

Life in recovery: a families' perspective

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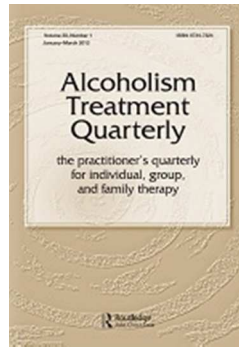
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3 **Life In Recovery: A families' perspective**
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Life In Recovery: A families' perspective

Abstract

While the Life in Recovery series has provided valuable insights into the transformation of the lives of people in recovery and has helped to frame that by recovery method and approach, by gender and by location, it has not assessed the impact of recovery on those immediately surrounding the person in recovery. The Families Living in Addiction and Recovery (FLAR) survey was an attempt to address this by inviting family members to report on their experiences, both as witnesses and in their own right as people going through their own version of recovery. Based on two half-day workshops in London and Sheffield, a revised survey for family members was developed that assessed both the family member's observations of recovery and their own personal journey. In total, 1,565 surveys were completed and returned, reflecting much of the positive experience of the previous surveys. They also showed the extent of adverse effects of addiction and the subsequent benefits of recovery to family members. However, recovery is not a linear process and much of the data in this paper discusses the impact of user relapse on family member functioning. The implications for ongoing support for family members and further research around the recovery journeys of family members are discussed.

Keywords: Life in Recovery; families; relapse; support; needs

Introduction

Misuse of alcohol and other drugs (AOD) continues to plague the UK. In its most extreme manifestation, there were 7,327 alcohol-specific deaths in the UK in 2016 (Office for National Statistics, 2017a). The alcohol-specific death rate remains unchanged for the past four years and is higher than 15 years ago. During 2016, there were 3,744 drug poisoning deaths in England and Wales (Office of National Statistics, 2017b) and 867 in Scotland (National Records of Scotland, 2017). Drug deaths in England and Wales increased 2% from 2015 and were the highest recorded since 1993 (Office of National Statistics, 2017b). Similarly in Scotland, drug deaths have risen dramatically, with 2016 reflecting the highest number since 1996, 23% more than in 2015 and more than twice as many as 10 years earlier (National Records of Scotland, 2017). As alarming as these numbers are, the full impact of AOD misuse is far more widespread, adversely affecting addicts physically, mentally and socially across a broad range of domains.

Adding to the evidence of individual harm from AOD misuse, there is a growing body of research evidencing the impact of addiction on family members (Gruber & Taylor, 2006; UKDPC, 2012; Drugscope and Adfam, 2009). AOD misuse has been shown to negatively affect parenting abilities, the experiences of children, and the emotional, physical and financial wellbeing of family members across a broad spectrum of domains (O'May et al., 2017; Stenton et al., 2014; Laslett et al., 2010; Gruber & Taylor, 2006; Brown & Lewis, 2002).

With growing evidence that addiction negatively impacts on family members, a critical enquiry is whether, in like manner, recovery positively impacts on families. Moreover, the question arises whether family members experience their own recovery journey, unique and individualised from the AOD using family member, and to increase the research focus on families in addiction and recovery. The current study specifically examines these two questions. A third question explored in this study is whether or not there are variations in change reported by respondents with family members in recovery compared to those with family members who have returned to active AOD use.

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3 Finally, one of the limitations noted in each prior Life in Recovery (LIR) study is the survey's self-
4 report nature. No previous study has provided an opportunity to validate the person in recovery's
5 self-report. With Families Living with Addiction and Recovery (FLAR), although generalised, family
6 members were asked to provide their own reports of their loved ones' recovery journeys. Thus, we
7 begin the investigation by reviewing whether family members' observations of their loved ones'
8 recovery validates the latter's reports.
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16 *1. What is recovery, and what are the stages of recovery process?*
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19 There have been a number of attempts to develop consensus definitions of addiction recovery, with
20 two frequently cited from the UK Drug Policy Commission (UKDPC) (2008) and the Betty Ford
21 Institute Consensus Group (2007). Recovery is described by the UKDPC as 'voluntarily sustained
22 control over substance use which maximises health and wellbeing and participation in the rights,
23 roles and responsibilities of society' (2008, p 6), while the Betty Ford Institute Consensus Panel
24 defines recovery from substance use disorders as a 'voluntarily maintained lifestyle characterised by
25 sobriety, personal health and citizenship' (2007, p 222). Both of these definitions are predicated on
26 three factors - positive changes in active participation in society, improvements in global health and
27 wellbeing, and reductions or elimination of substance use. However, the term remains contested
28 (e.g. Valentine, 2011; Wincup, 2016), and there is no equivalent definition for the recovery
29 experience of the family member.
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43 There is recognition that recovery is a journey and not an event, and that it takes around five years
44 before recovery can be regarded as self-sustaining (Dennis et al., 2005, 2007). The Betty Ford
45 Institute Consensus Panel (2007, p 224) categorised recovery in three-stages: early recovery (the
46 first year), sustained recovery (between one and five years), and stable recovery (more than five
47 years). There is an evidence base suggesting that relapse risk reduces up to five years from achieving
48 abstinence and that it plateaus after this point (Best et al., 2010), contributing to the idea that stable
49 recovery is approximately a five year journey.
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3 Although the definition of recovery remains a subject of debate for policy makers and practitioners
4 alike (Best, Beckwith, et al., 2015; White, 2008), over the past decade the concept of recovery has
5 become a common feature of drug policy in the UK and US (HM Government 2008, 2010, and 2012;
6 Northern Ireland Executive, 2011; Scottish Government, 2008; Welsh Assembly Government, 2008;
7 Humphreys & Lembke, 2014). The recovery concept has become integral to the understanding of the
8 process of transition from active addiction to abstinence or remission (White, 2008).
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16 While addiction to alcohol and other drugs (AOD) is widely viewed as a chronic, relapsing condition
17 (O'Brien & McLellan, 1996; White, Boyle & Loveland, 2003), there is increasing evidence that people
18 can and do achieve recovery from AOD addiction (Dennis & Scott, 2007). Sheedy & Whitter (2009)
19 estimate that 58% recover; Dennis & Scott (2007) similarly estimate the number at 58-60%; and
20 White (2012) estimates a 50% recovery rate, based on reviews of the existing research evidence.
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26 Recovery is increasingly viewed as a process rather than a state, with many pathways, or methods,
27 to change from problematic use to abstinence, remission or management (Cano, et al., 2017).
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30 Insufficient evidence exists to date around how and why people recover (and don't), what pathways
31 are available, and the dimensions of the journey, and what its social and societal implications are.
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36 *2. How do we measure recovery?*

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39 While the concept of recovery is not new (Berridge, 2012; Yates & Malloch, 2010) and is now
40 embedded in policy in the UK and US, nevertheless the measurement of it has proved challenging
41 (White, 2012), and the notion of subjective lived experience remains contested. Only within the past
42 decade has recovery measurement been operationalised. In 2012, the US recovery advocacy
43 organisation Faces and Voices of Recovery (FAVOR) published the findings of an online survey of
44 people in recovery (Laudet, 2013), which attempted to capture experiences of recovery across a
45 series of life domains. The FAVOR survey marked a foundational building block for international
46 efforts to measure recovery, and provided a framework that can be embedded in multiple research
47 studies.
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3. FAVOR survey

The FAVOR LIR survey was developed around four domains - physical health, mental health, substance use and recovery, and life experiences in addiction and recovery, with the final domain including 44 items representing experiences and measures of functioning in the domains of work, finances, legal, family, social, and citizenship. After responding to basic demographic questions, respondents were asked questions about their recovery journey for when the person was "in active addiction" and again "since you entered recovery" (Laudet, 2013). A total of 3,228 surveys were completed and returned. On average, the participants 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).

4. Australian, UK and Canadian surveys

In 2014, one of the authors of this report developed an Australian version of the US LIR survey (Best, 2015). The Australian Life in Recovery (ALIR) attracted a survey response of 573 participants, with reporting addiction careers averaging 12 years in duration, and on average nine years of recovery time. The author concluded that "These results are consistent with the findings of the US Life in Recovery Survey (Laudet et al., 2013) in showing dramatic reductions in pathology and improvements in wellbeing from active addiction to recovery. The Australian results are also important in that they support the suggestion that there are clear improvements that happen over time in recovery. Those in recovery for the longest reported markedly higher levels of psychological wellbeing and quality of life and much lower levels of need for professional support for emotional or mental health issues" (Best, 2015, pp27-28), consistent with the FAVOR survey which had also shown clear benefits associated with longer periods of time in recovery.

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3 The following year, following on the success of the ALIR, one of the authors of this report developed
4 an UK Life in Recovery (UKLIR) survey (Best, Albertson, et al., 2015). The UKLIR resulted in 802
5 successful completions. The average length of time UK respondents had been in recovery was 8.3
6 years (with a wide range of 0-54 years), with an average age of initiating the recovery journey being
7 38.4 years (range of 15 to 69 years). The authors found that "the longer recovery can be sustained,
8 the more the benefits are accrued to the individual, their families and their communities. ... this
9 survey echoes the findings of prior recovery surveys in Australia and the US, adding to a growing
10 body of evidence suggesting that while recovery can be a broad and differentiated experience, it is
11 one that should be celebrated, acknowledged and supported across communities" (Best, Albertson,
12 et al., 2015, p36).

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15 In a more recent LIR survey, conducted in Canada (McQuaid et al., 2017), there were 855 responses.
16 As in the other studies, self-reports of people in recovery showed marked changes across all of the
17 domains, including in family functioning. The authors concluded that "In sum, the LIR data reveal
18 that long-term recovery is attainable and sustainable even when addiction is marked by high severity,
19 complexity and chronicity. Moreover, many individuals in recovery report a good quality of life and
20 lead meaningful lives contributing to their families and to society. These findings provide hope for
21 individuals and families affected by addiction, and help inform professionals seeking to assist them,
22 as well as policy makers considering the value of providing funding for treatment and recovery
23 programs for this population" (McQuaid et al., 2017, p47). However, all of the surveys cited above
24 gathered data only from those with a direct experience of addiction and recovery, and not from
25 those family members affected by this process.

26 27 28 *5. Family experiences of addiction and impacts on the family*

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31 There is a small but growing body of research exploring the impact of addiction on families, but a
32 gap around the effects of addiction recovery on families (Gruber & Taylor, 2006; UKDPC, 2012;
33 Drugscope and Adfam, 2009). There is limited evidence relating to the experiences of users' families

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3 as participants in addiction careers and almost nothing about their experiences of the recovery
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5 journey. The impact of the user's transition from use to recovery on the family member's wellbeing
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7 remains poorly articulated (Drugscope and Adfam, 2009; UKDPC, 2009). The effect of living with a
8
9 family member who is dependent on alcohol or other substances is substantial and long-lasting. To
10
11 illustrate, over 70% of participating family members in the current study reported lifetime emotional
12
13 or mental health problems, and over one-third suffered from those problems at the time of the
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15 survey (Andersson, et al., 2017). Copello and Orford (2002) argue that we must also understand the
16
17 centrality of the family system that experiences, manages and ultimately may resolve addiction
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19 issues.
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22 The value of interventions for the family should not be overlooked as recovery is greater than
23
24 cessation of substance misuse. Recovery should bring other benefits, such as alleviation of the
25
26 physical and mental strains associated with addiction, and the journey to reintegration with social
27
28 networks and communities. Intrinsic to this is the resumption or development of a varied and
29
30 fulfilling life, characterised by hope and engagement with society and community, all of which
31
32 develops along an ongoing recovery journey (Best & Laudet, 2010). This is embedded within a
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34 developmental pathway in which recovery is characterised as a process rather than a state.
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38 Whereas previous treatments sometimes pathologized the family (on occasion, categorising them as
39
40 'enablers', 'co-dependents' or 'saboteurs'), and some of those individually focused interventions
41
42 persist, a strand of the current literature recognises families as a valuable resource to individuals and
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44 people who suffer in their own right (Adfam & Drugscope, 2009; Orford et al, 2010; Velleman, 2010).
45

46
47 There is some evidence illustrating the negative impact of addiction on close, extended and non-
48
49 biological families in emotional, well-being, fiscal and practical terms (such as housing and
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51 employment status) (Brown & Lewis, 2002; Berends et al., 2012; Copello & Orford, 2002; Laslett et
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53 al., 2010; O'May et al., 2017; Borton et al., 2017). These stresses and strains create barriers that
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55 hinder the individuals in the family and the family as a unit in amassing the positive recovery capital
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3 vital to navigating their recovery journey (Cloud & Granfield, 2008; Granfield & Cloud, 2009; Laudet
4 & White, 2008; White & Cloud, 2008).

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8 The treatment of families of substance abusers has developed from a pathology-focused model of
9
10 causality to a focus in the 2000s on children as victims (Velleman, 2010). This is exemplified in the
11
12 'Every Child Matters' (2003) strategy with its focus on substance misusing parents, their 'at-risk'
13
14 children and children in vulnerable, chaotic families who were perceived to be at risk of addiction
15
16 themselves (HM Government, 2003; Velleman, 2010). Likewise, the "Hidden Harm" report by the
17
18 Advisory Council on the Misuse of Drugs (ACMD, 2003) focused on the harms to children from
19
20 addicted parents and made reference to the wider damage to families resulting from parental
21
22 substance abuse.

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25 Substance misuse can have far reaching impacts on parenting abilities, the experiences of children
26
27 and the emotional, physical and financial wellbeing of family members (Gruber & Taylor, 2008;
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29 Brown & Lewis, 2002; Laslett et al., 2010; O'May et al., 2017 ; Stenton et al., 2014). Schmid and
30
31 Brown (2008) illustrated the mixed impact of the early recovery stage upon children within the
32
33 family. For example, the newfound sobriety and accountability of their parents, and the resulting
34
35 loss of independence may disrupt family processes and coping approaches, leading to bad behaviour.
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37 This may actually present a recovery-related challenge to the family (Schmid & Brown, 2008). The
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39 recovery of one family member may shift dynamics within the family; for example, the re-
40
41 engagement of the parent in traditional adult roles may reduce the self-worth, purpose and identity
42
43 a child developed when assuming adult roles in lieu of their parent (Schmid & Brown, 2008), and
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45 further distort their developmental trajectory. In other words, we cannot assume that the recovery
46
47 journey of the user will result in equivalent improvements in the family.

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51 There is a greater incidence of psychiatric diagnosis and mental health problems among children of
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53 problem drinkers. The negative impact of substance misuse in the family on parenting abilities and
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55 children's psychological, behavioural and cognitive wellbeing have been widely studied and this can
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3 manifest in a tendency to abuse substances themselves, as well as in low self-esteem, depression
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5 and lower academic and social functioning (Gruber & Taylor, 2006; Copello & Orford, 2002;
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7 Velleman et al., 1993). Furthermore, substance abuse is a significant factor in child neglect and
8
9 abuse, particularly where social care involvement is concerned (Gruber et al., 2001; Laslett et al.,
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11 2010).

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14 The presence of an addict in the family and the associated behaviours can have an influence on
15
16 family members' own drinking, as per Christakis and Fowler's (2009) theorisation of hyper-dyadic
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18 spread, through which they illustrated that across degrees of separation there can be an impact on
19
20 the health, behaviours and emotions within a social network, as they have illustrated in the case of
21
22 smoking and happiness (Christakis & Fowler, 2009; Best & Laudet, 2010). The work of Christakis and
23
24 Fowler proposes the idea of contagion of behaviour patterns where both positive and negative
25
26 behaviours are spread through social networks, and is important in understanding the public health
27
28 and socially driven impacts of substance use on networks including but not restricted to families.

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31 Laslett et al. (2010) illustrated the considerable physical harms associated with problem drinking,
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33 finding that 42% of domestic violence-related deaths were related to another's drinking and almost
34
35 1.3 million people per year were negatively affected 'a lot' by the drinking of a
36
37 family/friend/household member. The main categories of drink-related harms to others involving
38
39 hospitalisation are child abuse, domestic violence and road crashes.

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43 Furthermore, health problems due to addiction don't just affect the drinker or their partners. Foetal
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45 defects, injuries from domestic violence, nutritional deficiencies from neglect and mental health
46
47 problems are all consequences of substance misuse that affect those proximal to the addict (Sokol et.
48
49 al., 1980; Laslett et al., 2010). The drinker's own health can also affect the family, for example if they
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51 become disabled or suffer from chronic health conditions through their substance misuse then
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53 family members may have to emotionally and practically support them by assuming responsibility
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55 for caring duties (Zajdow, 1995 and 1998; Charles et al., 2009).

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3 The financial effects of supporting a problem drinker have been explored by O'May et al. (2017),
4 who showed that family and friends often bear the brunt when the drinker cannot fund their habit,
5 including the payment of fines and the consequences of accidents and injuries. Furthermore, the
6 dynamics of the relationship will also have impacted upon the drinker's perception of that family
7 member (O'May et al., 2017), and changes the roles and security within families. The borrowing of
8 money was also a contentious issue in relationships between problem drinkers and their family and
9 friends, often straining or ending relationships, with either the lender or their loved ones feeling
10 exploited and used (O'May et al., 2017).

11
12 Often the comorbidity of substance addiction and problem gambling can lead to dire financial
13 circumstances (Stewart & Kushner, 2003). So too can the co-occurrence of mental health, criminal
14 justice involvement and housing problems. This can impact not just on the material wealth of
15 families as money and housing may be put at risk or lost, but their overall wellbeing (social, health,
16 status, security, employment and education). Common co-occurrences such as homelessness and
17 increases in family violence may also be associated with physical and experiential loss for parents,
18 children and spouses due to the gambling and addiction of their loved one (Darbyshire et al., 2001;
19 Orford et al., 2005; Custer & Milt, 1985; Castellani, 2000).

20
21 Arguably, the most traumatic consequence of problem drinking which affects family and friends for
22 the rest of their lives is bereavement. Templeton et al. (2016) interviewed 106 adults and found that
23 many family members had trouble living with the possibility of death, the challenges of official
24 processes, problems of stigma and grief, and the challenges of obtaining support. Therefore, the
25 bereavement can mean death but also the perceived loss of the valued and cared for family member
26 who is seen to be lost even while still alive, which is referred to as 'anticipatory grief'.
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30 Treatment for family members is geographically patchy, inconsistently linked to statutory provision
31 of addiction treatment (at least in the UK), and is rarely delivered through health services. Much of
32 the provision of family support is voluntary but varies by locality, although there is an extensive
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3 network of Al-Anon groups both in the UK and the US, and a smaller but visible presence of other
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5 groups such as Families Anonymous and SMART Family and Friends. Accordingly, there are calls for
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7 exploration of how services and strategies can support and coordinate these local groups, not just as
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9 resources for the recovery of the individual, but to support family members who have suffered and
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11 need to recover in their own right (Gruber & Taylor; UKDPC, 2012; Drugscope and Adfam, 2009). In
12
13 spite of this, there are concerns that the welfare system directly and indirectly penalises the families
14
15 of substance misusers (Reeve, 2017; Schmidt, et al., 1998; Copello et al., 2010), and there may well
16
17 be a hidden cost to families.
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19
20 This project furthers this approach by adding to the evidence base and through offering a voice to a
21
22 previously hidden population (Velleman, 2010; Brown & Lewis, 2002). White and Savage (2005)
23
24 asserted that family members' responses to the addiction of a loved one are not pathological but
25
26 normal responses to trauma, and therefore should be expected to be the norm rather than the
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28 exception.
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30 31 *6. Family members own recovery processes - 5-step and Al-Anon* 32

33
34 While there are a range of family support options available, the most readily available source of
35
36 support for many family members is Al-Anon, which is founded on the social community recovery
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38 model, and has its foundations in the principles of 12-step mutual aid. The assumption underpinning
39
40 this model is that the family member cannot be responsible for the recovery of the addict, but rather
41
42 must focus on their own wellbeing. There are more than 24,000 Al-Anon groups in 130 countries,
43
44 with over 800 Al-Anon groups operating across the UK and Ireland with face-to face, telephone and
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46 electronic meetings. (White, 1998; Timko et al., 2012; Al-Anon Family Groups: UK and Eire, 2017).
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50 Members of Al-Anon describe mutual aid as helping a transformation in their view of the drinker and
51
52 the nature of addiction, information, advice and support, friendship and belonging, and self-worth
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54 and assertiveness (Stenton et al., 2014). Corrigan's (2016) illustration of AA's benefits to family
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3 resilience supports this, noting that the key areas of support are around personal growth (self-
4 awareness, improved self-esteem, spirituality, acceptance), new tools and techniques for managing
5 family issues (problem solving skills, sense of community) and change in thinking (re-evaluation of
6 self, of addiction and relationships). Family members were positive about mutual aid groups but
7 bemoaned the inaccessibility of information on family support services (Corrigan, 2016).
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14 Public recounting of individual stories is central to the structure of 12-step meetings. In what
15 Arminen (2004) has dubbed 'second story' telling, others in the group reflect the structure and
16 themes of previously recounted stories, with a strong emphasis on 'no cross talk'. This is a strong
17 example of the social learning and social control components of recovery outlined by Moos (2007).
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23 Desirable groups and membership of them strengthens social identification and in Al-Anon as in AA,
24 family members are posited as survivors and as valuable in their own right (Ashforth & Mael, 1989).
25 The shared goals, common history and mutual positive identification all enhance the adoption of a
26 positive social identity and incorporation of pro-recovery individuals into the family's social network
27 (Buckingham et al., 2013). The resolution of these roles is a key factor in families' recovery and
28 ability to replace negative experiences and feelings of isolation with membership of a group that
29 supports and understands their trauma (Buckingham et al., 2013; Johannsen et al., 2013).
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39 A second model of family support is the Stress-Strain-Coping-Support (SSCS) model. SSCS treats the
40 experience of a family affected by substance misuse as an inherently long term and stressful one,
41 exposing the family to mental and physical strain which commonly manifests in ill health. Central to
42 the management of this stress and strain are information, coping mechanisms and social support.
43 Social support is a resource for coping skills and one that is vital to the individual's health (Orford et
44 al., 2010), although 'recovery' is not an explicit goal of this approach.
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52 Informed by the SSCS model the 5-Step Method is a brief intervention aimed at addressing the
53 needs of adult family members (Copello et al., 2010). The 5-step Method consists of: 1.) Listen,
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3 reassure and explore concerns. 2.) Provide relevant, specific and targeted information. 3.) Explore
4 coping resources 4.) Discuss social support 5.) Discuss and explore further needs (Copello et al.,
5
6 2010). There is a growing evidence base suggesting the 5-Step Method yields long-term
7
8 improvements in mental and physical strains and improvements in coping. It appears to be equally
9
10 effective with long suffering families and families with relatively recent problems (Velleman et al.,
11
12 2011; Copello et al., 2010).

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16 A third support model is the Community Reinforcement and Family Training (CRAFT), which
17
18 developed from the Community Reinforcement Approach (Copello et al., 2005). The influence of
19
20 family members in the recovery of addicts is the central feature of CRAFT, a behavioural approach
21
22 designed to help concerned significant others (CSOs) intervene where addicted family members
23
24 have refused treatment (Copello et al., 2005; Meyers et al., 1998). CRAFT focuses on working with
25
26 CSOs to reinforce non-substance-misusing behaviour through a positive reinforcement process. In
27
28 their 1998 study involving 62 CSOs, Meyers and colleagues assessed whether family members using
29
30 CRAFT procedures could change their own behaviours. 74% were successful in getting their loved
31
32 ones to seek treatment within 6 months - 71% of those sought treatment through CRAFT. The
33
34 evidence also established personal benefits for the CSOs from the CRAFT procedures, with improved
35
36 physical and emotional well-being during treatment and maintenance of those improvements after
37
38 the project's completion. Meyers and colleagues noted that the improvements realised by CSOs
39
40 were not dependent on their loved ones' entry into treatment. Addicts reported reduced conflict
41
42 and improved relationships with their CSO over a 3-month period (Meyers et al., 1998).

43 44 45 46 **Rationale for the paper**

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49 The Life in Recovery surveys completed to date produced a rich evidence base about the experiences
50
51 of people transitioning from a life in addiction to a life in recovery. But these surveys only presented
52
53 family life experiences from the perspective of the person in recovery and had not accounted for the
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55 experience of those affected by their addictions. To address this gap , the FLAR project was designed
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2
3 to advance our understanding of the recovery journeys of families of present and former substance
4 users. The purpose of this study is to describe the findings and to compare the experiences reported
5 by respondents with family members in recovery vs those with family members who have returned
6 to active AOD use. The paper thus sets out to answer four research questions:
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12 RQ1 - Do family members of people in recovery validate improvements reported by the former
13 addict?
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17 RQ 2 - Does recovery positively impact on families?
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20 RQ3 - Do family members experience their own recovery journey?
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23 RQ4 - Are there variations in change reported by respondents with family members in recovery
24 compared to those with family members who have returned to active AOD use?
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26

27 **Methods**

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29
30 The Families Living with Addiction and Recovery (FLAR) was funded by Alcohol Research UK and in
31 partnership with Adfam, the project was designed to revise the LIR model to measure the
32 experiences of families of those in recovery. Adapting the UKLIR survey (Best et al., 2015), the FLAR
33 survey was developed across phases to generate a process of co-production and ownership for
34 family members.
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42 Co-production was a key feature of the FLAR project, underpinning both the development and
43 distribution of the survey. In order to collect information on the lived experience of family members
44 of problem drinkers and drug users, we sought to engage with both service providers, our local
45 patient-public involvement group, Sheffield Addiction Recovery Research Panel (ShARRP), and the
46 target population throughout the three phases of the FLAR project, namely: consultation and survey
47 development; piloting of the survey; recruitment of research participants and completion of the
48 survey.
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3 During the consultation phase, two workshops were held in Sheffield and London. Approximately 70
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5 research participants attended the events. While the FLAR survey was initially intended to replicate
6
7 the UKLIR survey (Best et al., 2015), feedback from the workshops indicated that family members
8
9 considered it essential that the questionnaire addressed and gave voice to their own experiences of
10
11 addiction and recovery as opposed to the experiences of their loved ones, and that it was broad
12
13 enough to include those whose family member had relapsed. The workshops provided a consistent
14
15 response that helped inform the re-drafting of the survey to include experiences of family members.
16
17
18 The draft survey was piloted online through Survey Monkey, receiving approximately 30 responses.
19
20 The pilot results were then reviewed by the expert advisory group, with potential revisions to the
21
22 questionnaire discussed and agreed.
23

24
25 In order to maximise our response rate, access hard to reach participants, and those in distant
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27 locations across the UK (and internationally), the research team developed an online survey on the
28
29 Survey Monkey platform that was distributed through microblogging service Twitter, and an
30
31 assortment of other on- and offline groups. Hard copies of the survey were also made available.
32
33

34
35 Both for the workshops and the distribution of the survey, Adfam's network of family support groups
36
37 was essential in accessing a diverse range of groups throughout the UK. We also had contact from
38
39 FAVOR, the peer-based recovery representative organisation in the US, who promoted the survey
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41 widely as did William White, who promoted the survey through his blog. The FLAR project was
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43 approved by the Sheffield Hallam University Ethics Committee.
44

45 46 **Results**

47 48 Data analysis

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3 Survey Monkey survey responses were downloaded into an SPSS file. The data were cleaned and
4
5 recoded for purposes of data analysis. Descriptive statistics and bivariate analyses were conducted
6
7 using SPSS 22.
8
9

10 *1. Basic descriptive statistics*

11
12 A total of 1,565 people ($M = 52$; range 18-81) completed the survey, and 1,559 reported their gender.

13
14 Participants included 87.7% females, 11.8% males and 0.4% identified their gender as other. Of the
15
16 participants, 70% were employed, full-time (51.4%), part-time (12.5%) or self-employed (7.1%).

17
18 Slightly over half (51.4%) had a postgraduate or degree level education, while 12.8% had some
19
20 secondary school, 18.8% completed A levels (12.7%) or GCSE (6.1%) and another 6.5% had
21
22 vocational qualifications.
23
24

25
26 Most participants (67.7%) were married or living with a partner, while 23.6% were divorced,
27
28 separated or widowed, and 8.8% were single and never married. There were 588 (38%) participants
29
30 with dependent children with an age range of 0-16 years. The participants' relationship to the AOD
31
32 user varied - 735 (48.1%) were a parent, 361 (23.6%) a spouse or ex-spouse, 158 (10.3%) a child, 133
33
34 (8.7%) a sibling, 20 (1.3%) a friend, with 122 (8.0%) defining as other.
35
36

37
38 Participants rated their physical and psychological health using a 1-10 scale, resulting in a mean
39
40 physical health score of 7.4 ($SD = 2.1$) and mean psychological score of 6.6 ($SD = 2.4$). At the time of
41
42 completing the survey, 36.9% were receiving help or treatment for emotional or mental health
43
44 problems (missing, $n=16$); 71.9% had never received such treatment (missing, $n=17$). Quality of life
45
46 was measured using the World Health Organization's 26-item WHOQOL-BREF categorised into four
47
48 domains: physical, psychological, social and environment. Respondents reported lower mean scores
49
50 across all domains, particularly in social and psychological domains, than population norm scores
51
52 (included in brackets) (Hawthorne et al., 2006):
53
54

- 55 • physical = 69.9 (norm = 73.5)
- 56
- 57
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- psychological = 61.7 (norm = 70.6)
- social = 58.5 (norm = 71.5)
- environment = 73.3 (norm = 75.1)

Thus, it is particularly in the areas of social and psychological quality of life that family members fall short of population norms.

Participants were asked to categorise the recovery status of AOD user. All but 7.7% responded to this question and the chart below indicates the results:

[Insert Chart 1 approximately here.]

1
2
3 Participants responded to a series of questions concerning finances, family and social life, health,
4
5 legal issues, work and education.
6

7 8 *2. Overall mapping of change* 9

10
11 Survey respondents validated findings in prior LIR surveys that their family members in recovery fare
12
13 better across all of the domains when in recovery than when they were in active addiction. Even
14
15 more significantly, the data reflect that family members themselves who reported their own
16
17 recovery journeys show markedly improved functioning across all domains evaluated.
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19
20 In our study, the mean length of recovery for the family member with AOD problems was 45.2
21
22 months (according to $N=920$, 58.8% of respondents). Using correlational analysis, longer recovery
23
24 duration was associated with significantly better psychological health ($r=0.08$, $p<0.05$) and better
25
26 quality of life ($r=0.09$, $p<0.05$) for family members. Only in the domain of physical health was the
27
28 association unclear, yet even there a small effect size was observed.
29

30 31 **a. validation of users' report** 32

33
34 FLAR participants uniformly reported that their family members experienced positive change in
35
36 nearly all 44 items measured within the domains of finances, family and social life, health, legal
37
38 issues and work and education, validating the users' reports from prior LIR surveys.
39

40
41 With regard to finances, in active addiction 82% of the former addicts had bad debts, with that
42
43 number reducing to 69.1% for those in recovery; 76.2% in active addiction could not pay their bills,
44
45 while 58.3% were unable to do so in recovery, indicating ongoing financial problems in recovery.
46

47
48 Concerning family and social life, 41.6% of active addicts were reported to have lost custody of a
49
50 child while in active addiction, and 13.3% regained custody during that time; in recovery. Lost
51
52 custody decreased to 20.7%, while regained custody increased to 19.9%. A similar, if more stark,
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54 contrast was revealed in the domain of family violence. 33.4% of active users were reported to have
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3 perpetrated family violence, compared to 11.3% in recovery¹. Paralleling the finding on family
4 violence perpetration, 16.3% of active users suffered family violence, compared to 9% of those in
5 recovery. While only 14.7% of active users were reported by family members to have participated in
6 family activities, 70.7% of those in recovery were reported to have done so.

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12 In the broad area of taking care of one's health, 23.7% of people in active addiction reported taking
13 care of their health, with that number more than doubling (59.4%) for people in recovery.

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17 Untreated emotional and mental health problems were reported to have existed for 87.8% of active
18 users, dropping to 55.2% of those in recovery.

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22 Particularly stark differences were reported with legal issues. 64.1% of family members reported
23 that active users had been arrested, compared to 21.3% of those in recovery. Jail or prison time was
24 reported to be experienced by 43.8% in active use, with a reduction to 19.9% of those in recovery.

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28 And in terms of offending behaviours, 67.4% were reported to have caused damage to property
29 while in active use, compared to 20.2% in recovery. Likewise, 85.5% of active users drove under the
30 influence of alcohol or other drugs, compared to 28.1% of those in recovery. Although family
31 members endorsed improvements in legal domains as had been reported in UKLIR, there was
32 variation between the self-reports of people in recovery in UKLIR and family members in FLAR.
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Family members reported active users having higher baseline levels of involvement in legal issues in
addiction than indicated by the users, and substantially reduced but nonetheless higher involvement
in these domains in recovery than indicated by the former user. This suggests potential reporting
bias, but it is not possible to determine whether that bias is reflected in the self-reports, family
member reports, or both.

Chart 2. FLAR and LIR legal domain responses compared

¹ In LIR surveys, participants were asked about being either perpetrators or victims; for FLAR this was separated into two individual questions to ensure that victimisation and perpetration were each accounted for independently.

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3 **[Insert Chart 2 approximately here.]**
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12 Finally, in the domain of work and education, while 67.8% of active users were reported to have got
13 fired or suspended compared to 26.7% in recovery, only 38.5% of those in active use who were
14 employed received good job/performance evaluations compared to 65.5% in recovery. Just over half
15 of those in active addiction were steadily employed, while nearly 90% of those in recovery had
16 steady jobs.
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24 *3. Comparison of respondents with family members in recovery versus those with family members*
25 *who had relapsed*
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28 Although the survey was initially targeted at capturing the experiences of people with family
29 members in recovery, 33.2% of former users were reported by their family members to have
30 relapsed at the time of the survey, according to the responding family members. The family
31 members of those who had relapsed reported poorer physical and psychological health, and poorer
32 quality of life than those whose family members were still in recovery.
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40 In order to identify any contrasts in the experiences of respondents with family members in recovery
41 and those with family members in active use, the five 'recovery' categories were recoded into a
42 single category of 'recovered' and compared to the 'returned to using' cohort. T-test analysis of the
43 data uncovered significant differences between the cohort, with respondents with family users in
44 recovery exhibiting much greater levels of physical health, psychological health and quality of life
45 than their comparative cohort. See Table 1.
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53 **[Insert Table 1 approximately here.]**
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3 A return to active use had negative impact not only on the using family member, but on the
4 reporting family member as well. These differences were revealed starkly when assessing key
5 wellbeing items. See Table 2.
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13 [Insert Table 2 approximately here.]
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21 Discussion

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23 The paper has shown two crucial things - the first is that as witnesses, the family members have
24 largely endorsed the reports of people in recovery about the diversity and depth of impact that
25 recovery has in all of the five life domains examined. As noted in the findings concerning legal issues,
26 while family members endorse the reports of improvement by the former user, the levels of adverse
27 engagement are reported higher by the family witnesses during both active addiction and recovery.
28
29 Second, the study has also shown just how widespread the adverse consequences of addiction are to
30 family members. In areas as diverse as employment, health, criminal justice and social functioning,
31 family members experience considerable damage, but that this is improved significantly in recovery.
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33

34 While much of this is repaired by the user undertaking a recovery journey, this is not a complete
35 reversal and there is clearly residual damage. This is further evidence that recovery is not a linear
36 journey, and that relapse can have devastating effects not only for the user but also for the family
37 members who appear to experience some kind of cumulative damage and harm. There is also
38 evidence that the longer the user remains in recovery the greater the improvement in functioning
39 for family members, although there are not clear associations across all domains. The study used a
40 survey method and so we can say little about the subjective experiences of family members but
41 what is presented here is a clear mandate for better guidance and support for family members.
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3 *Policy directions*
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5 The evidence derived from this study demonstrates the need for expansion and/or enhancement of
6 family-focussed support services. Moreover, support should be ongoing and varied for family
7 members to recognise the dynamic and individualised nature of recovery, and to be able to separate
8 out their own needs and supports separate from those for family members.
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15 *Future research directions*
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17 While the picture is increasingly clear that family members of people in recovery (condition A) fare
18 better than family members of people in active use (condition B), what isn't known is the
19 comparative experiences of family members of people who have not begun a recovery journey at all
20 (condition C). With the data comparing conditions A and B revealing that family members in A report
21 better outcomes than those in B, we can hypothesise with some level of confidence that family
22 members in condition A would also fare better than those in condition C. But what about the
23 comparison between conditions B and C? Is there a resilience increase for those with family
24 members entering recovery? Do those with a relapsing family member fare better or worse than
25 those with a family member who has not entered recovery at all?
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37 Also, future work could include an individualised study with family members of people in recovery
38 and the family members in recovery to further investigate, assess and granulate validation data.
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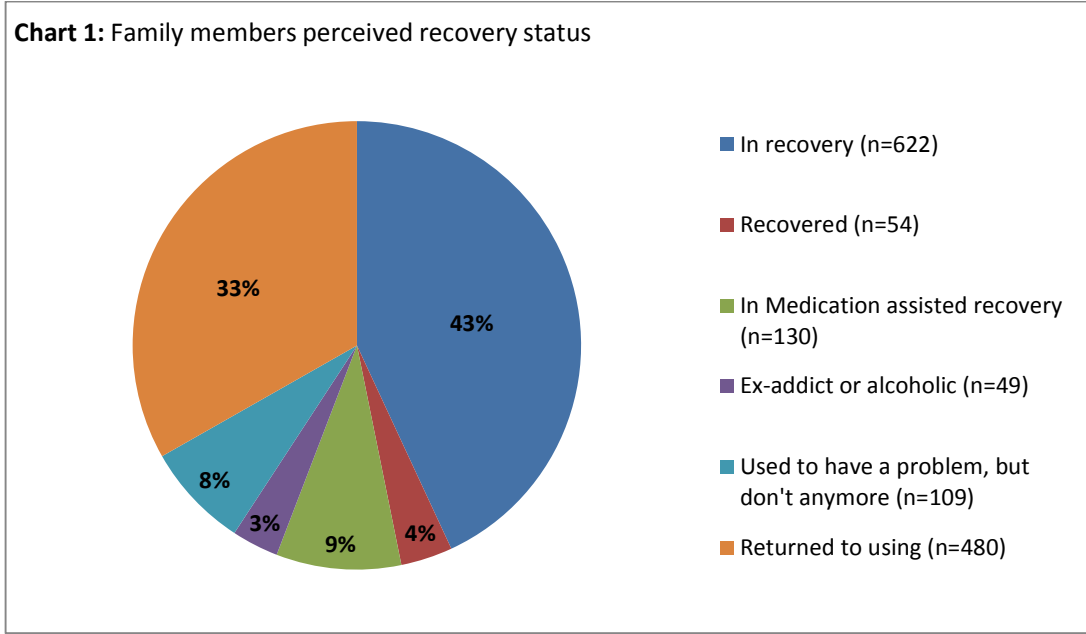
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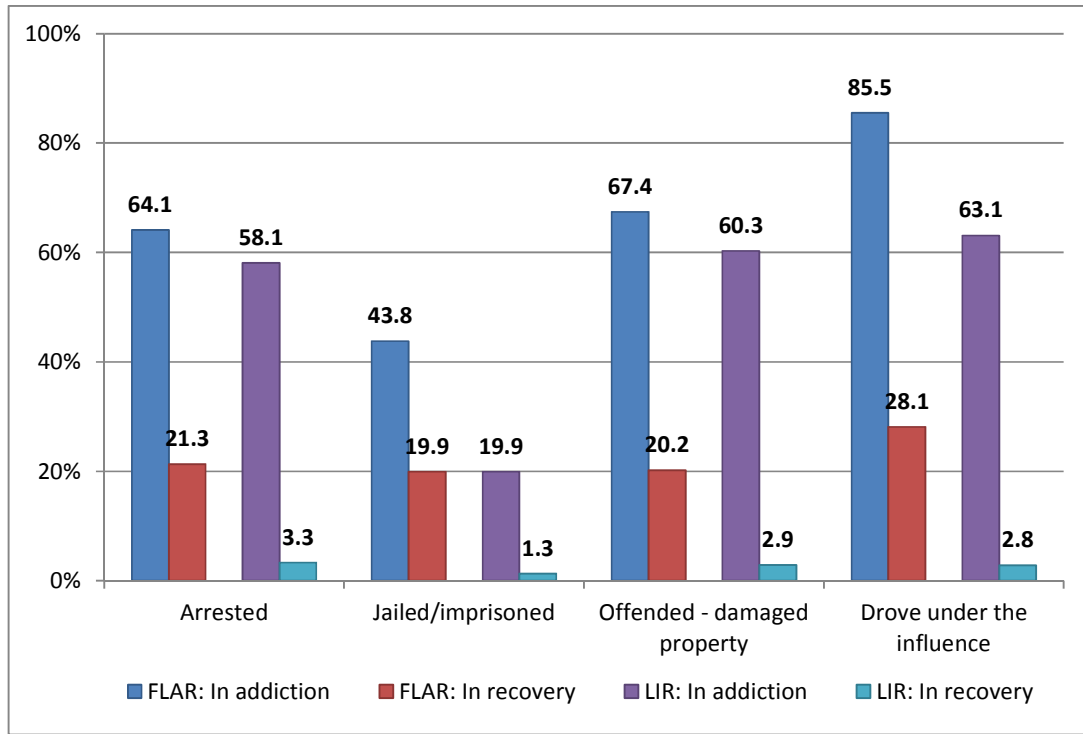
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Peer Review Only

Chart 2. FLAR and LIR legal domain responses compared



Review Only

Table 1. Health and QOL of respondents compared between those with 'recovered' vs. 'relapsed' family members

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

Table 2. Wellbeing of respondents compared between those with 'recovered' vs. 'relapsed' family members

Wellbeing domain - at time of survey completion	RECOVERED %	RELAPSED %	chi-square and significance
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)	48.4	24.1	35.30, 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 activities (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, <.01
Had frequent A&E 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