers that don't know enough about addiction'.* (Male, 50-54)

> *'Before I went to rehab, I was not at all informed. When I asked about it before the government put extra money into it, I used to be told there was too long of a waiting list.'* (Male, 40-44)

This lack of consistent, accurate information at the macro level often funnelled individuals into narrower treatment paths, primarily methadone, without their knowledge that other options existed:

> *'The only treatment I ever knew about was from my CPN – methadone programme. I never knew of anything else'.* (Female, 35-39)

Thus, the macro-level environment, encompassing provider communication, institutional protocols (e.g., referral pathways), and broader structural arrangements, including long waiting times, geographic variation, and restrictive eligibility rules, repeatedly failed participants. Without a proactive, well-advertised, and consistent flow of information, many remained trapped in uncertainty, reinforcing the perception that RR was simply not an option for them.

Meso-level (community and social network) influences on informedness ('community-derived information')

In the absence of any consistent formal, reliable guidance from organisations and professionals, participants often turned to friends, family, and local community resources. These meso-level

networks became essential conduits of information about RR. Many respondents learned about the existence of rehab simply by speaking to peers who had attempted it, by attending recovery cafés (community-led, typically abstinence-based hubs for people with experience of substance use), or through informal encounters in hostels and community mutual aid groups (e.g., Narcotics Anonymous, SMART Recovery). Here, experiential knowledge, lived and shared by those who had engaged with RR or at least attempted to, filled some of the information vacuum left at the macro level.

> *'I knew a few people who had gone and the feedback they had was good'.* (Female, 40-44)

> *'From what I have learned from people in this group'.* (Male, 45-49)

> *'Before being part of recovery groups I was not informed of rehab however after speaking with others in the groups I now feel more informed'.* (Male, 45-49)

These meso-level discussions, while informative, were naturally a mix of positive and negative, and not always accurate. Individuals regularly encountered conflicting accounts: some people reported good outcomes and encouragement, while others spoke of relapse, funding difficulties, or RR centres that did not offer the support expected:

> *'The only information I had on rehab was from the folk I ken [know] that have been and they have failed it and relapsed'.* (Male, 45-49)

> *'I have heard of people accessing other rehabs but you're always told you won't get funding for rehab.'* (Female, 30-34)

In many cases, social interactions with family members or peers in community settings such as recovery cafés or lived experience groups were highlighted as critical turning points, where individuals gained new insights:

> *'Because of my social circle, attending recovery café and knowledge from those who have been to rehab'.* (Male, 45-49)

> *'I have learned from staff at this café about what goes on in rehab and the benefits of going'.* (Male, 35-39)

These informal networks sometimes included workers from third-sector organisations (i.e., charities, voluntary, and non-profit groups) or individuals connected to local services (e.g., community addiction teams), who could offer partial clarification. The meso-level, therefore, represented a patchwork of information sources, some reliable, others contradictory. Regardless of accuracy, these networks proved instrumental in sparking initial awareness and encouraging participants to explore RR further. In doing so, meso-level influences often prompted individuals to move from a state of ignorance or misinformation, resulting from macro-level failings, towards active inquiry and eventual understanding.

Micro-level (individual) routes to informedness ('personal responsibility')

Faced with systemic silence and fluctuating community narratives, many individuals undertook a proactive, personal approach to becoming informed. At this micro level, participants described taking

responsibility for researching their treatment options, using online searches, reading leaflets, asking specific providers pointed questions, or even writing letters to request a place in rehab. This self-driven route to informedness demanded persistence, patience, and determination:

> *'Because you're not informed unless you make it your business to ask about rehab'.* (Female, 40-44)

> *'Unless you go looking for rehab the information is not there. I had been to addiction clinics and it wasn't until I went to* [third-sector drug treatment and recovery service] *that I heard about rehab'* (Male, 35-39)

> *'I accessed it through prison. I had to write to them to ask for a bed for my drug and alcohol addiction'* (Male, 50-54)

Personal responsibility often emerged as a compensatory mechanism: lacking a reliable macro-level source of information or having only partial meso-level guidance, individuals stepped into the role of researchers and advocates for themselves. Some described approaching health or social care workers, prison officers, or different services to gather leaflets or information packs. Others pursued readiness through active engagement, joining lived experience groups, attending peer-led support sessions, and making repeat inquiries until they uncovered viable options:

> *'Through my own work I've got to know some things'.* (Male, 30-34)

> *'I got leaflets last week as I've started the process of applying into rehab'* (Male, 35-39)

> *'Since I have been thinking of going to rehab, prison officers have taken me through a folder which details what each rehab is about'.* (Male, 30-34)

Micro-level routes to informedness were closely tied to the concept of readiness, both a precondition and an outcome of becoming informed. Individuals commonly implied, or directly stated, that gaining knowledge was itself a demonstration of seriousness or motivation, and that this readiness, in turn, facilitated their access to more information and eventually to rehabilitation programmes:

> *'I've had to ask and ask for any treatment that I have been given'.* (Female, 40-44)

> *'I had to go out and find info about the rehabs myself – they weren't very well advertised'.* (Male, 50-54)

> *'If you've taken steps already that's a good sign'.* (Male, 45-49)

Moreover, multiple RR experienced respondents positioned readiness as central for success, reinforcing the necessity of individuals adopting personal responsibility for their drug treatment.

> *'It's most suited to people who are ready to sort their issues and are crying for help.'* (Male 45-49)

> *'If you go in* [to rehab] *not 100% ready it will not work'.* (Male, 35-39)

In these narratives, personal responsibility is intertwined with a sense of agency and empowerment. Taking action on one's own behalf was not simply a fallback option; it was sometimes the only viable route to clarity and access.

Interplay between the macro, meso, and micro levels

In summary, these three levels of informedness, macro, meso, and micro, did not operate in isolation. Rather, participants' journeys reveal a dynamic interplay among them. Macro-level silence and inconsistency forced many to rely on meso-level networks, where information was available but not always accurate or complete. In turn, this partial understanding often prompted individuals to take micro-level steps, leveraging personal responsibility and self-directed research to piece together a coherent understanding of RR.

The cumulative effect of these struggles was a complex pathway to informedness. While some individuals eventually succeeded in navigating these levels to find and access RR, others remained uncertain, misinformed, or discouraged. The resulting patchwork of knowledge meant that 'informedness' was often contingent upon personal circumstance, social connections, and the capacity to persevere through systemic barriers. In some cases, an individual's determination and active engagement at the micro level was what finally overcame the gaps at the macro level and the inconsistencies at the meso level.

DISCUSSION

Scotland's National Mission on drug deaths (7) provides a policy framework that aspires to patient-centred care, rights-based approaches, and expanded treatment choices for those experiencing problem substance use. The MAT standards (8) were introduced to operationalise these ideals, prioritising accessibility and responsiveness within substance use services. Despite these commitments, the findings outlined indicate that, in practice, many individuals lacked consistent, proactive information about RR, reflecting a persistent gap between policy aspirations and on-the-ground realities. This discrepancy appeared to be amplified by the structural complexities of RR funding, service capacity, and stigma surrounding problem drug use, as evidenced by Public Health Scotland's broader evaluation of RR (31). Previous studies have reported similar tensions, where macro-level guidelines emphasising patient choice are undermined by local commissioning constraints and insufficient staff training (27,33). Thus, although the National Mission (7), and Rights, Respect and Recovery (5) advocate autonomy and informed decision-making, the study's results revealed that many participants felt systemically neglected. This resonates with broader evidence from substance-use contexts which highlight persistent delivery barriers, like stigma, misaligned goals, and fragmented services that undermine patient-centred models (34), and further, that autonomy is hollow when treatment options are so constrained that clients cannot meaningfully choose (35).

Becoming informed about residential rehabilitation in this context required navigating a landscape marked by macro-level communication shortcomings, meso-level community-derived information, both supportive and contradictory, and micro-level personal initiative. This three-tiered analysis revealed how systemic shortcomings shape (and often complicate) the routes to informedness, placing pressure on already vulnerable individuals to seek alternative sources of information and, ultimately, to shoulder the responsibility themselves for uncovering the help and support they need. Participants who reported never being proactively offered or told of RR, frequently discovered its existence through chance encounters or peer-led discussions, and faced the burden of piecing together contradictory information. These circumstances often deterred engagement with RR, or delayed it significantly, mirroring the phenomenon of partial knowledge and rushed decisions documented by Neale et al. (27) in the context of new opioid replacement therapies.

Despite the MAT standards promoting an ethos of proactive communication, participants repeatedly highlighted the absence of direct RR information. Many experienced a default presumption by services that community-based MAT was the primary or only viable route. Such macro-level inertia channelled individuals towards standard treatment options without fully exploring alternatives (27). The perceived systemic silence within Scotland's complex health and drug treatment infrastructure represents a faltering of the 'informed patient' model (21). Whilst policies aimed to boost patient empowerment, structural and commissioning rigidities slowed the translation of these frameworks into consistent front-line practice. Indeed, the UK clinical guidelines list a range of macro-level issues for the consideration of policy-makers and healthcare planners including concerns about the mixed evidence base for RR and its cost-effectiveness (11) which may manifest in the communication shortcomings identified in the present study. The gap between theory and reality was stark. Respondents felt they had to fight for basic knowledge about RR, sustaining a cycle of unawareness and service-level neglect, through failures to communicate and facilitate access to available treatment options. Importantly, Perkins and colleagues' (28) study indicates that greater awareness may expose barriers such as waiting times, eligibility rules, and abstinence expectations, which can temper interest. For some, it also reinforces preference for community or harm-reduction approaches, or reflects prior RR experience, showing that awareness guides informed choice rather than automatically driving uptake.

Amid macro-level shortfalls, participants commonly relied on meso-level sources, peers, family, and community support groups, to learn about RR. This reliance echoed findings from Staiger et al. (26), who noted the pivotal role of community ties in maintaining retention in residential treatment settings, especially for those with co-occurring mental health conditions like social anxiety. Although these informal networks offered vital experiential insights, their accounts were inconsistent (26). Some heard inspiring success stories, while others were discouraged by anecdotes of limited funding or rigid programme rules. The resulting patchwork often left participants uncertain about RR's true nature or accessibility (33). Encounters with contradictory meso-level narratives demonstrate the dual-edged nature of community-derived knowledge. Accurate peer-led accounts can mobilise individuals to investigate formal pathways. Conversely, misinformation or scepticism can deter them from pursuing RR. While peer input can catalyse inquiry, it cannot replace comprehensive, professionally validated sources of information.

Participants commonly described personal research efforts to remedy macro-level communication failings and meso-level inconsistencies. Some turned to the internet; others peppered key workers or multiple providers with questions, or joined repeated information sessions. This resonates with the 'do-it-yourself' pathways identified by Staiger and colleagues (26), wherein patients had to self-advocate for tailored residential interventions. Such micro-level agency demonstrated resilience and motivation yet also revealed an inequitable transfer of responsibility onto individuals often living with stigma, co-morbidities, or precarious housing. Although some participants navigated these three levels successfully, many faced a dynamic interplay that hindered genuine informed decision-making. Macro-level oversight or inaction funnelled them into conflicting meso-level stories, prompting sporadic bursts of micro-level self-advocacy. In each instance, the fragmentation of knowledge channels compromised the realisation of the National Mission's ambitions for patient-centred, rights-based care (7).

IMPLICATIONS FOR IMPLEMENTING THE MAT STANDARDS AND NATIONAL MISSION

The findings presented point to four key recommendations for policy makers. Implementing the MAT standards and fulfilling Scotland's National Mission may be strengthened by introducing mandated communication protocols, formal peer collaboration, reduced micro-level burdens, and holistic monitoring. First, consistent with the Scottish MAT standards (8), guidance and staff training should ensure RR is presented as one option within a continuum of care, rather than defaulting to community MAT. This would counter assumptions that RR is inaccessible due to funding or eligibility, or that abstinence is always required, while acknowledging the mixed evidence base. Next, formally endorsing and training peer educators or navigators can help maintain accurate and consistent RR messaging, mirroring calls to systematise peer-led networks in addiction services (26). Third, developing accessible toolkits (paper or digital) and scheduling dedicated 'RR readiness sessions' could alleviate the pressure on individuals to self-educate in difficult circumstances (21). Finally, ongoing evaluation of how people become informed, drawing on the National Mission and Public Health Scotland data sets, will clarify how macro-level objectives translate into local practice, helping fine-tune policy adjustments over time.

LIMITATIONS

This study has several limitations. First, the analysis drew on secondary qualitative data from open-text survey responses, which, while rich, do not provide the depth of primary qualitative interviews. Second, the sample comprised individuals with varied experiences of problem substance use, including some with prior residential rehabilitation, others engaged in community treatment, and some in long-term recovery; it cannot be assumed to represent the full spectrum of perspectives across Scotland. Third, as with any qualitative work, the findings reflect participants' perceptions at a specific moment in the implementation of Scotland's RR programme, and may not capture subsequent policy or service developments.

CONCLUSION

Participants' narratives regarding routes to informedness about RR in Scotland emphasised how systemic, community, and individual factors intersected to produce inconsistent knowledge and opportunities. While the MAT standards and the National Mission highlight the value of patient-centred care and promote broader treatment option access, everyday experiences revealed pervasive communication gaps. Strengthening macro-level guidelines, bolstering meso-level communication networks, and lessening the micro-level burden are all necessary to ensure that individuals are not forced to rely on a patchwork of partial truths when making critical decisions about their treatment journeys. By proactively closing these knowledge gaps, Scottish services can better align with national policy goals and the rights-based commitments set out in Rights, Respect and Recovery, the National Mission plan and forthcoming Human Rights legislation.

DECLARATIONS

Competing interests

The authors declare the following potential conflicts of interest: one author has previously worked managing residential rehabilitation centres; the lead author and one co-author have personal lived experience as former patients in residential rehabilitation programmes, whilst the remaining three researchers with lived experience had never been to RR. These experiences provided valuable insights into the research context; however, all authors have adhered to standard academic practices to ensure objectivity in data collection, analysis, and reporting.

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Author contributions

JD led the writing of the manuscript, qualitative data analysis, original draft preparation, writing, review, and editing. AP led the original study and contributed to conceptualisation, funding acquisition, methodology, analysis, supervision, original report preparation, writing, review, and editing. SS, KG, FC, and JR contributed to the original draft manuscript preparation, review, and editing. JS, WL, and JN contributed to manuscript review and editing. All authors read and approved the final manuscript.

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Availability of data and materials

The data that support the findings of this study are held by Public Health Scotland and are not publicly available due to confidentiality agreements and data protection requirements. Access may be considered upon reasonable request and with permission from Public Health Scotland.

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