

Understanding recovery from a family perspective: a survey of life in recovery for families

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Understanding recovery from a family perspective: A survey of life in recovery for families

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INSTITUTIONAL DETAILS

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EXECUTIVE SUMMARY

A growing body of research describes how the lives of dependent drinkers can change as they move from active addiction to recovery. The *Life in Recovery* surveys in the US, UK, Australia, Canada and South Africa all reveal marked improvements in physical and psychological health, family functioning, employment and education, reductions in crime and community engagement (Best, 2014; Best et al, 2015). However, no surveys have, until now, assessed the experience of recovery from the perspective of family members.

For family members, recovery is experienced in two senses. They observe the journey of the recovering drinker; however, they also embark on their own journey of change as a consequence of their experiences. The work presented here attempts to describe both aspects.

Method

The *Life in Recovery* survey asks substance users about their life experiences during active addiction and, subsequently, in recovery. This project adapted the *Life in Recovery* survey to capture the experiences of family members around recovering drinkers.

During the design phase, half-day public involvement workshops were held in Sheffield and London, each attended by 30-40 people. Two key issues emerged:

- For many participants, their family member had relapsed and could not be regarded as being in recovery
- The standard *Life in Recovery* survey needed significant amendment to become relevant to the needs and experiences of family members.

The draft survey was extensively amended in the light of the workshops. It was further refined, and then piloted, following comments from a project advisory group containing academics, practitioners and experts by experience.

The survey ran for three months, and was circulated nationally via Adfam support groups, social media, and other partner agencies. It was also circulated internationally with the support of Faces and Voices of Recovery (FAVOR) and William L. White.

The surveys were completed by individuals who had a family member in, or attempting, recovery from dependent drinking. All findings, therefore, reflect the experiences of the survey respondents rather than the drinker in, or seeking, recovery.

Findings

There were 1,565 valid completions of the online survey.

- 48.1% of respondents were parents
- 23.6% spouses or ex-spouses
- 10.3 were children
- 8.7% were siblings
- 1.3% were friends

The majority of participants were women (87.7%) and the average age was 52. Around two-thirds of the sample were married or living with a partner. Just over half (51.4%) were in regular employment, and a similar number had a degree or postgraduate qualification. The sample, therefore, had higher qualifications than the national average, which suggests a skew towards people with higher levels of 'cultural capital' among respondents. This should be borne in mind when interpreting the results.

Over one-third of the sample (36.9%) were receiving help or treatment for emotional or mental health problems at the time of survey completion, with 71.9% having received help at some point for emotional or mental health issues.

Respondents reported family members with a number of dependencies, often multiple:

- 62.6% alcohol
- 67.7% illicit drugs
- 34.8% prescription drugs
- 7.3% 'legal highs' or Novel Psychoactive Substances

The average length of the substance-using career was 14.1 years. 78.8% had attended a treatment programme at some point for their addiction problems.

Although the survey was initially targeted at those in recovery, 33.2% of former users had relapsed at the time of the survey, according to the responding family member. The family members of those who had relapsed reported poorer physical and psychological health, and poorer quality of life than those whose family members were still in recovery.¹

Changes experienced by respondents during the recovery journey

- 55.1% of respondents reported having debts during their family member's active addiction, compared to 44.0% during recovery²

¹ 'Recovery' is used here to describe the period when a dependent drinker seeks to change their drinking to overcome the problems they have experienced. For most, but not all, respondents this implied abstinence. The term is not used prescriptively (there is no single model for recovery), nor does 'relapse' imply that recovery ends completely.

² The term 'active addiction' is used here to describe the period of heavy drinking prior to embarking on the recovery journey. This term is used pragmatically and does not imply a particular model of addiction or dependence.

- 27.7% of respondents reported that they couldn't pay their bills during their family member's active addiction, compared to 17.6% during recovery
- 31.7% were victims of family violence during their family member's active addiction, compared to 10.5% during recovery
- 4.7% were perpetrators of family violence during their family member's active addiction, compared to 0.9% during recovery
- 46.1% had untreated emotional or mental health problems during their family member's active addiction
- 8.7% had frequent use of healthcare services during their family member's active addiction period, compared to 2.7% during recovery
- 5.0% of respondents were arrested while their family member was in active addiction, compared to 2.0% during recovery
- 12.9% of respondents drove under the influence of alcohol or drugs while their family member was in active use, compared to 3.9% when they were in recovery
- 3.4% of respondents served prison time while their family member was in active use, compared to 1.2% when they were in recovery
- 8.7% of respondents were fired or suspended from work while their family member was in active use, compared to 4.0% when they were in recovery
- 59.2% of respondents got positive work appraisals while their family member was in active addiction, compared to 89.9% during recovery

These effects were even more dramatic when the drinkers who had relapsed were considered separately. Respondents also reported high rates of grief in relation to the perceived loss of the person drinking heavily (even though they had not died in most cases) and elevated rates of stress, although these tended to diminish as their loved one started their recovery journey.

Changes experienced by the individual in recovery

The proportion of drinkers who were victims of family violence fell from 26.3% to 9.0% when they entered recovery. The the proportion who were perpetrators of family violence fell from 33.4% to 11.3%.

Conclusion

Family members of people in addiction and recovery have important things to say, and yet their voices are rarely heard. While there is a well-established research evidence base showing the impact of addiction recovery on the lives of drinkers (and other substance users) themselves, this is the first piece of work that illustrates the impact - across multiple domains - of recovery on family members around dependent drinkers. The effect of living with a family member who is dependent on alcohol or other substances is substantial and long-lasting: over 70% of participating family members reporting lifetime emotional or mental health problems, and over one-third suffered from those problems at the time of the survey.

Whether the person with substance use issue is currently using clearly affects the wellbeing of family members. Those family members who reported that a loved one

was in recovery showed markedly better functioning across all of the areas of physical and psychological health, and quality of life than when the loved one had relapsed. In other words, family members are not only positively influenced by the recovery of the dependent drinker, they are also susceptible to reversals if these gains are lost. This is critical given the finding that the impact of recovery crosses so many domains of the family members' lives.

This report highlights the toll that addiction exerts not only on individual drinkers but on those around them, and it clearly establishes the importance of recovery in mitigating some of these adverse effects. At the same time, it shows that while families as a whole experience significant benefits through the recovery journey of loved ones, not all of the emotional damage is reversed, and relapse undermines at least some of the positive gains.

It is clear that family members need support not only to assist loved ones dealing with addiction but in their own rights. The challenges faced by many of our participants in finding the right kinds of support suggests that such services are both needed and inadequately provided, with too great a reliance on voluntary community groups run by committed peers.

This report confirms the need for a focus on families, as well as individual substance users, when planning treatment and recovery interventions. It shows that family members are both a resource to support recovery, and people whose own lives can be transformed through recovery. Supporting families is essential to developing an integrated approach to reducing alcohol harms, and understanding the experiences of family members plays a key role in achieving this goal.

INTRODUCTION AND CONTEXT

Overview of the literature

There is a small but growing body of research exploring the impact of addiction on families, but a gap around the effects of addiction recovery on families, and this gap is consistent with a move away from individualistic approaches to social and contextual models of addiction and recovery (Gruber and Taylor, 2008; UKDPC, 2009; Adfam and Drugscope, 2009). Research concerning the recovery experiences of problem drinkers and drug users continues to develop, but there is limited evidence relating to the experiences of drinkers' families as participants in addiction careers and almost nothing about their experiences of the recovery journey, and the impact of the user's transition from use to recovery on the family member's wellbeing (Adfam and Drugscope, 2009; UKDPC, 2009).

The definition of recovery is contested (Ashton, 2008; White, 2007). Nevertheless, the concept is gaining traction in the treatment and policy field (at least in the UK and US), as definitions move away from a medical conceptualisation of disease to one recognising the lived experience of the individual. Such approaches consider physical and mental health as well as quality of life, engagement in society and personal aspiration (Best and Laudet, 2010; Betty Ford Institute Consensus Group, 2007 and 2008; Ashton, 2008). Copello and Orford's (2002) argue that we must also understand the centrality of the family system that experiences, manages and ultimately may resolve addiction issues. We should also heed the value of interventions for the family and acknowledge that recovery is greater than cessation of substance misuse. Recovery should bring other benefits, such as alleviation of the physical and mental strains associated with addiction, and the journey to reintegration with social networks and communities. Intrinsic to this is the resumption or development of a varied and fulfilling life, characterised by hope and engagement with society and community, all of which develops along an ongoing recovery journey (Best and Laudet, 2010; Kastukas, 2014). This is embedded within a developmental pathway in which recovery is characterised as a process rather than a state.

Central to this framing is the concept of recovery capital. This consists of personal capital (such as resilience, physical health, finances, education and employment), social capital (social identity and group involvement) and community capital (the availability and accessibility of resources, such as support groups and the availability of alcohol and drugs services in the locality; Best and Laudet, 2010; Best et al, 2015; Best et al, 2016; Laudet and White, 2008, 2007). These components of recovery resource are dynamically linked and can create both vicious and virtuous circles depending on the spiral of connections and opportunities available. While the concept of recovery capital is increasingly widely used, its application as a family concept has not yet been explored.

While current UK addiction policy is focussed towards recovery (HM Government 2010, 2017), evidence around the effectiveness of recovery oriented strategy is in its

infancy, with limited evidence around the impact of their addiction on their social networks (Humphreys and Lembke, 2014; Ashton, 2008), and on the role of recovery on family integration and functioning.

Cloud and Granfield (2009) have argued that recovery capital extends to negative factors. In addition to assets, barriers such as poverty, ill health and environment can impact on a person's ability to develop and access resources that may accrue recovery capital. Both positives and negative aspects of recovery capital are pertinent in understanding the trajectory of the recovery journey. Among families, stigma can be a powerful barrier: secondary stigmatisation a common experience for the family members of addicts and is often linked to feelings of isolation and social exclusion.

Whereas previous treatments sometimes pathologized the family (on occasion, categorising them as 'enablers', 'co-dependents' or 'saboteurs'), and some of those individually focused interventions persist, a strand of the current literature recognises families as a valuable resource to individuals and people who suffer in their own right (Adfam and Drugscope, 2009; Orford et al, 2010; Velleman, 2010). There is some evidence illustrating the negative impact of addiction on close, extended and non-biological families in emotional, well-being, fiscal and practical terms (such as housing and employment status; (Brown and Lewis, 2002; Berends et al, 2012; Copello and Orford, 2002; Laslett et al, 2011; May et al, 2017; Borton et al, 2017). These stresses and strains create barriers that hinder the individuals in the family and the family as a unit in amassing the positive recovery capital vital to navigating their recovery journey (Cloud and Granfield, 2001, 2008 and 2009; Laudet and White, 2008).

Treatment for family members is geographically patchy, inconsistently linked to statutory provision of addiction treatment (at least in the UK), and is rarely delivered through health services. Much of the provision of family support is voluntary but varies by locality, although there is an extensive network of Al-Anon groups both in the UK and the US, and a smaller but visible presence of other groups such as FA and SMART Family and Friends. Accordingly, there are calls for exploration of how services and strategies can support and coordinate these local groups, not just as resources for the recovery of the individual, but to support family members who have suffered and need to recover in their own right (Gruber and Taylor; UK Govt, 2003; Adfam and Drugscope, 2009). In spite of this, there are concerns that the welfare system directly and indirectly penalises the families of substance misusers (Reeve, 2017; Harris, 2010; Copello et al, 2010), and there may well be a hidden cost to families - something that is explored in this study.

Conceptualisation of families of addicts

The treatment of families of substance abusers has developed from a pathology-focused model of causality to a focus in the 2000s on children as victims (Velleman, 2010). This is exemplified in the 'Every Child Matters' (2003) strategy with its focus on substance misusing parents, their 'at-risk' children and children in vulnerable, chaotic families who were perceived to be at risk of addiction themselves (HM Government, 2003; Velleman, 2010). Likewise, the "Hidden Harm" report by the Advisory Council on

the Misuse of Drugs (ACMD, 2002) focused on the harms to children from addicted parents and made reference to the wider damage to families resulting from parental substance abuse.

Acknowledgement of the family members and the family unit as victims who also need to recover and accumulate recovery capital in order to do so is gaining traction in the literature and this has had an impact on practice through addiction treatment services. This project furthers this approach by adding to the evidence base and through offering a voice to a previously hidden population (Velleman, 2010; Brown and Lewis, 2002). White and Savage (2008) asserted that family members' responses to the addiction of a loved one are not pathological but normal responses to trauma, and therefore should be expected to be the norm rather than the exception.

An addict in the family: the impact

Substance misuse can have far reaching impacts on parenting abilities, the experiences of children and the emotional, physical and financial wellbeing of family members (Gruber and Taylor, 2008; Brown and Lewis, 2002; Laslett et al 2010; May et al; Stenton et al, 2014). Brown and Schmid (2008) illustrated the mixed impact of the early recovery stage upon children within the family. For example, the newfound sobriety and accountability of their parents, and the resulting loss of independence may disrupt family processes and coping approaches, leading to bad behaviour. This may actually present a recovery-related challenge to the family (Brown and Schmid, 2008). The recovery of one family member may shift dynamics within the family; for example, the re-engagement of the parent in traditional adult roles may reduce the self-worth, purpose and identity a child developed when assuming adult roles in lieu of their parent (Brown and Schmid, 2008), and further distort their developmental trajectory. In other words, we cannot assume that the recovery journey of the user will result in equivalent improvements in the family.

There is a greater incidence of psychiatric diagnosis and mental health problems among children of problem drinkers. The negative impact of substance misuse in the family on parenting abilities and children's psychological, behavioural and cognitive wellbeing have been widely studied and this can manifest in a tendency to abuse substances themselves, as well as in low self-esteem, depression and lower academic and social functioning (Gruber and Taylor, 2006; Copello and Orford, 2002; Velleman et al, 1993). Furthermore, substance abuse is a significant factor in child neglect and abuse, particularly where social care involvement is concerned (Gruber and Fleetwood, 2001; Laslett et al, 2010).

The presence of an addict in the family and the associated behaviours can have an influence on family members' own drinking, as per Christakis and Fowler's (2009) theorisation of hyper-dyadic spread, through which they illustrated that across degrees of separation there can be an impact on the health, behaviours and emotions within a social network, as they have illustrated in the case of smoking and happiness (Christakis and Fowler, 2009; Best and Laudet, 2010). The work of Christakis and Fowler proposes the idea of contagion of behaviour patterns where both

positive and negative behaviours are spread through social networks, and is important in understanding the public health and socially driven impacts of substance use on networks including but not restricted to families.

Laslett et al (2010) illustrated the considerable physical harms associated with problem drinking, finding that 42% of domestic violence-related deaths were related to another's drinking and almost 1.3 million people per year were negatively affected 'a lot' by the drinking of a family/friend/household member. The main categories of drink-related harms to others involving hospitalisation are child abuse, domestic violence and road crashes. Furthermore, health problems due to addiction don't just affect the drinker or their partners. Foetal defects, injuries from domestic violence, nutritional deficiencies from neglect and mental health problems are all consequences of substance misuse that affect those proximal to the addict (Sokol et. al, 1980; Laslett et al, 2010). The drinker's own health can also affect the family, for example if they become disabled or suffers from chronic health conditions through their substance misuse then family members may have to emotionally and practically support them by assuming responsibility for caring duties (Zajdow, 1995 and 1998; Charles et al, 2009).

Arguably, the most traumatic consequence of problem drinking which affects family and friends for the rest of their lives, is bereavement. Templeton et al (2016) interviewed 106 adults and found that many family members had trouble living with the possibility of death, the challenges of official processes, problems of stigma and grief, and the challenges of obtaining support. Therefore, the bereavement can mean death but also the perceived loss of the valued and cared for family member who is seen to be lost even while still alive, which is referred to as 'anticipatory grief'. The financial effects of supporting a problem drinker have been explored by O'May et al (2017), who showed that family and friends often bear the brunt when the drinker cannot fund their habit, including the payment of fines and the consequences of accidents and injuries. Furthermore, the dynamics of the relationship will also have impacted upon the drinker's perception of that family member (O'May et al, 2017), and changes the roles and security within families. The borrowing of money was also a contentious issue in relationships between problem drinkers and their family and friends, often straining or ending relationships, with either the lender or their loved ones feeling exploited and used (O'May et al, 2017).

Often the comorbidity of substance addiction and problem gambling can lead to dire financial circumstances (Grant et al, 2002; Stewart and Kushner, 2003). So too can the co-occurrence of mental health, criminal justice involvement and housing problems. This can impact not just on the material wealth of families as money and housing may be put at risk or lost, but their overall wellbeing (social, health, status, security, employment and education). Common co-occurrences such as homelessness and increases in family violence may also be associated with physical and experiential loss for parents, children and spouses due to the gambling and addiction of their loved one (Darbyshire et al, 2001; Orford et al, 2005; Custer and Milt, 1985; Castellani, 2000).

Orford et al (2001) illustrated that the range of coping strategies employed by families (engaged, tolerant-inactive and withdrawal) correlated variously with the health of the family and the levels of family conflict. Building on Orford's work, Lewis and Byrd (2001) developed a family typology to illustrate the varying responses and attitudes of families which concluded that an integrated, open and collective response was the most beneficial and healthy.

Angres and Angres (2008) set out the following stages of reaction families commonly experience when the problem drinker enters treatment. Despair, anger, fear and tolerance. Prior to this, the 'honeymoon phase' of initial efficacy of family meetings occurs, due to shared experience, bonding, improved communication and insight. Following treatment, the emotional journey is not over. Families may experience disappointment, that the recovering drinker may be sober, but they are not without the 'personality defects' it was treatment would 'cure'. The new life of the recovering addict and their interests outside of the family may also lead to disappointment and a sense of loss or abandonment. Much is likely to have changed, in terms of the practical, emotional and social dynamics, and the next important phase is acceptance of the reality of the new life, as recovery is welcomed and embodied in the family. The recovery of the individual and the family is an integrated process; growth occurs as inter-familial relationships deepen and family members are able to consider themselves more (Angres and Angres, 2008).

Models of family support

There is widespread recognition that there are insufficient specialist treatment services for family members, that too few addiction services offer specialist family functions, and that workers in these services may have limited training and knowledge for working with family members, and that too few evidenced family interventions are implemented in routine practice.

While there are a diverse range of support options available, the most readily available source of support for many is Al-Anon, which is founded on the social community recovery model. The assumption underpinning this model is that the family member cannot be responsible for the recovery of the addict, but rather must focus on their own wellbeing and recovery. Over 800 Al-Anon groups operate across the UK and Ireland, and telephone and electronic meetings mean 24/7 care is available (White, 1998; Timko et al, 2012; Trico and Staudenmaier, 1989; AlAnonUK.org.uk, 2017). There is an emerging evidence base about the effectiveness of family support groups.

AA is no longer perceived by academics as religiously aligned, with evidence of its effectiveness linked to changes in social networks, personal growth and self-surrender (Kelly, 2016). Kelly (2017) has summarised the evidence base suggesting that women and men both benefit from 12-step involvement but do so in different ways - men primarily through changes in social networks, women primarily through the beneficial impact on abstinence self-efficacy. However, despite the proven benefits of mutual aid to family, community, society and government (Adfam and Drugscope; Corrigan, 2016; Cain, 1991; Humphreys, 1996), the association of Al-Anon with

religious frameworks has resulted in a wariness and derision from a proportion of treatment professionals, who perceive fundamental philosophical differences between specialist treatment and 12-step mutual aid. Mutual aid groups, such as 12-step groups will not accept financial support, and formal treatment services and clinicians are often wary and dismissive of these meetings, resulting in segregation and oversight (Best et al, 2010; Day et al, 2005; Gaston Lopez et al 2010; Verdehus et al 2009; Best et al, 2016).

Members of Al-Anon describe mutual aid as helping a transformation in their view of the drinker and the nature of addiction, information, advice and support, friendship and belonging, and self-worth and assertiveness (Stenton et al, 2014). Corrigan's (2016) illustration of AA's benefits to family resilience supports this, noting that the key areas of support are around; personal growth (self-awareness, improved self-esteem, spirituality, acceptance), new tools and techniques for managing family issues (problem solving skills, sense of community) and change in thinking (re-evaluation of self, of addiction and relationships). Family members were positive about mutual aid groups but bemoaned the lack of information in public places and the inaccessibility of information on family support services (Corrigan, 2016).

Public recounting of individual stories is central to the structure of 12-step meetings. In what Arminen (2004) has dubbed 'second story' telling, others in the group reflect the structure and themes of previously recounted stories, with a strong emphasis on 'no cross talk'. This both acknowledges each other's feelings and experiences and adds to the shared experience. Members avoid advice giving, instead focusing on sharing experiences. Through the storytelling and second storytelling of Al-Anon, members vindicate each other's experiences, and the focus of the group on shared experience can reduce negative experiences and stigmatised identities as family members are offered a distinctive way of thinking about addiction, the addict, their roles and responsibilities to the addict and to themselves (Cain, 1991). This is a very strong example of the social learning and social control components of recovery outlined by Moos (2007).

Prestige strengthens social identification and in Al-Anon as in AA; family members are posited as survivors and as valuable in their own right (Ashford and Mael, 1989). The shared goals, common history and mutual positive identification all enhance the adoption of a positive social identity and incorporation of pro-recovery individuals into the family's social network (Cruwys et al, 2014; Goffman, 2009). These can generate a sense of belonging, shared goals and purpose for the family. The resolution of these roles is a key factor in families' recovery and ability to replace negative experiences and feelings of isolation with membership of a group that supports and understands their trauma (Buckingham et al, 2013; Johannsen and Brendryen, 2013)

The Stress-Strain-Coping-Support (SSCS) model treats the experience of a family affected by substance misuse (and other related harms) as an inherently long term and stressful one, exposing the family to mental and physical strain which commonly manifests in ill health. Central to the management of this stress and strain are information, coping mechanisms and social support. Social support can be formal or

informal and comprise of emotional and practical (e.g. personal/interpersonal and material) support. Thus social support is a resource for coping skills and one that is vital to the individual's health (Orford et al, 2010). Informed by the SSCS model the 5-Step Method is a brief intervention aimed at addressing the needs of adult family members (Copello et al., 2010). There is also an adapted version of the 5-Step Method, called Steps to Cope, for children and young people (eg Templeton and Sipler, 2014).

The 5-step Method consists of the following steps: 1.) Listen, reassure and explore concerns. 2.) Provide relevant, specific and targeted information. 3.) Explore coping resources 4.) Discuss social support 5.) Discuss and explore further needs (Copello et al, 2010). There is a growing evidence base suggesting the 5-Step Method yields long-term improvements in mental and physical strains and improvements in coping. It appears to be equally effective with long suffering families and families with relatively recent problems (Velleman et al, 2011; Copello et al, 2010). However, funding limitations and limited infra-structure for family-focused interventions mean this approach is not widely delivered, and workers often do not have the protected time required to deliver the interventions.

Familial attitudes to and engagement in drinking are significant barriers to treatment, recovery and service engagement. There was found to be a strong correlation between perceived benefits of drinking and the likelihood of withdrawal coping (the strategy of coping with the stress by withdrawing from the situation). In a study by Orford et al (2002), families also said they would prefer moderate drinking as the goal as they did not want to withdraw the benefits of drinking from the other family members. There was also a relationship between perceived drawbacks of the drinker stopping and the level of the family member's own drinking; this suggests that citing moderation not abstinence as the goal may not entirely stem from a desire for the addict to keep enjoying the benefits of drinking but from the family member's own attachment to drinking, though this warrants further exploration. Factors contributing to a more optimistic outlook about controlled drinking included: minimisation (consumption is not what it once was), fear of seeming intolerant, perceived benefits of drinking and their own heavy drinking (Orford and Dalton, 2005).

Conclusion

The recovery movement is gaining currency in the field of addiction (White, 2007), and 'recovery' is now used formally and informally to refer to mental, physical, practical and social transitions; we recover from disease, from trauma or from setbacks, and we do so as part of a journey of growth and change. This socially focused model of recovery is defined by those it affects, developing beyond a biomedical model and resulting in broader aspirations of a 'healthy, productive and meaningful life' (White, 2007). Best (2014) has argued that recovery should be considered as an intrinsically inter-personal process and this is key to the transition to a strengths model where personal growth is embedded in and contingent on community engagement and community development. Acknowledging that families must also recover from a range of issues, that this is an ongoing process with

ups and downs, and the ways in which formal and informal resources can and do support this is a timely, valuable contribution to the body of work reducing the harms of addiction across society.

The aim of this project is to develop a version of the established Life in Recovery series of surveys targeting the experiences of family members both as recovery witnesses and in terms of their own journey of recovery, to explore the functioning and wellbeing of family members at different stages of their recovery journey and to chart the changes across life domains in functioning from when their family member was in active addiction to recovery.

Method

The Families Living with Addiction and Recovery (FLAR) project is built on a well-established research methodology and is part of an emerging partnership between Sheffield Hallam University and Adfam. Adapting the first UK Life in Recovery (LiR) survey (Best et al., 2015), which SHU ran, managed and published, and replicating the success of this method in the US (Laudet, 2013) and in Australia (Best et al., 2015), the survey was developed across phases to generate a process of co-production and ownership for family members.

In the initial US project (Laudet, 2013), 44 items representing experiences and measures of functioning in work, finances, legal, family, social, and citizenship were supplemented with basic demographic questions and questions about recovery stage; each question was asked for when the person was "in active addiction" and again "since you entered recovery." A total of 3,228 surveys were completed and returned. On average, the participants in the survey had an active addiction career of 18 years and had started their recovery journey at an average age of 36 years. The author concluded that "Recovery from alcohol and drug problems is associated with dramatic improvements in all areas of life: healthier/better financial and family life, higher civic engagement, dramatic decreases in public health and safety risks, and significant increases in employment and work" (Laudet, 2013, p3).

Similar findings were reported by Best (2014) for Australia and Best et al (2015) in the UK, with some differences in sample characteristics. One of the interesting features of the Life in Recovery surveys has been that around half of the respondents in each survey have been women.

To give a second and more recent example, in the Canadian study (Canadian Centre on Substance Use and Addiction, 2017) there were 855 responses, 53.0% of whom identified themselves as women. As in the other studies, the self-reports of those in recovery showed marked changes in family functioning. While 41.2% of the Canadian sample reported committing or being victims of family violence during active addiction, this dropped to 4.9% in recovery. Similarly, while 10.4% reported losing the custody of children in active addiction, this dropped to 1.4% in recovery. Thus, the perception of the people in recovery was of significant changes in family functioning and wellbeing.

However, the LiR surveys completed to date only present such a family life experience from the perspective of the person in recovery and does not account for the experience of those affected by their addictions. To address this research question, the FLAR project advances our understanding of the recovery journeys of families of present and former substance users.

Co-production was a key feature of the FLAR project, underpinning both the development and distribution of the survey. In order to collect information on the lived experience of family members of problem drinkers and drug users, we sought to engage with both service providers and the target population throughout the three phases of the FLAR project, namely: consultation and survey development; piloting of the survey; recruitment of research participants and completion of the survey.

Consultation and survey development

The topics selected for inclusion were generated through consultation with family members of problem drinkers and drug users, and service providers. There were four primary activities undertaken by the project partnership prior to distributing the questionnaire online and in hard copy:

1. An extensive programme of awareness raising and engagement was undertaken with family support groups around the UK; and a project advisory group was recruited including people who had lived experience as family members
2. From this cohort, and with considerable support and input from Adfam's family support group network, we recruited two groups of between 30 and 40 family members to participate in half-day workshops in Sheffield and London, where the project rationale and method was outlined and individuals participated in individual and group activities including reviewing the content of the previous Life in Recovery surveys.
3. Based on the extensive data and material collected at this stage, a draft instrument was prepared and revised in consultation with both the project partners and with the project advisory group.
4. The final preparatory stage was a formal pilot involving some of those who had participated in the earlier workshops. This resulted in a survey that was primarily intended for distribution online but with a paper version available for those who preferred a hard copy of the questionnaire.

Each of these phases is discussed in more detail below:

Workshops: Utilising Adfam's existing network of family members and service workers, as well as Sheffield Hallam University's local connections, the research team held two structured workshops in Sheffield and London. The workshops attracted approximately 70 research participants from a diverse array of backgrounds and with a wide variety of drug and alcohol related experiences. Following the two workshops,

feedback and comments were collated into themes, in order to determine the relevant content and domains for the survey. While the FLAR survey was initially intended to replicate the LiR survey (Best et al., 2015), feedback from the workshops indicated that family members considered it essential that the questionnaire addressed and gave voice to their own experiences of addiction and recovery as opposed to the experiences of their loved ones. Such feedback undoubtedly reflects the tendency of policy, practice and research to neglect the family member and their experiences of addiction and recovery, with primacy given to the user's journey and needs. As a result, the survey was adapted to focus more heavily on the family members' experiences and their recovery journeys.

Piloting of the survey

Based on the findings of the focus groups, a draft instrument was developed and circulated within the project team to improve the readability and focus of the measure. The draft survey was piloted online through Survey Monkey, receiving approximately 30 responses from participants who had taken part in the two workshops. The survey provided respondents with the opportunity to comment on both content and construction of the survey, as well as to report any issues or concerns which were raised by the questionnaire. The survey pilot results were then reviewed by the expert advisory group, consisting of members from Sheffield Hallam University, Adfam, Alcohol Research UK, an external academic, and a family member representative, with potential revisions to the questionnaire discussed. In order to maintain the integrity of the survey design process, the group voted on each proposed change to the final survey.

The final survey was launched after a thorough review of responses from participants by the research team and the expert advisory group. While the survey was active online, the target population still had opportunity to influence its structure and content, as they were able to leave comments and feedback at the end of the survey. The research team also received emails from participants who experienced difficulty in completing the survey, particularly during the early stages of data collection. In response, mistakes or technical problems with the online survey were corrected. The final draft of the survey and associated documents is included in Appendix I.

Recruitment strategy

In order to maximise our response rate, access hard to reach participants, and those in distant locations across the UK (and internationally), the research team developed an online survey that was distributed through microblogging service Twitter, and an assortment of other on- and offline networks and groups. Hard copies of the survey were also made available for those who did not have access to or were not comfortable completing the online version.

Research partner Adfam and their service users played a significant role in the distribution of the survey and in achieving the large number of successful

completions. Adfam has approximately 4,500 twitter followers whilst each twitter user is, on average, connected to 208 other individuals, presenting an effective system through which the survey could be circulated amongst service users, co-workers, family members, friends and other relevant individuals. We also had contact from FAVOR, the peer-based recovery representative organisation in the US, who promoted the survey widely as did William White, a key US recovery academic and advocate, who promoted the survey through his blog. Although the elusive nature of the techno-mediated networks makes it difficult to ascertain exactly how survey participants became aware of and accessed the FLAR survey, it is evident that our co-producers were extremely active in raising awareness of the questionnaire among affected family members of problem drinkers and drug users; a cohort who would have been difficult to access through other research approaches. Limitations regarding the reach of the FLAR survey include: it was not available in any language other than English, and; those under 18 were excluded from taking part. Nevertheless, the FLAR survey yielded 1,565 completed responses within 12 weeks of data collection.

Data analysis

Survey Monkey survey responses were downloaded into an SPSS file. The data were cleaned and recoded for purposes of data analysis. Descriptive statistics and bivariate analyses were conducted using SPSS 22. In addition to this, we analysed qualitative answers given that further explored recovery strategies employed by the cohort, which has revealed some of the positive recovery gains made from engaging with groups and organisations supporting families. A thematic analysis was used to aggregate this data.

THE FAMILIES LIVING WITH ADDICTION AND RECOVERY SURVEY SAMPLE

Gender and age

Gender and ethnicity profile

Of the 1,565 participants who completed the online survey, 1,559 reported their gender.

- 11.8% male
- 87.7% female
- 0.4% other

1,195 respondents (81.6% of valid responses) described themselves as 'white' or 'white British'; 1.1% of the sample described themselves as 'Black'; 1.5% described themselves as of 'Mixed Heritage'; 0.3% as 'Asian'; and 13.7% as 'Other'.

Age profile

- The mean age was 52 years (median= 54), with a range between 18 and 81 years.

Relationship, education and employment

Family relationship³

- 1,554 participants reported their marital status.
- 67.6% married or living with partner
- 23.6% single and divorced, separated or widowed
- 8.8% single and never married

Education

- 51.9% postgraduate/degree
- 12.7% A or AS level
- 6.1% GCSE or O level
- 12.8% some secondary school
- 0.8% regulated (e.g., apprenticeship)
- 6.5% vocational qualification
- 9.1% other

Employment

- 51.4% employed full-time

³ (although this is not necessarily the relationship to the addicted person)

- 12.5% employed part-time
- 3.1% unemployed
- 2.1% student
- 14.2% retired
- 3.1% disability living allowance
- 7.1% self-employed
- 2.4% volunteer
- 4.0% other

Most participants (67.7%) were married or living with a partner at the time of the survey. Fewer people reported being single and divorced, separated or widowed (23.6%) and only 8.8% were single and had never married. Of the 1,556 who completed the survey, 588 (38%) reported having dependent children. They had an average of 1.42 children under the age of 18 (range between 0-16 children).

Slightly more than half of the sample had a postgraduate or degree level education (51.9%), while the rest had lower levels of educations. This suggests that the sample is highly educated, and this may create a sampling or response bias in spite of the large overall sample size, as the level of education is higher than the national average. This may have led to a skew in responses.

About half of the sample had steady employment (51.4%); with the two other most common categories being retired (14.2%) and part-time employment (12.5%). For those who were employed, they worked an average of 37.3 hours per week (range between 0 and 100 hours).

Health and wellbeing

Using a simple 'ladder' rating scale of between 1 and 10, respondents ranked their physical and psychological health, with higher scores represented better functioning. The mean physical health rating was 7.4 (with a standard deviation of 2.1). The mean psychological health rating was 6.6 (with a standard deviation of 2.4). In spite of these positive ratings there were high levels of untreated psychological health problems reported by respondents:

Physical and psychological health

- 36.9% were receiving help or treatment for emotional or mental health problems at the time of the survey (missing, n=16)
- 71.9% had ever been treated for emotional or mental health problems (missing, n=17)
 - 41.2% of whom accessed treatment before the family addiction issue
 - 76.0% during the family addiction issue
 - 50.9% after the user had started on their recovery journey

Primary addiction profile of the user

When in active addiction, the sample (missing, n=18) reported that:

- 968 (62.6%) had experienced a primary issue with alcohol
- 1047 (67.7%) had experienced a primary issue with illicit drugs
- 113 (7.3%) had experienced a primary issue with legal highs
- 75 (4.8%) had experienced a primary issue with gambling
- 538 (34.8%) had experienced a primary issue with prescription drugs
- 222 (14.3%) had experienced a primary issue with other behaviours

These figures sum to more than 100% as a number of family members reported the user had been dependent on more than one substance as a primary problem in their substance using careers.

Relationship to user

The sample (missing, n=36) contained a range of relationships to the user, with the most prevalent being parents, followed by spouse or ex-spouse.

- 735 (48.1%) parent
- 158 (10.3%) child
- 361 (23.6%) spouse/ex-spouse
- 133 (8.7) sibling
- 122 (8.0%) other
- 20 (1.3%) friend

Categorisation of recovery status for the user (as perceived by family member)

- The mean substance use career for the user was 14.1 years (SD=11.37); median is 10.
- This perceived substance using career is shorter than those reported in the UK Life in Recovery cohort. For male addicts, the reported substance using career was 22.4 years and for women slightly shorter at 17.7 years in the UK survey of people in recovery.

The perceived recovery categories of the user, in the eyes of the family member

- In recovery: 622 (43.1%)
- Recovered: 54 (3.7%)⁴
- In Medication Assisted Recovery: 130 (9%)
- Ex-addict or alcoholic: 49 (3.4%)
- Used to have an alcohol problem, but don't anymore: 109 (7.5%)
- Returned to using: 480 (33.2%)

⁴ Removing three impossible values, those who reported their loved one's status as in recovery or recovered noted that they had been so for an average of 35.6 months (SD=65.5), median of 12.

Most family members reported that their loved one was 'in recovery', but a third of the sample reported, in contrast, that their loved one had returned to using substances. Less than 10% of the loved ones were in the other categories. 7.7% did not answer this question.

For those who reported that the drinker was in recovery, the average length of time in recovery was 45.2 months.

1205 (78.8%) reported that their loved one had attended a treatment programme for their alcohol or drug problems at some point in their recovery journey (missing, n=35).

All recovery categories were recoded to 'recovered' and 'returned to using', to allow comparisons to be made of family wellbeing comparing these two groups. T-tests between these two categories revealed significant differences (see table 1). Family members who reported that the user had relapsed fared much worse in terms of health, psychological wellbeing and quality of life at the time of the survey compared to those who were reported to be in recovery or to have recovered.

Variable	t-test and significance	Mean (SD) - Recovered	Mean (SD)- Using
Physical health (past 4 weeks)	4.85***	7.64 (2.10)	7.06 (2.23)
Psychological health (past 4 weeks)	7.53***	6.94(2.90)	5.88(2.59)
Quality of life (past 4 weeks)	6.91***	7.30(2.33)	6.33(2.59)
Quality of life-BREF	6.70***	65.43(23.89)	53.38(25.59)

Table 1: Family member wellbeing as a function of the using status of the user at the time of the survey

Where the user has returned to use substances, the family member reported significantly poorer functioning in the areas of physical health, psychological health and quality of life (with both indicators of quality of life showing the same effect).

FAMILY MEMBERS: CHANGES IN LIFE EXPERIENCES DURING THE USER'S ACTIVE ADDICTION AND RECOVERY

In this section, we report the primary measures of the Life in Recovery scale reporting for both family members' own experience and for the family member's perception of what has happened to the user in this time. The results are split into the five sections of the Life in Recovery Survey, starting with issues of finance. We do not report all 44 items where the survey asks for information about the change from active addiction to recovery, only those that we feel are noteworthy. Information on all other items is available from the authors.

Finances

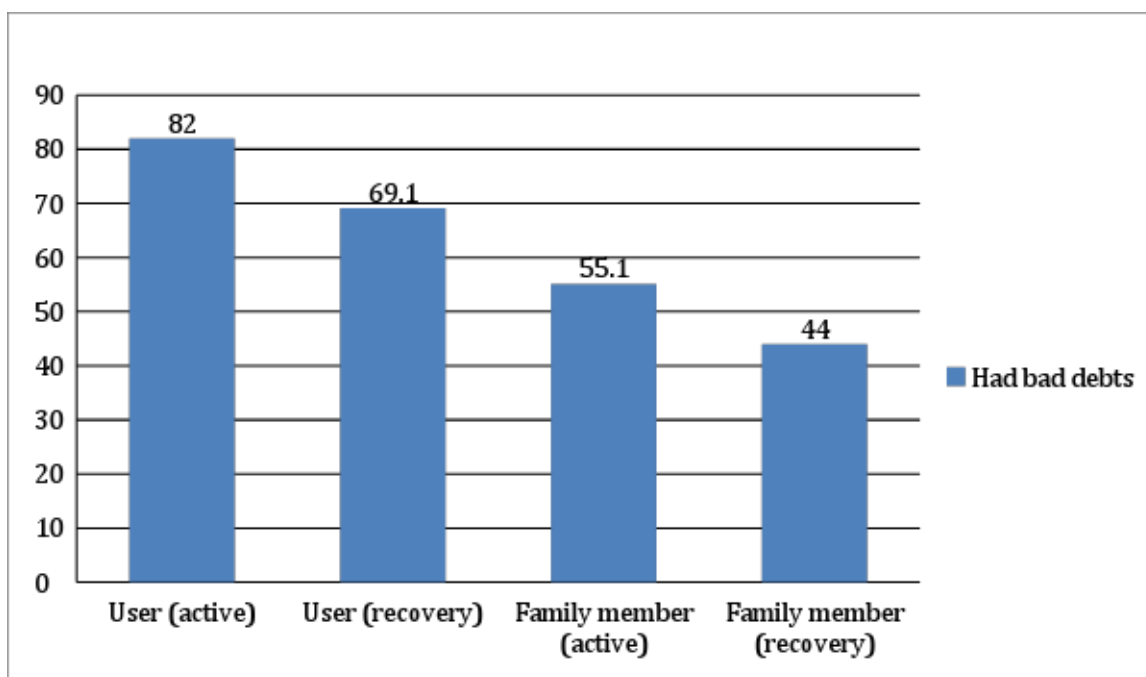


Figure 1: Bad debts for the user and for the family member during use and in recovery

What this Figure shows is that there are improvements in debt for both family members and for users, but that the level of debt is lower in both phases for the family member. Nonetheless, more than half of all family members were in debt during active addiction and over 40% remain in debt during the user's recovery, suggesting ongoing financial problems resulting from the addiction period, and that these are not completely resolved in recovery. This may be particularly interesting given the high education and full-time employment status in the sample.

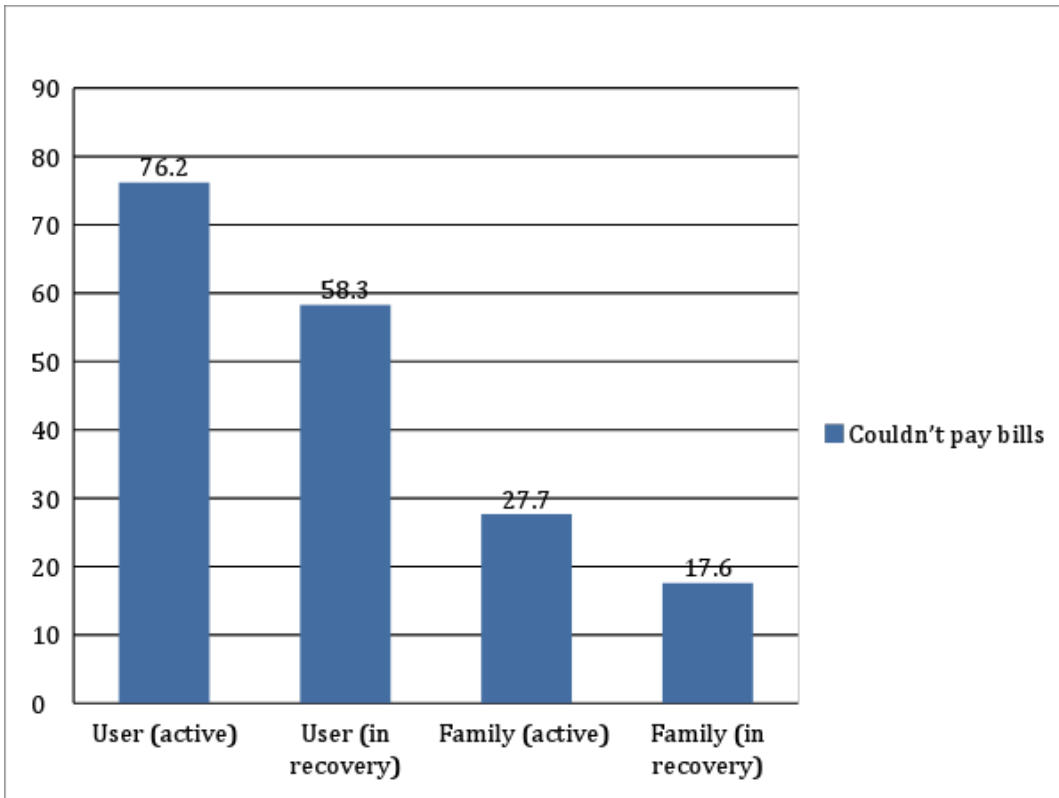


Figure 2: Proportion of family members and users who could not pay bills during active addiction and recovery

While 76.2% of users could not pay their bills during active addiction and 58.3% in recovery, the equivalent figures for family members were 27.7% during active addiction and 15.3% when the user was in recovery. In Figure 3, this is extended to issues of bad credit.

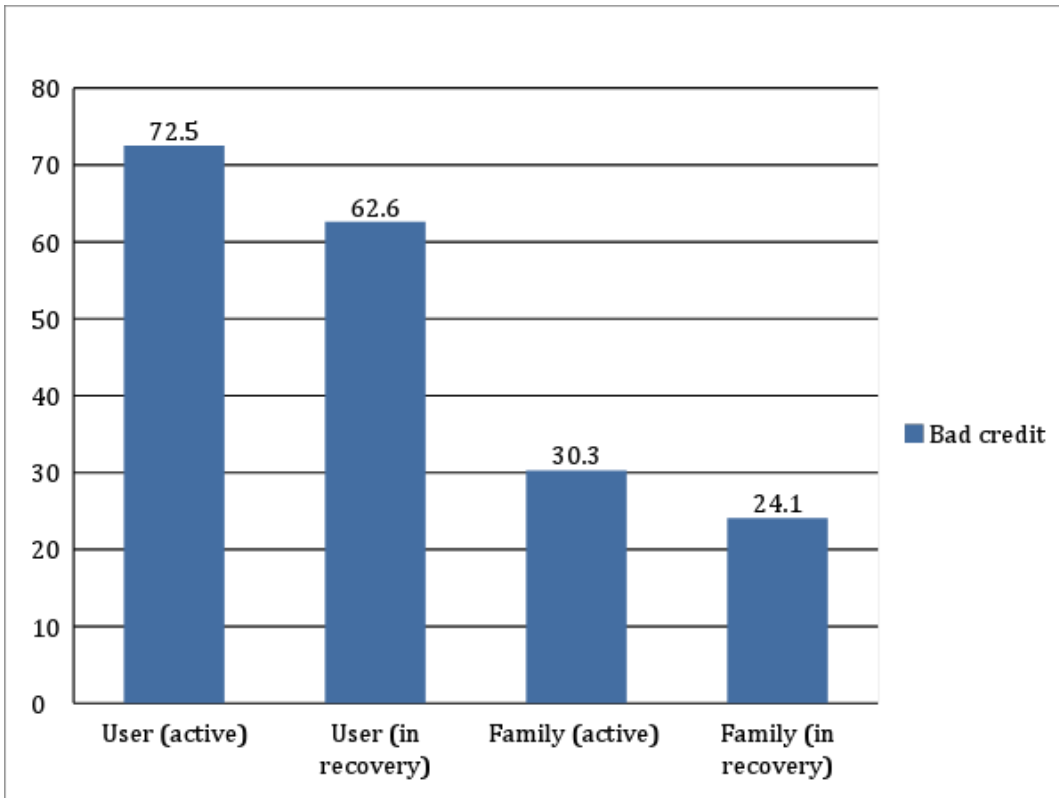


Figure 3: Proportion of users and family with bad credit in active addiction and in recovery

In the domain of bad credit ratings, there are much more severe problems reported for the user both in recovery and in active use, and broadly similarly improvements in bad credit ratings when there is a transition from use to recovery. However, it is of concern that, even when the user is in recovery, around one quarter of family members report bad credit. The next domain of finance to be considered, presented in Figure 4, relates to the inability to pay bills. More than three-quarters of users are reported not to be able to pay bills, with this problem persisting for 58.3% in recovery.

However, it is also notable that 30.3% of family members were unable to pay bills when the individual was actively using, with only a small improvement to 24.1% when they transition to recovery.

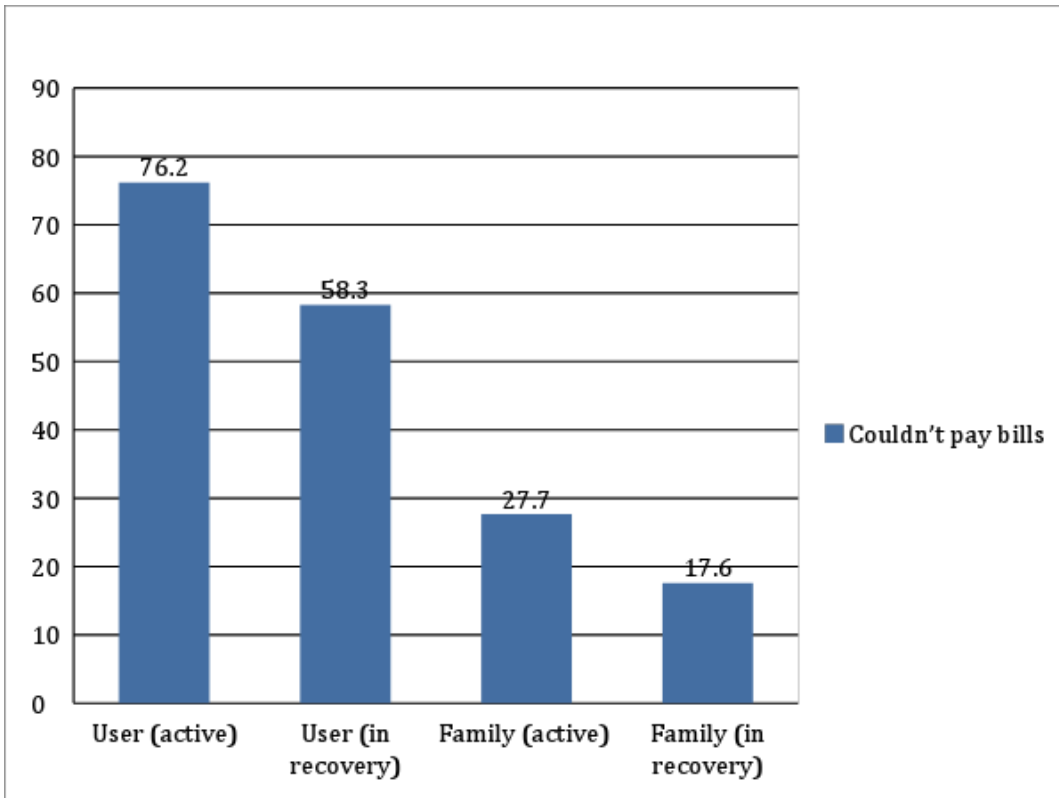


Figure 4: Proportion of users and family who couldn't pay bills in active addiction and recovery

In Figure 5 below, the analysis is extended to family members and users' experiences of bankruptcy:

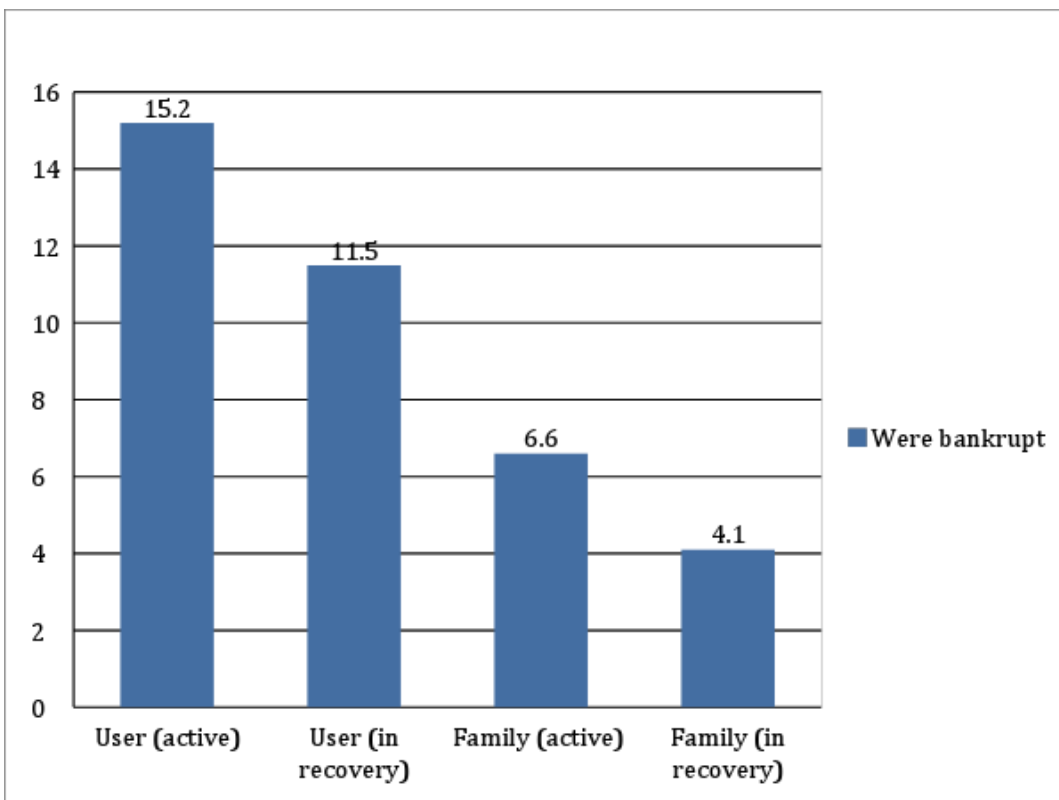


Figure 5: Proportion of users and family who were bankrupt in active addiction and recovery

The proportion of users who were bankrupt reduced from 15.2% to 11.5% from active addiction to recovery, while the proportion of family members bankrupt reduced from 6.6% to 4.1%, suggesting lower problem levels in family members but consistent improvements in both groups when the user achieved recovery.

Overall, in financial matters, family members reported improved financial status when the user was no longer in active addiction. Fewer individuals had debts, bad credit, were bankrupt and could not pay bills. However, many of the problems that families experienced around finances persisted although we cannot state with any confidence whether persisting problems are residual effects of the user's debts or financial problems. The emerging pattern here is of significant problems for both users and family members during active addiction with clear indications of improvement when the user is in recovery, but that there are residual problems for a high proportion of former users and for a significant minority of family members.

Family and social life

In this section, we examine the changes in family life and social functioning that is associated with the transition from active addiction to recovery, with the respondent both in the role of witness for the user and reporting on their own personal experiences. As in the finances section, the data presented below are a selection of the items collected to present the most important reported changes. The next graph (Figure 6) examines child custody issues, reviewing both the loss of child custody (for reasons other than divorce) and regaining custody of children.

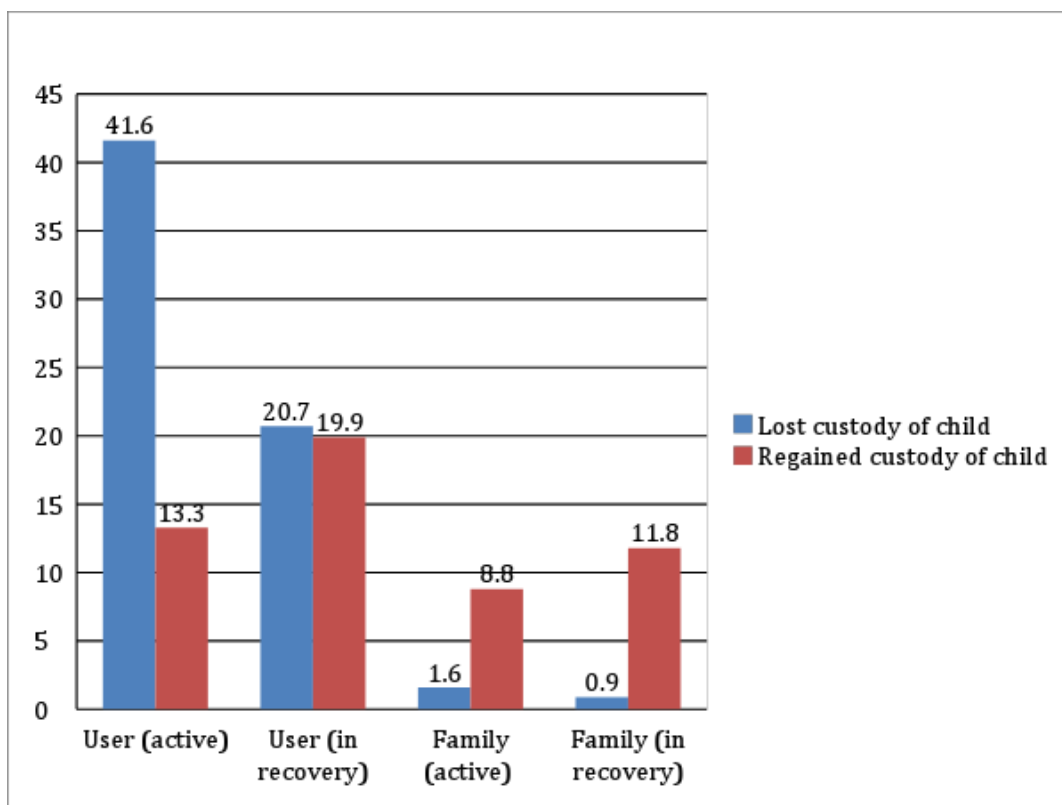


Figure 6: Loss and regaining of child custody during active addiction and recovery for both family members and users

There is a disparity between the figures here for drinkers and family members as many of the family members are not partners; and some of those who are will have been separated and so the two figures will not coincide. What is clear from the graph is that there are very low rates of loss of child custody for family members both during addiction and recovery; but high rates of regaining children (8.8% during the user's addiction and 11.8% during recovery). For the users, the family members reported a clear reversal - a marked drop in children taken into care during active use followed by a marked increase in regaining custody of children once they had started on their recovery journey.

A similar contrast is in the experiences of family violence with the data for this presented in Figure 7 below:

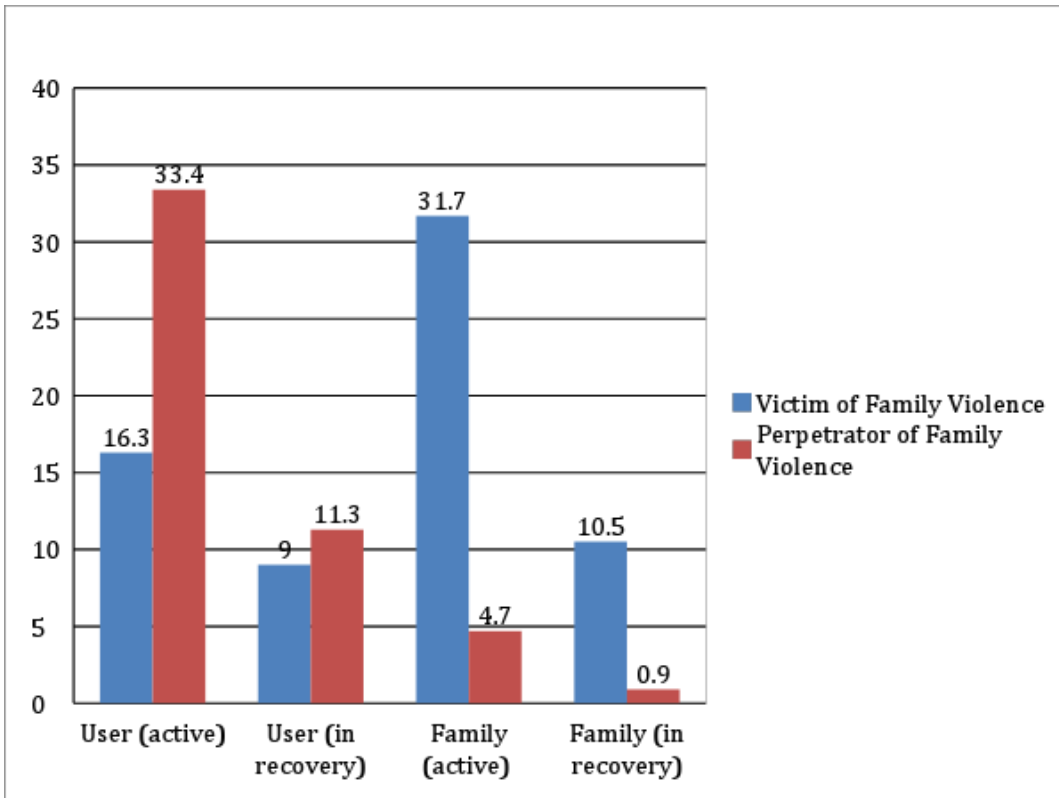


Figure 7: Experiences of perpetration and victimisation of family violence during active addiction and recovery for users and family members⁵

There are clearly high levels of family violence reported in the phase of active addiction - 16.3% of users and 31.7% of family members are reported to be victims of family violence during the phase of active addiction, while 33.4% of users and 4.7% of family members are reported to be perpetrators of family violence during active addiction. This is a clear indication of the damaging impact of addiction on family violence.

There are marked reductions in these figures during the recovery phase with 9% of users and 10.5% of family members reported as victims of family violence during active use and 11.3% of users and 0.9% of family members as perpetrators during recovery. This would suggest that recovery is clearly associated with reductions in family violence but that it is not eradicated during the period of recovery (subsequent analysis will show how this is broken down when subsequent relapse is taken into account).

Moving on from the issue of family violence and child custody to broader questions of active involvement in family activities, Figure 8 summarises the level of participation in family events both in active addiction and in recovery:

⁵ As with the loss of children, there are multiple members in most families and so the respondent may not be the victim in the cases attributed to the drinker

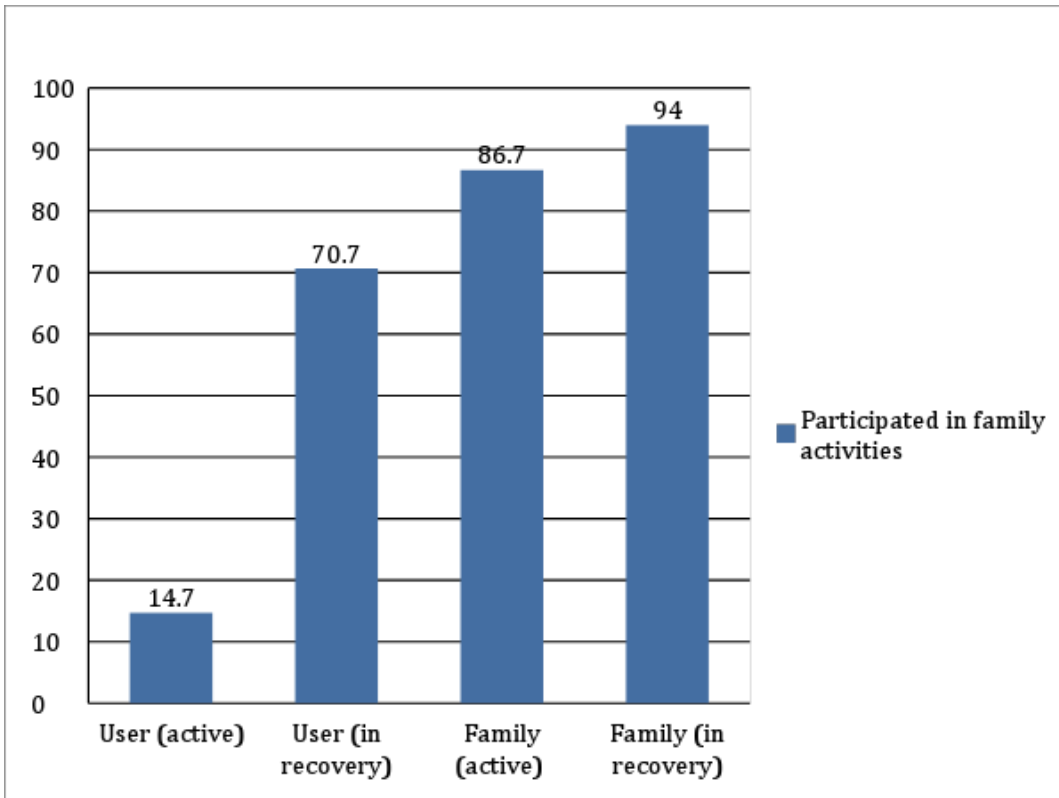


Figure 8: Proportion of users and family who participated in family activities in active addiction and in recovery

There is a very clear and dramatic improvement in the user's participation in family activities, reported by family members, rising from less than 15% to just over 70% from active addiction to recovery, with a slight improvement also in family members' active engagement. In a similar vein, Figure 9 below examines volunteering or community involvement for both the family member and the user, both in active addiction and in recovery:

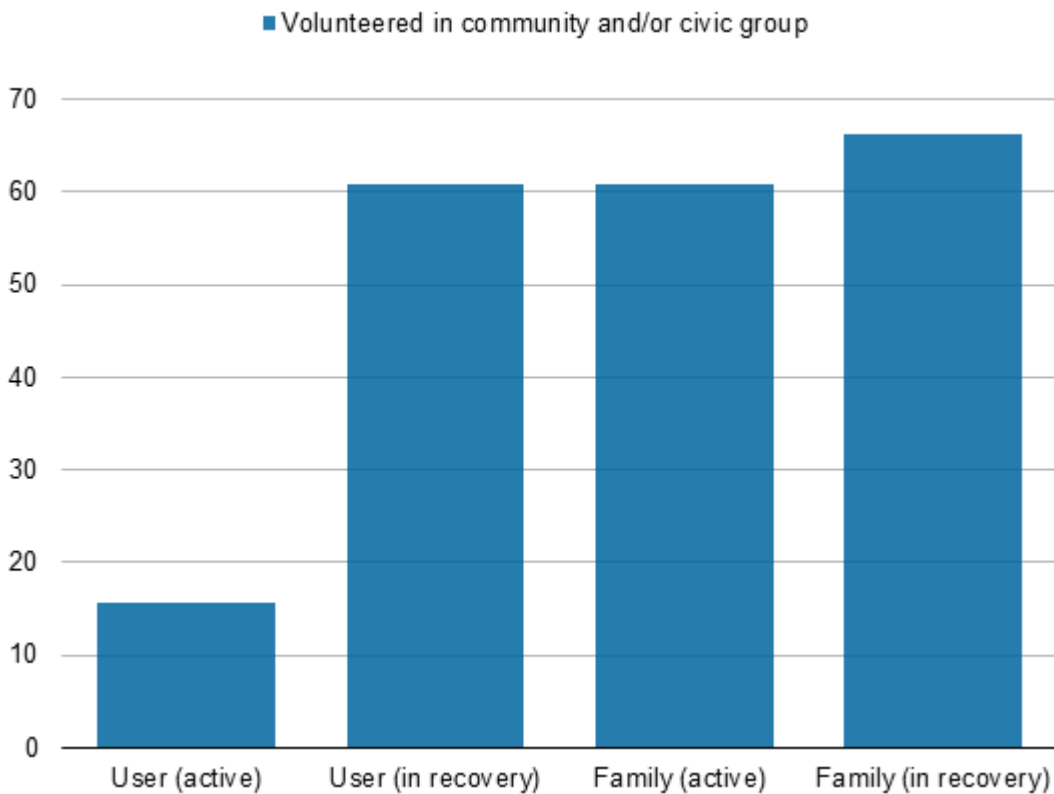


Figure 9: Proportion of users and family who volunteered in the community and/or civic groups in addiction and in recovery

While there was a huge improvement in community participation and volunteering among users making the transition to recovery, again there is only a modest improvement in civic participation in family members. However, it is important to note that, for both groups, the rates of participation in civic activities exceed the general public when the current recovery window is considered (it is generally estimated that around 40% of the general public actively participate in community activities).

There have been significant differences and improvements in virtually all of these areas of social and family involvement with a similar pattern - dramatic improvements in the user as they transition to recovery and consistent but more modest changes in the family member, with some problem issues, particularly around domestic violence, not yet adequately addressed.

Health

The third domain investigated looked at changes in health functioning, with the key items and indicators reported below for both the user and the family member. The first indicator regarding regular exercise is reported in Figure 10 below:

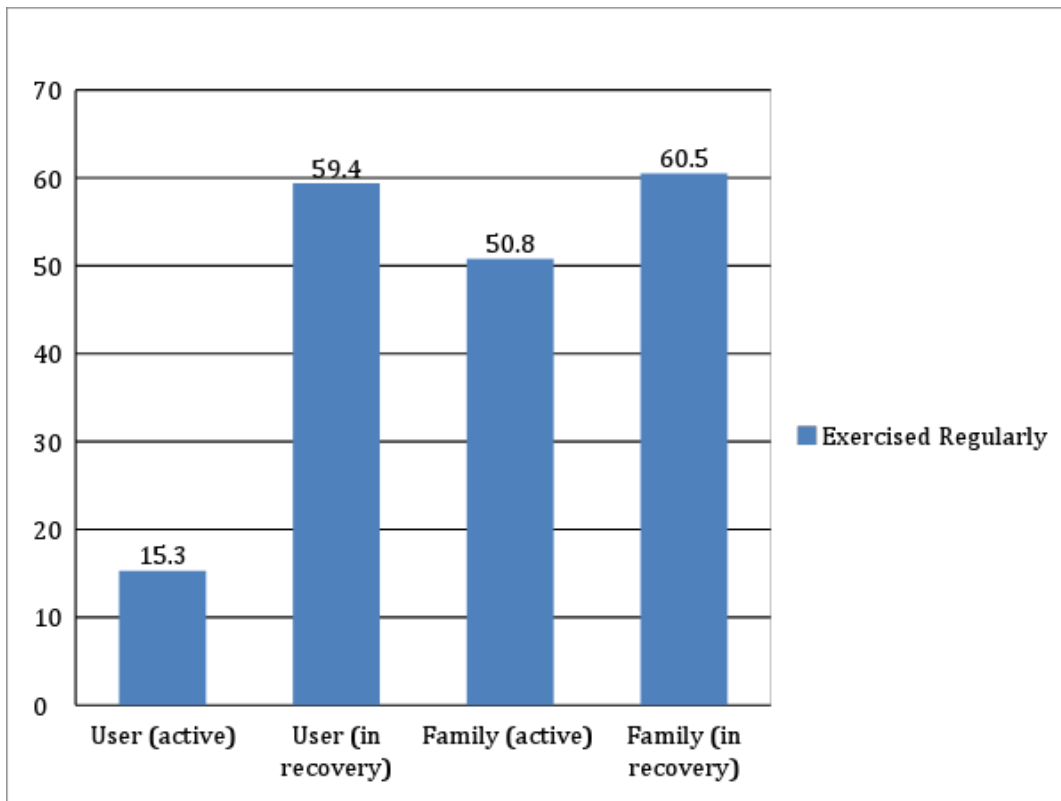


Figure 10: Proportion of users and family members who exercised regularly in addiction and in recovery

As with a number of the family and social indicators, the same trend is apparent. The family member reports a dramatic improvement in the user's wellbeing and a slight improvement in their own (albeit from a much higher baseline). Thus, for exercise, just under two-thirds of both users and family members are reported to do this in recovery compared to around a half of all family members and around one in six users in the period of active addiction. Figure 11 below reports on untreated emotional and mental health problems both in active addiction and in recovery:

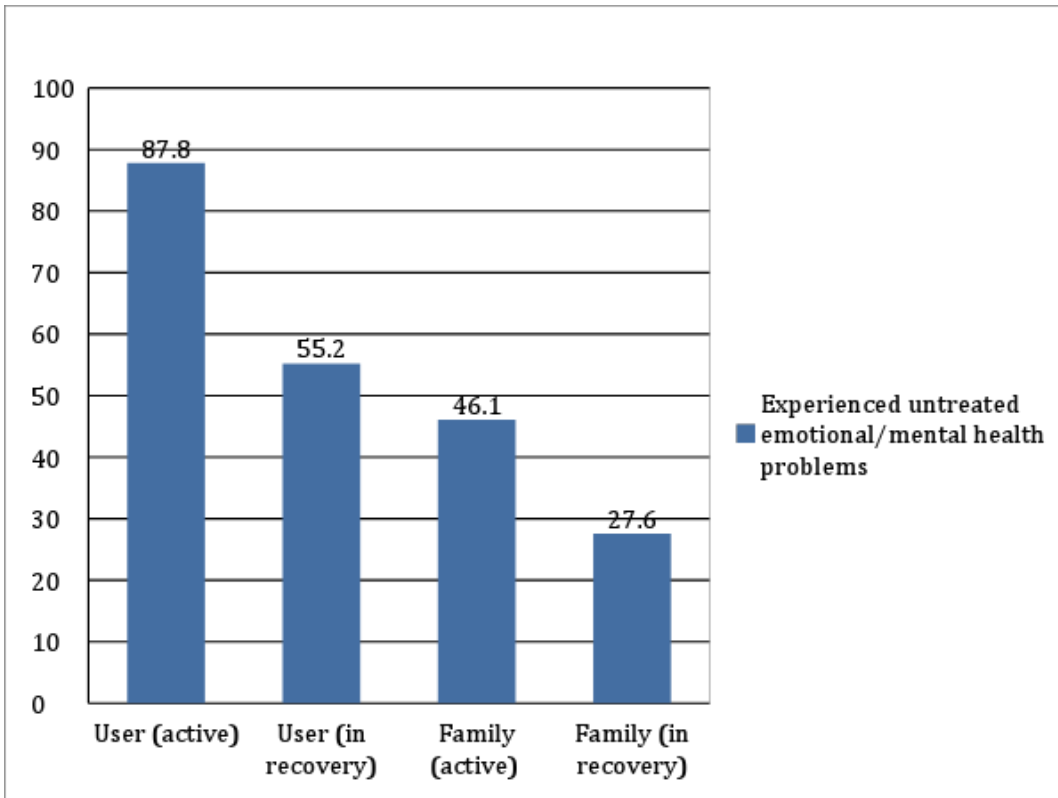


Figure 11: The experience of untreated emotional/mental health problems among users and family in active addiction and in recovery

While there are stepwise improvements in both groups, it is important to note that the levels of untreated emotional and mental health problems remain high, with over half of former users and over a quarter of family members reported to have residual and ongoing mental health issues in the recovery period. Whether this is an issue of poor help-seeking behaviour, or whether these are problems that are sufficiently entrenched that they are resistant to positive change, this is extremely worrying in terms of an invisible and poorly addressed chronic consequence of addiction, that is likely to exert a continuing toll on the family as a group and the individuals within it. In Figure 12 we switch to acute physical health risks examining the rates of hospitalisation in both the user and the family member⁶:

⁶ It is important to note that there is evidence that drinkers will attend hospital both for acute physical health effects and for other forms of non-acute health support

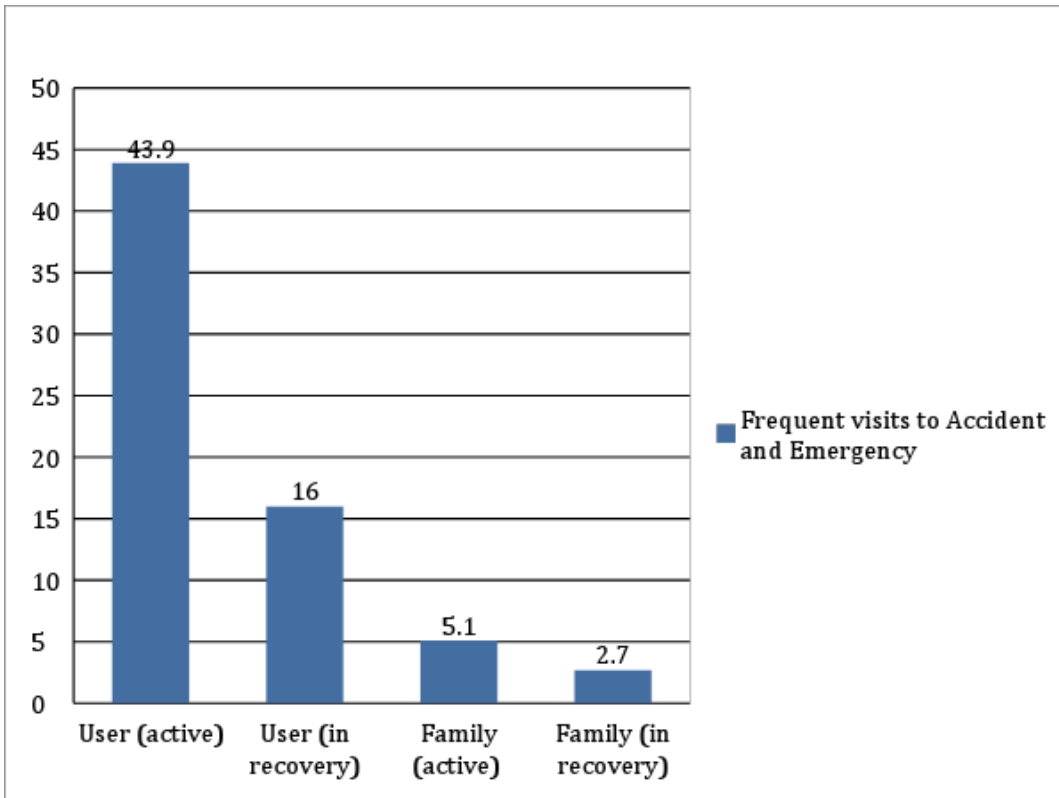


Figure 12: Proportion of users and family who made frequent visits to Accident and Emergency wards in active addiction and in recovery

Thus, while the proportion of users who frequently attend accident and emergency units has dropped from 44% to 16%, a dramatic improvement, this still remains worryingly high in the recovery period. There is also a clear reduction in attendance for family members, from a much lower baseline. In Figure 13 below, this analysis is extended to more general use of healthcare services:

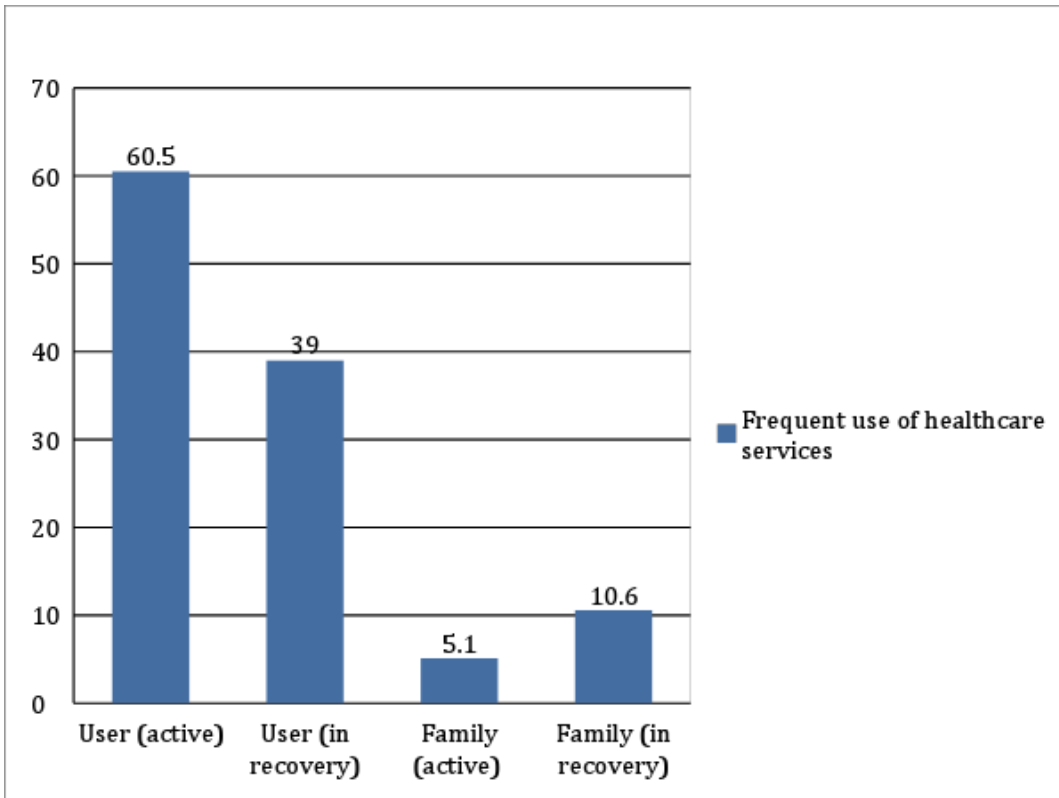


Figure 13: Proportion of users and family who frequently used healthcare services, in active addiction and in recovery

As with use of accident and emergency this cannot be assumed to be indicative of adverse events and is likely to include preventative medicine including various forms of health screening and check-up. Thus, while there is a dramatic reduction in uptake from users following the transition from use to recovery, there is actually a marked increase in health service utilisation among family members, possibly indicating improvements in self-care and health awareness. This is reflected in the data for dental check-ups reported in Figure 14 below:

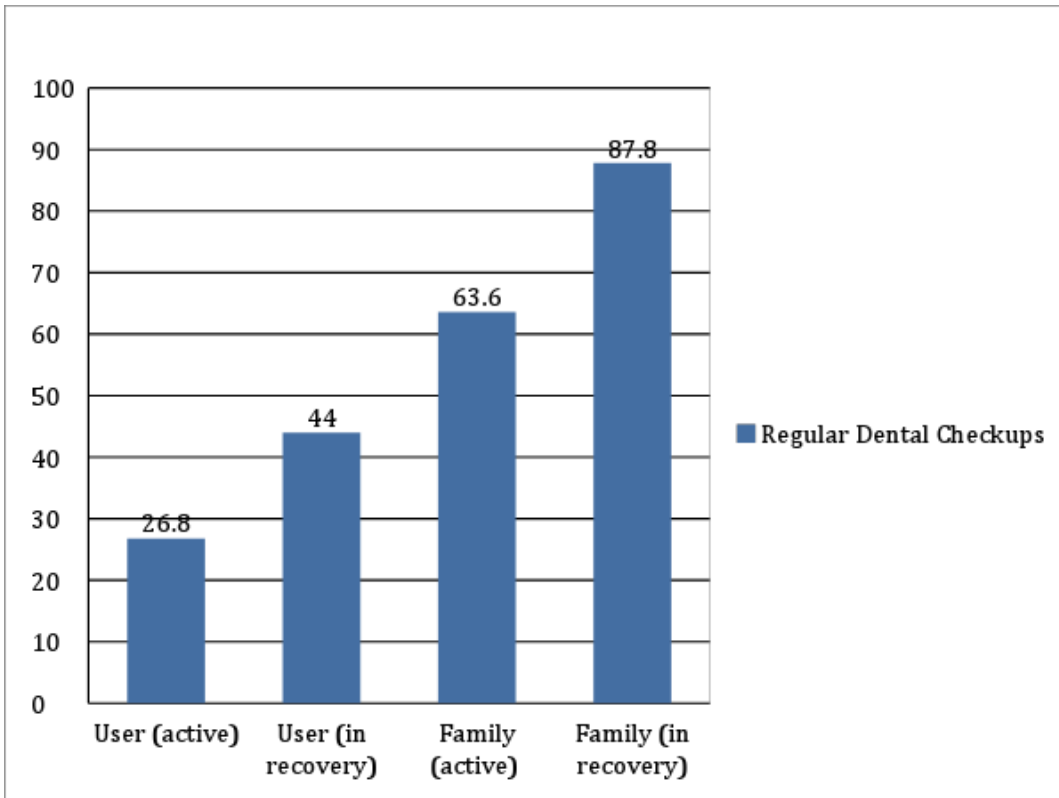


Figure 14: Proportion of users and family who underwent regular dental check-ups in active addiction and in recovery

While there is a marked improvement in dental check-ups among users, the overall rate remains low with less than half regularly having their teeth checked according to their family members. In contrast, there is a marked improvement in family members from a much higher baseline of around two-thirds while the users was in active addiction to just under 90% in the recovery phase. The final measure in this section reported in Figure 15 below is also around medical self-care and reports on whether the individual is registered with a General Practitioner:

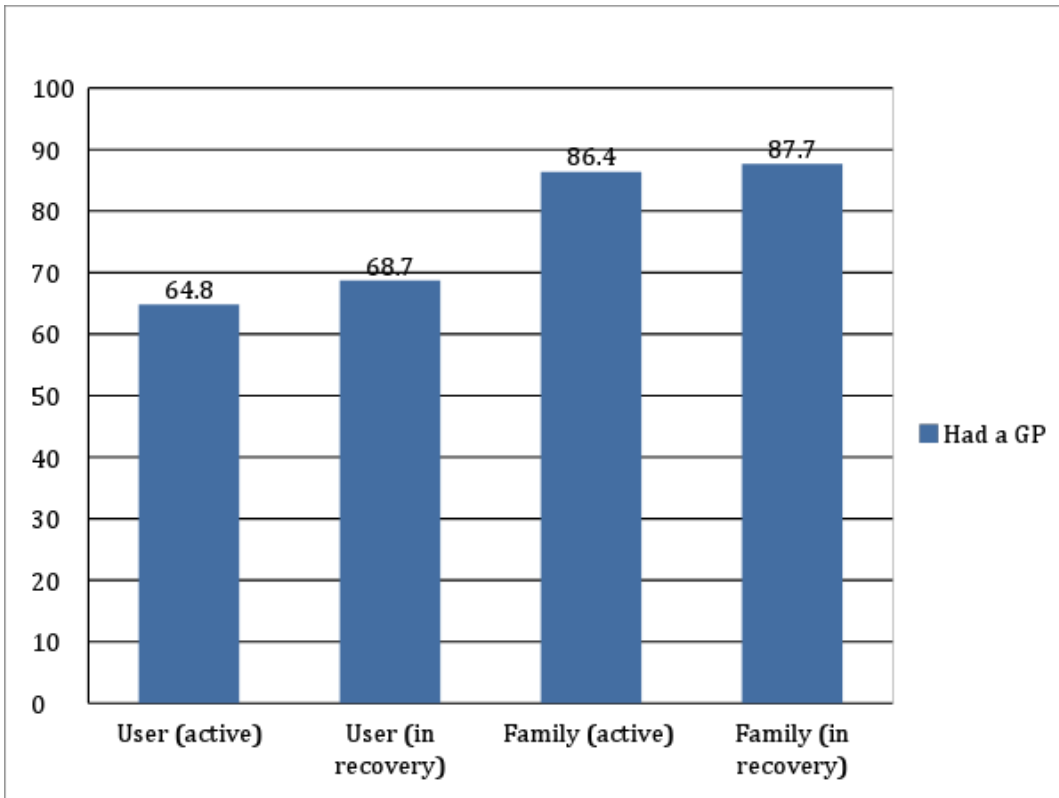


Figure 15: Proportion of users and family who had a GP in active addiction and in recovery

There is much less evidence of change in this indicator with family members reporting that around two thirds of users had a GP both in active addiction and in recovery and that the equivalent figures for themselves is around 85% at both stages of the addiction recovery journey, which appears to be broadly consistent with population norms. As above, however, this cannot be regarded as indicative of no improvement as the reasons for engaging with general practice may well be different. Thus, in examining one aspect of wellbeing, health and nutrition, there is clear evidence of improvement (see Figure 16 below):

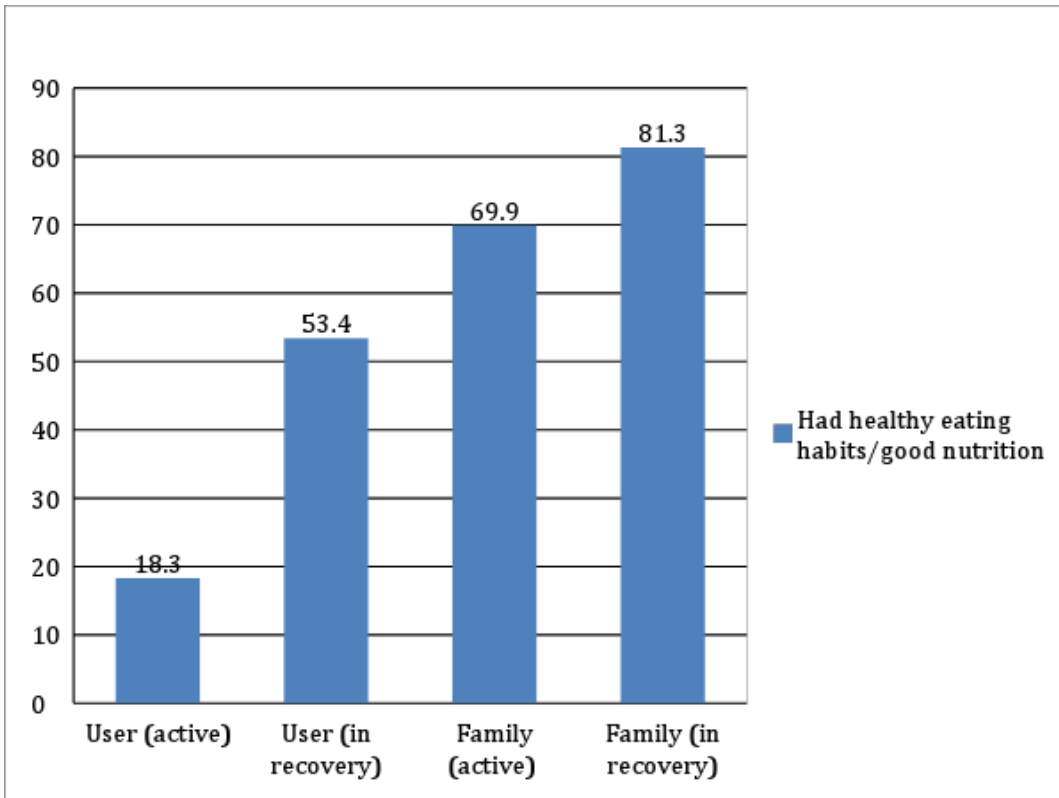


Figure 16: Proportion of users and family who reported healthy eating habits/good nutrition in active addiction and in recovery

The family members report very poor eating habits in the active addiction phase for users with marked improvements in recovery, but with only half of the user group eating healthily in recovery. In contrast, the baseline of good nutrition is much higher in the family member group, but with room for a clear improvement to the recovery phase.

One area of public health of particular interest is around smoking with tobacco consumption both a significant morbidity and mortality risk in its own right and also as an established trigger and risk factor for relapse to illicit substance use and to drinking. Data for changes in smoking are reported in Figure 17 below:

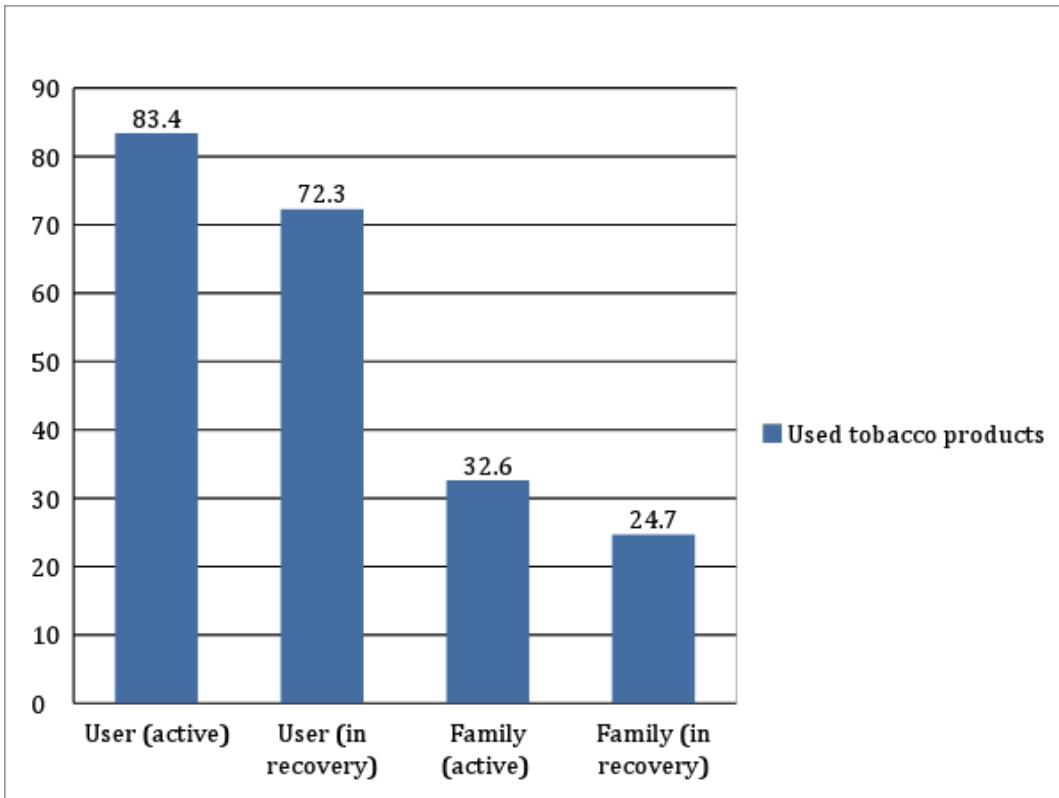


Figure 17: Proportion of users and family who used tobacco products in active addiction and in recovery

While the family members report a small improvement in smoking rates in users (from 83.4% to 72.3%), there is an equivalently modest improvement in rates of smoking in family members from 32.6% to 24.7%. There are two clear conclusions to draw from this - the first is that family members are reporting a much higher rate of smoking in people in recovery than is reported by those in recovery (56.7% in the UK Life in Recovery survey compared to 72.3% here). The second is that family members themselves are smoking at elevated rates both when their family members are using but also with a residual health effect into recovery. One of the other key implications for the Family Life in Recovery survey method is that it can be regarded as a form of collateral data for the self-report of individuals in recovery. This would suggest a possible under-reporting of negative public health behaviours by people in recovery.

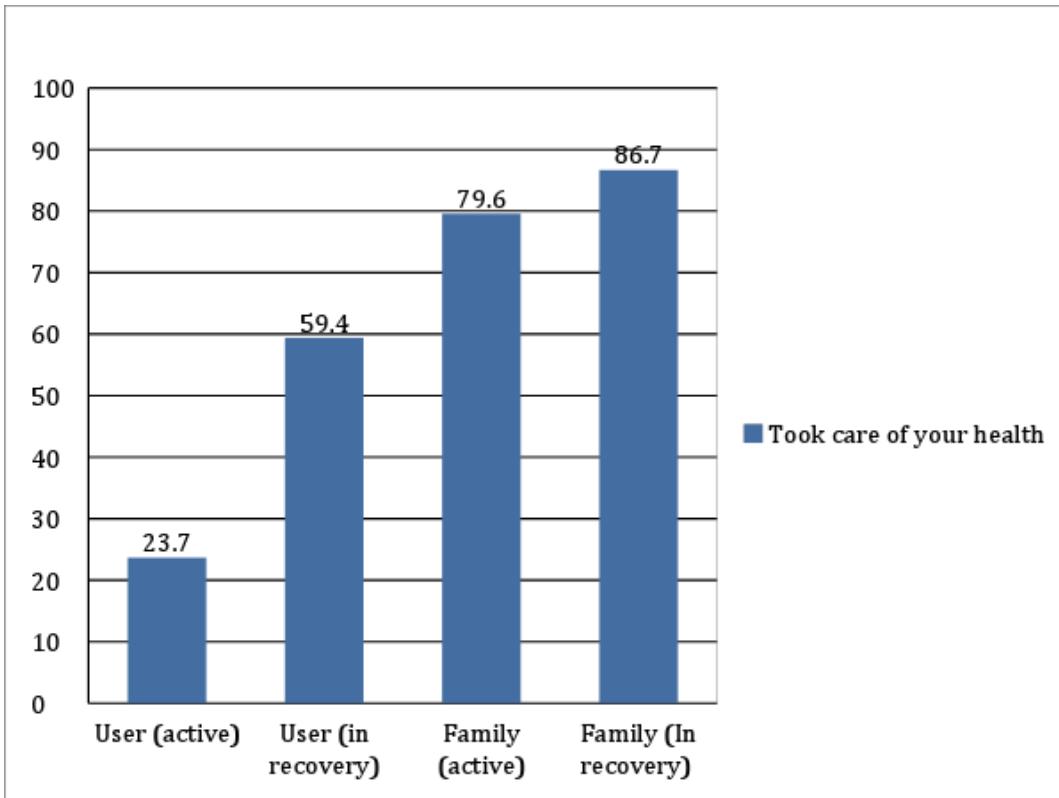


Figure 18: Proportion of users and family members who reported taking care of their health in active recovery and in addiction

Nonetheless, as is shown in Figure 18 above, there are clear and consistent improvements in health and self-care from active addiction to recovery for both the user and for the family member. As in many of the previous health indicators, there is a dramatic improvement reported by family members in the self-care of the users, and a smaller improvement from a much higher baseline, among the family members themselves. Again, however, this does not account for changes in those who have relapsed and this is discussed and reviewed further below.

Legal Issues

As in previous sections, we report graphically for active addiction and for recovery for both users and family members, starting with Figure 19 below which the rates of arrest for family members and users in active addiction and in recovery:

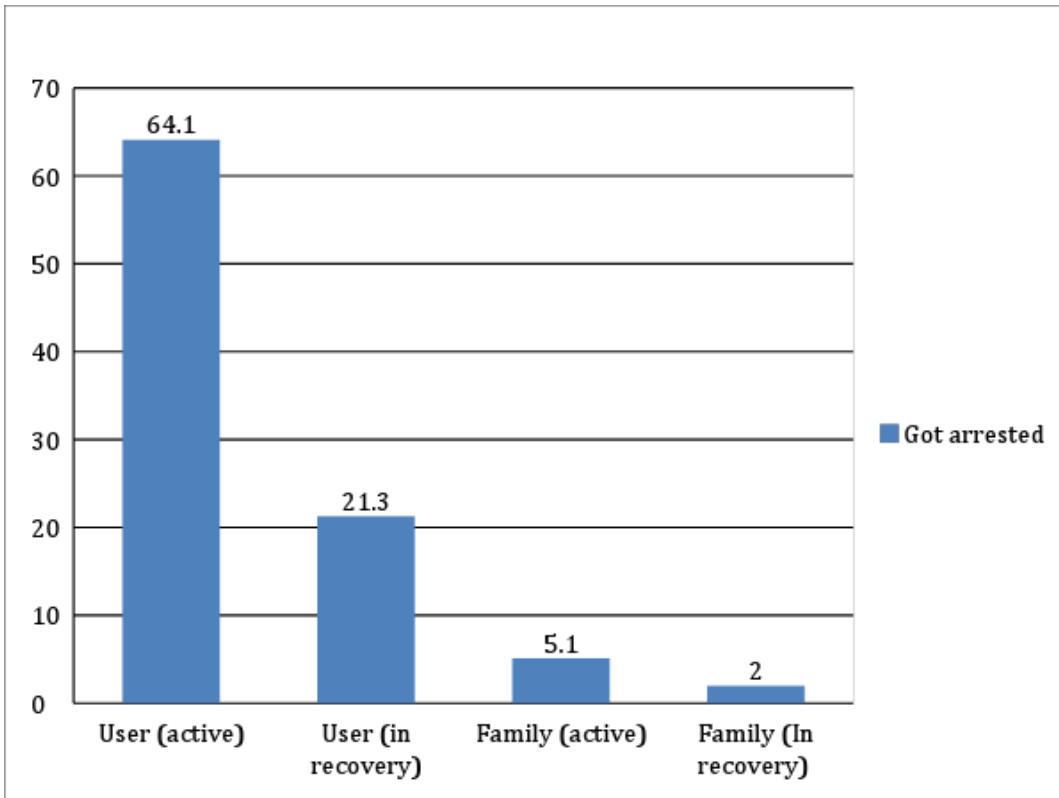


Figure 19: Proportion of users and family who got arrested in active addiction and in recovery

Family members report that users have a massive reduction in arrests from 64.1% during active addiction to 21.3% in recovery. However, proportionately, there is an even more dramatic reduction in arrests reported by family members from more than 5% when the user was in active addiction to 0.2% when the user is in recovery. Again this reflects a trend where the baseline levels are much lower for family members for harmful behaviours, but there is an equally dramatic effect of recovery on their wellbeing. A very similar pattern of results is shown for damage to property in Figure 20 below:

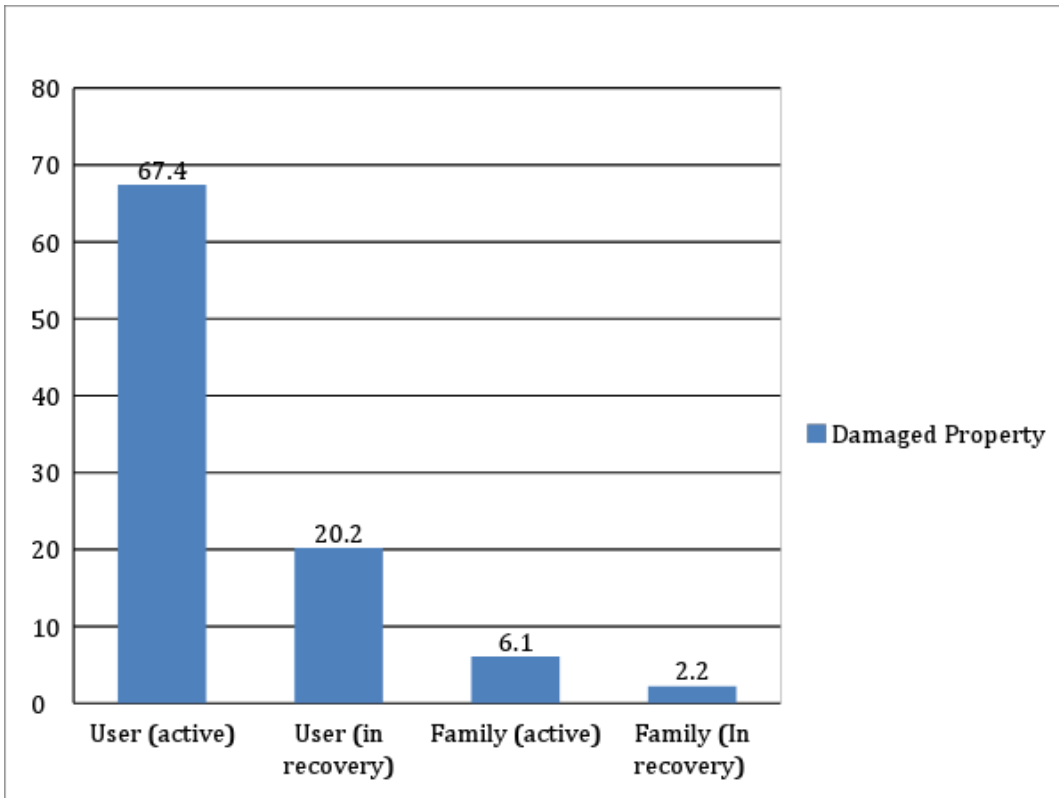


Figure 20: Proportion of users and family who caused damage to property (their own or others) in addiction and in recovery

Again, family members report that users' rates of offending dropped from around two-thirds in active addiction to 20% in recovery, while the rate of offending for the family members also drops to about a third of the level reported while the user was in active addiction, from 6% to 2%, continuing this trend of lower baseline but similar reductions in adverse life events. Figure 21 below reports on the levels of driving under the influence both in active addiction and in recovery.

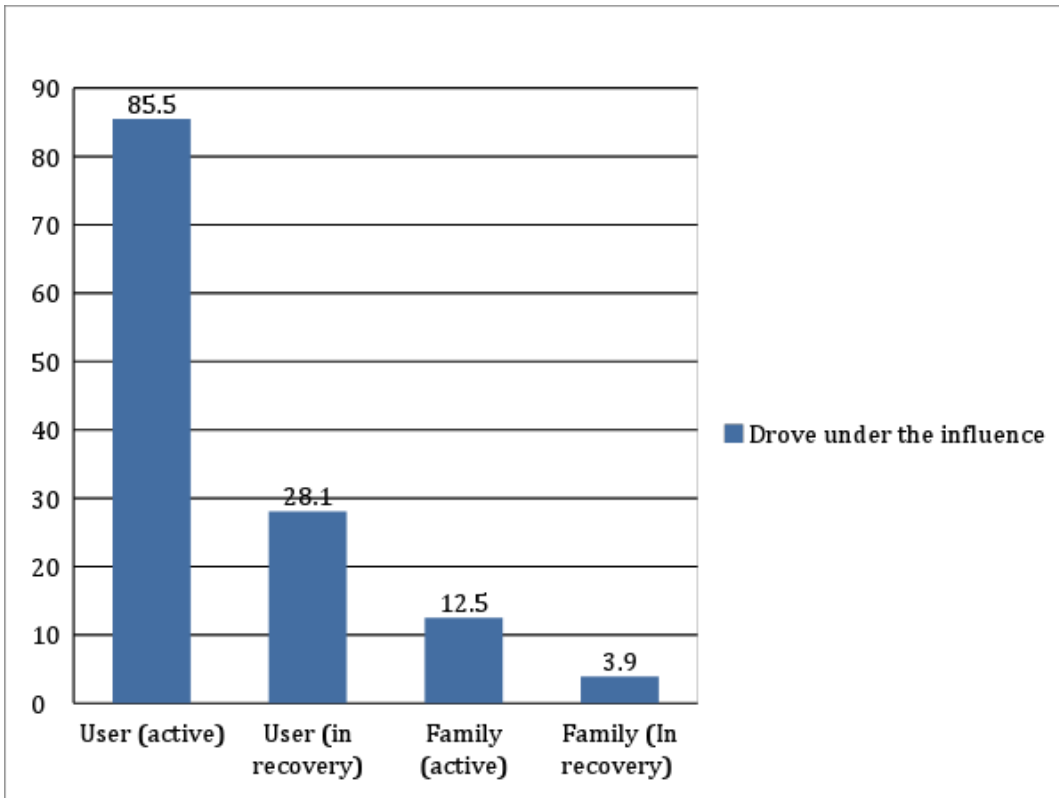


Figure 21: Proportion of users and family members who drove under the influence of alcohol and/ or other drugs while in active addiction or in recovery

The family members report exceptionally high rates of driving under the influence of drink or drugs during the users' active addiction at over 85%, and although this drops dramatically, it is worrying that family members report that 28% of users continue to drive under the influence during their period of recovery. Again, while there is a dramatic reduction from the user's time of active addiction to recovery, it is also worrying that one in eight family members admit to driving under the influence while the user was in active addiction, reducing to 4% when the person is in recovery. Further research is required to assess the public health implications of this effect. Losing and regaining their driving license is reported in Figure 22 below:

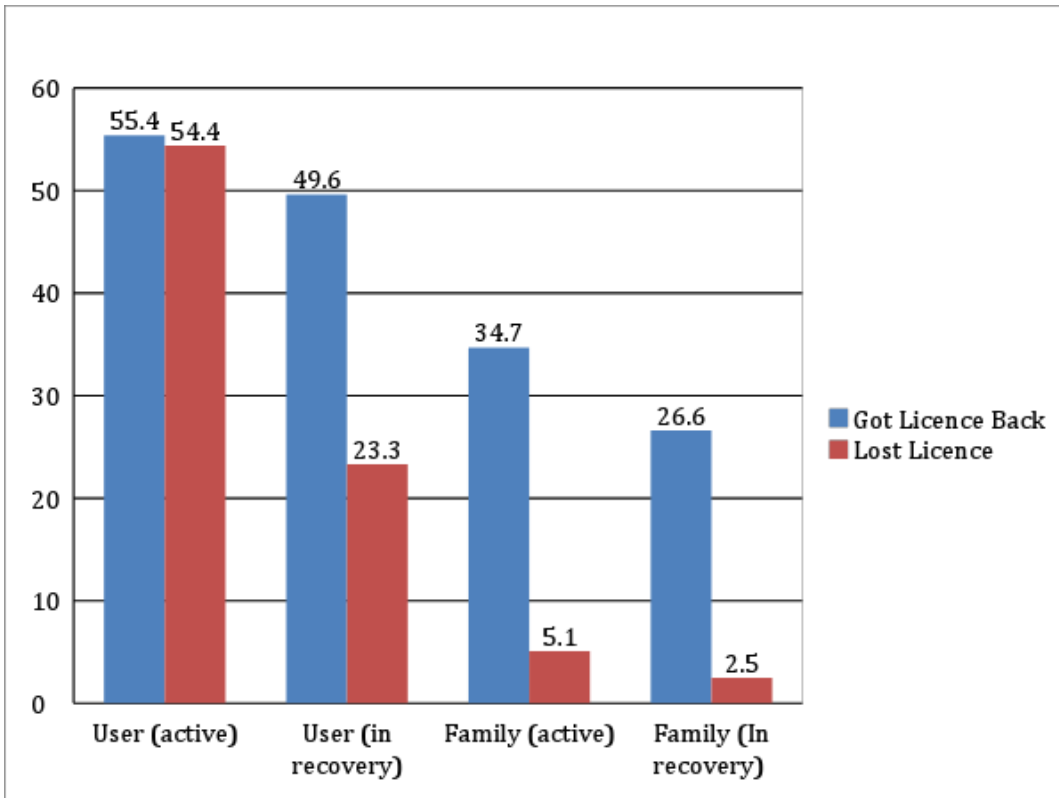


Figure 22: The loss and regaining of a driving licence by users and family in active addiction and in recovery

While there is only a minor change in regaining driving licenses for users in active addiction and recovery, the rate of loss of license by users is reported to have dropped by more than half from active addiction to recovery. A similar pattern is reported by family members who reported a similar reduction rate in the loss of license from active addiction to recovery. Figure 23 reports on overall involvement with the criminal justice system, in any context, from active addiction to recovery:

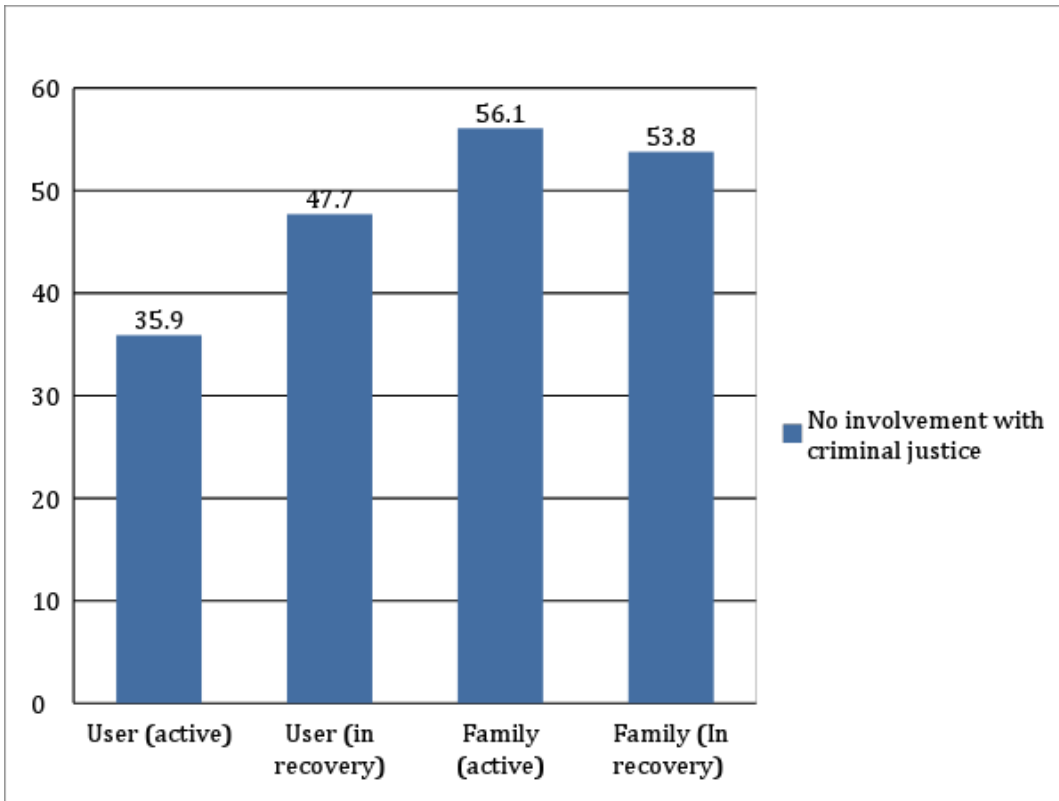


Figure 23: The proportion of users and family with no involvement with criminal justice in active addiction and in recovery

While only one third of users were reported by family members to have NO contact with the criminal justice system in active addiction, this increased to just under half in recovery. It is perhaps surprising that there was actually a slight decrease in non-involvement with the criminal justice system. However, it is important to note that we do not have a breakdown on what the causes of the contact with the criminal justice system would be. Also, related to the criminal justice process, Figure 24 below reports on parole or probation involvement:

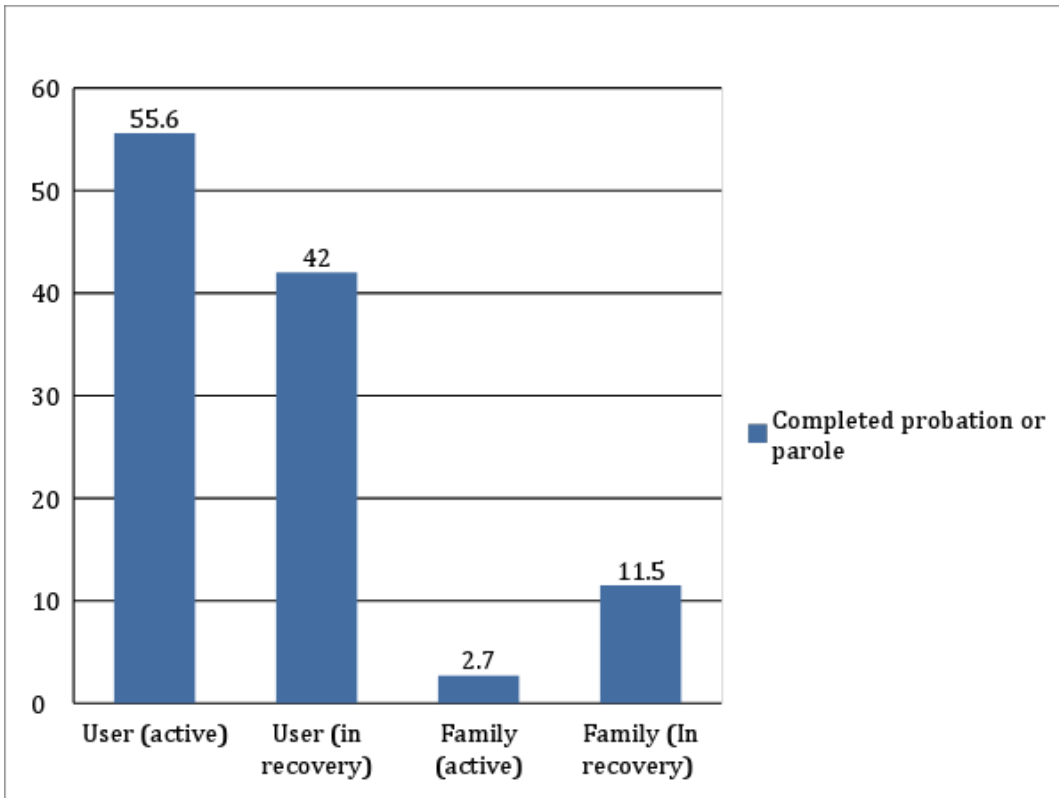


Figure 24: The proportion of users and family who completed probation or parole while in active addiction and in recovery

There is an interesting pattern reported here - with the completion of parole or probation reducing in users from 55.6% in active addiction to 42.0% in recovery, suggesting reductions in engagement with the criminal justice system. Among family members, the opposite pattern is reported - with a marked increase from 2.7% in active addiction to 11.5% in recovery, perhaps suggesting that criminal justice involvement is not finally completed for family members until beyond the start of the user's recovery journey. However, this is a speculative interpretation and further work is needed to unpick what is potentially a troubling and unexpected finding.

The next chart (Figure 25) deals with the restoration of a professional license either in active addiction or in recovery:

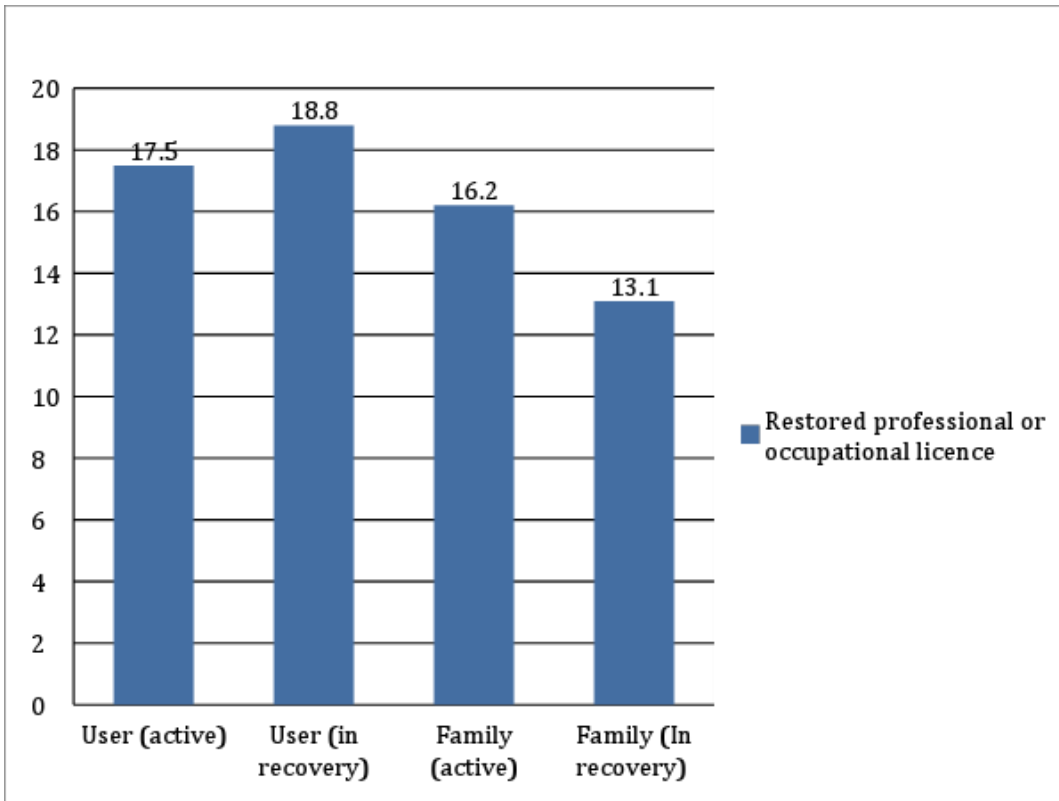


Figure 25: The proportion of users and family who had their professional or occupational licence restored while in active addiction and in recovery

There is relatively little change in the restoration of professional credentialing for users in recovery and in active addiction (with only a small increase) in contrast to the slight decrease among family members during the same transition. It is, however, impossible to know whether these changes are indicative of the resolution of short or longer-term problems. Figure 26, the final chart in this section, shows changes in time in jail or prison during addiction and recovery.

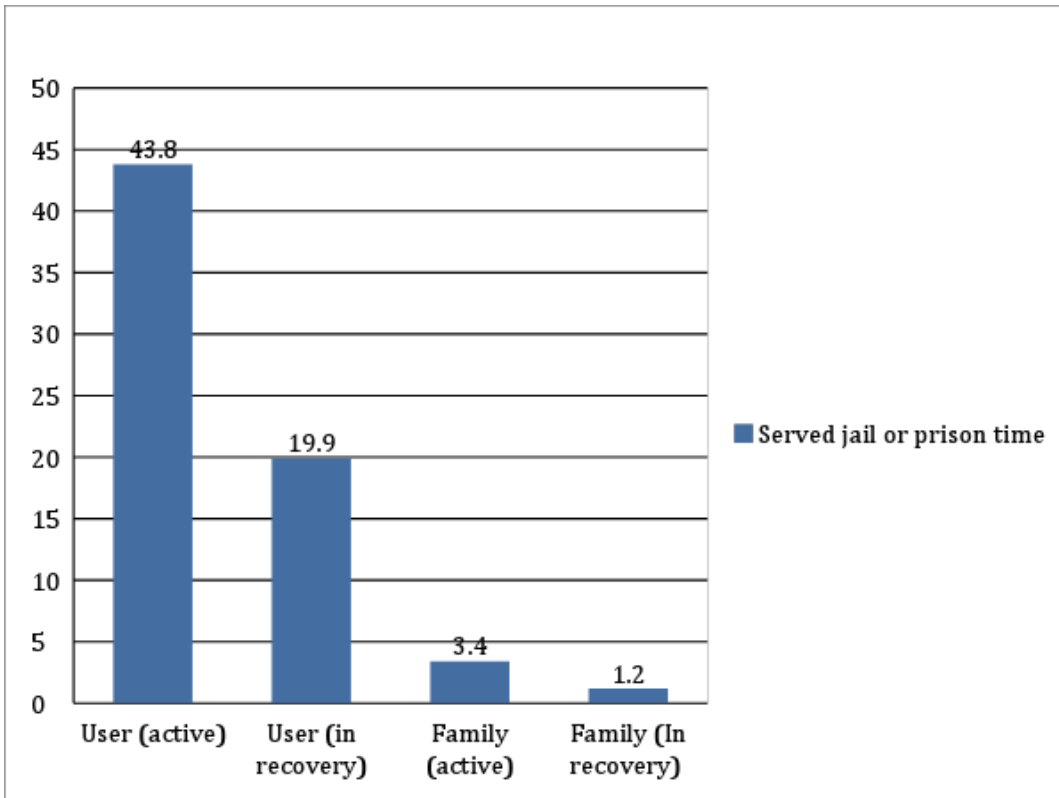


Figure 26: The proportion of users and family who served jail or prison⁷ time while in active addiction and in recovery

The proportion of users reported to serve jail or prison time is consistent with previous Life in Recovery rates showing huge reductions from 43.8% in active addiction to 19.9% in recovery. However, there is previously unreported evidence of an elevated rate of imprisonment for family members at 3.4% during active addiction reducing markedly to 1.2% when the user enters recovery.

This is a key finding and an important finding to close the section with in that it represents another 'hidden' cost of addiction both during the active phase and even into recovery. This is further evidence of the ripple effect of addiction on families and the reverse process that can happen with recovery. What this section has clearly shown is that there are serious repercussions for family substance use problems across multiple life domains that can result in hugely damaging effects for family members, and that not all of these are resolved when the drinker achieves some form of recovery.

Work and education

In the final section of data comparing active addiction to recovery for users and for family members, we look at the area of work and employment, starting with dropping out of education or school, as shown in Figure 27 below:

⁷ While the words are used interchangeably in a UK context, in the US jail is more commonly used for short-term remand and prison for longer-term sentences post-conviction

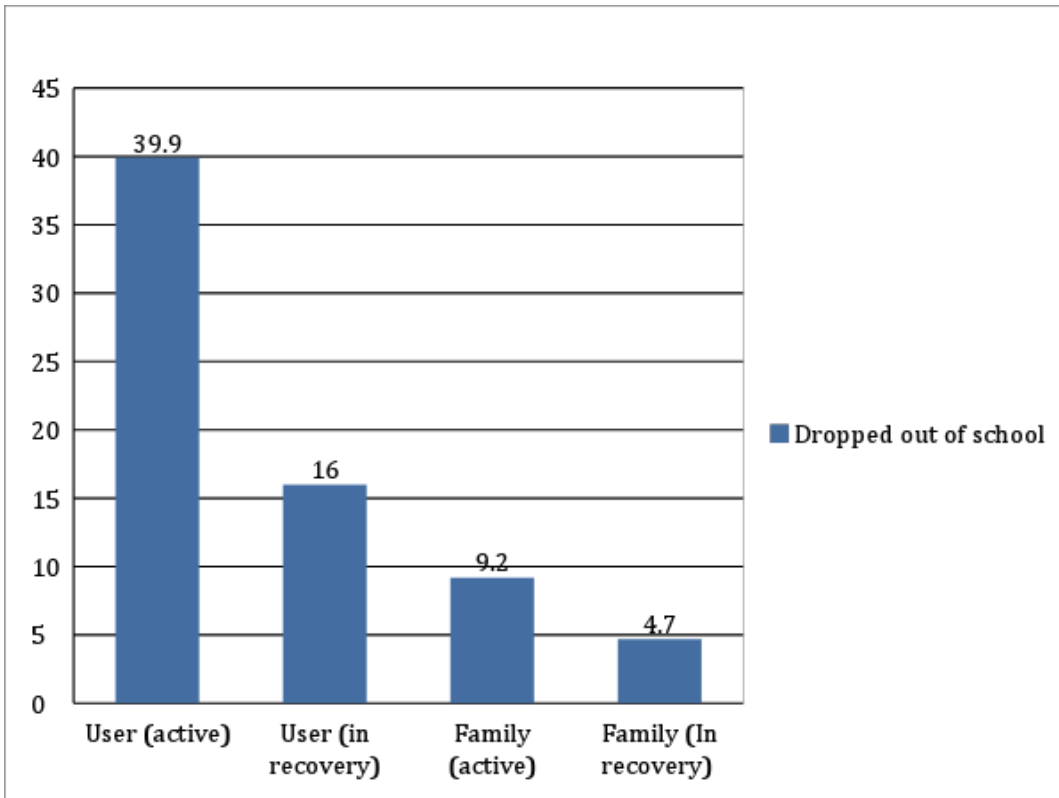


Figure 27: The proportion of users and family members who dropped out of school or college while in active addiction and in recovery

There are clear improvements from active addiction to recovery consistent with many other indicators. The family members report that around 40% of active users dropped out of school or college dropping to 16% in recovery. However, there is also clearly a cost to family members with nearly 10% dropping out in active addiction and this improving to 4.7% when the user enters recovery. Figure 28 below shows the changes in rates of getting fired from active addiction to recovery.

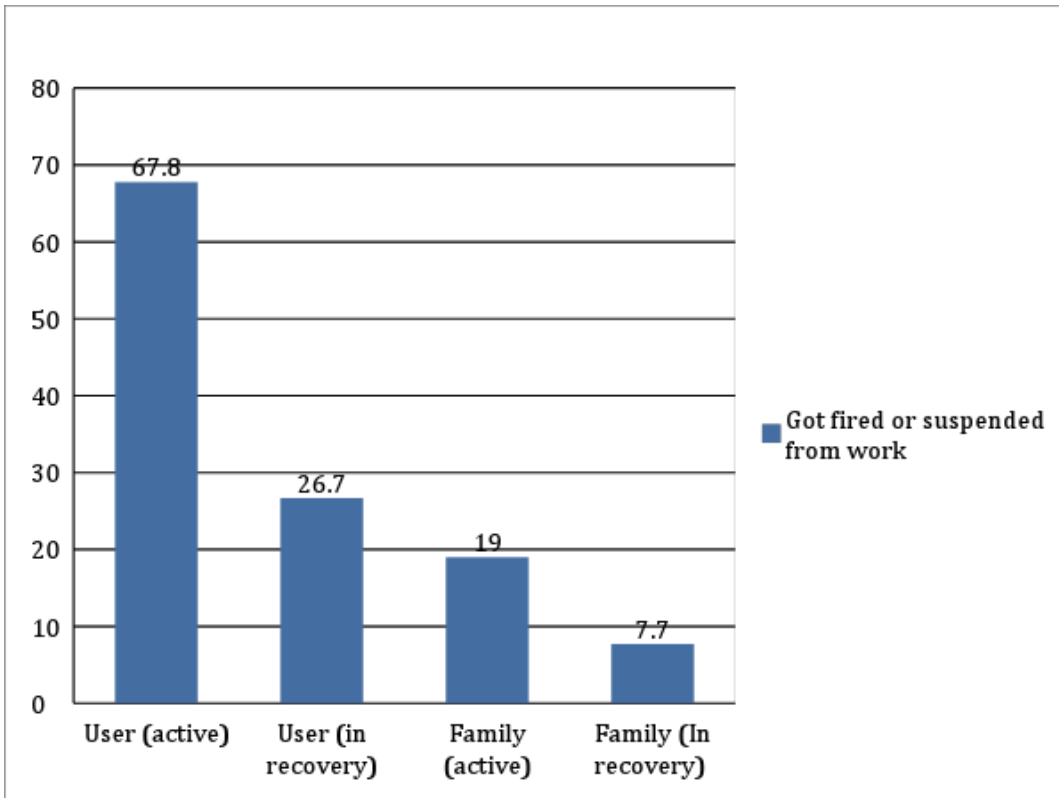


Figure 28: The proportion of users and family members who got fired or suspended from work while in active addiction and in recovery

Again, the figures here are dramatic but unsurprising for addicts with a large proportion of users (68%) reported to have been fired or suspended during their active addiction phase and this reduces to 27% in recovery, although this is worryingly high number. However, again the surprising figure is that nearly one in five family members reported that they were sacked or suspended during the active use period of the user and that this figure dropped by almost two-thirds on entering recovery. Again, this would suggest that the survey is showing a hidden cost of addiction, not previously reported, and a further indicator of the range of adversities experienced by families that are affected by addiction. In Figure 29, the data illustrates the changes in further education or training.

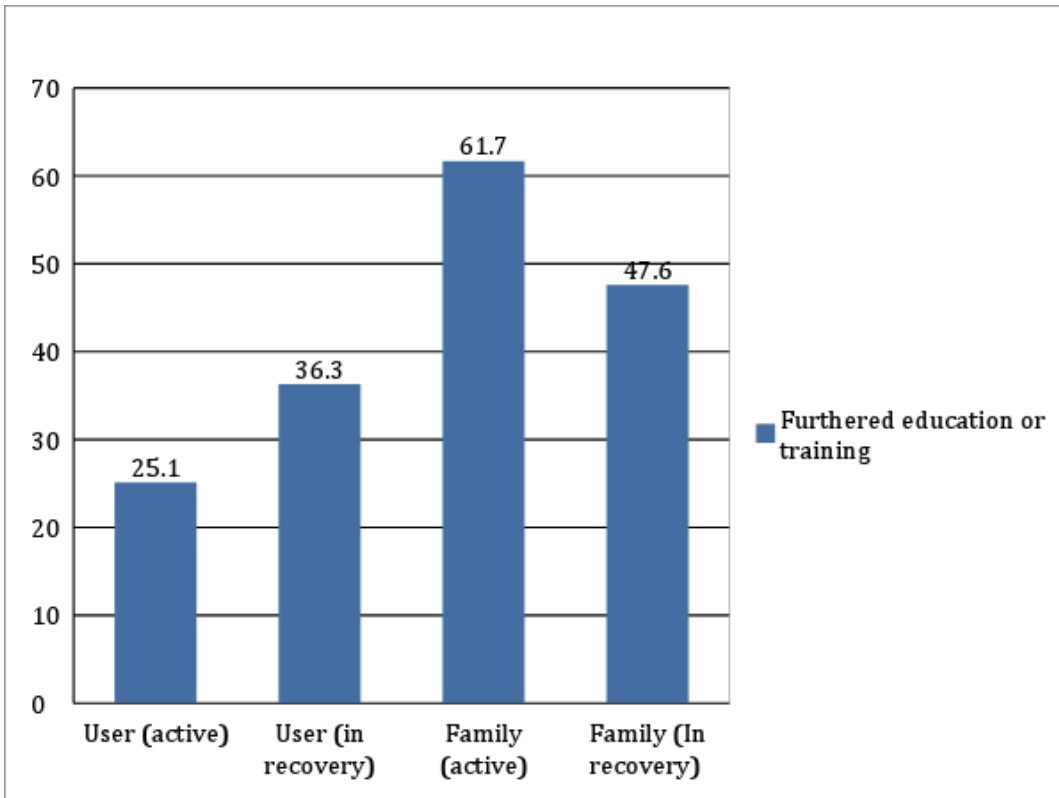


Figure 29: The proportion of users and family members who furthered their education or training while in active addiction and in recovery

While there is a steady improvement in rates of engagement in training or education for the users as they transitioned from active use to recovery, the situation is reversed for family members with a higher proportion reporting training and education during the user's active use than during the recovery period. There is no immediate explanation available for this although we can speculate that this may relate in part to seeking more knowledge about addictions. Positive job evaluations are reported in Figure 30 below:

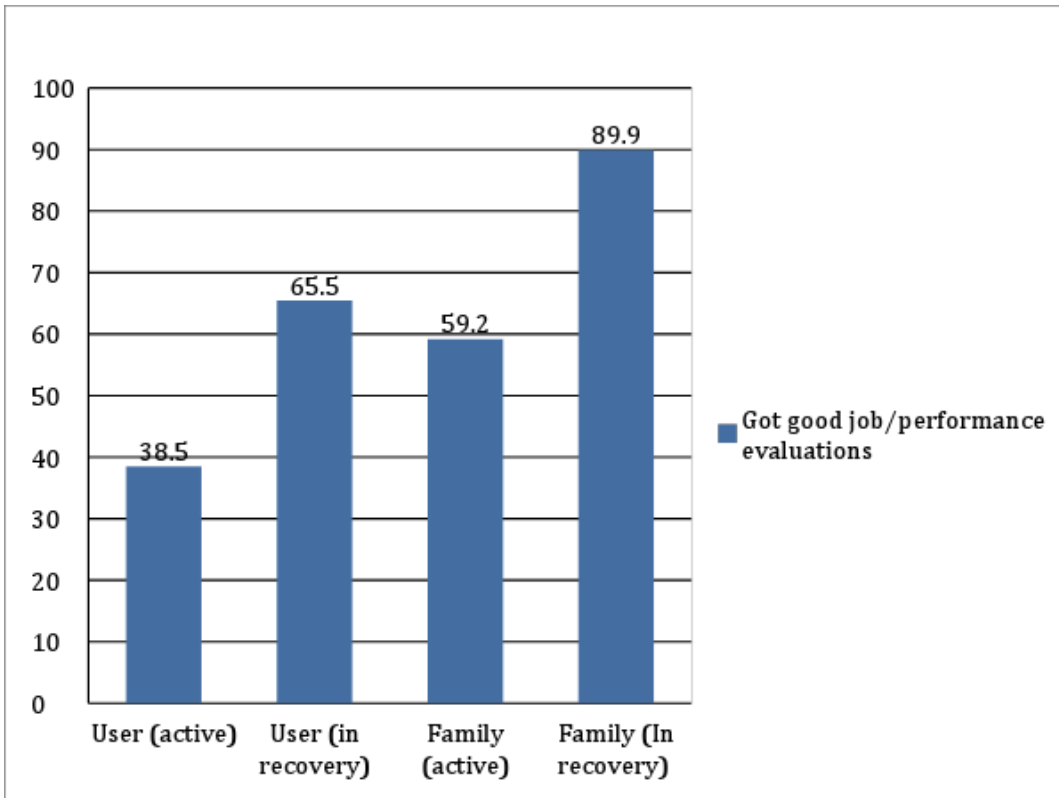


Figure 30: The proportion of users and family who got good job/performance evaluations while in active addiction and in recovery⁸

The proportion of users who received positive job evaluations were reported by family members to have increased from 38% in active use to 65% in recovery. What is perhaps most surprising is that the level of improvement in job evaluations is equally dramatic for family members with a 30% improvement for family members, further indicating the damage that active addiction inflicts in the lives of family members. This is another strong indicator of the ripple effect of addiction and then recovery throughout the family. Figure 31 below indicates the rates of starting their own business in addiction and recovery.

⁸ Because of the lengthy period of problem substance use for most participants, many will have received both positive and negative appraisals at different times

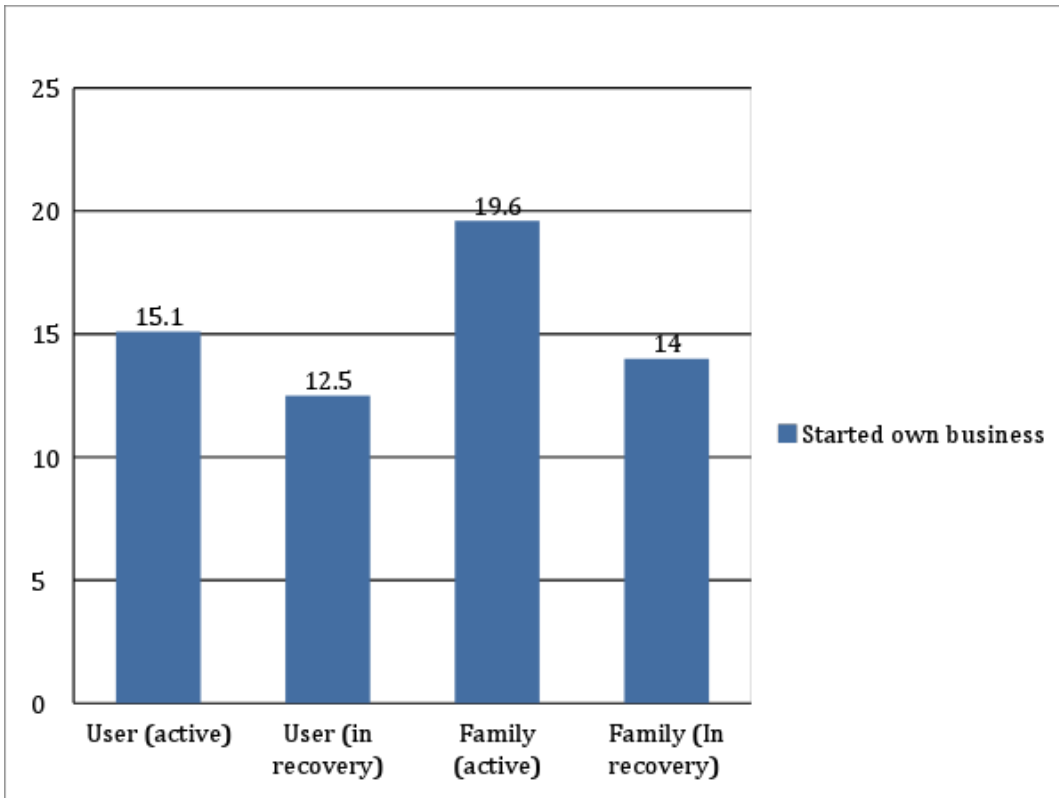


Figure 31: The proportion of users and family who started their own business while in active addiction and in recovery

It is perhaps surprising that there is a small decrease in levels of starting their own businesses from active addiction to recovery for both users and for family members, particularly at a time when there is a high rate of business start-ups in the general population. The final indicator, in Figure 32, reports on the rates of steady employment from active addiction to recovery.

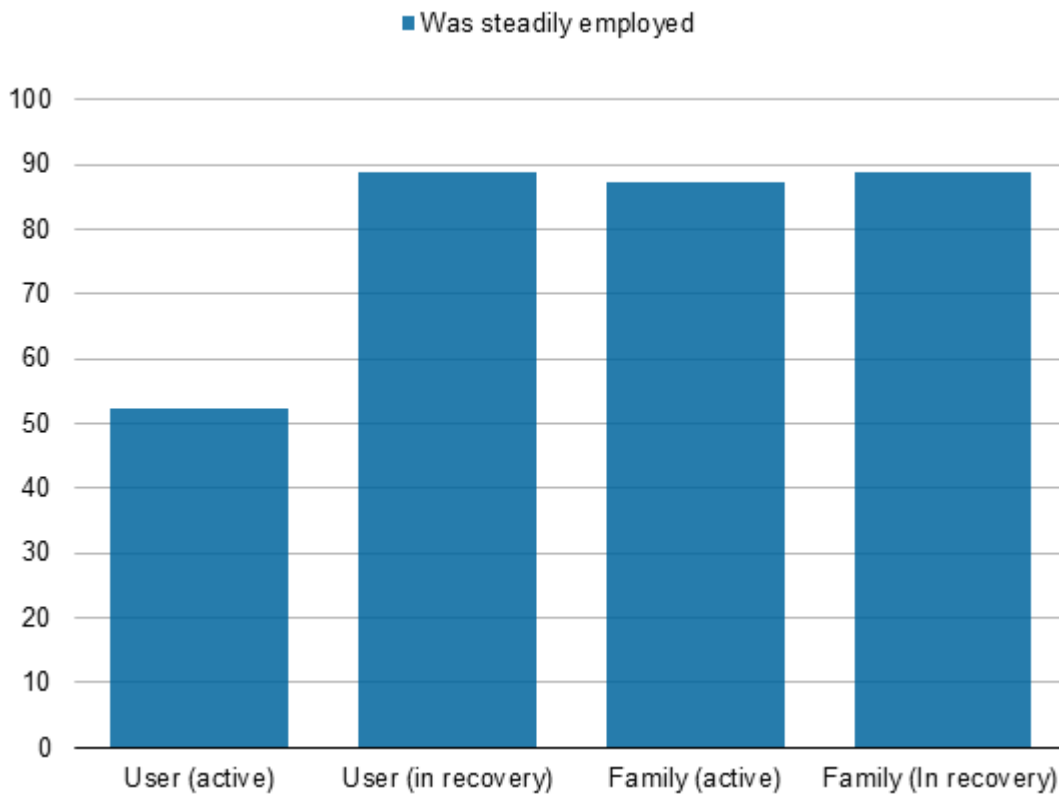


Figure 32: The proportion of users and family members who were steadily employed while in active addiction and in employment

There is a consistent high rate of steady employment for family members and this is almost matched by users when they achieve recovery, rising from a rate of only around 50% when in active use. Given the high rates of education and employment reported, it is likely to be the change figure that is the key finding here for people in recovery.

Thus, the core findings from this section are that there are marked improvements in working performance and outcomes for users and family members as the user makes the transition to recovery. The survey shows clearly that family members are affected in their professional lives by addiction in the family and that there are dramatic improvements in occupational functioning and performance when the user achieves recovery.

Relationships between perceived recovery status of the user and life experiences of user and family member

As has been shown above, there are marked improvements for both family members and for users across all five domains, although it is important to note that these findings are not causal and other unrelated or common cause factors may have influenced these results. However, the effects reported here may mask a weakening effect caused by the fact that not all of the family members are related to users who have managed to sustain their recovery. What is shown in Table 2 below is the differences in wellbeing between family members whose relative has sustained their

recovery and those who have relapsed, for some of the key items identified from the pool above:

Question - answered at the time of the survey completion	% Recovered	% Not recovered	Chi-squared (sig)
Bad credit (user)	60.7	70.9	6.12, p<.05
Couldn't pay bills (user)	56.3	67.1	6.47, p<.05
Couldn't pay bills (family)	15.5	24.9	8.32, p<.01
Lost custody of children (user)	15.2	39.2	26.48, p<.001
Participated in family activities (user)	76.2	50.6	43.33, p<.001
Planned for future (user)	48.8	24.1	35.50, p<.001
Was victim of family violence (user)	7.4	14.7	8.21, p<.01
Was victim of family violence (family)	7.6	19.0	18.34, p<.001
Was perpetrator of family violence (user)	7.6	24.4	35.78, p<.001
Volunteered in community/civic group (user)	40.9	20.5	23.08, p<.001
Exercised regularly (user)	45.3	23.5	26.47, p<.001
Experienced untreated mental health problems (user)	48.6	79.5	52.38, p<.001
Experienced untreated mental health problems (family)	25.2	35.6	7.57, p<.01

Had frequent Accident and Emergency room visits (user)	13.2	28.1	21.71, p<.001
Had frequent use of health care services (user)	37.2	47.9	6.51, p<.05

Table 2: Comparing wellbeing between family members whose relatives have sustained recovery and those who have relapsed

There are clear and consistent differences in the expected direction, with the majority reaching statistical significance. Not only were the users more likely to have bad credit and be unable to pay bills if they had relapsed, the family members themselves were also markedly more likely not to be able to pay their bills if the user had relapsed. Family members were also much more likely to report that the user participated in family activities if the user had remained in recovery (76%) than if they had relapsed (50%) and that they were twice as likely to plan for the future (48% compared to 24%), with both of these differences statistically significant.

There are also marked differences around family violence with the user twice as likely to be the victim of family violence (14.7%) if they had relapsed compared to those who had sustained their recovery (7.4%). This effect is even more stark for the family member with 19.0% of families where the user had relapsed reporting being a victim of family violence compared to 7.6% where the user had sustained their recovery (again both of these differences are statistically significant). The same effect applies to perpetration of family violence - while the user is reported to be the perpetrator in 24.4% of families where relapse had occurred the equivalent figure is 7.6% where recovery is sustained. Thus, sustaining recovery significantly reduces the likelihood of violence in the family.

The impact of relapse is equally evident for both physical and mental health. Where the user had relapsed, the user had much higher rates of untreated emotional and mental health problems than when recovery was sustained (79.5% compared to 48.6%) with equally strong differences in emotional and mental health problems among family members (35.6% compared to 25.2%). All of these differences are statistically significant. Finally, for use of acute medical services, there were significantly higher rates of emergency room services and general medical services when the user had relapsed.

Overall, it is clear that in the families where the user had relapsed, there was significantly poorer wellbeing and functioning than where recovery had been sustained. This applies to key areas such as physical and mental health, family violence and financial problems including debt. Although the relapse had more evident impact on the user, there was also a clear impact on the health and wellbeing of the family member. The overall picture that this creates is one in which recovery is associated with significant improvements across all five life domains for the user and for their families but that this recovery is fragile and that returning to use is likely to lead to adverse effects across all of the reported domains, with a greater

effect on the user but clear and consistent adverse effects on the family, particularly in areas of family violence, debt, emotional and mental health and health service utilisation.

Impact of duration of recovery

In total, 920 respondents (58.8% of the total sample gave information about the length of recovery duration for the drinker or user). The mean length of time in recovery was 45.2 months, or just under four years.

The duration of recovery was associated with better functioning among family members. Using correlational analysis, longer duration of recovery was associated with significantly better psychological health ($r=0.08$, $p<0.05$) and better quality of life ($r=0.09$, $p<0.05$). There was, however, no clear association with physical health and the effect sizes are small. Nonetheless, the findings here would suggest that longer periods of recovery by the drinker are associated with improvements in wellbeing and psychological health in the family members.

FAMILY MEMBERS' COPING STRATEGIES

In this section, we examine what recovery means as an experience for family members and how they see their own experiences over the course of the addiction and recovery journeys of the family members. As we asked of the user, so we asked from the family members whether they considered themselves to be in recovery and about the methods they had used to support their recovery journey and pathway.

Your recovery

- recovery meaning
 - 536 (53%) see themselves as being in recovery⁹, suggesting that this is a common experience for family members, and that recovery is a meaningful description of their own journey
- success of strategies
 - 512 (89.7% of respondents who answered this question) found the strategies they had deployed had been successful in their recovery. It is important to note that there is a high rate of missing data here with almost two-thirds of the sample missing this question suggesting that either they did not have such strategies or that this issue of recovery did not apply to them

Grief

In the course of running the focus groups, one of the key themes that emerged was of family members experiencing a sense of loss that felt like grief, even when the user was both still alive and still in contact, often resulting from a feeling that the family had 'lost' the real person that they had known and loved. For this reason, the survey included a standardised research measure of resilience and grief to assess the impact of the adverse experiences the family members had suffered, based on a scoring system in which 24 or above represents severe vulnerability; 21- moderate; and 20 or below is regarded as low levels of grief. The average score was a mean of 15.8 (SD=5.5) out of a possible total of 36 (range 0-31).

A score below 20 denotes a low vulnerability, suggesting that those in the sample who had experienced bereavement had quite good levels of resilience in response to the adversity experienced. The range of score indicates that there were individuals who had severe vulnerability, but that this was not the norm for this sample.

Stress -perceived stress scale- active addiction

Again, based on the discussions in the focus groups, a key area that was discussed was around stress, with many of the participating family members reporting high

⁹ There were 573 questionnaires completed where this question was not answered

levels of stress. To address this, a brief standardised instrument assessing stress was included in the survey with the following properties:

- Maximum score is 40.
- The PSS investigates the stress level in the past month.
- The average score for the sample was 24.8 (SD=6.9). Range between 0 and 40.
- One sample t-test using the means by gender from the norm table shows that both men and women have significantly higher average stress scores when their loved on was in active addiction than the normal population.
- One sample t-test against norm
- men: $t(117)=18.00$, $p<.001$; mean 23.6 (SD=6.79)
- women: $t(850)=47.2$, $p<.001$; mean 24.9(6.9) - please compare these scores against the norms in Table 3 below:

Norm Table for the PSS 10 item inventory

Category	N	Mean	S.D.
Gender			
Male	926	12.1	5.9
Female	1406	13.7	6.6
Age			
18-29	645	14.2	6.2
30-44	750	13.0	6.2
45-54	285	12.6	6.1
55-64	282	11.9	6.9
65 & older	296	12.0	6.3
Race			
white	1924	12.8	6.2
Hispanic	98	14.0	6.9
black	176	14.7	7.2
other minority	50	14.1	5.0

Table 3 (from Cohen & Williamson (1998)): Population norms for the PSS stress scale

An analysis of stress scores was then conducted to compare recovery status of user vs perceived stress in past month, using a one-way ANOVA which revealed that family members' stress levels in the past month was statistically significant, indicating that there was a difference in stress levels between the recovery groups. Post-hoc tests (i.e., Tukey's HSD) showed that mean stress levels were significantly higher when the user had returned to using ($M=18.9$), compared to in recovery ($M=15.0$), recovered ($M=14.8$) and used to have a problem ($M=16.1$). This supports the previous findings that relapse is associated with significant increases in stress levels among family members.

Thus, while it is not surprising that stress levels are elevated, they are much higher among women than men, and are markedly higher when the user has relapsed to active substance use.

When comparing participants' stress levels from when the user was in active addiction and the participants' perceived stress during the last month, there was a significant difference. There are high levels of stress in family members and this is markedly higher when the person has returned to active use.

Quality of life - WHO

The World Health Organisation (WHO) has a standardised measure for quality of life that is called the WHOQOL-BREF. This consists of 26 items that categorise into four domains - physical quality of life; psychological quality of life; social quality of life; and environmental quality of life, which relates to satisfaction with the neighbourhood and the local area. The scales are adjusted to provide scores out of 100 with higher scores representing better quality of life. For the family members completing the survey, the means for the four domains at the time of survey completion are provided below with population norm scores measured by Hawthorne, Hermann and Murphy (2006) provided in brackets for comparison purposes:

- Physical = 69.9 (norm mean = 73.5)
- Psychological = 61.7 (norm mean = 70.6)
- Social = 58.5 (norm mean = 71.5)
- Environment = 73.7 (norm mean = 75.1)

It is interesting to note that the social and psychological means for family members are markedly lower than for the other domains, and markedly lower than the population norm means reported by Hawthorne and colleagues. Even for family members of users predominantly in recovery, there is clearly a residual adverse effect on their quality of life.

Help-seeking

This section of the survey focused on what type, level of engagement and satisfaction with different types of support: online information and advice, 12-step support, other, primary care and one-to-one support from family help services. Family members were most likely to seek support from online resources and services and the least used service was one-to-one family support services.

The support section had a higher proportion of missing values, likely due to drop-off as a result of fatigue from the length of the survey.

Online information and advice

- 755 had attempted to seek this support
- 631 had received this support
- 369 were currently receiving this support

- 539 were satisfied with this support

Slightly more than half (58.9%) of the family members who completed the survey reported some engagement with online support, and for the majority of those who had attempted this form of support, they had successfully engaged with this type of resource, suggesting that this is a highly accessible source of support. Participants overwhelmingly reported being satisfied with this type of support.

12-step support (Al-Anon)

- 564 had attempted to seek this support
- 527 had received this support
- 255 were currently received this support
- 376 were satisfied with this support

About one-third of the sample were involved in 12-step support at the time of the survey or had been at some point in the past. This is likely to be partly an artefact of distribution with groups such as AA and NA highly supportive of the user LiR surveys in the past, possibly influencing sampling. While fewer people engaged with 12-step support than online support, they also reported slightly lower satisfaction with this type of support, although around three-quarters did report satisfaction with online support. Only around one in six of the sample was actively involved in family self-help groups at the time of the survey.

Other

- 418 had attempted to seek this support
- 398 had received this support
- 254 were currently received this support
- 335 were satisfied with this support

Primary care

- 583 had attempted to seek this support
- 540 had received this support
- 331 were currently received this support
- 408 were satisfied with this support

A large number of family members had either attempted to seek or had received help from primary care. Slightly more than half who had ever engaged support from their doctor (61.8%) were engaged with primary care as a means of support at the time of the survey. Close to 80% of those who were receiving this support or had done so in the past were happy with the help they received suggesting that general practice is a major source of support for family members.

One-to-one help from family support service

- 341 had attempted to seek this support
- 326 had received this support
- 142 were currently received this support
- 261 were satisfied with this support

Interestingly, only around one in five of the total sample of family members had engaged with one-to-one help from family support services, although a larger group reported seeking help in this form. However, a large proportion was satisfied with this type of support, perhaps suggesting that family members are not aware of the services available to them.

Overall, the picture is of highly inconsistent help-seeking and relatively low levels of ongoing support, with general practice more likely to be used than either mutual aid groups or specialist family support services. Nonetheless, there were generally very high levels of satisfaction with the support received. Much more research assessment is required of what kinds of help are available and how effective they are. Future work building on these findings on family functioning will explore the relationship with family adverse experiences and the recovery status of the drinker in recovery.

Exploring recovery-focussed strategies and the meaning of recovery; qualitative analysis

In addition to the quantitative elements of this study, we asked a number of very brief, qualitative (open-ended) questions in the online survey. We did not use a quantification method for quotations and these are themes that have been identified by the research team in reviewing the downloaded responses to open-ended questions. Pertinent to our analysis we focus here on strategies to manage or cope with family addictions.

What strategies have you used start your own recovery journey?

While it is encouraging to learn that over half of the sample considered themselves to be on a recovery journey, it appears that having a recovery strategy was not understood to be a priority (see 5.1). Further, around one third of respondents have engaged with 12-Step groups for support. What is striking is the 12-Step orientation of many answers to the linked qualitative question. While it is recognised that other non-12-Step oriented strategies have been employed, the most easily discerned and analysable answers related to the 12-Steps.

For the question; *What strategies have you used start your own recovery journey?* 752 persons provided an answer. Most family based support offers help around family communication, housing and educational needs, while maintaining the central and positive role that the family plays in the recovery of an addict. They are often local voluntary groups but many are linked to larger organisations, such as Al-anon.

Of the 752 responses, 120 specified participation in 12- Step group support. Further, 107 specifically named Al-anon as their primary strategy employed for support; the largest 'named' group in our study. Many of the qualitative answers given were 12-Step orientated - key phrases such as, 'acceptance', 'forgiveness', 'detachment' and an understanding that addiction is a 'disease' are synonymous with 12-Step groups. The mechanisms of change and self-preservation, reported here, are taught to members of Al-anon and focus around self-care and detachment.

Examples of such responses included: *"Did not blame myself or my family for my brother's addiction, focused on myself, drew a line with my brother on what I would not tolerate in our relationship, listening when he needs to talk"*. Similarly, another respondent said:

"Detachment from his addiction. Trying to keep our lives balanced and healthy despite his addiction"

and:

"I don't give him anything. He has to sort his own mess out he has had many chances and abused them. I focus on my other kids and grandkids now"

It is clear from this that family members recognise the need to look after themselves and the rest of the family. These quotations demonstrate one of Al-anon principles of recovery; that in order for the family member to begin to recovery, they must recognise that as family members they have no control over a person's drinking/drug using, and that,

'Detachment is one of the most valuable techniques Al-Anon offers those of us who seek to reclaim ourselves. Simply put, detachment means to separate ourselves emotionally and spiritually from other people' (Al-Anon, 1996: 84).

Detachment can be interpreted in a very literal sense, with recommendations made to family members to either leave the environment, for example the home, and phone a friend or go to a support meeting. This psychological and behavioural response fits well for analytical purposes, with the Social Identity Model of Recovery (Best, et al., 2016). This model of change outlines how positive behaviour change occurs when a person belongs to a group where there is a common shared goal, positive behaviour change occurs. This change rests on four key components, these are; *social learning*, attending groups were observing and mirroring behaviour has a positive impact; *social control*, where adhering to the principles of recovery, such as detachment, become attractive; coping skills (learning how to practice principles of recovery and *behavioural economics*); where the individual learns that the benefits of adopting a new approach outweigh previous attempts to control/accommodate drinking/using behaviour, Moos, 2007).

Engagement with family support groups elicited positive outcomes for some respondents. The concept of 'self-care' featured strongly, with many persons reporting that they were now focussing on better diet, more exercise, a return to education and better employment prospects/careers. The role that religion and spirituality have played has also been reported as have been beneficial; the ability to forgive the drinker or substance user and relinquish resentment have been seen by some respondents to be a prerequisite for attaining inner peace:

'Forgiveness is no favor. We do it for no one but ourselves. We simply pay too high a price when we refuse to forgive. Lingering resentments are like acid eating away at us (Al-Anon, 1995: 87).

Online participation was widely cited by respondents and allows for greater anonymity and may afford much greater convenience - we know that a keen sense of shame and stigma are felt by some respondents and online interaction lessens this effect. Primary Care has also been cited as a resource for family members- general practice in particular was favoured. This is likely a reflection of the trust and faith placed in the medical profession's ability to help with a problem that is still widely conceived of as a 'disease'. One to one help offered by various counselling services are also a great source of comfort and strength. Trained counsellors are well placed to help individuals dealing with bereavement and loss of trust; issues that affected our family members. Last, our 'Other' category of strategies used by our respondents list many other positive activities engagement with, that persons have found hope and a sense of peace from participating in. These are many and varied, form re-

entering education, joining yoga and mindfulness classes to less recognised strategies, such as taking up kayaking or pottery.

In summary, from the qualitative findings there are two themes that have led to positive outcomes for our respondents. First, a development of a greater understanding of both the person with the addiction and the family member's ability to comprehend their own motives, interactions and consequences. Second, seeking engagement with other persons, either professionally trained, or 'experts by experience'; that is persons that have learned successful coping strategies from other- not necessarily from Al-Anon, but other mutual help groups- it is both interesting and encouraging that persons report that that belonging to such groups gives purpose and meaning to an otherwise sometimes lonely and painful existence. In addition, the ability to perform a level of reciprocity also featured as a positive outcome- to help someone else also suffering the same emotional and psychological distress, as one respondent put it most succinctly:

"I participate in weekly Nar-anon (support group for persons with drug addicted intimates) meetings. I coach other parents who have a child with substance use disorder. I regularly talk to friends and family about addiction to increase understanding and ease the stigma".

OVERVIEW AND CONCLUSIONS

One of the primary aims of the series of Life in Recovery surveys has been to raise awareness about the experience of recovery. This study provides a powerful resource, extending our knowledge of family experiences of recovery. Some very clear messages emerge from this survey. Family members experience multiple adversities as a consequence of addiction. However, they also experience clear improvements in recovery (although this can be reversed, at least in part, in the event of relapse). However, what the current survey shows, which has not been demonstrated on this scale in previous studies, is how much the family members also suffer during addiction, and how wide-ranging the suffering is, with consequent and knock-on effects on communities and society more broadly. Many of these findings provide further evidence for the extent and severity of harms resulting from addiction in the family (eg Velleman et al, 1993; Orford et al, 2001). The evidence on treated and untreated mental health problems, for example, shows not only how prevalent these issues are but also how poorly addressed and treated they continue to be. Reflecting the journey of the recovering drinker, the family members experience considerable improvements in quality of life as their recovery journey progresses, although there continues to be a residual effect in some areas which are not completely overcome.

In other areas, our findings are both worrying and novel. The data on criminal justice involvement and employment are areas of concern, which need further investigation. The elevated rates of arrest and imprisonment during the user's active addiction are perhaps to be expected, but the fact that these rates remain above population prevalence even when the user is in recovery merits further investigation. The fact that 12.5% of family members reported driving under the influence of alcohol or drugs while the user was in active addiction, but that this only dropped to 3.9% during recovery is also problematic (but perhaps a further indication of the levels of stress and adversity experienced by family members, and is possibly an indication of the unmet levels of need in this group).

It is extremely worrying that 31.7% of family members report that they were the victims of family violence during the active addiction phase. The fall to 10% during recovery is an improvement, but remains far too high. Further, it is perhaps surprising that 4.7% of family members reported that they were the perpetrators of family violence during active addiction. While the figures for the recovery phase are confused by the fact that around one third of the users had returned to use, all of these statistics indicate that the family home may be a place of significant risk and turmoil during addiction, and even during recovery. This highlights the need for continuing research and the development of more effectively and widely-implemented interventions.

Addiction can have serious effects on employment, with consequent impact on the family. That 19% of family members were dismissed or suspended from work (and that this dropped to only 7.7% when the user was in recovery) indicates the impact of addiction on wider family functioning, and financial wellbeing. By contrast, the increase in positive work evaluations among people in recovery suggests positive impacts beyond the home.

Dependent drinking affects families in virtually all areas of life. However, their experiences often go unnoticed or unacknowledged in the wider community. This includes the availability and accessibility of support, or even information, as highlighted particularly in the qualitative section of this report. We need to develop a better focus on families to better support them in their own lives, and in recognition that families are often critical to successful and sustained recovery on the part of the drinker.

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