Research Report

Exploring changes to family support for those affected by someone else's drug use since the introduction of the Scottish Government's National Drug Deaths Mission

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Final report

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Declaration of interests

No members of our team have any competing conflict of interests to note.

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List of abbreviations

The following table describes various abbreviations and acronyms used throughout this report. The page on which each one is defined or first used is also given.

Table 1. List of abbreviations

Abbreviation	Description	Page
ADP	Alcohol and Drug Partnership	12
CAMHS	Child and Adolescent Mental Health Service	51
FSS	Family support service	12
National Mission	The Scottish Government's National Mission to reduce drug related deaths and harms	11
PHS	Public Health Scotland	12
WP	Work Package	11

Executive summary

Introduction

Scotland experiences high levels of drug-related harms and deaths compared with the rest of the UK and Europe, with major impacts on individuals, families, and communities. The Scottish Government's National Mission on Drug Deaths, launched in 2021, aims to reduce drug deaths and improve the lives of people affected by substance use, including family members and close contacts.

A key element of the National Mission is the [Framework for Holistic Whole Family Approaches and Family Inclusive Practice](#), which asks Alcohol and Drug Partnerships (ADPs) to audit and strengthen family support and to involve families in service design. This study, commissioned by Public Health Scotland, sits within the wider evaluation of the National Mission and focuses specifically on perceived changes in family support since 2021.

Study Aim and Objectives

The study aims to determine whether people affected by someone else's drug use perceive an improvement in the support available to them since the launch of the National Mission in 2021, and whether family support providers feel more able to deliver effective support.

The objectives are to explore, for family members, experiences of accessing support (including awareness, accessibility, and appropriateness), perceived improvements or deteriorations since 2021, and remaining gaps in provision.

For providers, the study examines perceived changes in family support, mechanisms behind improvements, unintended consequences of the National Mission, and ongoing gaps.

The study focuses on perceptions of change and cannot attribute causality solely to the National Mission.

Work packages

The study uses five work packages (WPs) combining quantitative and qualitative methods:

- **WP1** – an online survey of family members affected by a loved one's drug use, examining experiences of support, perceived changes since 2021, gaps and priorities.

- **WP2** – semi-structured interviews with family members, exploring experiences in depth, barriers and enablers to support, and views on system change.

- **WP3** – an online survey of family support providers, capturing perceived changes in services, gaps, capacity, awareness of the National Mission, and impacts on practice.

- **WP4** – online focus groups with family support providers, exploring themes from WP3 in more detail, including collaboration, workforce pressures and local variation.

- **WP5** – focus groups with young carers, focusing on their experiences of parental substance use, support received, and views on unmet needs and service priorities.

Participant characteristics

In total, 194 family members completed the survey (WP1), 27 took part in interviews (WP2), 66 family support providers completed the provider survey (WP3), 17 participated in provider focus groups (WP4), and 11 young people joined young carer focus groups (WP5). Participants live across urban, rural and island areas, with family members resident in 27 of 32 local authorities – but with a concentration of respondents in a small number of ADP areas, notably North Lanarkshire, Glasgow City and West Dunbartonshire.

The family member sample is predominantly female (around three quarters). Most family members have engaged with support services at some point. Provider respondents are mostly from third sector, charity or community organisations, with a high proportion bringing lived experience as family members or people who use drugs. Young carers are drawn from one specialist project operating in several local authority areas.

The study is not based on a representative sample and relies on self-reported, retrospective data. Findings should therefore be interpreted as a snapshot of perceptions rather than definitive measures of change or causal impact.

Key findings

Views of family members

Family members report that accessibility and availability of family support show modest improvement since 2021, but progress is uneven and many still struggle to find or reach support. Around one third of those who have used family support since 2021 say services are easier to access and that the range of support has increased, whilst a smaller minority perceive deterioration.

Amongst those who access family support, satisfaction and perceived quality are generally high. Just fewer than six in ten rate their overall experience more positively since 2021, and just more than six in ten score the quality of support in the upper range of a 0–10 scale. Peer support, group support, one-to-one counselling and text/chat-based support are particularly valued and receive very high satisfaction ratings.

Awareness and information remain major barriers. A substantial minority of family members who have not used support are unaware that services exist, and many who do seek help describe the system as confusing and hard to navigate. Difficulties include finding reliable information, understanding what is available locally, and knowing how to access it.

Families identify persistent gaps in provision, especially out-of-hours support, local availability, respite breaks, long waits, and insufficient diversity of options. Rurality and local context strongly shape access, with many describing a "postcode lottery". Experiences of stigma and variable responses in wider services (notably emergency care and primary care) also influence whether family members feel able to seek support, even where specialist family support is respectful and non-judgemental.

Support for children, young people, and young carers is reported as valued where available but patchy overall. Only a small proportion of family respondents report accessing dedicated help for children or young people within their families, and young carers describe long waits, inconsistent mental health provision and limited understanding in schools and social work. Many families and young people emphasise the importance of dedicated projects, youth-friendly activities and trusted adults, but these are not consistently available.

Family members' awareness of the National Mission is low, and few link perceived changes in support directly to it. Some perceive improvements in drug treatment or family inclusion, but many are unsure whether these relate to the Mission. There is widespread concern

about the sustainability of services when National Mission funding ends, with fears of a future reduction in support.

Overall, the findings suggest that whilst many family members experience difficulty finding or reaching support, experiences are generally positive once support is accessed, with services typically described as respectful, supportive and of good quality.

For a full set of key findings from WP1 and WP2 please see **Chapter 5** in the main report.

Views of family support providers

Family support providers generally report that provision has improved since 2021, particularly peer support, collaboration with other services, and workforce development. Around half feel that overall family support is better, and many describe growth in dedicated family services in some areas. Providers describe pockets of meaningful improvement within a system that remains fragmented, with access and quality continuing to vary by location and population.

Providers identify flexible access routes (online, telephone, and outreach), better training (including trauma-informed and family-specific training), stronger partnership working, and increased involvement of families in service design as key contributors to improvement. They also highlight the role of stronger ADP leadership, community-led initiatives, and cultural shifts that begin to reduce stigma. Accounts from both families and providers indicate that sustained resources, local leadership, and community-led action are critical in determining whether improvements are realised in practice.

At the same time, providers emphasise significant and persistent gaps. Out-of-hours support is the most commonly cited gap, followed by respite provision, outreach, services for specific populations (such as kinship carers, young carers, and minority ethnic families), and culturally appropriate provision. Many also point to limited mental health support for family members, insufficient advocacy, and gaps in bereavement and whole-family therapy.

Capacity and workforce pressures are substantial. Providers report expanding roles, rising caseloads, and emotional strain, with many concerned about job security, supervision and burnout. Services are often small and heavily reliant on volunteers and short-term funding, which undermines stability and makes it difficult to meet growing demand.

Awareness and understanding of the National Mission varies. Some providers feel mostly or fully informed and see the framework as helpful in shaping local work, whilst others

(particularly smaller or volunteer-led groups) feel unclear about the policy and its expectations. Many regard the Mission as a partly positive but not primary driver of change, noting that increases in trauma-informed and person-centred practice also arise from longer-term sector developments. Reported unintended consequences include increased demand and staff pressure, perceived imbalance between drug-related and alcohol-related family support, and anxiety about a funding "cliff edge" when Mission funding ends.

For a full set of key findings from WP3 and WP4 please see **Chapter 6** in the main report.

Considerations for research, policy, and practice

The study's findings suggest several high-level considerations:

- **Sustain and embed family support**: National and local decision-makers will need to ensure that improvements supported under the National Mission are maintained and extended beyond 2026, with stable, multi-year funding for family support services, including those supporting families affected by alcohol.

- **Reduce regional inequalities**: ADPs and commissioners need to address the "postcode lottery" by securing a basic level of family support in every area, including rural and island communities, and by improving coordination and referral pathways so families are consistently offered support wherever they first seek help.

- **Increase visibility and tackle stigma**: Services and partners across health, social care, and community settings need to strengthen information, signposting, and public awareness about family support, alongside continued efforts to challenge stigma so that families feel safe to come forward earlier.

- **Strengthen workforce capacity and wellbeing**: Employers and funders need to prioritise workforce support, including adequate staffing, training, supervision, and peer support for staff and volunteers, recognising the emotional demands of family support work and the risks of burnout.

- **Include children, young people and specific groups**: Policy and practice need to give greater priority to children, young carers, kinship carers, bereaved families, men, and minority ethnic families, ensuring that whole-family approaches are meaningful and that tailored, age- and culturally appropriate support is available.

- **Build and use the evidence base**: Future research and evaluation should continue to track changes in family support, explore what works best for different groups, and examine how to reach families who currently remain "missing" from services, informed by partnership with people with lived and living experience.

Chapter 1: Overview of the research study

1.1 Introduction

This is the final report of a study exploring changes to family support for those affected by someone else's drug use since the introduction of the Scottish Government's National Drug Deaths Mission ['National Mission'].

The study was conducted across five work packages [WPs] (comprising of either surveys, interviews or focus groups), with three WPs focusing on family members affected by a loved one's drug use (hereinafter referred to as 'family members'), and the other two focusing on family support providers.

- WP1 – Survey of family members affected by a loved one's drug use;

- WP2 – Interviews with family members;

- WP3 – Survey of family support providers;

- WP4 – Focus groups with family support providers; and

- WP5 – Focus groups with young carers.

We begin this report in **Chapter 1** by outlining where this study sits within the wider evaluation portfolio of the National Mission to reduce drug deaths and improve the lives of those impacted by drugs. **Chapter 2** outlines the research design and methods used to conduct the research, followed by an exploration of the study strengths and limitations in **Chapter 3**. In **Chapter 4** we describe and summarise the characteristics of those who participated in the research. **Chapter 5 (family members)** and **Chapter 6 (family support providers)** present the key findings in relation to the five WPs. A synthesis (discussion) of our analysis of all the key findings is laid out in **Chapter 7**. Finally, **Chapter 8** presents our conclusions and considerations for research, policy, and practice.

1.2 Background

The level of harms from drugs in Scotland is high in comparison to the rest of the UK and Europe, and causes preventable damage to people's lives, families, and communities. Tackling the high level of drug-related deaths in Scotland is a priority for the Scottish

Government. On 20th January 2021, the First Minister made a [statement to Parliament which set out a National Mission to reduce drug deaths](#) and improve the lives of individuals impacted by drugs, including family and friends.

A critical component of the National Mission is the support provided to families, recognising that substance use affects not just the individual but also their close network. One of the six key outcomes of the [National Mission drug deaths plan (2022-2026)](#) is dedicated to ensuring that *'children, families and communities affected by drug use are supported'*. This outcome signifies an understanding that the well-being of family members is intertwined with that of the person struggling with drug use, and that providing support to these families is essential for a holistic approach to drug policy.

To operationalise this commitment, the Scottish Government issued the [Framework for Holistic Whole Family Approaches and Family Inclusive Practice](#). This framework provides guidance to Alcohol and Drug Partnerships [ADPs] across Scotland, aiming to:

- Audit current family support provisions;

- Enhance and expand support services; and

- Incorporate family voices in the design and delivery of support services.

The framework recognises that family support needs to be readily accessible and should evolve based on input from families. It encourages ADPs to take a proactive role in shaping support systems that are responsive to family needs.

Public Health Scotland [PHS] have been asked by the Scottish Government to conduct a comprehensive evaluation of the National Mission to assess its impact, covering the period of 2021-2026.

This evaluation has included specific questions on whether family support has improved and to what extent. It has involved gathering feedback directly from family members as well as those delivering family support services [FSS], seeking insights into changes in the quality and accessibility of support.

This context reflects a commitment from the Scottish Government towards a holistic family-centric approach, where the National Mission on Drugs strives not only to reduce drug deaths but also to create a support network that addresses the diverse needs of affected families.

1.3 Study aim and objectives

The overall study aim was to determine if individuals affected by someone else's drug use perceive an improvement in the support available to them since the launch of the National Drug Deaths Mission in 2021. A secondary aim was to assess whether support providers feel more capable of delivering effective family support since the Mission's initiation.

The research objectives of the study were to explore the following:

- For family members affected by a loved one's drug use:

    o Assess their experiences in trying to access support, including awareness, accessibility, and appropriateness of available services.

    o Gather their views on whether family support has improved since 2021, identifying any positive changes (e.g., availability, accessibility, involvement in treatment processes) or negative changes.

    o Identify any remaining gaps in the support provided.

- For providers of family support:

    o Understand whether they perceive any improvements in the family support they deliver and pinpoint areas of progress or decline.

    o Identify mechanisms that may have contributed to improvements, such as funding, training, or service design influenced by family input.

    o Examine any unintended negative impacts of the National Mission or the Whole Families Framework (e.g., reduced focus on support for those affected by alcohol use).

    o Recognise ongoing gaps in the support available.

The research questions of the study were as follows:

- How have the **accessibility**, **availability**, and **quality** of family support services changed since 2021 for those affected by a loved one's drug use?

- What specific factors have contributed to **perceived improvements** or **gaps** in the family support experience?

- Are there **unintended consequences** of the National Mission's implementation that have affected family support?

- How do service providers view their **capacity** to support families, and what **improvements** or **challenges** have they encountered since the Mission's inception?

1.4 Language considerations

For the purpose of this study, we have interpreted *'family support'* as any type of help available to families or friends dealing with issues related to a loved one's drug use. Within this definition we include formal FSSs, peer support, family support groups, and recovery networks.

We have purposely chosen to use 'people-first' language. We use the term 'loved one' to refer to the person who experiences, or has experienced, problems with drugs, and we use the term 'family member' to refer to those affected by a 'loved one's' drug use.

The term 'family member' broadly includes: direct family members (husband, wife, partner, sibling, etc.); extended family (grandparents, uncles, aunts, etc.); those with caring responsibilities; and significant others (i.e. close friends).

We refer to the person whose drug use has affected family members as a *'loved one'*. This emphasises the individuality, equality, and dignity of people rather than defining people primarily by a problem or issue. We want to emphasise the importance of language in helping to challenge and reduce the pervasive stigma that is still attached to being a person who experiences, or is affected by, problematic substance use.

We use the term 'support provider' broadly to include any paid member of staff or volunteer within an FSS.

In this report, we have opted to use the term 'substance(s)' to encompass the use of both illicit and prescribed drugs, as well as alcohol. Scotland exhibits a notable prevalence of poly-substance use. Whilst our evaluation primarily concentrates on family members who are affected by a loved one's drug use, it is crucial to acknowledge that this may stem from the loved one's use of both illicit and prescribed drugs and potentially include alcohol.

Chapter 2: Project design

2.1 Introduction

The study comprised of five distinct and overlapping WPs, incorporating primary quantitative and qualitative data collection from family members and family support providers across Scotland. WPs 1 and 3 used primary quantitative online surveys. WPs 2 and 4 used qualitative interviews and focus groups, respectively. WP5 comprised of two bespoke focus groups with young carers.

A full description of the research methods for recruitment, data collection, and preparation of data for analysis is provided in the **Supporting Evidence Report** at **Appendix A**.

2.2 Contribution of work packages

Table 2 below maps out the contribution (partial, highlighted in amber, or full, highlighted in green) that each WP provides to each of the research questions.

Table 2. Contribution of work packages to areas of interest

Research questions	WP1	WP2	WP3	WP4	WP5
How have the **accessibility**, **availability**, and **quality** of family support services changed since 2021 for those affected by a loved one's drug use?	Green	Green	Green	Green	Amber
What specific factors have contributed to **perceived improvements** or **gaps** in the family support experience?	Green	Green	Green	Green	Amber
How do family support providers view their **capacity** to support families, and what **improvements** or **challenges** have they encountered since the Mission's inception?	–	–	Green	Green	–
Are there **unintended consequences** of the National Mission's implementation that have affected family support?	Amber	Green	Amber	Green	Amber

2.3 Recruitment and sampling

A national service mapping exercise was undertaken to compile a comprehensive database of FSSs across Scotland. This included direct engagement with all 32 ADPs. This was supplemented by a wider set of communications using publicly available databases of both specialist and non-specialist FSSs via Scottish Families Affected by Alcohol and Drugs (SFAD) and A Local Information System for Scotland (ALISS). The mapping exercise was further strengthened by a search of the Scottish Drug Services Database hosted online by the Scottish Drugs Forum. The database enabled wide dissemination of survey links and invitations, resulting in a geographically diverse sample (see in particular **Chapter 4 'Sample Characteristics'** and **Appendices B** and **F** in the **Supporting Evidence Report** for further details).

The inclusion criteria for family member and family support provider cohorts were:

- **Family members:** Scottish residents (family or friends) affected by a loved one's drug use.

- **Family support providers:** organisations or workers delivering support to family members since 2021 or earlier.

A summary of study methods, recruitment, sampling, and activity completed is presented in **Table 3** below. Fieldwork activities took place between March and May 2025.

Throughout the report, individuals who completed the survey are referred to as respondents, whilst those who participated in interviews or focus groups are referred to as participants. This distinction is made to ensure clarity when presenting findings.

Table 3. Summary of study methods, recruitment, sampling, and activity completed

Method	Description	Number
WP1 Family members quantitative survey	WP1 consisted of a detailed quantitative online survey, hosted on the JISC Online Survey platform, and open to family members across Scotland. The survey included sections on the loved one's drug use, family inclusive practice, experiences of family support, awareness and availability, non-engagement, perceived impact, and gaps. Recruitment was through the national contact database developed in the service mapping exercise, with links circulated via specialist and non-specialist family support providers, community networks, and social media. Follow-up reminders were also issued, to encourage engagement.	**194** respondents
WP2 Family members semi-structured interviews	WP2 consisted of a series of semi-structured telephone interviews with family members. Participants were recruited through an opt-in option at the end of the WP1 survey, where respondents could leave their contact details if interested in taking part. From these, a purposive sample was selected to ensure coverage across urban, rural, and island areas, and to capture a range of experiences of family support. Interviews explored experiences of support, perceptions of change since 2021, barriers and enablers, and ideas for improvement.	**27** participants
WP3 Family support providers quantitative survey	WP3 consisted of a detailed online survey of family support providers across Scotland, hosted on the JISC Online Survey platform. The survey covered practitioner roles, perceived changes in services since 2021, gaps and recommendations, awareness of the National Mission, and its impacts. Recruitment was carried out through the national contact database developed in the service mapping exercise, with survey links circulated via specialist and non-specialist family support providers, community networks, and social media. Follow-up reminders were also issued to encourage participation.	**66** respondents

Method	Description	Number
WP4 Family support providers focus groups	WP4 consisted of a series of online semi-structured focus groups with family support providers. Participants were recruited from WP3 survey respondents who had opted in to further participation by leaving their contact details. From this pool, a purposive sample was selected to ensure representation across different geographical contexts (urban, rural, and island) and service types, with no more than one participant per organisation. Discussions explored perceived changes in services since 2021, current challenges in delivery, and ideas for improvement.	**Three** groups with a total of **17** participants
WP5 Young carers focus groups	WP5 consisted of two age-appropriate, semi-structured focus groups with young carers, accessed via the Scottish Families Affected by Alcohol and Drugs (SFAD) Routes project. Routes supports young people aged 12 to 26 affected by familial alcohol and drug use and has expanded from its long-standing base in East and West Dunbartonshire to several other local authority areas. Participants were recruited through Routes groups, and sessions were facilitated under Wrexham University ethical approval (ID4471). Conversations followed a flexible, semi-structured schedule designed to be safe and age-appropriate, focusing on young carers' experiences and perspectives.	**Two** groups with a total of **11** participants

2.4 Analysis

A summary of the approach to data analysis, both quantitative and qualitative, is presented below. A full description is provided in **Appendix A** in the **Supporting Evidence Report**.

2.4.1 Quantitative data analysis

Survey data were imported into R for cleaning and analysis. Variables were coded appropriately, missing data and "other" responses handled consistently, and Likert items recoded numerically. Descriptive statistics were summarised in frequency tables and distributions. Statistical disclosure control was applied, with small numbers suppressed. Optional free-text comments were coded thematically and used to contextualise findings.

Throughout this report, where the number of responses are provided in brackets, for example (n=63), this refers to the total number of responses used in the analysis (excluding missing data but including 'I prefer not to say' and 'I am not sure' responses).

2.4.2 Qualitative data analysis

Interviews, focus groups, and open-text responses were thematically analysed using a coding framework aligned to research questions, with inductive codes added to capture participants' perspectives. Quotes were anonymised and contextualised. Analysis considered cohort overlap, geographical variation, and the limits of standalone text-box analysis, reinforcing the importance of triangulation across data sources.

2.5 Ethics

Ethics approval for the project was received from Wrexham University Research Ethics Committee (ID4471, dated 27/01/2025).

NHS Research Ethics Committee (REC) review was not required for this study as no participant recruitment was required via NHS services.

Chapter 3: Strengths and limitations

3.1 Introduction

This is the largest study of its kind to date in Scotland.

3.2 Limitations

This study was not based on a representative sample, and the results should be interpreted against the backdrop of the participant characteristics, as presented in detail in **Chapter 4**. Participation was uneven across Scotland. Over one quarter of respondents to the survey of family members were from North Lanarkshire, whilst some regions had very few or no participants[1].

Efforts were made to reach a varied group; however, it was not possible to target a representative sample due to the lack of available or detailed information about the overall composition of the target population. The family member sample skews heavily female (around 73% women), and three ADP areas (Glasgow City, North Lanarkshire, and West Dunbartonshire) accounted for 59% of responses. Most family members had already engaged with support services; therefore, those who have never accessed support are likely missing from our data. These sampling biases reduce the generalisability of results.

Another limitation is the reliance on self-reported, retrospective data, which can introduce *recall bias*, as memories of past circumstances may be imperfect. Any reported improvements or gaps cannot be attributed solely to the National Mission – other factors during this period could also have influenced family support. In short, the study provides a snapshot of perceptions but cannot establish clear cause and effect.

Some WPs had relatively small or localised samples, affecting the breadth of insight they provide. For example, the young carer focus groups (WP5) included 11 young people from two local services, and the family support provider focus groups (WP4) had 17 participants in total. Whilst these sessions yielded rich qualitative information, their findings are

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[1] Several questions highlight differences between support in North Lanarkshire compared to the rest of Scotland. Their loved ones tended to primarily use stimulants, compared to opioids elsewhere. They were less likely to report seeking and/or engaging in family support, less informed about support, and perceive it to be less available. One explanation could be that North Lanarkshire family members have more negative experiences of family support. Another could be that individuals were able to share the WP1 Family Member survey with a much broader network of family members due to strong networks of family support in the area.

illustrative of those particular participants and may not reflect all young carers' or providers' experiences. The number of responses to the two surveys was relatively modest in relation to the estimated number of family members and loved ones affected. 194 individuals responded to the family members survey (WP1), and 66 to the providers survey (WP3). We mitigated the risk of *response bias* (i.e., those who chose to take part may differ from those who did not) by ensuring anonymity and a supportive environment, but some voices and perspectives may remain under-represented.

3.3 Strengths

A strength of this study is its broad reach. We recruited participants through family support organisations nationwide to achieve a geographically diverse sample; including family members from 27 of 32 local authority who spanned urban, rural, and remote communities. Such wide coverage means the findings are relevant to a range of local contexts.

Another strength is the involvement of lived experience researchers, who have personal experience of drug use and family support. Their involvement helped build trust with participants, which led to more honest, in-depth responses. This reflects the National Mission's emphasis on putting lived experience at the heart of drug policy conversations.

The study's mixed-method design further strengthens the evidence. By combing surveys of family members (WP1) and providers (WP3) with in-depth interviews and focus groups (WP2, WP4, WP5), we were able to cross-check findings across quantitative and qualitative sources – for example, checking that themes from interviews aligned with survey patterns. By gathering both statistical data and personal stories, we gained a nuanced understanding of changes and needs. We engaged a diverse range of participants, which included parents, partners, siblings, extended family members, and friends of people who use drugs, as well as young carers. This breadth of perspective ensures the conclusions speak to many different family situations.

Finally, the research was carried out with rigorous ethical standards and care for quality. The project received university ethics approval, and we put strong measures in place to protect participants' confidentiality. Identifying details were removed or anonymised in transcripts and survey comments, and small numbers in data were suppressed to avoid identification. These practices created a safe space for participants to share openly and enhance the credibility of our findings by ensuring data were handled responsibly.

Chapter 4: Sample characteristics

4.1 Introduction

This chapter presents the headline characteristics for all survey respondents (WP1 and WP3), interview participants (WP2), and focus group participants (WP4 and WP5).

Full socio-demographic characteristics of participants are provided in the **Supporting Evidence Report**. **Appendix B** presents details of family members who completed the WP1 survey and those who participated in a WP2 interview. **Appendix F** presents details of family support providers who completed the WP3 survey and those who participated in a WP4 focus group.

4.2 Family member survey respondents (WP1)

In total, 194 people completed the family members survey.

- 73% of the sample were female and just 25% were male.

- Respondents were resident in 27 out of the 32 Local Authority areas in Scotland.

- Three ADP areas accounted for 59% of responses. These included: 27% from North Lanarkshire, 21% from Glasgow City, and 11% from West Dunbartonshire.

- 15% of respondents had a loved one who is deceased.

- 61% of respondents reported that their loved one had engaged with drug treatment or support services (including recovery) since 2021.

- 43% of respondents were involved in the care of their loved one.

4.3 Family member interview participants (WP2)

In total, 27 people participated in the family member interviews.

- 93% of the sample were female, and only 7% were male.

- 74% were the parent of a loved one, 22% siblings, and 19% spouse/partner. Children and extended family members both made up 7% of the cohort.

- 37% of respondents lived in 'large urban' areas, with a further one third of respondents (33%) indicating that that lived in 'other urban' areas. The remaining respondents (30%) lived in accessible or remote small towns or rural locations[2].

- Participants were drawn from a wide geographical range of 20 Local Authority areas, with the largest representation from West Dunbartonshire (n=3).

- 48% had other family members in their household affected by their loved one's drug use; 19% provided kinship care or acted as carers for their loved one.

- 44% had founded, worked for, or volunteered in a support service, with some having received funding or set up services independently.

4.4 Family support provider survey respondents (WP3)

In total, 66 people completed the family support providers survey.

- Respondents were 75% female, 22% male, and one identified as non-binary.

- The sample included FSSs from across Scotland, six of which had national coverage.

- The vast majority of provider responses (88%) were from Third Sector, Charity or Community Groups, with just 6% coming from statutory services. One respondent was 'not sure' what type of organisation they worked for.

- One in four respondents (26%) had personal experience of drug use; 16% had experience of accessing drug services for themselves; almost two thirds (61%) had a loved one who experiences (or has experienced) problems with drugs; and 45% had previously sought, engaged with, or received family support for themselves.

4.5 Family support provider focus group participants (WP4)

In total, 17 family support providers participated across three focus groups.

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[2] According to the Scottish Government's Urban Rural Classification. scottish-government-urban-rural-classification-2020.pdf

- 82% of participants were female, and 18% were male.

- Participants represented services from 14 Local Authorities across Scotland, along with one nationwide provider.

- 47% of focus group participants had between two and five years' experience in providing support to families, and the remainder (53%) had over five years' experience.

- 59% said that their service offered peer support or support groups.

- 59% had experience as a family member of someone who uses (or has used) drugs.

4.6 Young carer focus group participants (WP5)

In total, 11 young people participated across two focus groups, all of whom had experience of parental alcohol and/or other drug use, and mental health challenges.

- One group, held in East Dunbartonshire, consisted of six participants, including an even split of females and males. Ages ranged from late teens to early twenties. Several members of this group had attended since the service began, with all having attended for over four years.

- The second group, held in West Dunbartonshire, consisted of five participants, including four females and one male. Ages ranged between 16 and 18. Several members of this group had attended since the service began, whilst others had joined in the past year.

Chapter 5: Views of family members

KEY FINDINGS:

- **Experience of accessing support:** 68% of survey respondents had sought, received, or engaged with support, yet awareness remains low. The system is described by interview participants as confusing and difficult to navigate, with uncertainty around available services.

- **Accessibility and availability show modest improvement, but progress is uneven.** More than a third of survey respondents who have sought, received or engaged with FSSs since 2021 report it is easier to access since 2021 (35%), and a similar proportion (36%) report that the range of support has increased, whilst a smaller minority report deterioration.

- **Quality and satisfaction are generally positive amongst those who engage.** About 57% of survey respondents rate their overall experience of family support as better since 2021, and 63% rate current quality at 6-10 on a 0-10 scale. 'Text/chat support' (96%), 'peer support' (92%), 'one-to-one counselling' (92%), and 'advocacy training or workshops' (90%) all have satisfaction ratings of 90% or more (i.e. 90% or more survey respondents report that they are satisfied).

- **Awareness remains a barrier for many.** Two in five (39%) of survey respondents report finding information hard to locate. Of those who have not engaged, 29% are unaware support exists and 17% report being unaware of 21 support options listed.

- **Key gaps persist.** Survey respondents most often identify a 'lack of support outside office hours' (29%), 'lack of local family support' (26%), 'long waits' (25%), 'limited respite' (25%), and an 'insufficient range of options' (25%) as the key gaps. Interview participants describe how rurality and local context significantly shape their experience of accessing family support.

- **Experiences of stigma and variable encounters affect engagement.** Many interview participants describe respectful support in FSSs, and half (50%) of survey respondents report being treated with more respect by staff since 2021; yet reports of stigmatising encounters, especially in emergency care, and limited GP signposting remain. Interview participants call for more joined-up working with primary care.

- **Involvement in a loved one's care is mixed but improving for some.** 43% report that they have been involved in their loved one's treatment/support since 2021; of those, about half (50%) report that involvement has become easier. Satisfaction with involvement varies.

- **Support for children and young carers is valued but patchy.** Only 19% of families accessing family support report that they have accessed specific help for children/young people within their families. Where available, young carers value dedicated services but describe inconsistent provision and long waits for mental health support.

- **Communities frequently step in to fill gaps.** Some interview participants describe how they have established peer groups, helplines, and local initiatives to extend the reach of family support, particularly where statutory or commissioned support is thin.

- **Sustainability and the National Mission:** Awareness of the National Mission is generally low, and families are uncertain whether recent improvements are linked to it. There are concerns around sustainability post-2026.

5.1 Introduction

This chapter presents the views of family members, gathered and analysed from an online survey (WP1, N=194) and from a set of interviews (WP2, N=27). Also included is data from two young carers focus groups (WP5, N=11).

WP1 received a disproportionately large response from North Lanarkshire family members (27% of WP1 respondents). Differences for this subgroup included higher stimulant involvement and less positive experiences of involvement in a loved one's treatment and of family support access and awareness. These differences are footnoted in the chapter where relevant.

Because we have integrated the data from the survey, interviews, and focus groups, it is important to understand how we are reporting 'who said what' throughout this chapter. So, for the purposes of consistency and clarity we have chosen to use the following terms:

- '**Survey respondent**' – where we are referring to an individual who has completed the WP1 online survey.

- 'Interview' or 'focus group participant' – where we are referring to an individual who has participated in an interview of focus group.

- 'Family member' – where we are referring to a combination of those who have completed the WP1 survey and/or a WP2 interview.

In the main, we have structured this chapter according to the following three groupings of family members within the data:

- **Group A** (n=131): Family members who have sought and/or received, or engaged with (at any point), any kind of family support for themself (as a result of being affected by their loved one's drug use).

- **Group B** (n=63): Family members who have **NOT** sought and/or received, or engaged with (at any point), any kind of family support for themself (as a result of being affected by their loved one's drug use).

- **Group C** (n=194): All family members who responded to the survey (i.e. a combination of Group A and Group B).

These groupings are based on the different sets of questions that were asked of each individual group of family members, as noted in the table below.

Table 4: Survey question sets – by family member grouping

Question set	Topic (number of questions)	Group A (n=131)	Group B (n=63)	Group C (n=194)
1	Consent and eligibility (5 questions)	–	–	Yes
2	Loved one's drug use (4)	–	–	Yes
3	Family Inclusive Practice (6)	–	–	Yes
4	Family support (4)	Yes	–	–
5	Your experience of family support* (84)	Yes	–	–
6	Overall experience/impact (3 questions)	Yes	–	–
7	Seeking family support (5 questions)	Yes	–	–

Question set	Topic (number of questions)	Group A (n=131)	Group B (n=63)	Group C (n=194)
8	Awareness of family support options (46)	–	Yes	–
9	Reasons for not seeking, receiving, or engaging with family support (4)	–	Yes	–
10	Most important types of family support (7)	–	–	Yes
11	Gaps in FSS provision (4)	–	–	Yes
12	Final thoughts (1)	–	–	Yes

Note: * Within the large question set #5 for Group A on 'your experience of family support' there were questions asked about family members' awareness of family support. Group B were asked the same set of 'awareness' questions but these were contained within question set #8.

Following presentation of data relevant to the three groups of family members listed above, this chapter leads on to present three further sections of findings:

- Awareness and perceptions of the National Mission on Drugs;

- Support for children, young people, and young carers; and

- Other themes arising from the data.

Each section of this chapter presents a thematic analysis of the evidence, drawing on interview discussions, survey findings, or a combination of both. Additional insights are drawn from two focus groups with young carers held at a young person's service (specifically reported in **section 5.6**), adding further depth to the findings.

A selection of illustrative quotes are included throughout this chapter, with a wider selection of qualitative examples provided in **Appendix D**. To indicate who is speaking in each quote, we have applied short descriptors. For example, [SR-01] refers to a family member survey respondent, whilst [IP-01] refers to an interview participant, and [YCFG1/2] refers to a participant from Young Carers Focus Group 1 or 2. Some of these descriptors mirror those used in **Chapter 6** but reflect the views of a different respondent group.

5.2 The views of family members (Group A)

This section of the report details the responses of the grouping of family members (n=131; 68%) who answered '**yes**' to the following question, 'Have you ever sought and/or received, or engaged with, any kind of family support for yourself (as a result of being affected by your loved one's drug use)?' [3]. This group were subsequently asked a series of questions that covered a range of topics in relation to their experiences of seeking, receiving, or engaging with family support. In particular, this group were asked a specific set of questions relating to whether they had experienced any changes regarding family support (availability, accessibility, and quality) since 2021. A slightly smaller group (n=120) of respondents are reported for these 'change' questions, due to 11 family members being excluded from such questions because they haven't sought, received, or engaged with any family support since 2021 (i.e. their experiences of family support are pre-2021 only) [4].

5.2.1 Awareness of FSSs

As seen in **Figure 1** below, survey respondents who have (at any point) sought, and/or received, or engaged with any kind of family support (n=131) were presented with a list of 21 different types of family support and asked whether they were aware of each one. Not all respondents provided a response for every option, with some items left unselected.

Awareness was generally moderate to high, with over 50% of respondents aware of 18 out of the 21 support types listed. Lower awareness was evident for 'respite services to provide family members with a break' (63% unaware), 'financial advice or support for families' (66% unaware), and 'legal advice related to a loved one's drug use' (71% unaware).

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[3] This included 110 out of 141 family members from the rest of Scotland (i.e. 78% of the rest of Scotland cohort) and 21 out of the 53 family members from North Lanarkshire (representing only 40% of the North Lanarkshire cohort).

[4] Only 19% of North Lanarkshire survey respondents (i.e. 10 respondents, n=53) reported that they have been receiving/engaging with family support since January 2021, compared to over 65% from across the rest of Scotland (i.e. 92 respondents, n=141).

Figure 1. Awareness of family support options

Support option	Aware (%)	Not aware (%)
Group support (n=130)	80	20
Peer support groups (n=130)	78	22
Naloxone (n=129)	73	27
Educational workshops (n=128)	72	28
Support for your own recovery (n=129)	72	28
Alternative therapies (n=129)	71	29
One-to-one counselling (n=129)	67	33
Support for managing boundaries (n=128)	65	35
Online support forums (n=128)	64	36
Bereavement support (n=129)	62	38
Telephone helpline (n=129)	62	38
Navigating treatment options (n=129)	59	41
Text or chat support (n=129)	57	43
Outreach services (n=128)	56	44
Family therapy (n=130)	55	45
Support for own use of drugs (n=128)	55	45
Support for young people (n=128)	55	45
Advocacy training or workshops (n=129)	52	48
Respite services (n=128)	38	62
Financial advice or support (n=128)	34	66
Legal advice (n=127)	29	71

■ Aware (%) ■ Not aware (%)

Respondents who had sought or received support from FSSs were asked how informed they felt about the help and support available to them on a scale of zero to ten – where zero equals 'not at all informed' and ten equals 'fully informed'. As indicated in **Figure 2** below, half (47%) of respondents felt 'quite' or 'fully' informed about services, choosing a rating of 6-10, 35% chose 0-4, and 18% felt relatively neutral (choosing 5).

Figure 2. Rating of how well-informed family members feel about the help and support available to them (n=131)
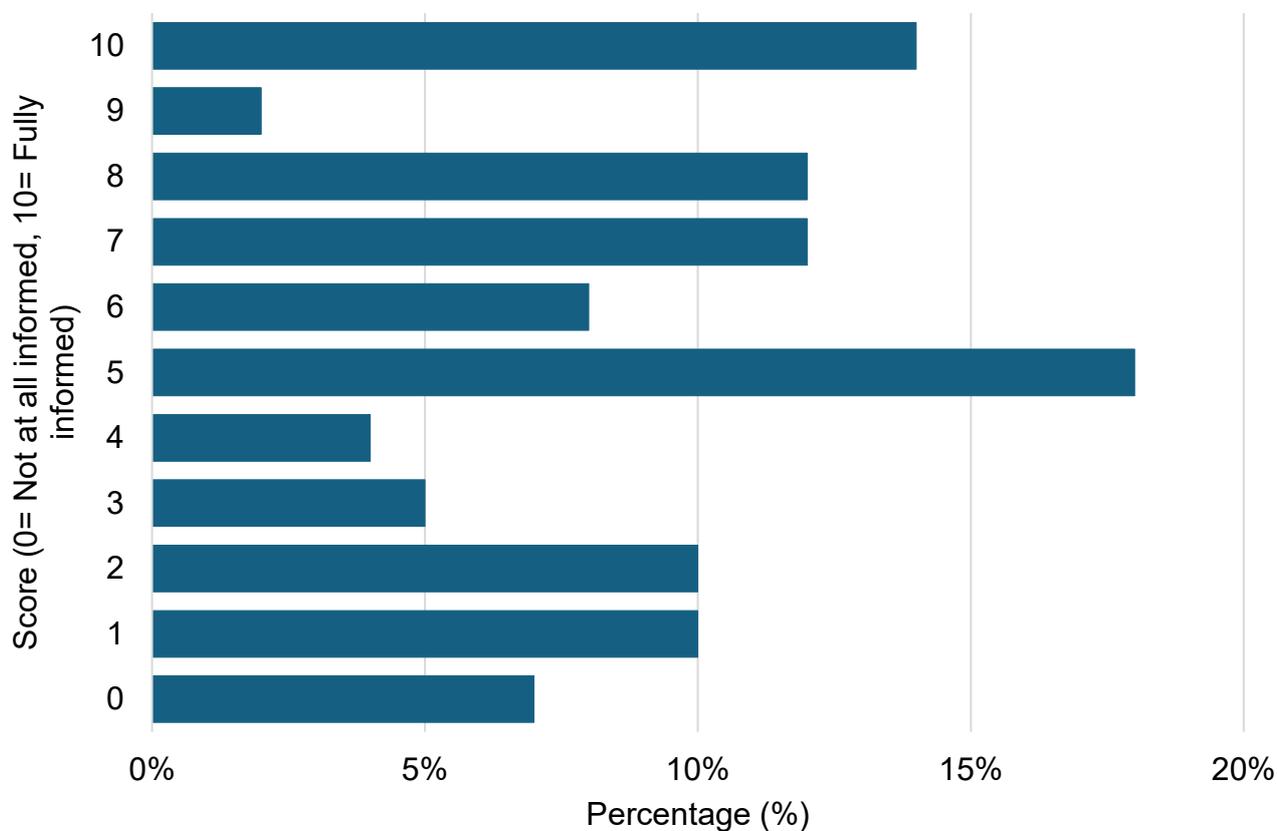
Note: 9 missing responses.

21% of respondents first found information about FSSs through the service that their loved one currently attends (or previously attended), and 19% did so through friends and family[5] (see **Table B23** in the Supporting Evidence Report). 39% said it was difficult to find information, and 34% said it had been easy. 27% felt indifferent (see **Table C6** in the Supporting Evidence Report).

Visibility emerged as a consistent theme across the data, with many calling for greater awareness amongst professionals and the wider public. Family members identified limited access to information as a barrier to accessing support, as one noted, '*we found it difficult to find any information'* [SR-03].

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[5] Most commonly, 29% of North Lanarkshire survey respondents (i.e. 6 respondents, n=21) who have engaged with FSSs reported that they first found out about family support from family or friends, compared to 17% of family members (i.e. 19 respondents, n=110) from across the rest of Scotland.

One respondent stressed, '*information must be easily accessible and timely',* [SR-164] and another felt there needs to be *'more promotion'* [SR-172] of services. Another suggested, '*support needs to be advertised',* [SR-56] as once in place, it is considered to be highly beneficial.

> 'It was difficult to find out how to access support but once in place it's been invaluable.' [SR-158]

Several recognised a need for more proactive FSSs.

> 'They should contact families rather than families having to contact them... Families don't always know they exist.' [IP-01]

5.2.2 Changes to accessibility of family support services since 2021

Group support (76%) and peer support (75%) sessions were the most commonly accessed types of family support amongst respondents[6] and they were also noted as being the main type of family support accessed by 23% and 16% of respondents respectively (see **Tables C2 and C7** in the Supporting Evidence Report).

Those who have sought, received or engaged with FSSs since 2021 were then asked if they had experienced any changes in accessibility. As shown in **Figure 3** below, 35% of respondents said that family support is now either 'much easier' or 'easier' to access since 2021, whilst 14% said it had become 'harder' or 'much harder' to access over the same period.

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[6] Just under three in five (57%) of North Lanarkshire respondents (i.e. 8 respondents, n=14) have accessed group support sessions for families compared to just under four out of five (79%) of those from the rest of Scotland (i.e. 78 respondents, n=99). Just under a third (36%) of North Lanarkshire respondents (i.e. 5 respondents, n=14) have accessed peer support groups compared to just over four out of five (81%) of those from the rest of Scotland (i.e. 80 respondents, n=99).

Figure 3. Changes in accessibility since 2021 (n=120)
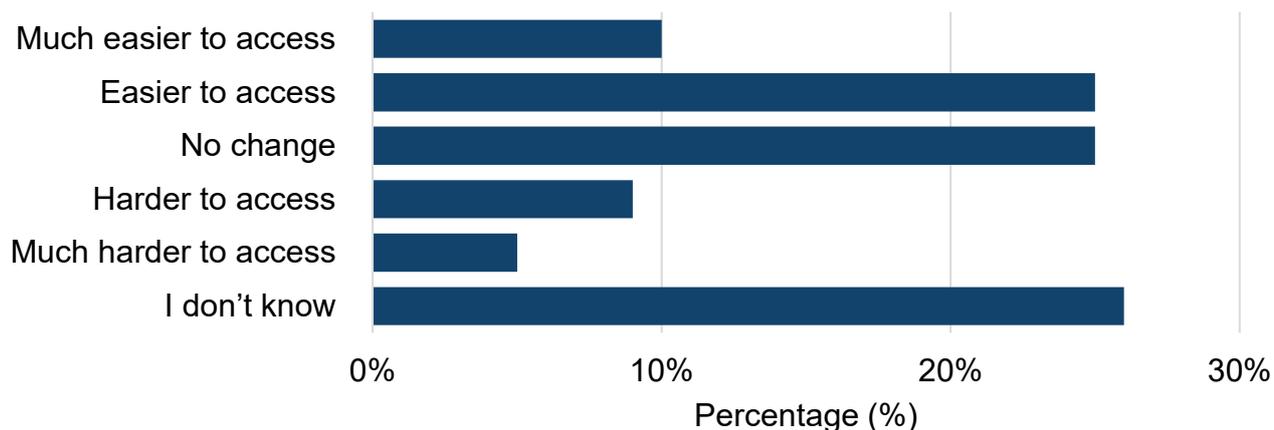
Note: 11 missing responses.

One respondent noted that services are now *'more accessible',* [SR-155] and an interview participant explained, *'visibility's increased... it's easier to find the service'* [IP-22].

Improvements have allowed some longer standing affected family members to signpost more recently affected family members to support groups, with one noting they *'didn't know anything about'* FSSs, as information *'was quite hard to access':*

> 'I don't know whether it's just improved in the last couple of years, or whether it's just because we know where to look…somebody has fed it to us and now we can pass it on.' [IP-03]

Several family members reported setting up their own supports, with one explaining how the *'whole-family approach'* within the National Mission has allowed them to run family support groups. They would like to run *'a satellite model'* to improve access and called for *'easier access to funding to pay for lets'* [IP-07] to make this possible.

5.2.3 Changes to availability of family support services since 2021

Respondents were asked to consider how the range, or amount, of support services for family members has changed since 2021. As can be seen in **Figure 4** below, 36% of respondents noted an increase in the range of FSSs, either a 'significant increase' or 'increase' in the range of FSSs, since 2021, whilst 17% said the range of FSSs had either 'decreased' or 'significantly decreased' over the same period.

Figure 4. Changes in availability since 2021 (n=120)
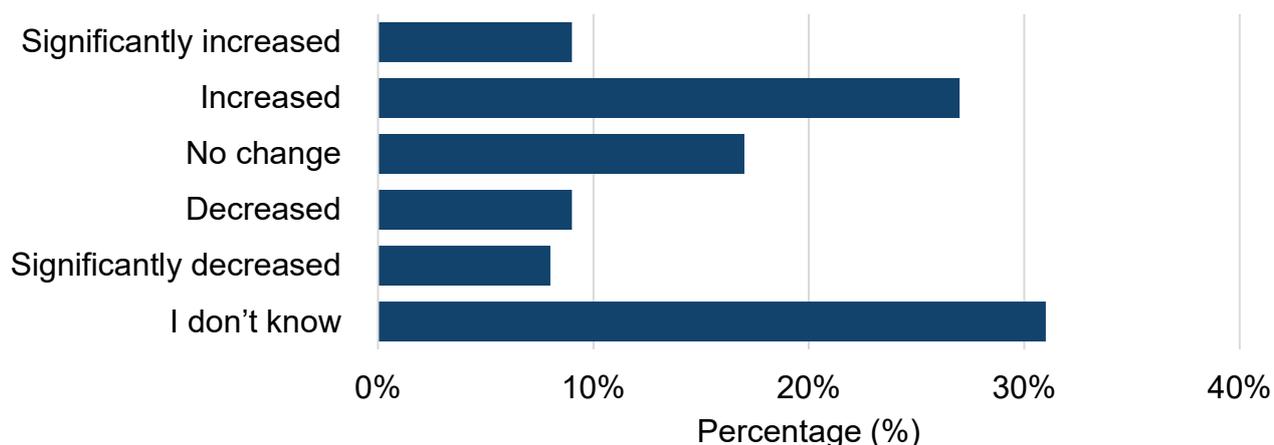
Note: 11 missing responses.

Several reported '*more options available'*, [SR-13] with '*a lot more stuff going on for people now'* [IP-13]. However, one participant highlighted the challenge of making FSSs available to all.

> 'I think improved a wee bit... because now there's a couple of groups, but it's still getting it out there to the wider community.' [IP-09]

Another pointed to the uneven nature of progress, noting that whilst examples of good practice exist, they are not consistent across the country:

> 'There's pockets of good practice up and down the country, but what I see in my area, absolutely not.' [IP-17]

Peer support groups were described as '*somewhat of a postcode lottery'* [SR-164] that '*needs more investment'* [SR-149]. Whilst some areas are seeing increased availability of peer support, others reported losses: '*the peer support service totally disappeared*' [IP-26].

5.2.4 Changes in the quality of family support services since 2021

Respondents were also asked a number of questions to consider changes in the quality of FSSs since 2021.

As can be seen in **Figure 5** below, 57% of respondents agreed that the support they are getting now is either 'much better' or 'a little better', whilst 32% saw no change, and a minority (11%) said it was now 'a little worse' or 'much worse'.

Figure 5. Overall experience of family support since 2021 (n=118)
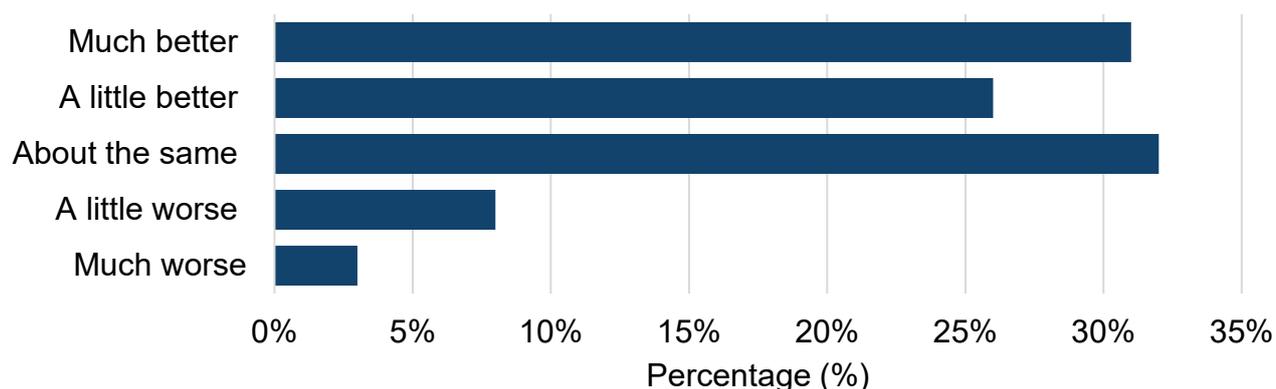
Note: 13 missing responses.

Respondents were asked about their satisfaction with all the different types of family support that they have accessed since 2021. Satisfaction ratings were overwhelmingly high, ranging from 62% of respondents feeling either 'satisfied' or 'very satisfied' with 'outreach services', to 96% 'satisfied' or 'very satisfied' with 'text or chat support'. 'Peer support', 'one-to-one counselling', and 'advocacy training or workshops' all had 'satisfied' and 'very satisfied' combined ratings above 90%. A further eight types of family support received the same combined satisfaction ratings ('satisfied' and 'very satisfied') between 80-90% (see **Table C11** in the Supporting Evidence Report).

Survey respondents who had accessed FSSs were asked to rate the quality of family support that is available to them currently, on a scale of zero ('very poor') to ten ('excellent'). As can be seen in **Figure 6** below, 63% of respondents rated the current quality between six and ten, whilst 13% felt neutral, and 24% selected between zero and four.

Figure 6. Rating of the quality of available family support (n=120)
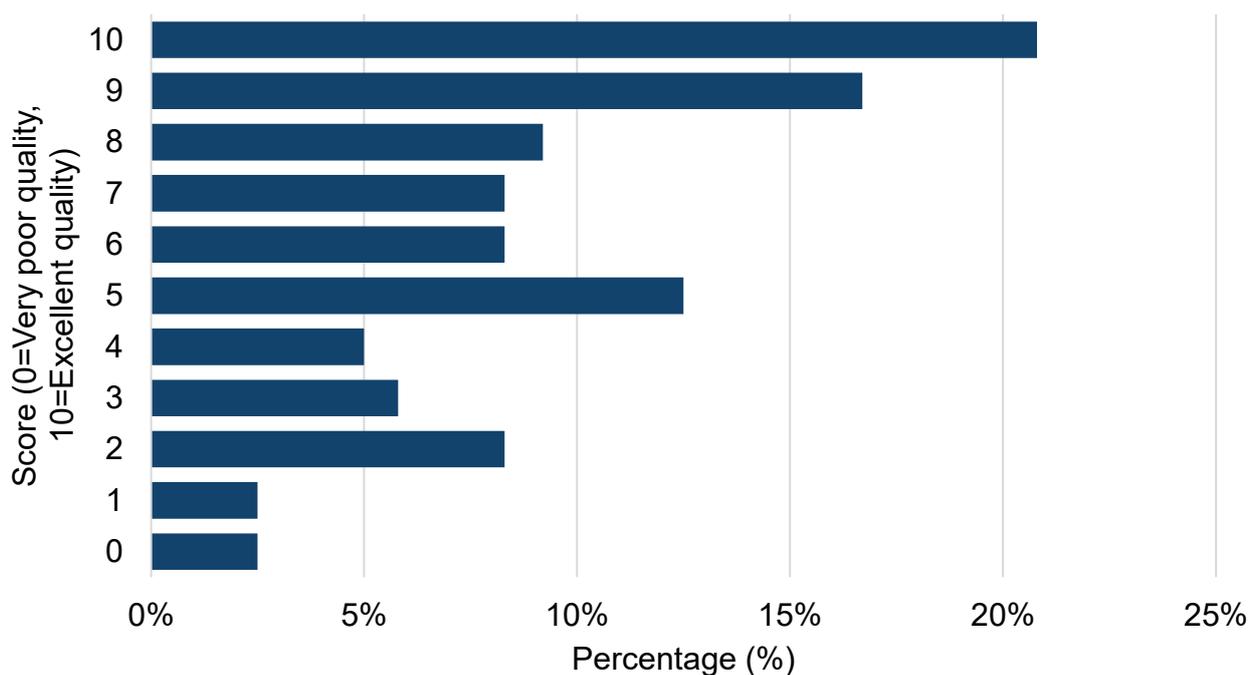
Note: 11 missing responses.

When asked how they would rate the help they have experienced from FSSs since 2021, almost two thirds of respondents (64%) rated their overall experience either 'very positively' or 'somewhat positively', whilst only 8% rated their overall experience either 'somewhat negatively', or 'very negatively'. The remaining 28% gave a 'neutral' rating [7] (see **Table C13** in the Supporting Evidence Report).

Experiences of primary care for family members needing support were mixed and considered to be a key area requiring improvement, as GPs were seen as central community figures who should play a more active role in supporting families.

> 'A lot of it really needs to start at the GP level.' [IP-09]

Some families encountered *'fantastic'* [IP-17] and *'supportive'* [SR-164] GPs, whilst others experienced stigma and GPs whose '*knowledge of support groups* [was] *limited'* [SR-164]. Several described emergency care settings as hostile, '*awful',* [IP-01] with staff having '*no idea where to signpost'* [SR-05].

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[7] North Lanarkshire respondents were far less positive about the help they have experienced from FSSs: 33% rated it positively (i.e. 7 respondents, n=21), when compared to the rest of Scotland sample (70%, i.e. 76 respondents, n=108). There was more neutrality in their ratings (52%, i.e. 11 respondents, n=21) compared to the rest of Scotland sample (23%, i.e. 25 respondents, n=108).

'The worst stigma for me... was at A&E.' [IP-11]

Others described improvements in primary care.

'Doctors are signposting to the right people... more recently over the last two years.' [IP-15]

Others agreed, highlighting a need for more joined up working between services.

'There needs to be more emphasis on the different support services talking to each other and being more joined up. GPs need to be more involved & aware of relevant services.' [SR-03]

Unfortunately, in spite of the recent progress in some areas, some respondents said that *'No aspects have improved'* [SR-142]. There were calls for *'more staff... to meet the need',* [SR-138] highlighting expressed concerns about capacity and resourcing.

5.2.5 Factors contributing to perceived changes in the family support experience

Survey respondents who have sought, received, or engaged with FSSs since 2021 were asked to reflect on how different aspects of their experience had changed over time. Questions explored perceptions of timeliness (see **Figure 7** below), frequency of support (see **Figure 8** below), respect or stigma from staff and services (see **Figure 9** below), and involvement in service design (see **Figure 10** below). The following results highlight how families felt these areas have either improved, stayed the same, or worsened over time.

Figure 7. Changes to the speed/timeliness of access to FSSs (n=117)
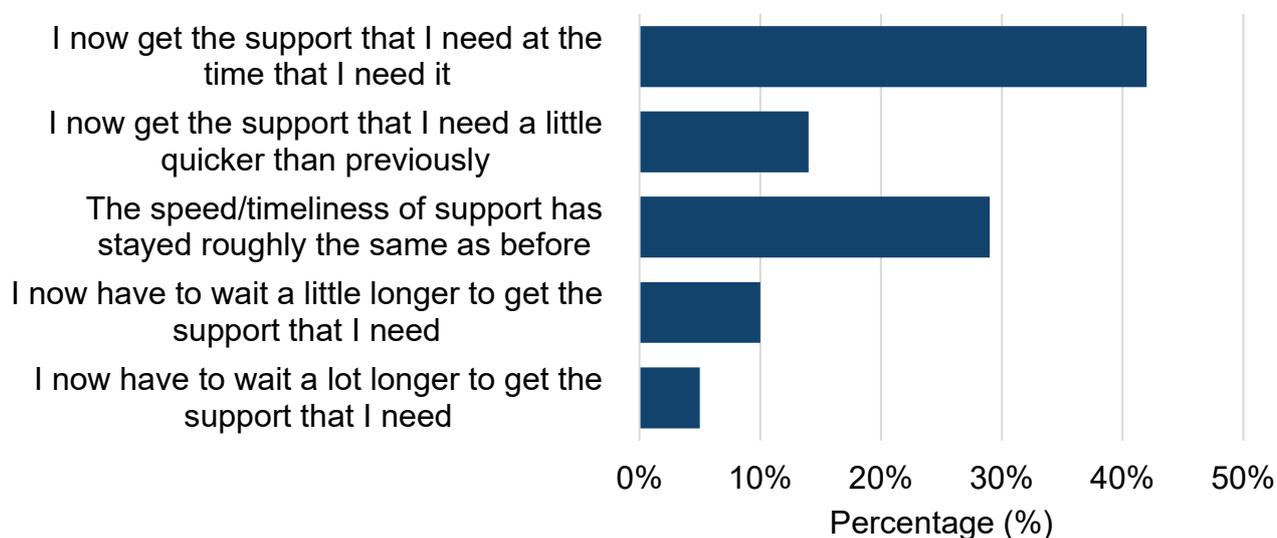
Note: 14 missing responses.

Over half (56%) of respondents said that they now get the support they need at the time they need it, or a little quicker than previously, whilst 15% reported having to wait a little or a lot longer. The remaining 29% felt that the speed or timeliness of support has stayed roughly the same as before. Several respondents noted that *'waiting times'* [SR-13&17] *'have increased'* [SR-13][8]. Despite this, many felt supported in the knowledge that FSSs are readily available, and *'always there when needed',* [IP-128] even if they currently do not access them:

> 'If we need to reach out to [family support provider], they'll get back to us and they'll help out and there's no hesitation.' [IP-09]

Figure 8. Changes to the frequency of family support (n=115)
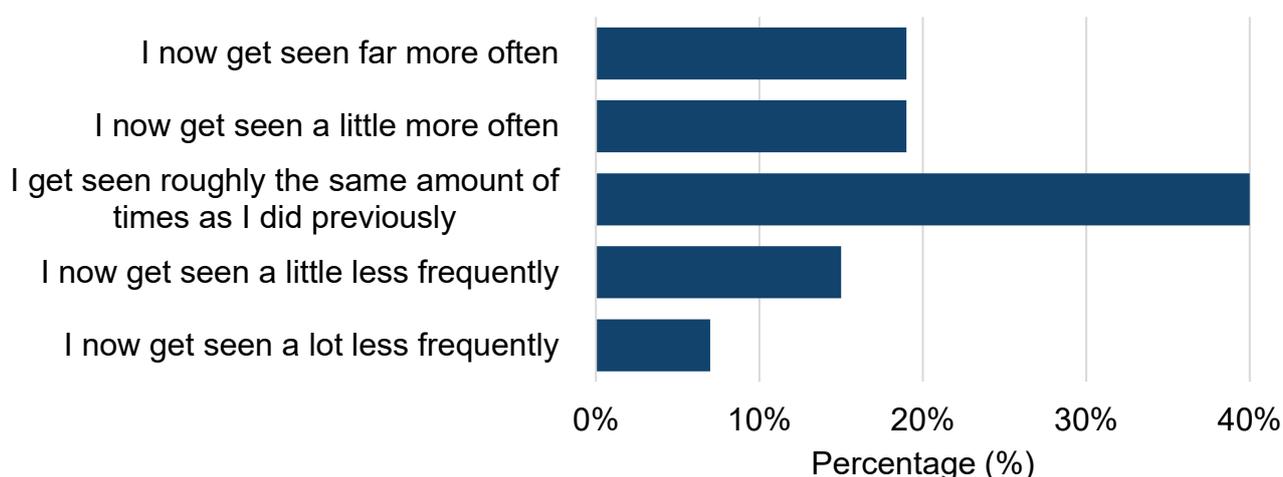
Note: 16 missing responses.

40% of respondents reported no noticeable change in the frequency of support, whilst 38% reported being seen 'far more' or 'a little more' often. 22% said that they are seen 'a little' or 'a lot less frequently'. Several commented on a limited availability of support outside of dedicated hours, with support channels amongst peers being set up as one option to address this gap.

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[8] Only one third (33%) of North Lanarkshire survey respondents (i.e. 6 respondents, n=18) reported getting access to help in a timelier fashion (since January 2021), compared to three out of five (60%) from across the rest of Scotland (i.e. 59 respondents, n=99).

'The support group I attend all help each other and don't fully rely on waiting until the weekly meeting if help or advice is required.' [SR-146]

Figure 9. Changes to experiences of stigma within family support (n=116)
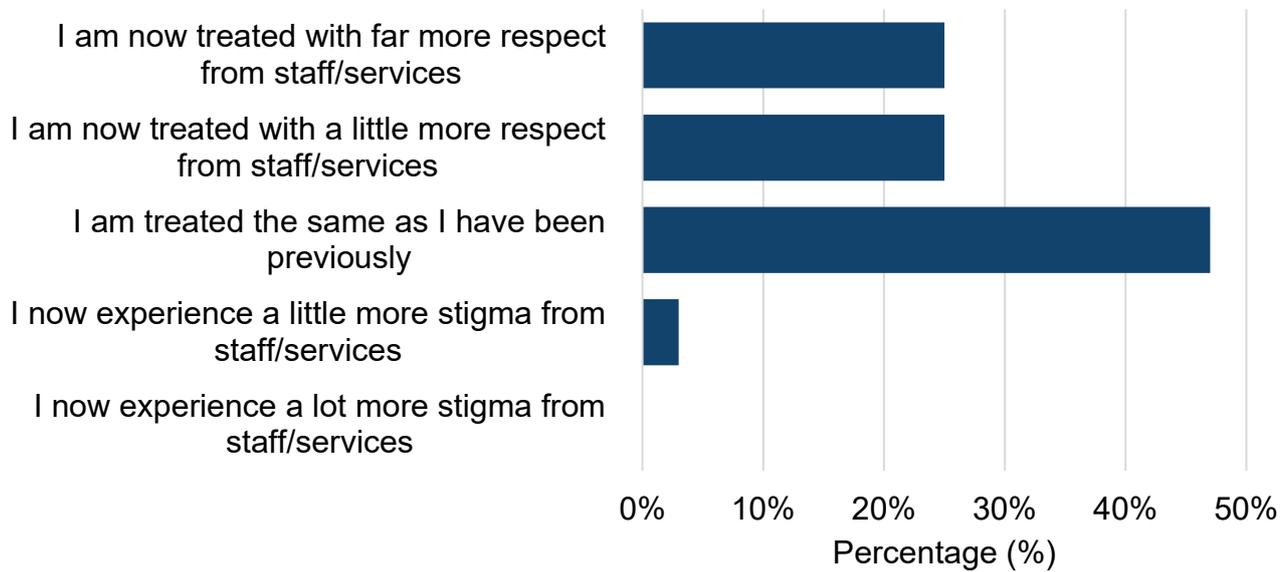
Note: 15 missing responses.

50% said that they are treated with 'far more' or 'a little more respect' since 2021, noting a *'reduction in stigma'* [SR-158], whilst 47% said that they are 'treated the same as [they] have been previously'. However, some described difficult experiences with staff with 3% reporting that they now experience 'a little more stigma' than previously. One respondent noted that *'staff are very patronising and dismissive'* [SR-142]. Another said that stigma is *'what stopped me seeking out help before* [their loved one] *died',* [SR-02] with others agreeing that '*stigma has got a massive part to play in people not accessing family support'* [IP-07].

Figure 10. Changes to involvement around service design (n=116)
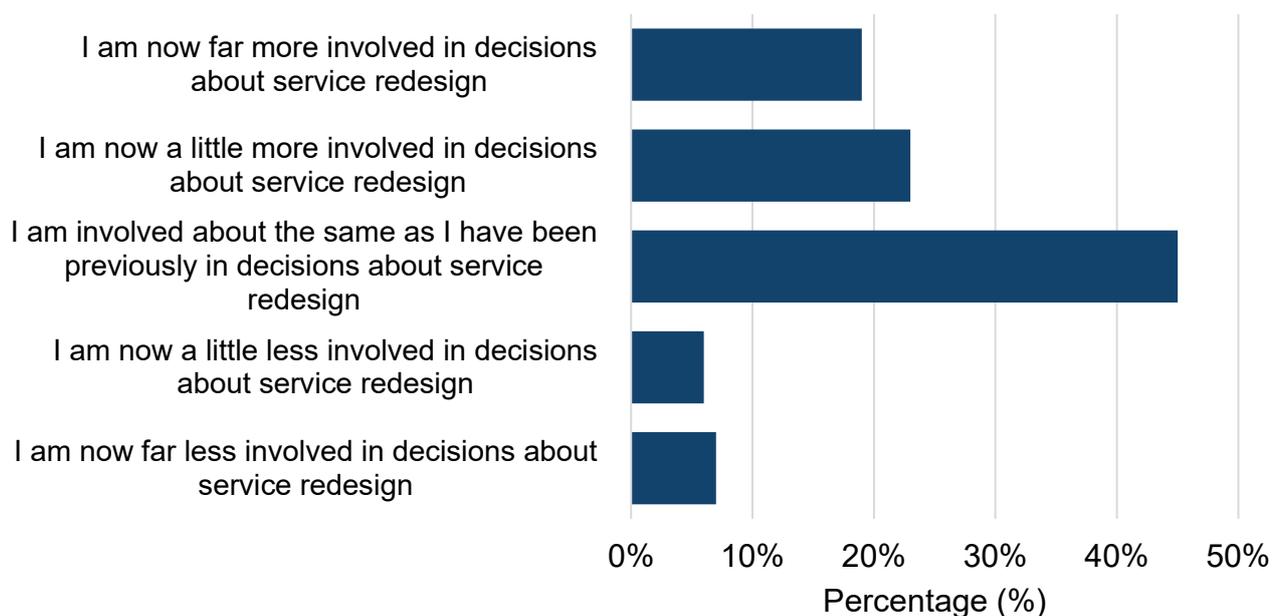
Note: 15 missing responses.

45% of respondents reported no noticeable change in their involvement around service redesign. However, a similar number (42%) reported being 'far more' or 'a little more involved'. A small minority (13%) reported being either 'a little less' or 'far less involved'.

Family members commented on other factors that have contributed to perceived changes in FSSs, such as increased funding, government policy, or environmental factors.

> '[Service] has improved because they've now got funding for an absolutely dedicated family support service.' [IP-14]

Notably, several highlighted how some supports have moved online, with less available face to face support, particularly since Covid.

> 'The online availability is better but there is no face-to-face support.' [SR-01]

Others considered whether changes were due to the National Mission, but many could not be certain of this.

> 'I think it has definitely improved… [the National Mission] must be doing something.' [IP-03]

Others instead saw improvements driven by communities rather than government policy.

'None of this is really kind of driven or coming from the government.' [IP-09]

5.3 The views of family members (Group B)

This section of the report details the responses of the grouping of family members (n=63) who answered '**no**' to the following question, 'Have you ever sought and/or received, or engaged with, any kind of family support for yourself (as a result of being affected by your loved one's drug use)?'. This group were subsequently asked a series of questions that covered a range of topics regarding their awareness of family support options and their reasons for not seeking, receiving, or engaging with family support.

5.3.1 Awareness of, and access to, FSSs

Amongst those who had never sought, and/or received, or engaged with any kind of family support (n=63), the data highlights mixed experiences of awareness regarding family support. Almost three in five (59%) were aware that family support is available. This proportion was made up of: 29% who have tried to access some family support; 17% who reported that, despite being aware, they had no idea about how to go about accessing it; and 13% who reported that they have been aware of FSSs, and that they have been in need of some, but nonetheless chosen not to access it. A smaller proportion (29%) noted that they were 'unaware' of support being available (and have therefore never sought or accessed any). The remaining responses (12%) were split equally between those who do not feel like they need any support (now or in the future) (8 respondents), and those who think they would benefit from some but are prevented for seeking or accessing some due to personal circumstances (4 respondents) (see **Table C20** in the Supporting Evidence Report). Of this latter group, only one type of personal circumstance, 'mental health problems', was cited by more than one respondent (3 respondents).

As seen in **Figure 11** below, this group of respondents were presented with a list of 21 different types of family support and asked whether they were aware of each one, and if not, would they have been likely or unlikely to have made use of it if they had been aware.

The most commonly recognised supports were 'telephone helplines for family members' (40%), 'educational workshops on drug use issues' (33%), 'alternative therapies for family members' (32%), and 'support specifically for children and young people in the family' (30%).

For each of the different individual family support options, a minimum of 60% of respondents reported they were unaware of each particular option, with the largest proportion of respondents (86%) being unaware of 'financial advice'.

17% (11 respondents) were unaware of all 21 support options.

Figure 11. Awareness of family support options (n=63)
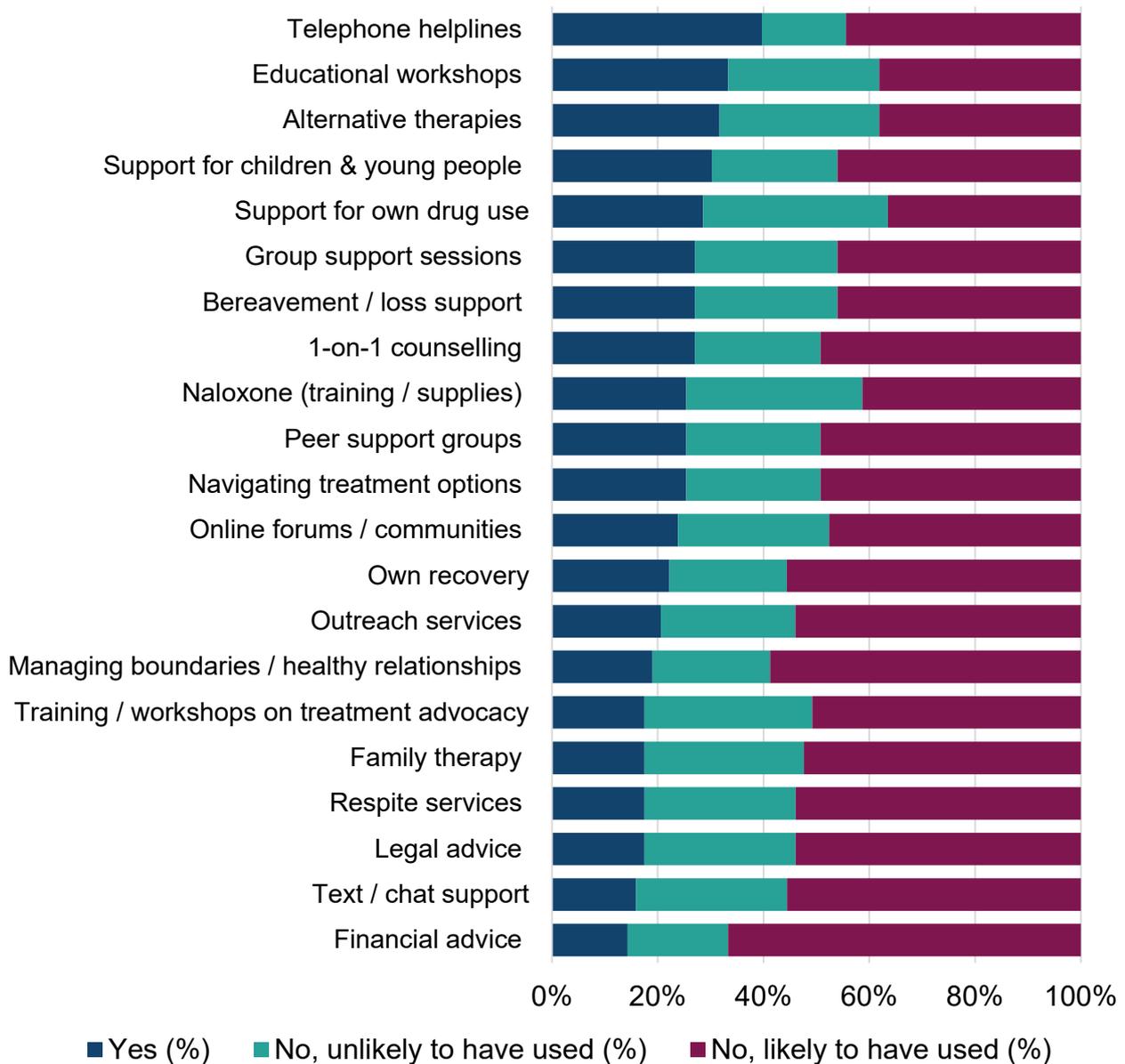
5.3.2 Reasons for not seeking, receiving, or engaging with family support

Those respondents who were aware of the list of supports in **Figure 11** above were asked why they had not accessed them. The options provided were either: 'did not want/need', or

'wanted but could not access'. The answers to these questions yielded low response rates, given the small numbers who answered 'yes' to the above 'awareness' question.

The vast majority of those who did answer (ranging from 64% to 100%) said they 'did not want/need' these supports.

Only five or less respondents noted that they 'wanted but could not access' any particular type of support. Due to the low numbers, we do not provide any further detail here.

Respondents were also asked to indicate whether, from a list of potential reasons for not receiving (or engaging with) family support, any applied to them. Almost one in three of the 37 (out of 63) respondents who answered the question indicated that they would 'prefer not to say'. One in four (24%, n=9) noted that they have 'a sense of shame or guilt, or fear of judgement', and the same number noted that they 'prefer to handle matters privately'. 16% (6 respondents) indicated that they do not have the means of transport or the available finances in order to attend family support. A further four respondents (11%) indicated that they have had previous negative experiences of family support (see **Table C21** in the Supporting Evidence Report).

Given the very small number of the above responses, these findings should be interpreted with some caution and are therefore not presented in any further detail.

5.4 The views of family members (Group C)

This section of the report details the responses of the whole cohort of family members who responded to the survey (n=194). All respondents were firstly asked a series of questions about their loved one's drug use, followed by their views and experiences of family inclusive practice. At the end of the survey, they were presented with two question sets relating to their views on the most important types of family support as well as any gaps in family support provision. Finally, all respondents were presented with an open-text box which asked them whether they had any other thoughts they wanted to share regarding their experiences of family support.

5.4.1 Most important types of family support for family members

Participants were asked to identify and rank the three types of support they considered most important for affected family members. Each participants' responses were weighted to reflect their ranked importance:

- The service they considered most important received 3 points;

- The second most important received 2 points; and

- The third most important received 1 point.

For each type of support, a weighted score was calculated by summing the points assigned across all respondents. To enable comparison between areas with different numbers of participants, each score is expressed as a percentage of the maximum possible score for that area (i.e. the total number of respondents multiplied by 3). **Figure 12** below presents the weighted percentages.

Figure 12. Weighted rank scores for most important type of support (n=194)
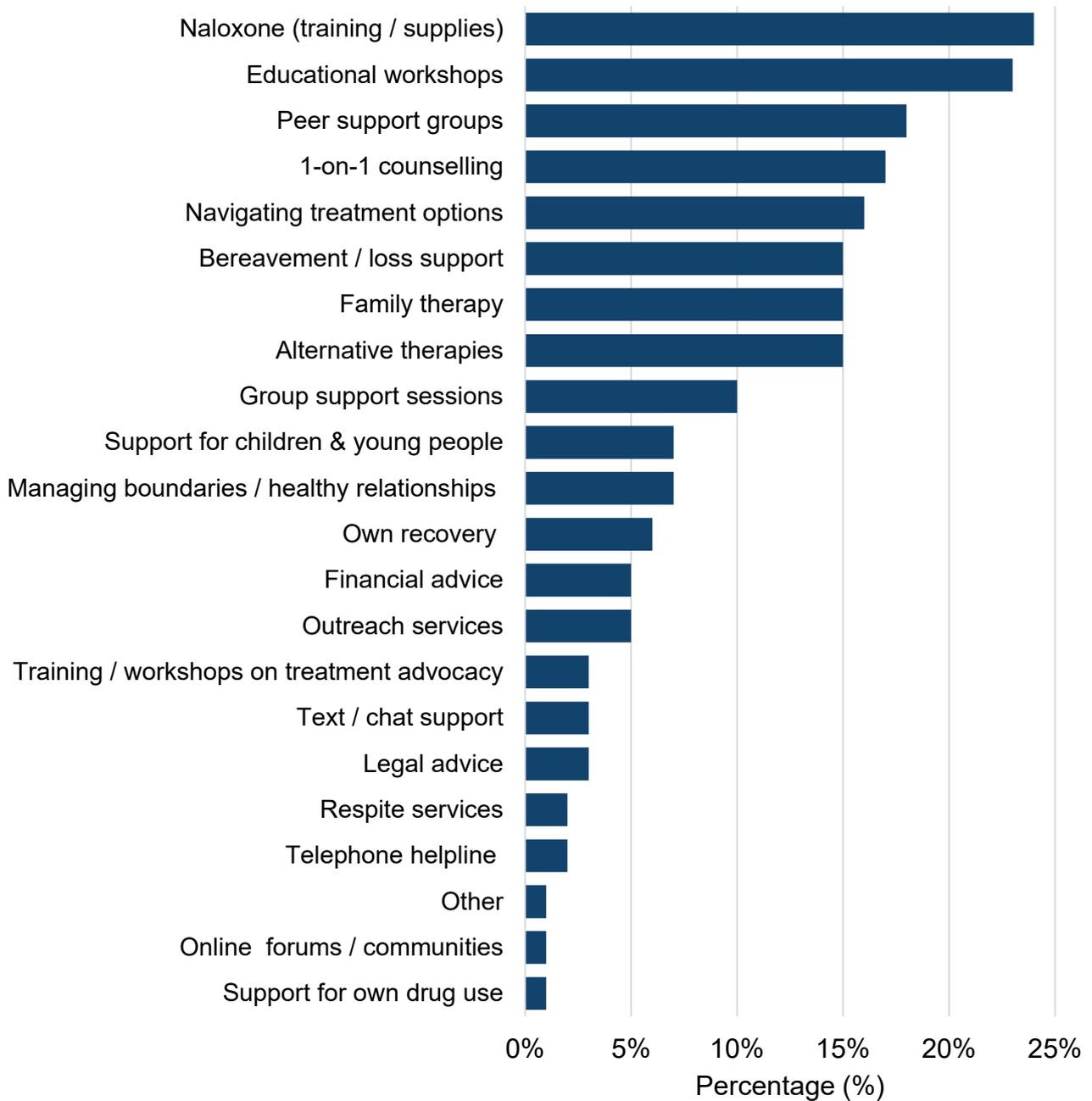
Note: Multiple responses allowed.

The types of family support considered to be most important (ranked 1st, 2nd, or 3rd) by just over one third of respondents (35%)[9] were 'access to naloxone (training and supplies)' and 'educational workshops on drug use, recovery, and/or self-care'. 'Peer support for family members' was a priority ranked by just over one quarter of respondents (26%), followed by

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[9] These numbers and percentages are different to those presented in Figure 12 as they represent the 'unweighted' scores. Data for these can be found in **Table C22** (see **Supporting Evidence Report – Appendix C**).

'one-on-one counselling for family members' and 'assistance with navigating treatment options for the loved one' (both 24%). Least ranked options were 'online support forums or communities for families' and 'support for own use of drugs' (both 2%).

5.4.2 Gaps in family support provision

All survey respondents were presented with a list of potential gaps in family support and were asked to note whether they considered any to be real and significant gaps in the current provision of family support services. As indicated in **Figure 13** below, almost three in ten (29%) noted that 'family support is not available outside of normal office hours'. Just over one in four noted a lack of local family support (26%), a lack of respite services, an insufficient range of support types, and long waiting times for FSSs (all 25%) as the most significant gaps.

Figure 13. Gaps in support (n=194)
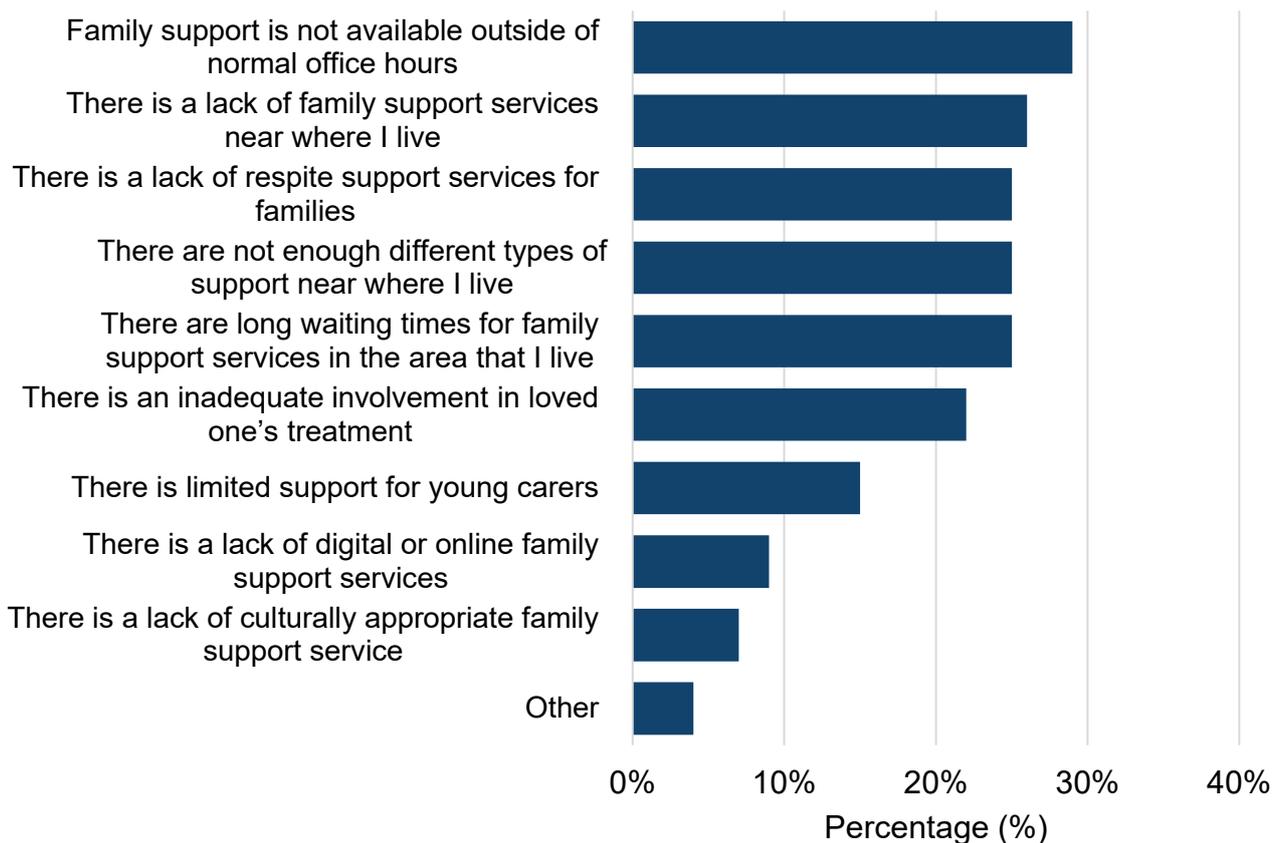
Note: Multiple responses allowed.

Family members cited ongoing gaps in FSSs, and access to these services was noted as being highly variable. Some described positive experiences whilst others described long waits, limited provision, gaps in care, and a lack of consistency across areas.

A lack of support 'outside of normal office hours' was the most commonly cited gap (29%).

> 'Services only work Monday - Friday, and at the weekend when things are bad, you can't access anything because they're not working.' [SR-170]

26% noted a lack of local FSSs, and 25% felt there are 'not enough different types of support', 'long waiting times', and a 'lack of respite support'. Whilst several family members felt they had been lucky to access some respite, others felt this was missing.

> 'Respite would be like gold, but it doesn't happen.' [IP-11]

Respite breaks had only been accessed by 17% of the 113 survey respondents who have accessed any form of family support, with 74% of those rating it highly (see **Tables C2** and **C11** in the Supporting Evidence Report).

There were questions around appropriate family support for those who had been bereaved, with some participants calling for more specific bereavement support.

> 'Once I lost [loved one], I actually said I didn't know if I had a place in the support group anymore.' [IP-12]

> 'There's nothing up here for families that have been bereaved.' [IP-18]

A recurring theme was regional inequality, with many feeling that the level of support depended largely on where you lived. Those living in rural areas often miss out on family support or are forced to travel, which may not be possible for everyone.

> 'There was a very big gap in our rural area... there were things for people seeking recovery... There wasn't so much for the family members.' [IP-26]

Participants described *'class divides',* [IP-21] as one explained their doctor in a '*middle class'* [IP-25] area had limited understanding around drugs.

Divides were also applicable to drug types. The data reflects a substantial use of stimulants, with one participant noting, '*Cocaine is everywhere. It's absolutely rife'* [IP-09]. 55% reported their loved ones to experience (have experienced) problems with stimulants, with 34% saying it was their primary drug[10] (see **Tables B10** and **B11** in the Supporting Evidence Report). Despite this prevalence, it was noted that families of those who use

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[10] More North Lanarkshire respondents (47%, i.e. 25 respondents, n=53) identified stimulants as their loved one's primary drug use when compared to the rest of Scotland (29%, i.e. 41 respondents, n=141).

cocaine are lacking tailored support. One did not *'know of any specific family support for families of cocaine users'* [IP-21].

All survey respondents were also asked to identify the types of family support that they felt were most missing (and needed). As indicated in **Table 5** below, they prioritised the following four broad areas: educational opportunities; therapeutic services; practical assistance; and smaller, but meaningful supports. All the educational and therapeutic supports identified were noted by at least one in four of all respondents.

Table 5. Ongoing gaps (n=194)

Category	Support needed	N	%
Educational opportunities	Workshops on drugs, recovery, self-care	51	26%
Educational opportunities	Guidance on navigating treatment systems	48	25%
Therapeutic services	Family therapy (including loved one)	42	22%
Therapeutic services	Bereavement support	42	22%
Therapeutic services	One-to-one counselling	39	20%
Practical assistance	Access to naloxone (training and supplies)	28	14%
Practical assistance	Financial advice	28	14%
Practical assistance	Group support sessions	26	13%
Practical assistance	Alternative therapies	25	13%
Practical assistance	Outreach services	25	13%
Practical assistance	Respite	25	13%
Smaller supports	More peer support groups	21	11%
Smaller supports	Legal advice	18	9%
Smaller supports	Chat/text services	17	9%
Smaller supports	Telephone helpline	15	8%
Educational opportunities	Training/workshops on treatment advocacy	15	8%
Smaller supports	Support for their own recovery	12	6%
Smaller supports	Support for managing boundaries/healthy relationships	11	6%
Therapeutic services	Online support forums or communities for families	10	5%
Therapeutic services	Support for your own use of drugs	4	2%

Category	Support needed	N	%
Other	No specific support types noted by these respondents (see **Table C24** in **Appendix C** of the Supporting Evidence Report).	3	2%

Note: Multiple responses allowed.

5.5 Awareness and perceptions of the National Mission

There was limited awareness of family members around the National Mission. Some acknowledged positive changes following its implementation; however, these were mainly considered in relation to support for drug use rather than reflecting a broader, more integrated approach to care.

> 'Mental health has got a lot of catching up to do, but the addiction side of it has got better from a National Mission perspective.' [IP-07]

Many emphasised that family inclusion remains limited, with one noting, despite the National Mission improving support *'slightly',* there's *'a long, long way to go for other services actually including families'* [IP-19]. Others observed only certain areas benefitting from the National Mission's improvements.

> 'I think from a government strategy perspective, it was quite clear... that there's certain areas in Scotland seem to be doing better.' [IP-09]

These positive changes were acknowledged as needing to be more widespread.

> 'It has more impact central belt... I do think it has had an impact but not anything as near as what probably you would have liked for it to do.' [IP-23]

One cause for concern was the sustainability of progress, particularly in light of the National Mission funding coming to an end in March 2026. A lack of clear direction was noted, leaving family members fearing for the future of FSSs.

> 'We know that the funding's ending. That's the terrifying part because there's so many services reliant on the National Drugs Mission money and there's no talk about what will happen when it ends.' [IP-04]

5.6 Support for children, young people, and young carers

Of the 113 survey respondents who have accessed family support and who answered a question on what type of support they had accessed since 2021 only 22 (19%) reported that they had accessed support for children and young people within their families, 15 (68%) of these were 'satisfied' with their experience. Children and young people were said to be *'majorly impacted by these issues',* [SR-14] yet one respondent noted there is '*less support for children'* [SR-95]. The contrast between the availability of adult services and the lack of provision for young people was highlighted, with one noting, *'good support for me but very little support for teenage children'* [SR-119].

Participants within the young carer's focus groups reported inconsistent support across services, schools, and social work. Many described the dedicated young carers support service as offering valued opportunities; for example, help with funding applications, acquiring bank accounts, getting into college or lifts to key appointments. In one instance, a young person identified how they had acquired some paid employment through their work with a young carer's summer camp. This support was also about experiencing new activities (such as, go-karting, snowboarding, camping, cooking, music, pottery etc.). Several of the young people identified these activities as something they had gone on to do consistently, as their *thing*, their hobby, and interest. One young person succinctly summarised all the value as, *'it gives you something to do, it gets you out of the house'* [YCFG2-01]. Another reflected on having *'a trusted adult you can talk to about things'* [YCFG-04]. Others talked of how the overall experience has helped them realise that they *'can't actually change'* [YCFG2-02] what was going on at home.

Participants in the young carers' focus groups spoke about the strength of the relationships between the young people and the *Routes* staff[11], and they were keen to suggest that their engagement with and support from staff members had improved their own mental health and made them less angry, lonely or suicidal.

The nature of the young people's encounters with other professionals and their perception of these were in deep contrast. Most consistent was the sense that their presenting behaviour at school was all too often seen as problematic rather than the symptom of the pressures they experienced at home. Overall, the accounts from the young people were of

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[11] Routes projects are run by SFAD and support young people aged 12-26 years affected by familial alcohol and drug use [Routes – SFAD].

school being difficult and unsupportive. There were one or two noted exceptions to this view, either an individual teacher or inhouse counselling service that helped.

The young people's accounts of engagement with social work were mixed and included a lot of negative experiences.

The two groups identified a need for more general services for young people, with a particular emphasis on youth clubs/leisure activities and Child and Adolescent Mental Health provision. One of the two groups was keen to emphasise the need for *'more assistance for the whole family instead of just the person with the drugs'* [YCFG1-03], but *'definitely not family therapy'* [YCFG1-03].

Inevitably, given the positive account above they all quite simply articulated the need for (more) dedicated young carers support services like the one that they attend.

Other family member interview participants echoed the need for enhanced support for young people, noting in particular the importance of prioritising funding for this group.

> 'Of all the things that you're going to spend money on, if you're not going to spend it on fixing your young people, what's the point in any of it.' [IP-22]

Some interview participants are kinship carers for their loved one's children and described mixed experiences of support for their situation. One individual thought social work could help *'because there's a child involved',* [IP-09] however they *'weren't very good'* [IP-09]. As the child was getting adequate care in their home, social work *'had no immediate concerns* [and] *couldn't really do anything'* [IP09], not even signpost them to supports that could help. They did eventually find a support charity who they described as *'brilliant'* [IP-09].

Another participant noted that whilst '*social care offered some support',* [IP-24] the support they accessed for their loved one's child, such as through the Child and Adolescent Mental Health Service [CAMHS] and play therapy, was inconsistent, often starting and then stopping.

> '[Name of child] had some play therapy, but it was stopped... I had CAMHS that was very useful which was stopped and the only thing on offer.' [IP-24]

A survey respondent had a similar experience, in that the support provided by CAMHS for their grandchild, of whom they had kinship care, was *'withdrawn despite* [them] *needing this',* to which they said their *'understanding is that there is not enough money to provide*

this' [SR-173]. The decline in the availability of family support for young people was felt elsewhere, as one participant shared that a few years ago, it was relatively easy to access help for their older children but currently their younger children are facing long delays.

> 'It's getting harder... I've never seen it like this before. Usually, you just wait maybe a couple of months, but it will be two years in the beginning of July.' [IP-27]

One participant described how their adult child joined them at a support group, however felt uncomfortable due to discussions about their peers (i.e., other children – adult or otherwise). This suggests a lack of appropriate support for some family members such as siblings, however, positively, they did note that '*there's something else for siblings now'*, [IP-22] with indications from other family members that young people's needs are beginning to be better recognised and catered for.

There were calls for *'family drop in sessions for parents, caregivers and* [their] *children'* [SR61], with the view that 'more support should be readily available' [SR-34].

5.7 Other themes

Analysis of the open-text survey responses and the family interviews identified two recurring themes. These did not fit neatly within our primary research questions, but they help to set the findings above in a broader context.

5.7.1 Prioritising support for loved ones

Many family members were less likely to prioritise support for themselves, as they described being too focused on their loved one to consider their own needs fully. One explained, '*you tend to forget about yourself*' [SR-116].

Others actively avoided support, reporting they felt '*a bit sickened'* [IP-20] or '*guilty*' [SR-160] at the thought of addressing their own needs.

> 'I've been more focused on getting [loved one] help all the time and not really thinking about me.' [IP-08]

Some respondents recognised that they need support too, describing themselves as '*the backbone of trying to assist their loved ones*' [SR-146].

One participant noted limited support for family members compared to the support available for their loved ones:

> 'There's always recovery for the addict, but there's never recovery for the loved one... It's always based on the person that is taking the drugs.' [IP-05]

It was acknowledged that FSSs benefit not only relatives but also the person they care about.

> '[My loved one's] wellbeing largely depends on how well we manage to cope ourselves with what's going on for [them].' [IP-20]

5.7.2 Filling the gaps: community-led family support

Numerous participants described how they have created the help that they could not find for themselves – i.e. they have filled in the gaps that they have seen and experienced yet felt were not being provided. Some described establishing peer support groups, recovery cafés, or community-led services; whilst others have developed resources such as a 24-hour helpline (described as the only one of its kind in Scotland) or digital tools like a QR code linking to local support options. These efforts were described as being essential to their communities.

> 'There wasn't any support. So, we created our own Recovery Café.' [IP-23]

Some interview participants reported accessing funding to establish these services. One praised the support received in securing such funding:

> 'I think that partnership working has helped us win the funding, and bereavement as well, because there's nothing … here for family's that have been bereaved.' [IP-18]

Chapter 6: Views of family support providers

KEY FINDINGS:

- **Family support provision shows overall improvement since 2021.** About half of survey respondents say family support has improved, with peer support the domain most often rated 'better' (61% of survey respondents). However, focus group participants say that these gains are not yet consistent across Scotland, and many providers remain unclear about the role of national policy in driving change.

- **Collaboration strengthens in some areas, though variation persists.** Providers describe greater openness from statutory partners and better partnership working in places, but others still face 'closed doors'.

- **Enablers include stronger ADP leadership, workforce development, and awareness-raising.** Providers link gains to local commissioning/funding, staff training, and campaigns that improve referrer and public awareness.

- **Persistent gaps centre on equity and specialist support.** The most significant gaps noted by survey respondents are: 'out-of-hours support' (74%), 'respite services' (62%), 'outreach' (50%), 'availability of services for specific populations – such as ethnic minorities, kinship carers, and young carers' (41%), and limited culturally appropriate provision (39%).

- **A broad range of unmet needs are identified.** Just under half (48%) of survey respondents identify 'access to mental health support for family members' as missing and needed. Just under one quarter (24%) call for more 'advocacy' and 'bereavement support' for families, and just over one fifth (21%) highlight 'family therapy involving the loved one' as an unmet need.

- **Capacity and wellbeing pressures are significant.** The workforce is deeply committed with 71% reporting changed roles and 61% bringing lived experience of having a loved one with experience of using drugs. However, caseloads are high; and many staff feel under pressure or at risk of burnout, with ongoing concerns about job security (41%) and burnout (18%). Some services rely on volunteers. A majority consider training access to be improving (62%), but supervision and support remain thin.

- **Some families are still 'missing' from provision.** Providers highlight young people who do not engage and describe low-barrier approaches (e.g. moderated messaging groups) to sustain contact.

- **The National Mission is viewed as a partly positive but not primary driver.** Many report better trauma-informed, person-centred practice, and improved cross-service working, yet few see the Mission as the main cause of change; concern grows that time-limited funding has created uncertainty and a potential "cliff edge" for services post-National Mission (March 2026).

- **Unintended consequences include increased demand and staff pressure, and perceived dilution or imbalance.** Providers note rising demand of support (30%), additional staff pressure (22%), and less focus on families affected by alcohol in some areas.

6.1 Introduction

This chapter presents the views of family support providers, gathered and analysed from an online survey (WP3, N=66) and from three focus groups (WP4, N=17). Throughout, the term 'survey participants' refers to contributors to the WP3 survey, 'focus group participants' refers to those involved in the WP4 discussions, and 'family support provider' refers to both groups. To show who is speaking, we have applied short descriptors to each quote. For example, [SR-01] refers to a family support provider survey respondent, whilst [FGP-01] refers to a focus group participant.

A selection of illustrative quotes are included under each section of this chapter, with a wider selection of qualitative examples provided in **Appendix G**.

Many contributors described a dual perspective: working as a family support provider whilst also drawing on lived experience as family members. Their insights therefore reflect both practice knowledge and personal understanding of the challenges families face. A detailed breakdown of participant characteristics is provided earlier in **Chapter 4**.

This chapter begins with changes in accessibility, availability, and quality of family support since 2021. It then explores factors that have contributed to either improvement or deterioration, identifies gaps, and considers capacity and workforce experiences. The final

sections address awareness and views of the National Mission, including its impacts, before turning to support for children and young people.

6.2 Changes in accessibility, availability, and quality of family support services since 2021

As shown in **Figure 14** below, family support providers have observed or experienced gradual improvements across key aspects of family support since 2021. Overall, more survey respondents felt that provision had improved than had got worse.

Figure 14. Changes to family support services since 2021 (n=66)
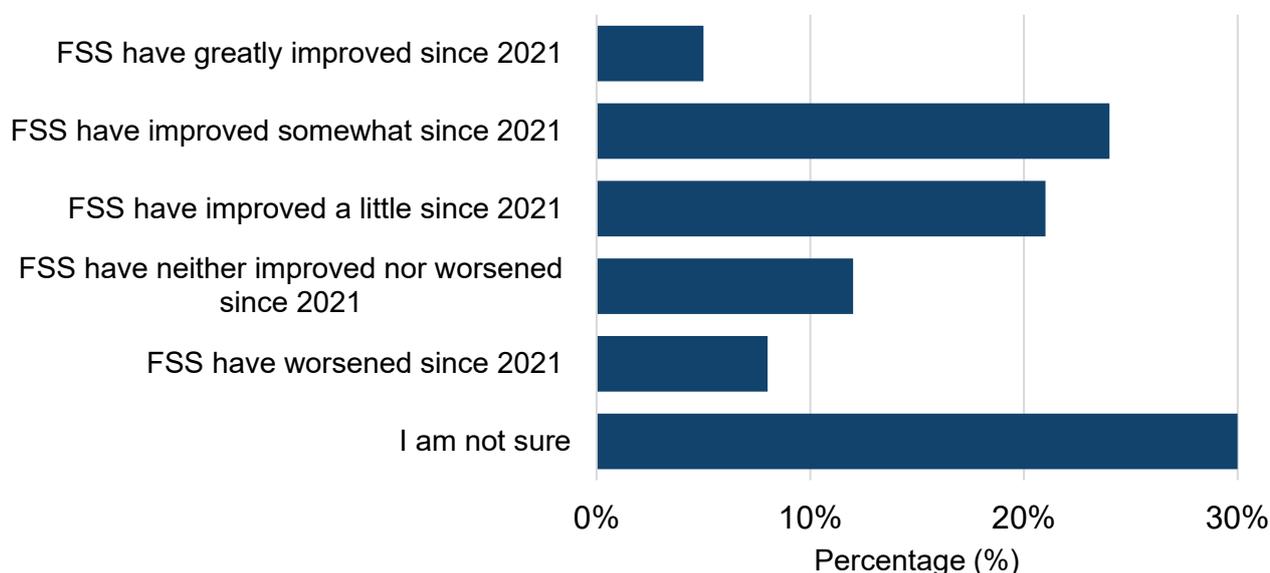
Half (50%) of respondents felt that FSSs have improved either 'greatly' (5%), 'somewhat (24%), or 'a little' (21%) since 2021. In contrast, 12% reported no change, whilst the remaining survey respondents, 8% said FSSs have 'worsened', and 30% were unsure whether any change had occurred.

Focus group participants echoed these mixed experiences, but some pointed to improvements in collaboration and efforts to include families. One participant described how it had once been difficult to engage '*even other third-sector organisations*', which felt like '*pushing at closed doors and not really getting any response*' [FG3-02]. The contrast was clear:

> 'Today, that's completely different.' [FG3-02]

Survey respondents were asked to assess how FSSs had changed during their time in post, with a focus on the past three to four years (see **Figure 15** below). Those with less than three to four years of experience, based their responses on the period they had been working with families. Respondents rated multiple aspects of provision as: 'much better', 'a little better', 'no change', 'a little worse', 'much worse', or 'don't know' and could answer across more than one domain. The distribution of responses varied across service areas.

Figure 15. Perceptions of changes to FSSs in the past 3-4 years (n=66)
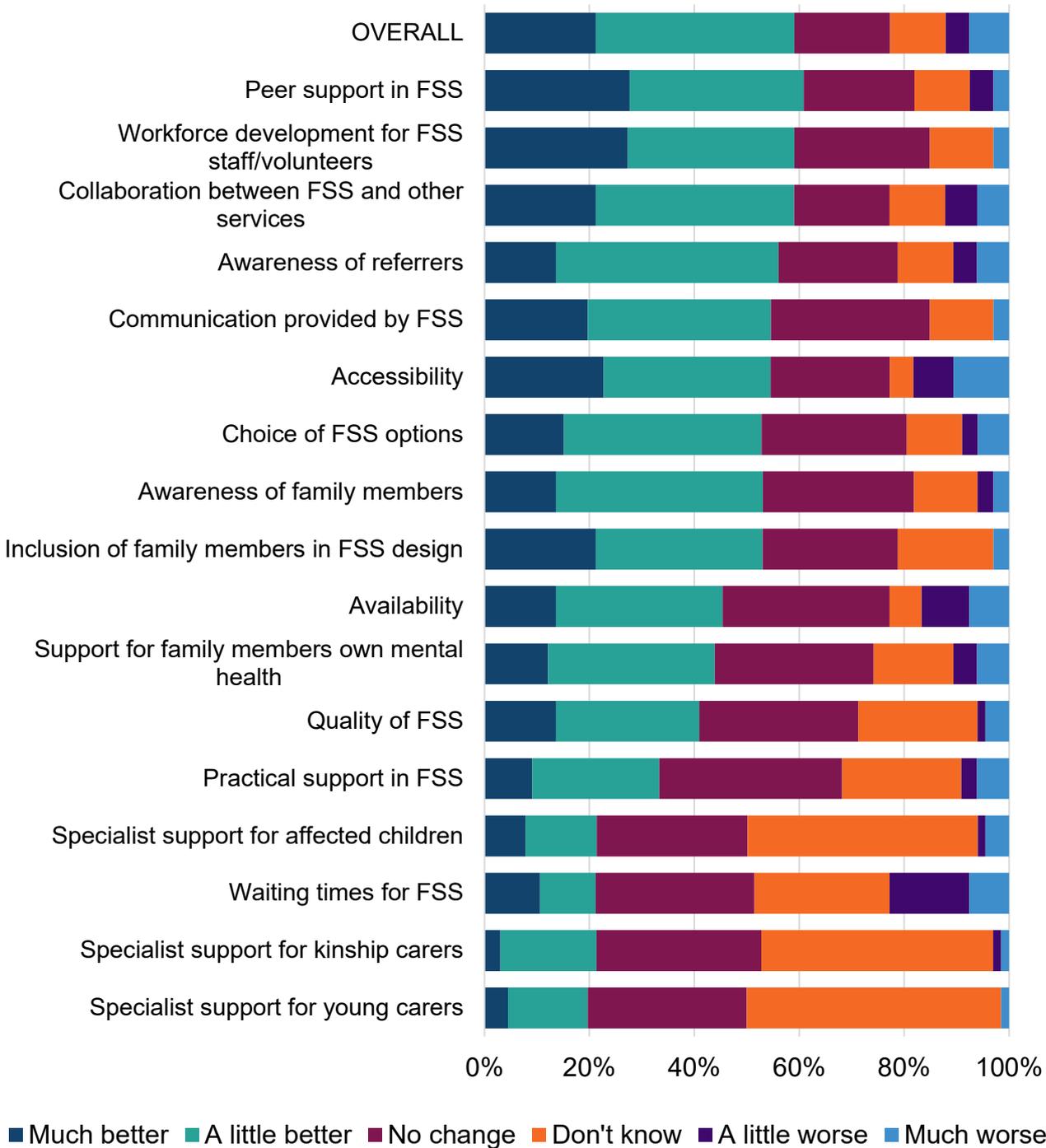
The highest combined proportions of 'much better' and 'a little better' responses were reported by 61% of respondents for 'peer support in FSSs'. Several respondents noted an observable increase in peer support provision, which was described as '*providing a huge impact*' [SR-16]. A similar proportion selected 'workforce development for FSS staff and volunteers' (59%), with one noting, '*training has been a lot more available for workers which has really improved practice*' [SR-04]. 'Collaboration between FSSs and other services' was selected by the same amount (59%) as an area which has shown improvement, with many highlighting an '*increase in referrals from other agencies and third sector organisations*', [SR-54] and improvements in '*information sharing*' [SR-57].

Just over half of the survey respondents reported the following domains as having improved: 'awareness of referrers' (56%), 'communication provided by FSSs' (55%), 'accessibility' (55%), 'choice of FSS options' (53%), 'awareness of family members (53%), and 'inclusion of family members in FSS design' (53%). Other domains, whilst still reflecting progress, showed more modest levels of improvement. 45% reported improvements in the availability of family support, 44% 'support for family members' own mental health', 41% in the 'quality of FSS', and one third (33%) reported 'practical support' as having signs of improvement. Perceptions of 'waiting times' for family support were notably divided. 21% observed improvements, whilst 30% reported 'no change'. Just under one quarter (23%) perceived waiting times to be 'a little worse', whilst a further 26% selected 'don't know'.

Just under half (45%) of respondents reported an increase in the number of available FSSs, often linked to the expansion of local provision, more staff, or new groups being set up. One respondent noted that national and local services '*have grown in the last 3-4 years*', allowing them to offer '*more support*', and '*proactively target harder to reach communities*' [SR-50]. Another reflected on the impact of new provision:

> 'There was no dedicated family support service in our region before 2020. This is now in place and has gradually grown over the last few years.' [SR-19]

However, around one in six (17%) reported that the availability of FSSs was much/a little worse, most often attributed to a '*lack*' [SR-07] or '*loss of funding*', [SR-44] meaning '*projects are continually having to end*' [SR-26]. Almost one third (32%) observed no change, as one focus group participant reflected, '*as far as I am aware, there has been no change to provision of family support in* [local authority] *for years*' [FG2-02].

Just over half (53%) felt that awareness of family members had improved, supported by stronger promotion through social media, outreach, and partnership work. Respondents highlighted that organisations are '*more visible*' [SR-13], with family support increasingly advertised online. A smaller proportion of survey respondents (6%) reported a decline, pointing to the persistence of stigma and weak signposting by statutory services, which left some families unaware of what support was available. 55% felt accessibility had improved, with one respondent highlighting, '*national services are self-referral and easily accessed*' [SR-22]. Another emphasised:

> 'Access to family support services has steadily improved over the last 3-4 years through a combination of service expansion, innovation and partnership building.' [SR-54]

Several respondents put this down to '*less stigma to accessing services*' [SR-57] and services now also being available online, '*which breaks down barriers for the families*' [SR-26]. Declines in accessibility were frequently put down to a '*lack of funds and staffing*' [SR-44]. As one respondent explained:

> 'The journey hasn't just been about adding services – it's been about removing barriers. Families now have multiple, accessible ways to connect with us, in formats that suit their realities and respect their emotional landscapes.' [SR-54]

Assessments of quality were also mixed. Just over two in five (41%) identified improvements, often linked to trauma-informed practice, staff training, and the adoption of structured, therapeutic approaches. One respondent summarised:

> 'Training has been a lot more available, which has really improved practice.' [SR-04]

Only 6% reported that the quality of FSSs were much/a little worse, most often citing reduced capacity and stretched resources, with one respondent noting that '*lesser funding means fewer staff*' [SR-44]. These pressures were seen as symptomatic of a deeper issue: without adequate resources, services cannot be both sustainable for staff and fully accessible to families. As one participant explained:

> 'Many families ask for support to be more accessible and available and this requires much more resources and system change around how services are run.' [SR-36]

Family support providers indicated that improvements in provision depended on sustained investment and structural change, rather than isolated initiatives.

6.3 Factors contributing to perceived improvements, deteriorations, and gaps in family support

Survey respondents were invited to reflect on the extent to which a range of factors had contributed to improvements in family support over the last 3-4 years. They were asked to rate each factor as having made a 'major', 'minor', or 'no contribution', or to indicate if they felt 'unsure' or preferred 'not to say'. To aid interpretation, 'major' and 'minor contribution' have been combined in **Figure 16** below, to show the overall perceived impact. Results are presented in descending order to highlight the most frequently cited contributors.

Figure 16. Factors associated with improvements to family support
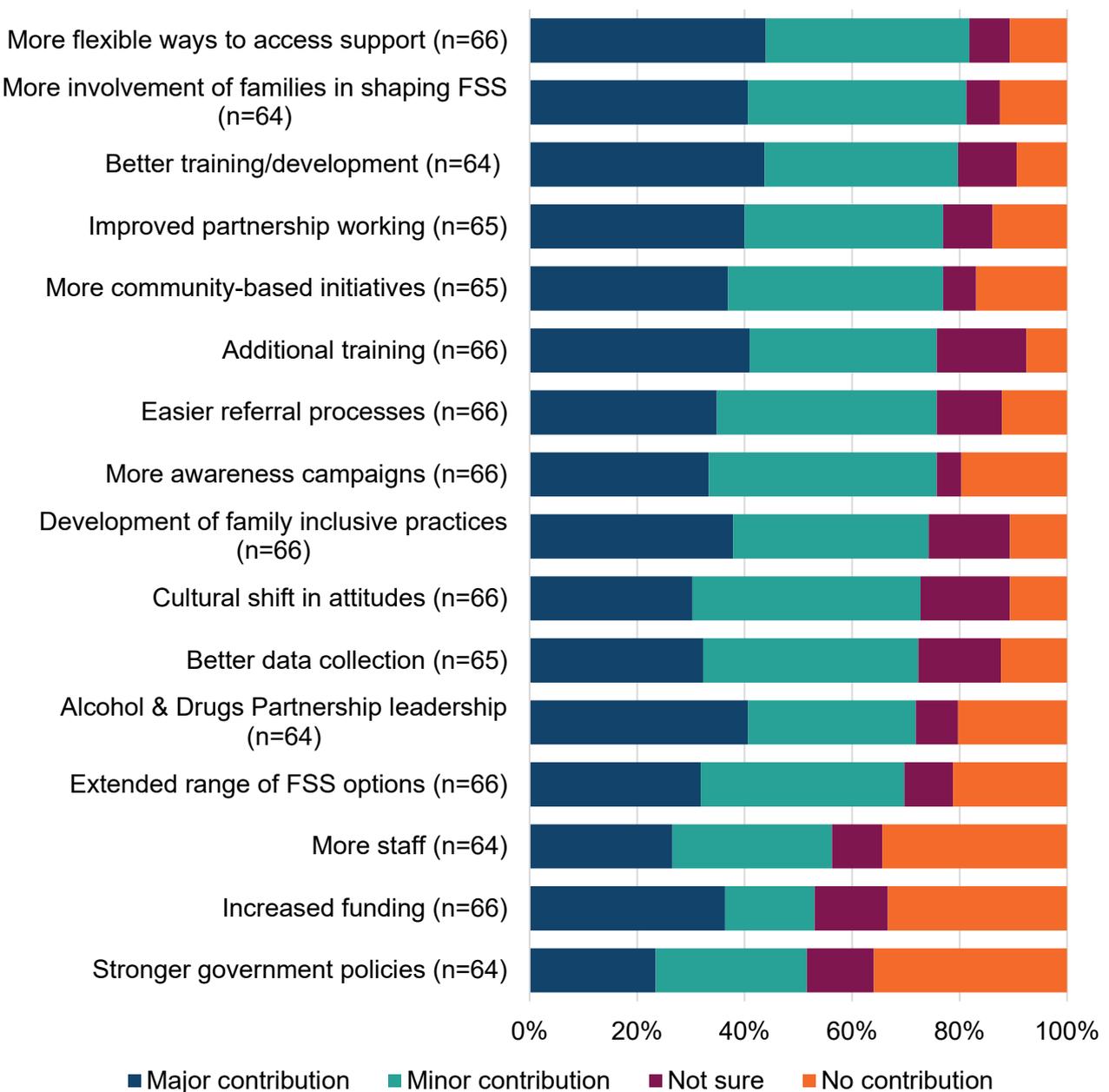
The most widely supported factor of contribution to improvements was the introduction of more 'flexible ways for families to access support', including online, telephone, and outreach options. The majority (82%) saw this as positive, with 44% rating it as a major contributor.

Service design and co-ordination were also highlighted. Just over three quarters of respondents (ranging from 76 to 81%) identified 'increased involvement of families in shaping services', 'better staff/volunteer training', 'improved partnership working between services', 'training specifically related to family/drug use', and 'simplified referral processes'.

Community and system-level enablers were noted by approximately seven in ten survey respondents (70–77%). These included 'family-led or community-based initiatives', 'public awareness campaigns', 'expansion of family inclusive practice', 'cultural shift in attitudes (resulting from efforts to tackle stigma)', 'improved data collection and evaluation', 'leadership by local Alcohol and Drug Partnerships (ADPs), and 'extended range of available support options'. Fewer respondents rated these as 'major' influences. One survey respondent described that despite a perceived '*lack of funding opportunities'* [SR-21], local prioritisation of family support by the ADP had enabled their service to secure funding for a new group:

> 'As family support is now a focus of the ADP's this has allowed us to apply and be success[ful] for funding to deliver a family support group.' [SR-21]

Structural investments received lower support. Just over half of respondents cited 'more staff hired (56%) and 'increased funding' (53%) as positive factors, with 27% and 36% respectively noting them as 'major' contributory factors. 'Stronger government policies and commitments' were identified by half (52%), with just under one quarter (23%) rating them as a 'major' factor.

Providers also pointed to wider influences such as professional affiliation, length of service, and policy context. One respondent noted that membership of a national professional body had raised standards, promoted continuous learning, and strengthened practice, which '*directly impacts the quality of the support we provide to families*' [SR-54].

All survey respondents were asked to indicate the extent to which a range of barriers had contributed to any deterioration in FSSs they had observed or experienced over the last 3-4 years. Response options ranged from 'major contribution' and 'minor contribution' to 'no contribution', 'not sure', and 'prefer not to say. **Figure 17** below shows how respondents rated each factor. To aid interpretation, figures for 'major' and 'minor contribution' have been

combined to show the overall perceived impact of each factor, and results are presented in descending order to highlight the most frequently cited contributors.

Figure 17. Factors perceived as contributing to deterioration in FSSs
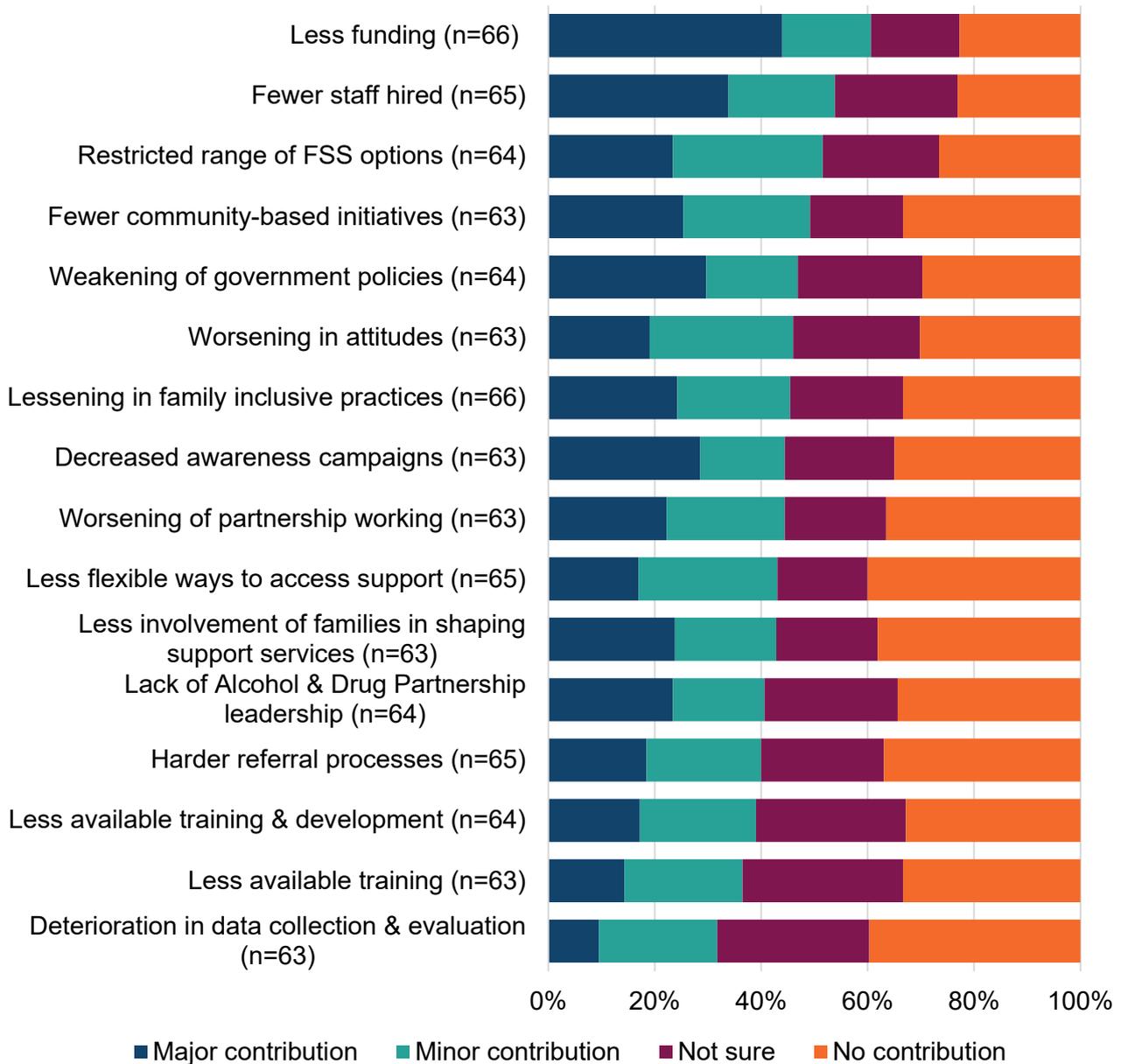
Most notably, 'less funding for FSSs' was selected by 61%, 'fewer staff hired' by 54% and 'restricted range of support options' by 52%, as contributing factors to deterioration, the only factors where combined responses exceed 50%. Other items received combined ratings below 50%: 'fewer family-led and community-based initiatives' (49%), 'weakening of government policies and commitments' (47%), 'lessening in family inclusive practices' (45%), and 'decreased awareness campaigns about FSSs' (44%).

Survey respondents described stigma as *'a huge barrier for families accessing support'*, [SR-04] that *'really stops them reaching out for support'* [SR-04]. 46% identified 'worsening in attitudes (increased stigma)' as either a 'major' or 'minor' contribution to a deterioration in FSSs. However, 73% did recognise a 'cultural shift in attitudes' as contributing to improvements.

In close-knit communities where *'there is no anonymity'* [FG1-08], families feared being recognised, sometimes travelling *'across the city to go to a different support group, so that they're not bumping into people'* [FG2-01].

> 'If somebody attends one of our meetings, the chances are you're going to bump into the same people that attended the meeting the next day in [name of supermarket]. [FG1-08]

Others noted that certain venues, such as housing offices, were avoided due to uncomfortable associations. Location was seen as important, and services had to be *'very considerate about the venues'*. [FG2-01]:

Despite efforts from *'development and engagement officers'* whose *'role is to raise awareness and reduce stigma'*, [FG1-04] barriers to open discussion persist. Participants emphasised that drug-related harm is widespread and affects many families yet is described as difficult to talk about. One participant noted that *'everybody knows someone'* affected and *'the problem is the size of Scotland'*, but *'we're just not willing to talk about it'* [FG3-05]. Still, in some areas, more conversations around family support were reported as helping to reduce stigma:

> 'I think there's more discussions of support for family members going around [local authority] now that people are feeling like they can come forward for that support and not feel stigmatised.' [FG3-04]

Some focus group participants noted a gender dimension to stigma. Support groups were described as *'predominantly mothers or women'*, [FG1-01] with men largely absent. In one service of nearly 200 members, only six were men, a disparity said to *'speak volumes'* [FG2-01]. Women were described as *'holding it all together'*, [FG2-01] carrying both the caregiving and emotional burden, whilst *'males and fathers who are often ignored in support contexts'* [SR-61]. Although there is a *'shifting focus, with attention given to'* [SR-61] male family members, some felt this might only improve *'over the generations'* [FG2SE-F].

'It's okay to reach out…we've just been hit with this historic culture of men don't need that kind of support.' [FG2-01]

Family support providers acknowledge improvements in access and delivery, but highlighted ongoing challenges with resourcing, consistency, and service design, reflected in views on unmet needs and areas requiring further development.

6.4 Ongoing gaps

Persistent gaps remain in the availability and accessibility of FSSs, particularly for those with specific needs or seeking help outside of standard hours. Survey respondents were asked to give their views on what they believe to be the most significant gaps in current provision, with the results presented in **Figure 18** below.

Figure 18. Most significant gaps in current provision (n=66)
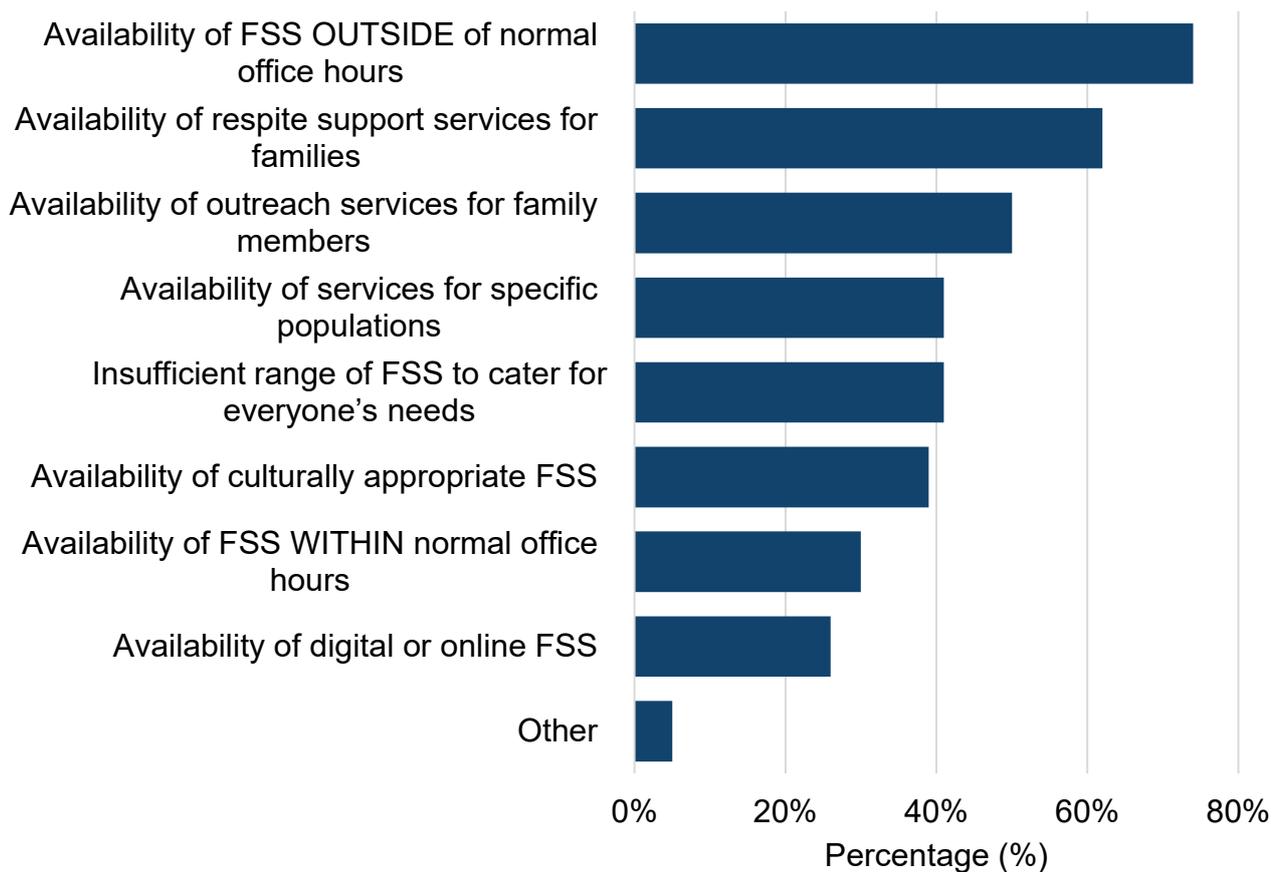
Note: Multiple responses allowed.

Nearly three-quarters (74%) identified a lack of 'support outside of standard office hours'. This priority issue was echoed in the focus groups pointing to persistent difficulties for

families seeking help during evenings or weekends, '*because they only work Monday to Friday, nine until five*' [FG1-01].

The lack of available 'respite services' was the second most significant gap, raised by 62% of respondents. Exactly half (50%) of the survey respondents reported limited 'availability of outreach services for family members', highlighting persistent challenges in engaging families who are not already connected to support. As one focus group participant noted:

> 'Why should families keep coming into a service, we should be going to them and meeting them where they are?' [FG1-02]

A second group of concerns related to the breadth and appropriateness of provision. Just over two in five respondents (41%) highlighted limited 'availability of services for specific populations', such as ethnic minorities, kinship carers, and young carers. Similarly, 39% noted the lack of 'culturally appropriate provision'. 'Availability of FSSs within office hours' was identified as a gap by 30% or respondents, whilst just over one quarter (26%) highlighted 'limited access to online or digital support'.

When asked to select the three family support activities they felt are missing (and needed), or of which they thought more is needed, survey responses (as shown in **Figure 19** below) centred on mental health and core therapeutic services.

Figure 19. Family support services that are missing (and needed), or where more is needed (n=66)

Note: Three responses allowed.

Just under half (48%) of the survey respondents identified 'access to mental health support for family members' as missing and needed. Just under one quarter (24%) called for more 'advocacy' for families navigating a loved one's treatment, and just over one fifth (21%) highlighted 'family therapy involving the loved one'. Almost a quarter of respondents (24%) reported that 'bereavement support' was missing and more is needed. One survey respondent highlighted the need for '*more specific bereavement groups for families*', [SR-04], noting that some family members were afraid to disclose the cause of death of a loved one in mixed groups '*for fear of others' opinions*' [SR-04]. Focus group participants also pointed to limited provision, with one observing that '*we've got 19 different family groups but only two bereavement groups*' [FG2-01]. The value of dedicated bereavement support was emphasised by another participant:

> 'The feedback that we're getting back from that is, "I just thought my life stopped when my loved one passed away, but I realise that I can actually have the tools to put my life back together again."' [FG1-02]

Interestingly, across the focus groups there were repeated calls for national helplines to support families affected by a loved one's drug use. Whilst some services reported to offer helpline support, participants noted significant limitations, particularly around availability during the '*wee small hours*' [FG3-02]. In many cases, '*there might be a messaging service, and somebody will call you back*' [FG3-02]. As one participant put it, the need remains clear and unmet:

> 'A national helpline is definitely [a] priority.' [FG1-01]

Focus group participants described an uneven landscape of family support provision in Scotland. They noted that what families can access often depends on geography, with some areas offering a range of services, and others providing little. This inconsistency was frequently characterised as a '*postcode lottery*,' [FG1-05] with reports that some families travelled long distances or even gave a false address in order to access '*another locality to get support*' [FG2-03]. As one provider put it:

> 'But it's a postcode lottery with everything. It depends where you live what you get, and it shouldn't be like that.' [FG1-01]

Providers also expressed concern about funding models that did not reflect actual levels of need. In some areas, resources were allocated through formulaic approaches rather than

being based on drug-related death rates or population size. This approach was described as '*unfair*', [FG3-01]. One survey respondent explained:

> 'There seems to be a postcode lottery in place for accessibility to services... this hasn't changed. All ADP areas should be doing the same thing and enable the statutory services to recognise the need for 3rd sector service.' [SR-52]

Others pointed to disparities in the use of national funding. In one area, the local ADP reportedly had '*an underspend of over a million pound*' (over several years) [FG1-05], even as volunteer-run groups struggled to cover core costs. In contrast, one family support service had reportedly 'grown astronomically' [FG3-02], from a single staff member to a whole team. Elsewhere, investment was described as shifting focus, with one participant noting, '*one of the ADP's focus points is expanding that family support*'. [FG3-04]. However, it was noted that coverage remains incomplete across Scotland:

> 'There's 32 ADPs in Scotland and there certainly isn't a family support group in every area.' [FG1-01]

For many, uncertainty was itself a burden. Participants simply '*want the best for individuals',* [FG1-02] yet concerns remained that they would still be '*expected… to do the same level of work*', [FG1-02] with far fewer resources. This sense of vulnerability led to further concerns that '*families are missing out on support that they could really benefit from*' [SR-63]. One focus group participant expressed:

> 'If that money becomes reduced, what's going to happen to the families that are sitting in my community that are really vulnerable? Are we going to end up back to square one again?' [FG1-02]

Overall, findings highlight a fragmented system of family support in Scotland. Investment since 2021 has expanded provision in some areas, but families continue to face barriers linked to geography, service design, and time-limited funding. Concerns about sustainability and inequity suggest that without consistent, long-term investment, improvements risk being partial and fragile.

6.5 Awareness and perceptions of the National Mission

This section explores participants' perceptions of the National Mission and its associated policies, including Whole Family Approaches and Family Inclusive Practice. For context, a

clear majority of survey respondents (79%) have been involved in delivering FSSs for at least 3-4 years.

As seen in **Figure 20** below, perceived awareness and understanding of the National Mission sit at a moderate level. Some focus group participants acknowledged that whilst '*there was a lot of talk about the policy*', [FG2-01] this did not always translate into clear understanding or practical insight.

Figure 20. Levels of awareness of the National Mission (n=66)
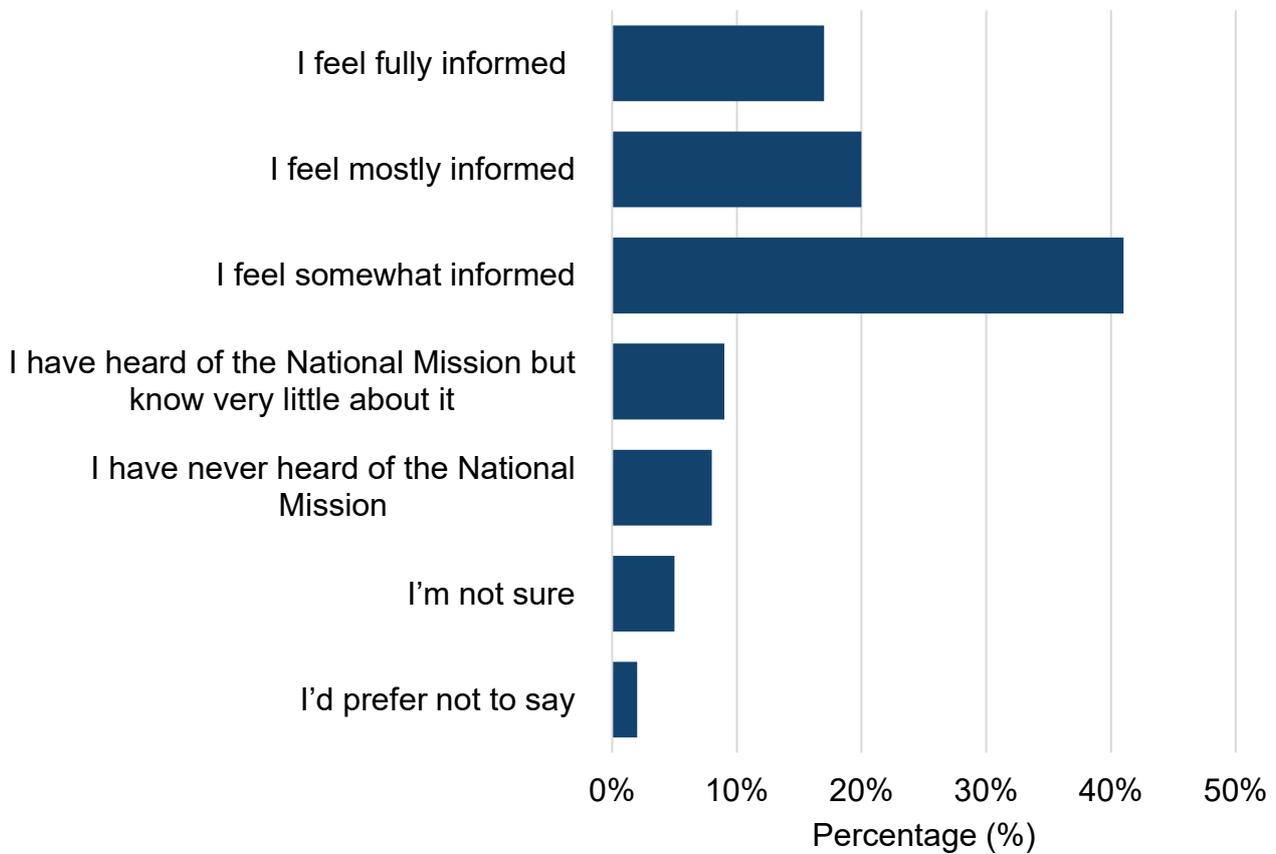
The largest proportion of respondents (41%) said they were 'somewhat informed' about the policy whilst 36% felt 'mostly' or 'fully' informed. However, focus group discussions suggested that some providers, particularly in smaller or volunteer-led groups, '*don't understand the National Mission',* [FG3-01] and its aims remain unclear.

> 'We were all volunteers, and we were just not knowledgeable about anything like that, about going for grants, the National Mission, nothing like that. That's where it was difficult for us.' [FG3-01]

Knowledge of the National Mission's 'Whole Family Approaches and Family Inclusive Practices' element followed the same pattern. As can be seen in **Figure 21** below, just over one quarter (25%) of survey respondents said they were 'somewhat informed' whilst a combined total of 47% reported they felt either 'mostly informed' or 'fully informed'.

Figure 21. Knowledge of the National Mission's 'Whole Family Approaches and Family Inclusive Practices' element (n=51)
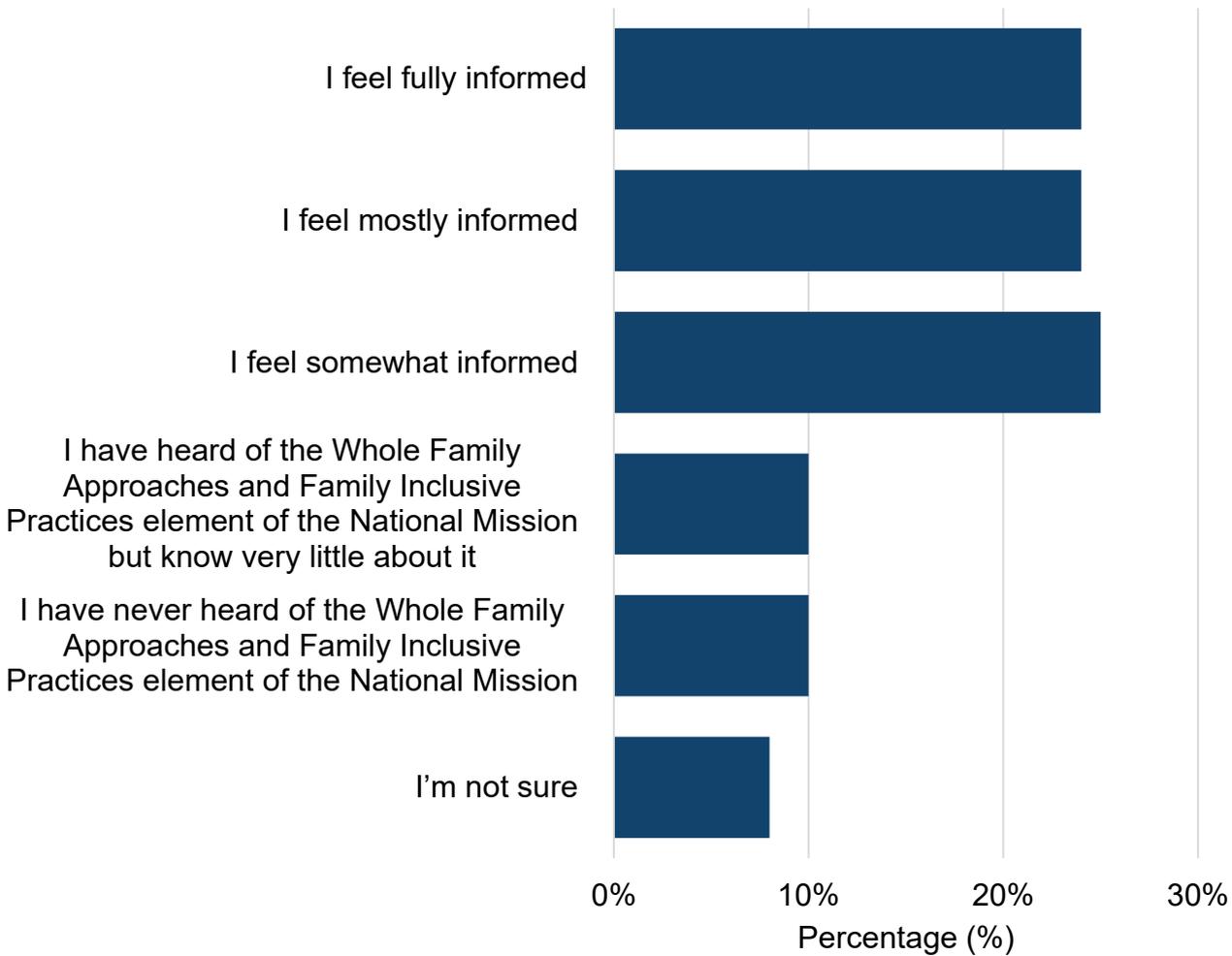
Note: 15 missing responses.

10% of respondents had 'heard of but knew very little about' this element of policy and 18% had either 'never heard' of it or were 'not sure'. Participants in one focus group noted that it '*still isn't widely understood about what* [a] *whole-family approach is',* [FG1-02] and another commented on the implications of this limited understanding.

> 'What does family inclusive support mean? How are we going to change and how are we going to embed that in our services? What training do we need?' [FG2-01]

This lack of shared understanding was linked to a perceived absence of practical guidance, with participants saying it *'didn't translate into a working policy'*, [FG2-01] and that '*no guidance that comes down to say this is what ADPs should be doing and how it's structured'* [FG2-03].

Some participants reported that family inclusive practice is more visible nationally, with policy developments increasing attention to whole-family approaches:

> 'That whole-family approach framework has driven a lot of the work that I've been doing … I feel like we're beginning to be able to use [it] to shape and influence what happens locally.' [FG3-05]

Whilst some participants described how the Whole Family Approach Framework had begun to influence local delivery, wider views on the overall impact of the National Mission were more mixed.

6.6 Perceived contribution and unintended consequences of the National Mission's implementation

As can be seen in **Figure 22** below, perceptions of the National Mission's specific contribution to improving family support were varied**.** Just over two in five (41%) of the 51 respondents who considered themselves to be (somewhat, mostly, or fully) informed regarding the National Mission (as indicated in **Figure 21** above), felt that it has made a contribution to improvements in FSSs; although only 4% viewed the National Mission as the primary driver of change, stating it has made the 'most significant contribution'.

Figure 22. Contribution of the National Mission (n=51)
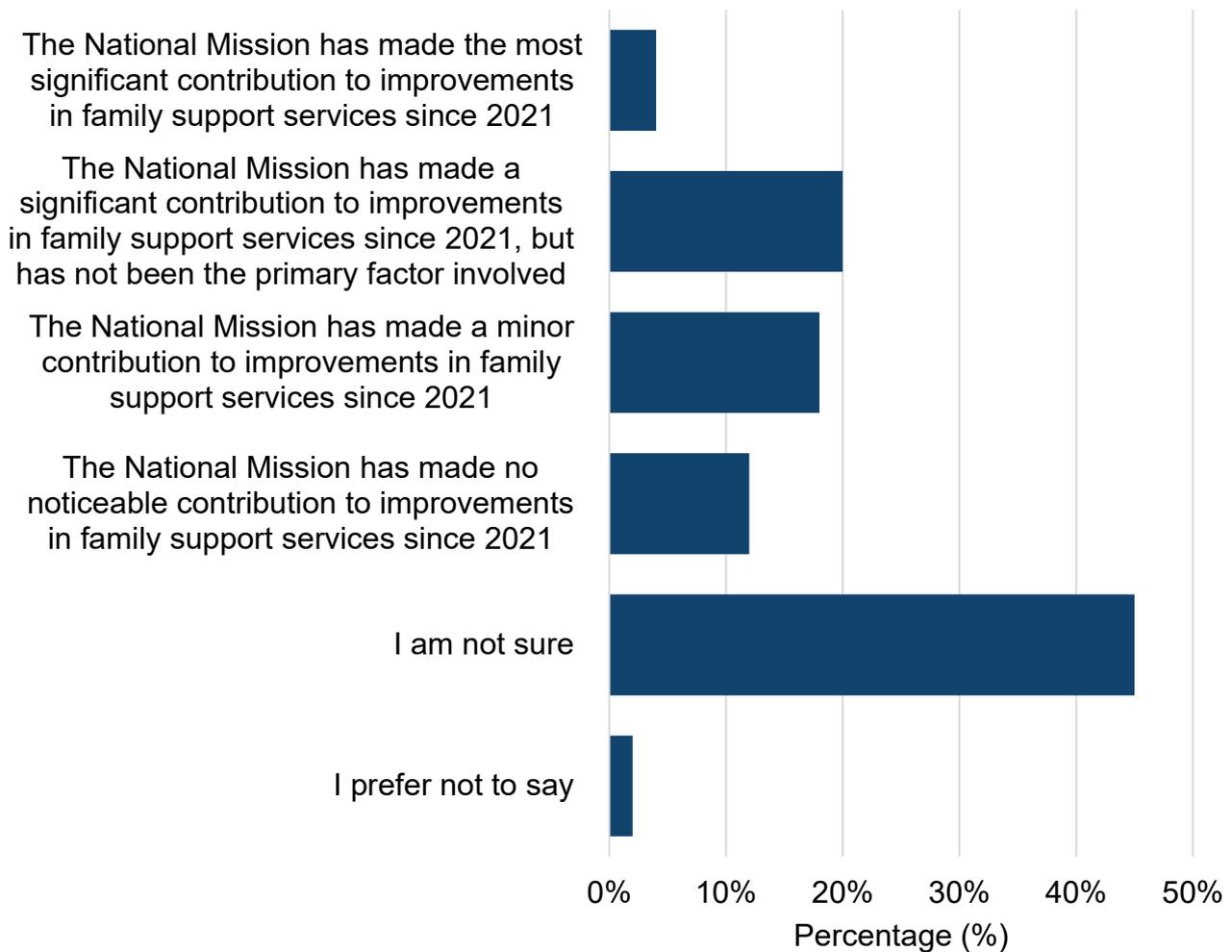
Note: 15 missing responses.

20% felt it has made a 'significant contribution', 18% described its role as 'minor', and 12% believed it has made 'no noticeable contribution'. Just under half (45%) were 'not sure' and 2% preferred not to answer. Focus group participants suggested they '*wouldn't say that the National Mission has had no role to play'* [FG3-06] in driving improvements of family support. Others were less certain, with one noting they '*don't know how much it's the National Drugs Mission'* [FG3-02]. Still others felt it had made minor difference because effective approaches were already in place:

> 'The "mission" has had almost no impact on our provision as we are leading the field in what we do, our model, etc. We are leagues ahead of the government we have been doing this for a long time.' [SR-07]

Contributors to the survey and focus groups noted that recent improvements were not necessarily attributable to the National Mission, but rather '*families have absolutely felt that the focus has been on MAT* [Medication Assisted Treatment] *standards*'. [SR-50]

> 'I wouldn't say that's down to a National Mission thing or anything. That's maybe down to a wee bit of MAT [Medication Assisted Treatment] standards.' [FG3-01]

Respondents were asked to indicate their level of agreement with a series of statements regarding changes in their practice since the introduction of the National Mission in January 2021. Response options included: 'strongly agree', 'slightly agree', 'neither agree nor disagree', 'slightly disagree', 'strongly disagree', and 'not sure'. As seen in **Figure 23** below, the distribution of responses varied across the statements, reflecting a range of perceived impacts.

Figure 23. Perceived impacts of the National mission

Figure 23. Perceived impacts of the National mission

Legend: Strongly agree, Slightly agree, Neither agree nor disagree, Not sure, Prefer not to say, Slightly disagree, Strongly disagree
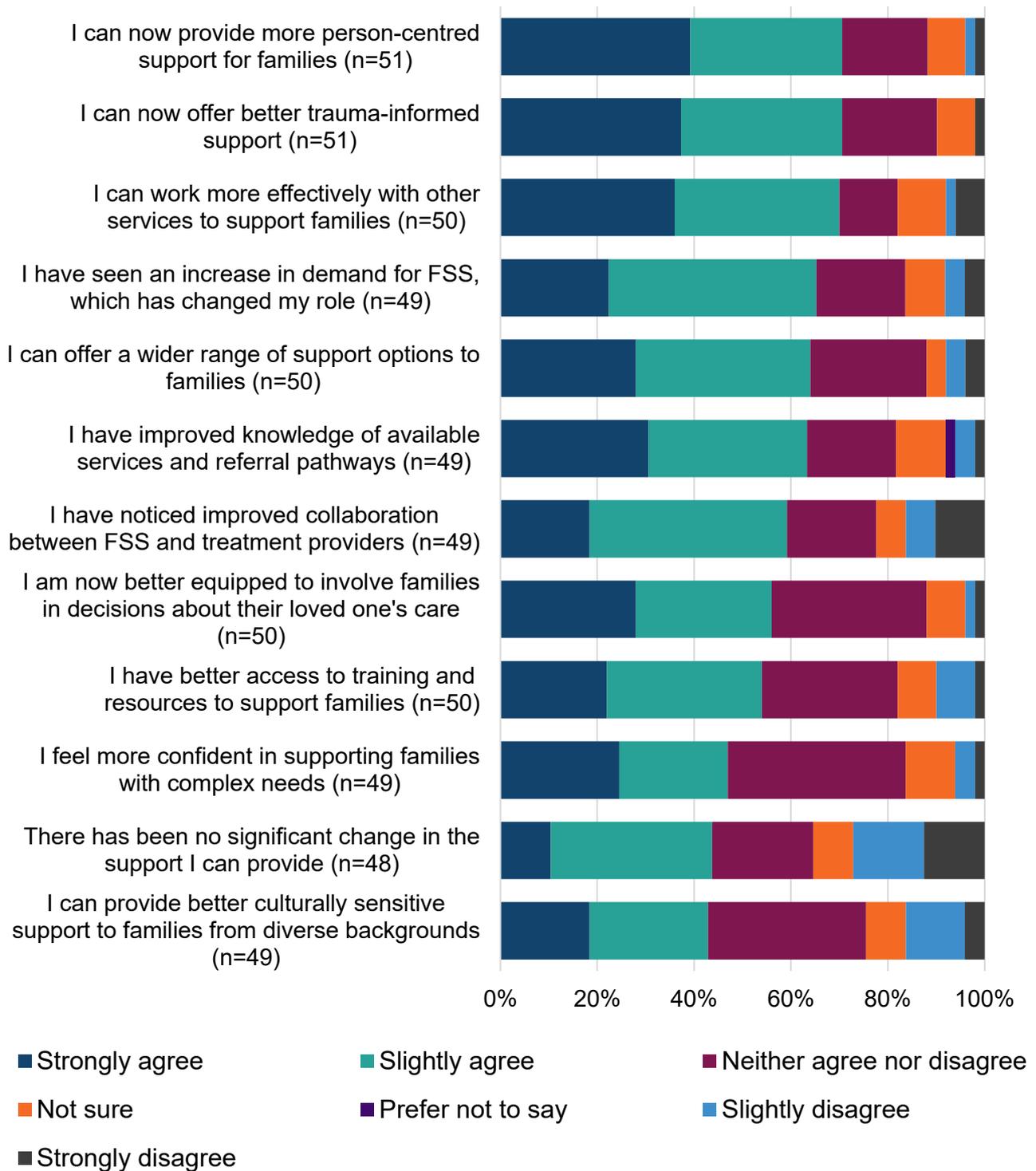
Respondents were most likely to agree with the statements that they can now 'provide more person-centred support for families' (71%), 'offer better trauma-informed support' (71%), 'work more effectively with other services to support families' (70%), and 'have seen an increase in demand for FSS (65%). One third of survey respondents (33%) 'slightly agreed'

that there had been 'no significant change' in the support they could provide since 2021, and 10% 'strongly agreed'.

Survey respondents were asked whether they felt the National Mission has (on balance), been a positive or negative influence on FSSs. As can be seen in **Figure 24** below, just over two fifths (43%) viewed the influence as positive, with 37% selecting 'mostly positive'. A further 10% described the impact as 'evenly split between negative and positive'. Few respondents reported negative views. However, 16% said the National Mission has 'not had much influence', and a combined total of 27% were 'not sure' or preferred 'not to say'.

Figure 24. Perceptions of the National Mission's influence on FSSs (n=51)
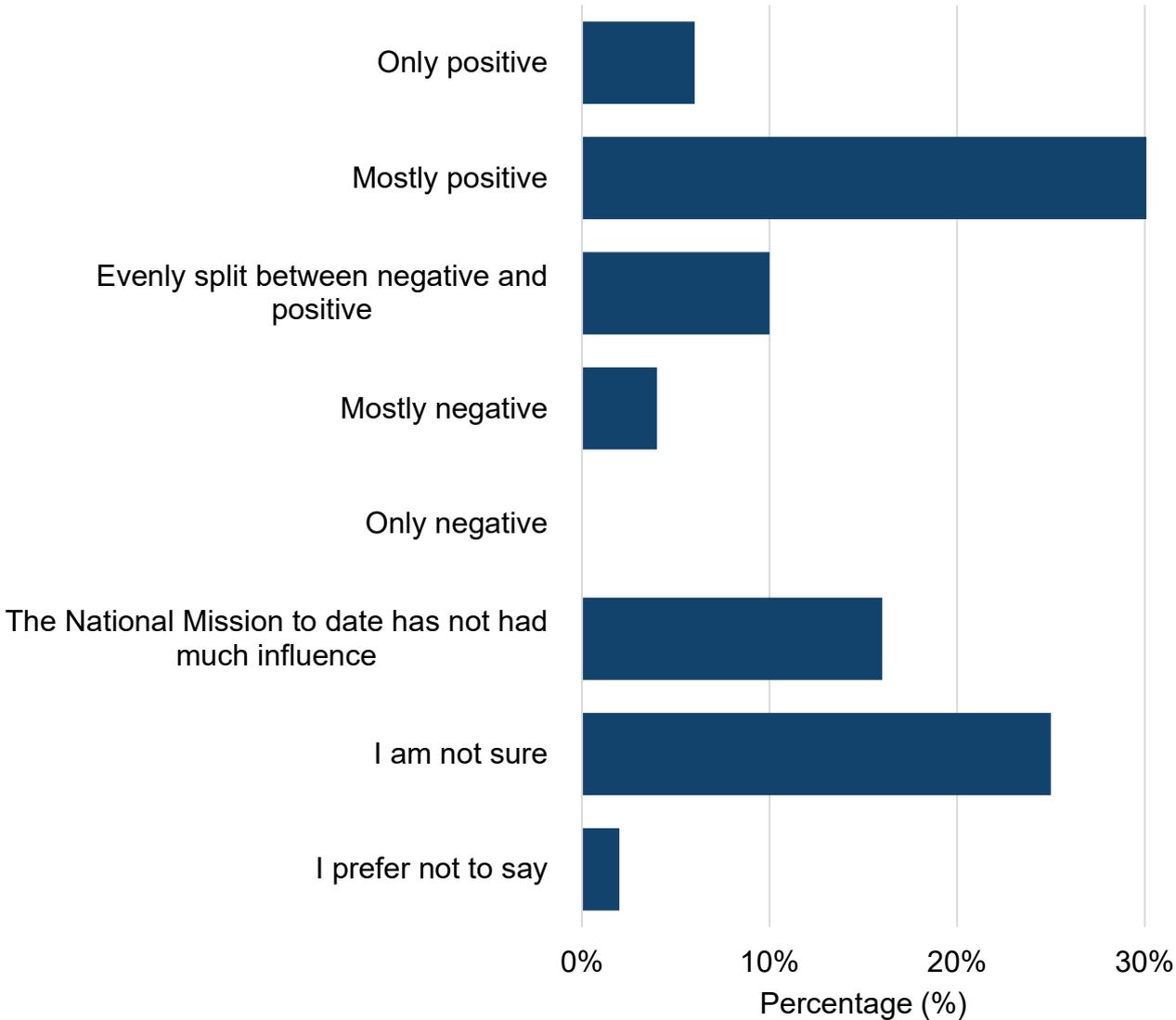
Note: 15 missing responses.

Survey respondents were also asked whether they had observed any unintended negative consequences arising from the National Mission. The results are provided in **Figure 25** below.

Figure 25. Unintended consequences of the National Mission (n=46)
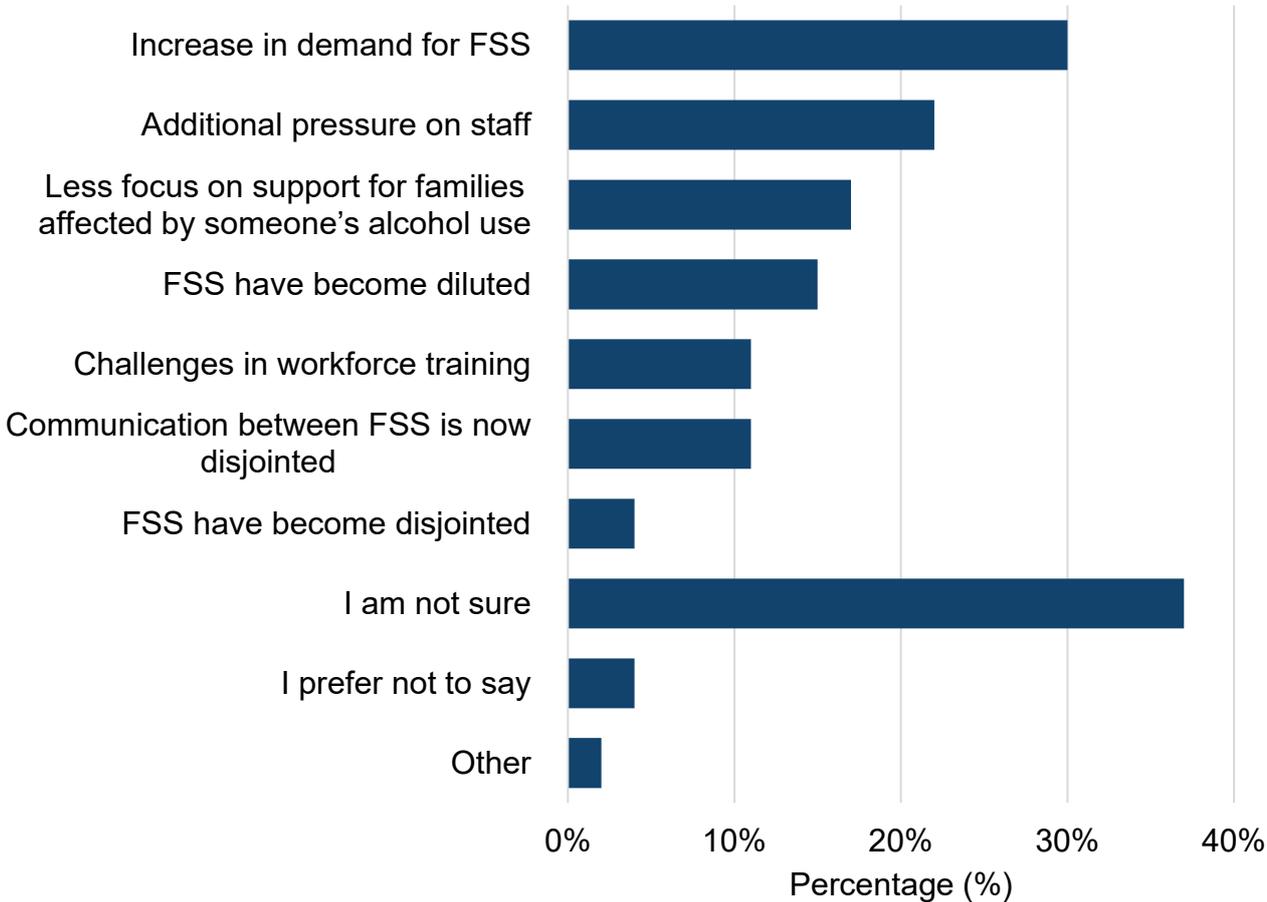
Note: Multiple responses allowed. This question was asked of the 51 participants who indicated they felt 'fully', 'mostly', or 'somewhat' informed about the National Mission. There were 5 missing responses.

The most frequently cited concern was an 'increase in demand for FSSs' (30%), followed by 'additional pressure on staff' (22%), and 'less focus on support for families affected by someone's alcohol use' (17%). Other concerns included 'dilution of family support', (15%) 'challenges in workforce training' (11%) and 'communication', (11%) and services becoming 'disjointed' (4%). A considerable proportion (41%) were either 'not sure' or would 'prefer not to say'.

Yet even where National Mission funding had a positive impact, participants expressed widespread anxiety about the future. Much of the investment was described as time-limited,

with the end of the funding cycle seen as a looming *'cliff edge'* [FG2-01]. Providers feared that services relied upon by families would be at risk, noting that *'funding has a big impact on staff retention and wellbeing which impacts family members indirectly'* [SR-56]. One respondent explained:

> 'I think worrying about continuation of funding is definitely a factor. Good staff move on and it's a constant concern for staff that resources are being stretched so you either dilute a great service or don't take new referrals.' [SR-56]

Still, some participants stressed that progress remained fragile without the necessary infrastructure and funding to support it. As one focus group participant explained:

> 'Government policies are saying these services are needed, but they're not backing it up with the necessary resources.' [FG1-02]

6.7 Providers views on their capacity to support families

Many survey respondents reported feeling well supported in their day-to-day roles, yet others highlighted underlying structural pressures. To explore these experiences, respondents were asked to indicate their level of agreement with a series of statements about working in family support. As can be seen in **Figure 26** below, a clear majority 'rather agreed' or 'strongly agreed' that they had sufficient support (86%), training (83%), and time (80%) to do their jobs well. However, a substantial minority described more precarious conditions.

Figure 26. Staff experience of support, training and working conditions

Legend:
- Strongly agree
- Rather agree
- Not sure
- Prefer not to say
- Rather disagree
- Strongly disagree
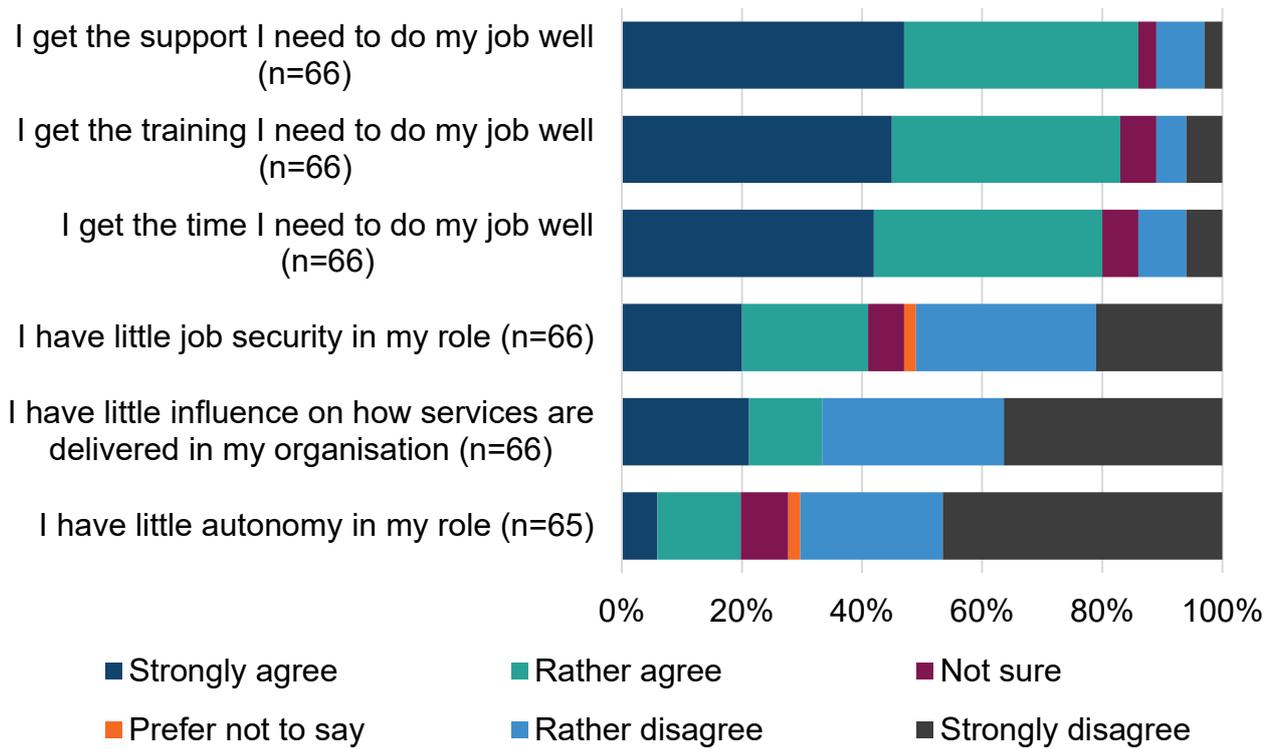
One third (33%) 'rather agree' or 'strongly agree' that they have 'little influence' over service delivery, and 41% 'rather agree' or 'strongly agree' that they experience 'little job security'. Even those who felt '*lucky*' they '*have the time*' [FG2-02] to contact families and provide support, there was an underlying awareness that service demands continue to outpace capacity.

> 'Everyone finds that they don't have the time or capacity to do all these things.' [FG1-03]

In addition, respondents were asked to note the extent to which their job roles had changed since 2021. The results are shown in **Figure 27** below.

Figure 27. Changes to job roles since 2021 (n=65)
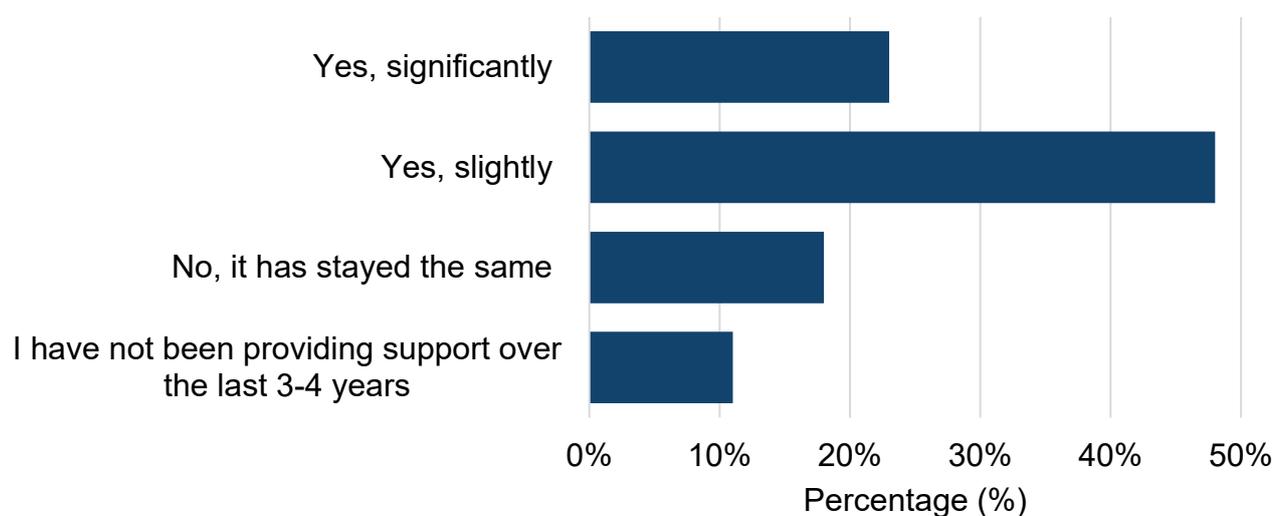
Note: 1 missing response.

Most respondents (71%) indicated that their role has changed either 'significantly' or 'slightly' over the last three to four years. Just under one fifth (18%) said their role had 'stayed the same' and 11% had 'not been providing support during this period.

Of those whose roles have changed (n=46), just over two in five (43%) said that they now provide a 'wider range of support to families'. A further 41% said that they are now 'dealing with more families'. The need for greater staffing capacity was a recurring theme. One survey respondent noted they needed '*another colleague to help with the workload'* [SR-18], and others called for '*more bodies, definitely more bodies'* [FG2-01]. One participant described the scale of demand:

> 'Well, we are really inundated now. My caseload now is sitting at 67, and my colleague's, maybe 75.' [FG3-03]

Participants reflected on the importance of collaboration with external services, particularly statutory partners, which were described as varied. Some highlighted limited or inconsistent collaboration, describing the absence of external support as ranging from '*a bit more difficult'* [FG2-03] to '*a constant battle'* [FG1-01]. For others, however, there was a clear sense of progress:

> 'I think there has definitely been a big improvement in collaboration in family support services … I think now statutory services are much more open to working alongside third sector services.' [SR-04]

Respondents were also asked to reflect on what support was available to them in their roles. They were asked to what extent the availability or quality of appropriate training had changed over the last 3-4 years. As can be seen in **Figure 28** below, 62% reported improvement to appropriate training (whether slight, moderate, or significant), and 24% reported 'no improvement(s)'. 14% reported a 'decline in quality and/or availability' or were 'not sure'. This reflects earlier findings, in which 77% of respondents reported that improved training and development was either a 'major' or 'minor' contributor to perceived improvements (see **Figure 16**).

Figure 28. Changes in the availability or quality of appropriate training since 2021 (n=66)
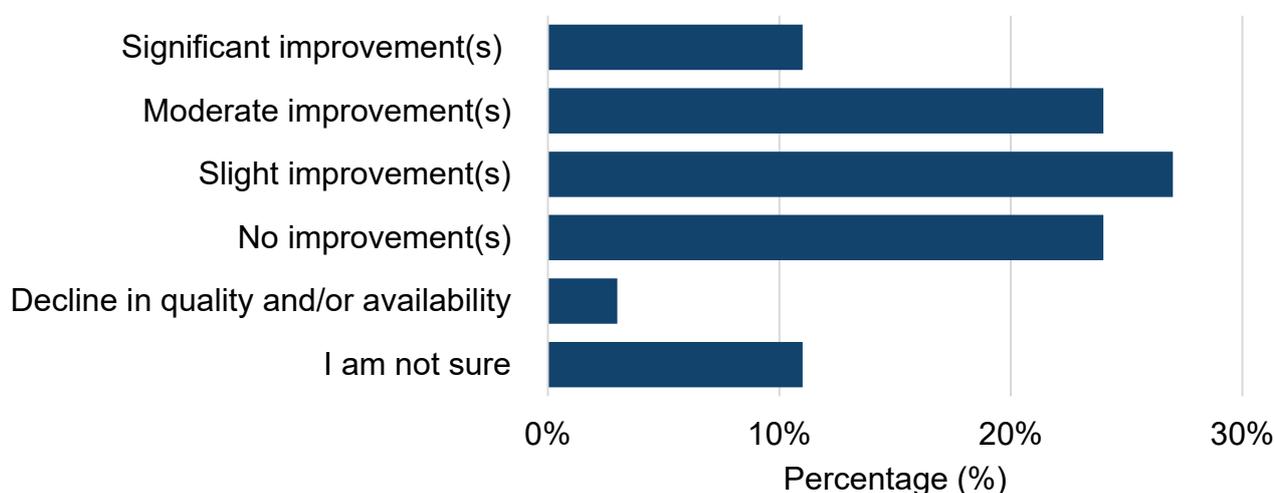
Despite these improvements, almost all staff (86%) still felt 'under pressure' in their roles either 'sometimes' (55%), or 'often' (32%). A further 70% felt 'at risk of burnout' either 'sometimes' (52%) or 'often' (18%) (see **Table G6** in the Supporting Evidence Report). The work was described by one focus group participant as '*a lot to carry*', [FG1-03] and another described an enduring lack of supervision:

> 'Who's supporting me? Where's my supervision? ... Nobody's ever offered me support.' [FG1-01]

Some participants reported operating with minimal staff and being '*supported with volunteers*', [FG1-04] raising concerns about capacity. In the absence of accessible services, volunteers fill critical gaps '*voluntarily 365 days a year*' [FG1-05].

> 'Families are on the frontline, and we are doing this 24/7 and it's wearing, wearing really thin.' [FG1-05]

Several respondents reflected on their own or a loved one's alcohol and/or other drug use as '*a large motivator to get into this kind of work'*. [FG1-03]. In some areas, lived experience was not only a source of personal motivation, but a valued form of expertise. One individual noted:

> 'I benefit from peer support… and supervision sessions and feel this is vital to increase your confidence and your appreciation of different approaches and strategies which can be used to support family members.' [SR-14]

Providers reported increasing service demands and expanding roles, and highlighted access to training as important for staff wellbeing and the quality of support offered.

6.8 Support for children, young people, and young carers

Just over one fifth of survey respondents reported improvements for both 'specialist support for affected children' (21%) and for 'kinship carers' (21%), and 'young carers' (20%) (see **Figure 15** above, 'Perceptions of changes to FSSs in the past 3-4 years'). For all three of these areas', reports of 'no change' and 'don't know' responses were high: almost half were unsure of any changes in 'specialist support for young carers' (49%), a little under half were uncertain of change for 'specialist support for affected children' (44%) and 'specialist support for kinship carers' (44%).

Despite growing availability and '*more* [name of young people's service] *projects across Scotland*', [SR-56] concerns at some local levels remained. One respondent highlighted: '*the criteria* [that] *a young person must meet to be offered support can sometimes feel restricted*' [SR-21]. This sense of uneven access led some to call for '*more training around drugs and alcohol… including how to support children impacted',* [SR-34] as well as stronger national investment and a clearer commitment to breaking the cycle of harm:

> 'I strongly believe more funding needs to go towards providing quality support for young people affected by a family member's substance use in order for us to stop the generational cycle of substance use in Scotland.' [SR-56]

Within one focus group, young people were described as '*missing*' [FG2-01] from services. Some were unaware that support existed, whilst others needed targeted outreach or specialist support. One participant questioned the availability and nature of provision, raising concerns about those not engaged with services:

'There must be young people with parents and they're living with that every day and how do we reach those people and what do we provide them?' [FG2-02]

Those who do access help sometimes struggle to relate to others in mixed-support groups.

'[Name of young person] didn't feel that they belonged in the group because the other people were talking about losing their mum or dad to cancer. And [name of young person] felt because [their loved one] was in drug addiction, it was a choice, and people wouldn't see it the same way.' [FG1-09]

To address these barriers, some services have introduced alternatives like confidential WhatsApp groups, offering lower-pressure ways to stay connected. One participant described a youth-focused, confidential, and moderated group:

'We've got some young people WhatsApp groups … nobody might say anything for a couple of weeks, but then actually, somebody has a crisis over the weekend, and everybody rallies around.' [FG1-09]

Whilst not a substitute for in-person contact, these digital approaches are considered to have contributed to reductions in stigma, protecting privacy, and expanding reach, particularly for younger people and those in more isolated areas. As one participant noted, the goal is '*to reach out to as many people as possible'.* [FG1-05]

Chapter 7: Discussion

KEY MESSAGES:

- Accessibility, availability, and quality of family support services are reported to have improved in some parts of Scotland since 2021, but progress remains uneven across regions and service types.

- Family members describe easier access and more peer and group options in some areas, yet awareness, out-of-hours cover, respite provision, and local 'postcode lottery' effects still limit who reaches support.

- Support that is reached is generally seen as respectful and high quality, particularly peer and one-to-one offers using trauma-informed, person-centred approaches. However, specialist provision for young carers, kinship carers, bereaved families, men, and minority ethnic communities remains limited.

- Improvements are most evident where ADPs and commissioners back family support with funding, workforce development, and awareness-raising, and where services collaborate closely with treatment, social care, and community initiatives, including digital and outreach models.

- Short-term and insecure funding, rising demand and workforce pressures constrain capacity and contribute to persistent gaps, including out-of-hours support and specialist or culturally appropriate provision. Providers describe high caseloads, emotional strain and reliance on volunteers.

- Family support providers feel better equipped than previously, with more skills, peer networks and recognition of their role, but emphasise that without multi-year investment and stronger integration with statutory services they cannot fully meet demand.

- Family members and providers generally do not view the National Mission as the main driver of change, and families often remain unaware of it. Reported unintended consequences include increased demand and staff pressure, a potential funding 'cliff-edge', a tilt towards support for drug-related rather than alcohol-related problems, and fragmented initiatives.

7.1 Introduction

Our discussion synthesises insights from family members, family support providers, and young carers on the impact of the National Mission on FSSs. We address the key evaluation questions: how the accessibility, availability and quality of support have changed since 2021; what factors have driven improvements or led to remaining gaps; any unintended consequences of the National Mission; and how service providers view their capacity and challenges. To be clear, this chapter outlines our interpretation of the key findings from the study.

By comparing the perspectives of different groups, we highlight common themes and differences in experiences, noting where improvements have been realised and where support is still lacking.

We cannot attribute changes solely to the National Mission. The evidence reflects perceptions over time, varies by place, and includes recall bias.

7.2 Changes to the accessibility, availability, and quality of family support services since 2021

The findings indicate that accessibility, availability, and quality of FSSs are reported to have improved in some areas since 2021, whilst remaining uneven overall. Family members describe modest improvements in access and the range of FSSs but also emphasise patchiness and local variation. Providers similarly report strengthened collaboration in places alongside ongoing variability. Together, these perspectives suggest gradual but inconsistent progress.

Around one third of family members who have sought, received or engaged with FSSs since 2021 say support is easier to access since 2021 (35%), and a similar share say the range of support has increased, whilst a smaller minority report deterioration.

Perceived availability shows some improvement; however, awareness of what exists continues to limit access for many. New peer support groups have been established in some areas, and some existing services have expanded their capacity. Even where services do exist though, awareness of them appears to be uneven. Some people only learn about available support after long periods of coping alone. These patterns point to an

offer of family support that is seen to be improving and growing but not yet reliably visible or reachable across localities.

The quality of support received is generally applauded by those who engage, but it can depend on what services are available. General peer-support groups are widely seen as helpful, but more specialised supports – such as professional counselling, whole-family therapy, or bereavement counselling – are not uniformly available across regions. Where these services are missing, families have limited options if they need more than basic peer support. Family members mostly described staff and volunteers as understanding and non-judgemental and found that peer support in particular helped them feel less alone. Family support providers echoed these changes, reporting that they are using more trauma-informed, person-centred approaches, and working more closely with other agencies – all of which has enhanced the support available to families. The study's evidence suggests that when support is reached, a majority are generally well regarded and appear to be improving in both reach and quality.

At the same time though, perceptions are somewhat mixed and equity concerns remain. Access to support still varies greatly by region. Families highlight out-of-hours gaps, long waits, limited respite, and insufficient range; rurality and local context are reported to shape access. Urban and central areas often have multiple support options, whereas many rural and remote communities still have few or no local services. Out-of-hours support appears to be the largest practical gap. Families struggle to get help at night and weekends; with around three-quarters of providers identifying this as a priority. Providers also point to persistent gaps affecting specific groups, including specialist and culturally appropriate provision.

Perceptions of quality also connect to experiences of respect and stigma. Many family members describe respectful support in FSSs and perceive improvements since 2021, whilst reports of stigmatising encounters in wider services (notably emergency care) and limited GP signposting continue. This divergence appears to influence whether people feel able to seek or sustain support. These factors mean that despite overall progress, many families still struggle to find timely and appropriate support when they need it.

Support for children and young people is reported to be valued where it exists but remains sparse, with families citing variable provision and waits for mental health support. In the two focus groups, young carers did not report any new services or improvements for people their age since 2021. They typically reported relying on a single specialist project in their

area, and they said schools and other mainstream services offer little to no help for their situation. Providers similarly note that some young people are 'missing' from provision, prompting low barrier approaches to maintain contact. These patterns indicate that perceived improvements in accessibility and quality are not yet evenly realised for younger family members. Due to the small number of young people who participated in the study, these findings should only be considered to be indicative and would need further testing to fully substantiate them.

7.3 Specific factors that have contributed to perceived improvements or gaps in the family support experience

Family members and family support providers both pointed to various factors behind the successes or shortcomings in family support since 2021. Understanding these helps to highlight and expose why progress has been stronger in some areas and what is holding back change in others.

Enablers of improvement are seen to include stronger local commissioning and ADP leadership, workforce development, and awareness-raising that improves referrer and public understanding of available support. Providers explicitly link progress to these drivers, suggesting that where they are present, FSSs can widen reach and enhance quality.

Additional funding dedicated to family support under the National Mission has enabled some services to expand or new ones to be set up. This has allowed certain areas to hire more staff or launch projects, leading to more support options where there were few.

Family support is largely delivered by third-sector organisations and volunteers. Many providers bring personal experience and strong commitment, driving improvements in service quality. Their empathy and dedication have spurred creative, flexible approaches (for example, peer mentoring and other informal support) that make help more engaging and accessible for families.

There is growing collaboration amongst services and adoption of good practices. Stronger links with substance use treatment services, and other generic services (both statutory and non-statutory), mean families are starting to receive more coordinated care. Training and sharing of expertise (for instance, in trauma-informed care) have contributed to improving consistency and professionalism. In some areas, involving family members in designing services appears to have made support more relevant to their needs.

From the family perspective, timeliness and frequency of support, respectful interactions, and meaningful involvement in loved ones' care are reported to contribute to better experiences. Families also describe the importance of clear information and navigation support, with confusion about what is available acting as a barrier. These elements provide an indication of whether improvements are actually felt in practice.

Constraints that hinder progress are widely reported. Families point to out-of-hours gaps, long waits, limited respite, insufficient range, and location-specific barriers, including rurality; providers highlight persistent deficits in equity and specialist/culturally appropriate provision. Where awareness of services is low or information is hard to find, progress on accessibility does not translate into uptake.

It is clear that regional disparities persist. Some rural and remote areas have little to no local support due to distance and lower resources. Families in these areas face a 'postcode lottery' in access to help, compared to those in well-served regions.

Many services still operate on short-term or limited funding. Demand has grown, but resources are reported to have not kept up, leading to waiting lists and uncertainty about keeping services running. This financial fragility should be considered to be a root cause of patchy provision.

Views converge on the value of peer support and trauma-informed, person-centred practice. Families report high satisfaction with peer and one-to-one offers, whilst providers describe observable increases in peer provision with positive impact. These factors are seen to enable engagement and sustain wellbeing when present.

At the same time, perspectives diverge on the extent to which broader system connections support families. Families emphasise limited signposting from GPs and variable experiences in emergency and primary care. Stigma around drug use continues to deter some from seeking help early, meaning improvements on paper don't always translate into more people getting support. Providers focus on collaboration gains with statutory partners, noting that these gains remain uneven. This divergence suggests that improvements in partnership working do not always translate into consistent, family-facing pathways.

Community action also appears to mitigate some gaps. Families describe establishing peer groups, helplines and local initiatives that extend reach where commissioned or statutory support is thin, indicating that improvement sometimes arises from bottom-up responses.

Certain groups of family members are not well served by current supports. Young people (young carers) have very few services suited to their age group. Kinship carers (such as grandparents caring for children) struggle to find support that addresses their practical and emotional needs. Families bereaved by drug-related deaths often lack access to specialised grief counselling. Support that engages men or people from minority ethnic communities is also limited. Because of these gaps, even with overall improvements, many individuals with specific needs still see little change in their experience.

Improvements have often occurred where there was clear support from policy and funding, combined with the efforts of a committed workforce and a move towards more integrated, best-practice services. Conversely, where resources are lacking, awareness is low, or needs are more specialised, progress has stalled, leaving noticeable gaps. Addressing these factors (by spreading funding more evenly, promoting services better, and developing support for under-served groups), will be crucial to ensure that positive changes reach all families.

7.4 The views of family support providers regarding their capacity to support families, and the improvements and/or challenges they have encountered since the National Mission's inception

Family support providers described a mix of pride in progress and frustration at limitations. Since the National Mission's start, many providers feel better equipped to support families. They have gained new skills through training (for example, in trauma-informed practice), formed stronger peer networks, and developed closer links with other agencies. Family support is now more recognised as a key part of addressing problematic drug use, which has empowered providers to advocate for families to be included in treatment and recovery processes. Some services have modestly expanded their offerings or teams, allowing them to help families in more ways than before. These developments mean providers can deliver higher-quality support than they could a few years ago.

However, major challenges remain, and overall capacity still falls short of demand. The most common concern is inadequate funding and staffing. Many services have very limited staff and depend on short-term funding, which constrains how many families they can assist and where. Demand for support has risen without a matching increase in resources, so providers often must prioritise who gets help first. This is stressful for staff and means some families may not get support when they need it. Heavy workloads and emotional strain are

widespread; providers worry about burnout and the loss of experienced staff under these conditions.

Providers also noted system-level issues. In some places, coordination with NHS or social services is still patchy. For example, not all professionals routinely refer families to support or share information. This lack of integration makes the family support provider's job harder, as families can slip through cracks between services. Often, family support workers try to fill gaps (like giving basic mental health or financial guidance) when other services aren't available, but they know this isn't sustainable.

Providers appreciate improvements in training, networking, and acknowledgement of their role, yet their ability to meet growing needs remains very limited by resource constraints. In terms of what would help now, our assessment of the priorities discussed by providers would include: multi-year funding to stabilise teams; embedding family inclusive pathways with statutory services; protecting supervision and training; and shared protocols to ensure every family gets an offer of support. Without these providers feel that it will be difficult to sustain and build on the progress made since 2021.

7.5 Unintended consequences of the National Mission's implementation that have affected family support

The study findings suggest that the National Mission is seen to have contributed to aspects of practice (for example, trauma-informed and person-centred approaches, and cross-service working) but is not widely viewed by providers as being the primary driver of change.

Family members' awareness of the National Mission is generally low, and they are uncertain whether observed improvements relate to it; they also express concerns about sustainability. This suggests that, from a family perspective, any Mission-related changes are not yet clearly visible or attributable at the point of use.

Despite the perceived benefits and well-intentioned focus on improving family support, participants noted some unintended side effects of the National Mission's implementation:

- **Rising demand on services:** Demand has risen over the last few years as awareness of family support has grown. Services welcomed this but reported pressure on staffing and waiting times.

- **Funding 'cliff-edge':** Time-limited funding is reported to have created uncertainty and a potential 'cliff edge' risk for services after the planned endpoint of the National Mission. This perceived instability appears to be affecting provider confidence in planning and maintaining capacity.

- **Focus on drugs over alcohol:** Because the National Mission centres on drug deaths, families affected by problematic alcohol use feel their needs have received less attention. Some support providers noted that funding and services have become more drug-focused, leaving a gap for those dealing with alcohol-related issues.

- **Fragmentation of opportunity:** The rapid rollout of multiple initiatives in a few (larger urban) areas has, in some instances, created a fragmented system hallmarked by the challenge of coordinating expanding service provision at pace. This has also led unintentionally to a widening of the inequality gap between the areas most served by FSSs (which tend to be the larger urban areas where there is existing capacity of resource to develop further funding bids), and those areas that are least served by FSSs (which tend to be the more rural and remote areas of Scotland where there is little existing capacity to focus on developing funding bids, etc.). This unintended effect points to the need for better communication and alignment of services under the National Mission to contribute to reducing this inequality.

These unintended consequences highlight the importance of pacing and supporting change. They suggest that future efforts should ensure resource increases go along with awareness-raising, that no group of families is unintentionally left behind by a narrow focus, and that better coordination and workforce support should accompany ambitious targets.

7.6 Conclusion

The findings show that family support in Scotland has indeed improved in some important ways since 2021, but these improvements have not been realised everywhere. Participants across all groups acknowledged positive changes – for example, more attention to families' needs, new support groups in some areas, and more family inclusive attitudes in services. However, they also highlighted significant ongoing challenges such as inconsistent access (a 'postcode lottery'), inadequate out-of-hours provision, and the absence of services for certain groups like young carers. There was a clear consensus on the need for sustained

funding and expansion of services to address these gaps, as well as better integration of family support into mainstream health and social care.

Family members and providers largely agree on the priorities moving forward. Both emphasise wider coverage of support across regions, tailoring services to under-served populations, and supporting the workforce to prevent burnout. Young carers added that the system must not overlook children and adolescents in families affected by a loved one's drug use – emphasising the importance of truly inclusive, whole-family support.

The National Mission has set a positive direction and delivered early benefits, but further effort is required to ensure these translate into lasting, nationwide change. The progress to date is encouraging yet fragile. Stakeholders have a clear sense of what to reinforce and what to improve. By acting on these lessons – ensuring no family or age group is left behind and providing resources to match demand – Scotland can build on the early momentum created by the National Mission and move closer to a comprehensive support system for all families impacted by drug use.

Chapter 8: Considerations for future research, policy, and practice

8.1 Introduction

This chapter looks ahead with an urgent call to address the gaps identified in this study. Drawing on the insights of family members, family support providers, and young carers, we will highlight key shortcomings in the current system and outlines steps to strengthen support.

Whilst some progress has been made since the launch of the Scottish Government's National Mission on Drugs in 2021, we have concluded that improvements remain uneven and fragile. Families continue to face major barriers – including patchy support coverage, persistent stigma, and limited help for children and young people. Across all participant groups, we have heard and observed a high level of agreement that much more needs to be done.

In this chapter we present our considerations for future research, policy, and practice, along with a set of clear recommendations, to help ensure that no family is left behind.

8.2 Considerations for research, policy, and practice

Access, visibility, and stigma: Families cannot use support they cannot find or do not feel safe to seek. Many people still do not know about services, and fear of judgement often keeps them from reaching out. The profile of family support must be raised further through clear public information and proactive signposting by professionals (GPs, social workers, and others). Family members called for an established national helpline and online directory as a 24/7 point of contact, along with better use of social media and community outreach to advertise help. Services should offer support outside normal office hours so that families have somewhere to turn at night or on weekends when crises often occur. In parallel, further efforts need to be made to tackle stigma so that family members feel able to seek help sooner. This means normalising conversations about drug problems and assuring people that asking for support is a sign of strength, not failure. Targeted efforts are needed to engage under-represented groups (for example, men and minority ethnic families), who can often be especially reluctant to come forward.

Ending the postcode lottery with better coverage and coordination: Stark regional inequalities mean that some areas have many supports whilst others have none. Every family should have help available, no matter where they live. ADPs and commissioners should ensure a basic level of family support in every part of Scotland, using creative solutions to fill gaps. This could include funding new groups in underserved regions, supporting outreach to rural and island communities, and expanding digital or telephone support for those unable to attend in person. Providing services is only part of the solution – coordination amongst services is equally important. Better integration across agencies (treatment services, health and social care, and community organisations) will help to prevent families from falling through the cracks. For example, when someone enters drug treatment, there should be an automatic offer of support to their family. Clear referral pathways and shared protocols can ensure that whenever a family seeks help – whether at a GP, hospital, or community centre – they are quickly connected to appropriate support. ADPs have a central role in promoting this joined-up approach locally.

Strengthening the workforce and harnessing lived experience: The people delivering support need more backing themselves. Frontline staff and volunteers are dedicated but often under-resourced and on short-term funding. Long-term investment is needed to stabilise and grow this workforce. That means moving beyond year-to-year funding so that FSSs are able to recruit and retain enough staff to meet demand. Supporting the workforce also means providing regular training (for example in trauma-informed and family inclusive practice) and ensuring staff get support to prevent burnout. Lived experience is a key strength in this field – many staff or volunteers have personal experience and bring unique empathy. Services should expand peer support roles and involve family members with lived experience in service delivery and design. These measures will enhance the quality of help provided and ensure families interact with a workforce that is skilled, resilient, and relatable.

Including young carers and early intervention: A significant gap is the limited, and regionally inequitable, support for children and young people affected by a relative's drug use. Young carers – children who support or live with someone using drugs – often receive little to no help. This must change. We need services tailored to younger family members and earlier intervention to prevent lasting harm. Schools and youth services should be key allies: staff need training to recognise when a child is struggling due to drug use at home and to respond or refer appropriately. Dedicated support for young people (for example, confidential peer groups, age-appropriate counselling, or simply a safe space to talk) can make a huge difference and help them feel less alone. Kinship carers (family members who

have taken over raising children) also need greater support – from practical assistance to respite – as they often step in with minimal help. In short, a 'whole family' approach means every age group is supported. The sooner that children in these families are supported, the better their chances to cope and thrive.

Maintaining momentum and using evidence: The National Mission's focus on families has spurred improvements, but there is concern about the future once this initiative ends. Short-term gains will mean little unless followed by sustained commitment. The Scottish Government should ensure that progress made under the National Mission is not lost. Family support must remain a priority and become a permanent pillar of Scotland's approach to supporting all those affected by drug use (whether their own or that of a loved one). This includes extending funding beyond the current term and broadening the scope to support all affected families (including those impacted by alcohol use). In addition, stakeholders should keep learning and adapting based on evidence. Ongoing evaluation and research can show which support approaches work best and demonstrate the benefits of helping families (for instance, improving family wellbeing and stability). Such evidence will strengthen the case for continued investment. Future research should also explore how to better reach any groups still missing out on support (for example, men and ethnic communities) and should actively involve people with lived experience in shaping questions and solutions.

8.3 Recommendations

We have developed the following set of recommendations that speak to the broad range of relevant stakeholders:

- **Policy makers (The Scottish Government):** Provide sustained leadership and funding for family support. Ensure that dedicated support for families continues beyond the National Mission's end date and becomes a permanent part of drug and alcohol policy. Mandate and resource the consistent adoption of the Whole Family Approach across Scotland – every area should offer core FSSs (including support for young carers and bereaved families). Expand the focus to include families affected by alcohol as well.

- **Commissioners (ADPs):** Identify and close gaps in local family support. Fund or facilitate services for families in areas currently lacking provision, particularly in rural or remote communities. Coordinate clear referral pathways with NHS, social

care, and third-sector agencies so that families are connected to help wherever they seek it. Fully implement family inclusive practices – for example, include young carers and kinship carers in planning – and make sure available funding for families is used. Promote the supports you provide to improve public awareness.

- **Drug treatment services:** Make family inclusion a standard part of care. With consent, involve family members in treatment discussions and planning for their loved one. Train staff to engage with families empathetically and recognise their needs. Importantly, whenever someone enters treatment, routinely offer their family (or partner) a referral to support for themselves.

- **Family support providers:** Continue to improve outreach and make services as accessible as possible. Offer flexible options – for example, meetings at evenings or weekends, drop-in sessions, and alternative ways to engage (meeting at neutral venues or via online forums). Involve people with lived experience in your teams and service design to keep support family centred. Support your staff and volunteers with training and measures to prevent burnout and advocate for stable funding to grow your capacity. Work closely with other local services to present families with a seamless network of help.

- **Affected family members:** You are not alone – help is available for you. We encourage you to seek support early, whether through a local family group, a helpline or by speaking to a health professional, rather than coping alone. Don't let shame or stigma stop you from reaching out; every family has a right to help. Your experiences are valuable – by sharing your perspective (for example, giving feedback or joining a family forum) you can help improve services and challenge stigma. Remember to look after your own wellbeing; getting help for yourself is a positive step for you and your loved one.

- **Researchers and evaluators:** Continue building the evidence base on what works for families. Evaluate the outcomes of different support models (e.g. peer groups, counselling, young carer services) to inform future investments. Investigate how to better reach and support under-served groups – for instance, explore ways to engage more male relatives or minority ethnic families. Involve people with lived experience (both family members and individuals in recovery) in designing and conducting studies for deeper insight.