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The Power, Capacity, and Resiliency of Women in Substance Use Disorder Recovery to Overcome Multiple and Complex Housing Transitions

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Abstract: Gendered understandings of housing transitions amongst women and especially amongst those in substance use disorder recovery are under-researched. To address this gap, this study explores the multifaceted challenges and pathways to housing stability amongst women in substance use disorder recovery in the UK. Through qualitative analysis of life course interviews with 15 women in recovery, it becomes evident that housing insecurity, instability, and frequent transitions are common experiences. The women in the sample faced housing instability, ranging from temporary supported accommodations to homelessness. Notably, escaping negative relationships with male partners emerged as a primary cause of homelessness among these women. What this article highlights, which has not been found elsewhere to date, is that housing transitions are essentially a social process for women in recovery. This study highlights the social dimension of housing transitions. The potency of social capital and social networks in determining housing stability and security amongst women is emphasised as they exchange negative forms of social capital for positive forms of social capital. Recommendations stemming from this study include the need for drug recovery and housing policies to integrate gender-specific strategies to adequately support women in recovery. Further, they need to adopt a broader perspective, emphasizing the importance of fostering positive social connections and networks when considering housing options for individuals in recovery. For women who have spent a long time in supported residential and therapeutic environments, there is a need to develop a scaffolded support system to help women transition to independent living. The utilisation of recovery capital (and CHIME) as frameworks may provide a basis upon which to map out holistic and sustainable pathways to housing stability and security for women in recovery due to their acknowledgement of interconnected and related life domains that produce change and transformation.

Keywords: women; gender; housing transitions; housing; accommodation; substance use disorder; recovery; recovery capital; resilience; social capital

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1. Introduction

Stable, secure, and quality housing is acknowledged as a vital element in initiating and maintaining recovery from substance use disorders (Polcin 2009). Studies indicate that individuals not residing in stable housing environments might encounter challenges in sustaining their recovery progress (Milby et al. 2005), and external stimuli and cues from the environment could contribute to return to use triggers (Shaham et al. 2003). There exists a necessity to pinpoint housing environments and related factors that facilitate recovery, whether following post-residential treatment while undergoing outpatient treatment for substance use disorders, or for those on other pathways.

There is a lack of research exploring female recovery pathways (Yates and Malloch 2010), as well as an oversight of gender in both conceptualising and measuring recovery capital (Best and Hennessy 2021). UK policy regarding recovery largely overlooks gender considerations (Wincup 2016). There is an increasing need for a gendered perspective

on recovery. The UK's recovery knowledge base is predominantly based upon males in substance use disorder recovery. This creates a significant gap in our understanding of recovery and especially gendered dynamics. Further, understanding housing transitions during recovery is crucial as there is even less understanding of the dynamic interaction between women's accrual of recovery capital, housing transitions, and homelessness (Best and Hennessy 2021).

This paper seeks to begin to address the gaps noted above through its exploration of how female housing transitions in the UK are negotiated using a recovery capital framework, adding depth to a gendered understanding of recovery. Specifically, the research question this paper addresses is: how does the application of a recovery capital framework contribute to understanding transitions in women's housing during the process of recovering from substance use disorders? The rationale for the use of a recovery capital framework is that it will allow for the exploration of a range of factors across three broad life domains relating to personal, social, and community capital in relation to housing transitions. This has the potential to enhance our comprehension of housing transitions amongst women in recovery to more effectively identify and support change (Hser et al. 2007) as the traditional approach has typically been to consider the impact of a single issue on housing transitions, e.g., gender, being a mother, interpersonal violence, etc. A life course approach has been employed to explore the dynamics of substance use disorder recovery processes. This approach advocates for studying substance use disorder recovery due to its complex and long-term nature, requiring an integrated, multidimensional, and holistic perspective. (Hser and Anglin 2010).

1.1. Gendered Pathways

From the dearth of research conducted in this area, distinct pathways have been shown to exist between males and females. Research into women's substance use has highlighted an increased prevalence of mental health disorders, histories of both childhood and adult physical and sexual abuse, and involvement in sex work (Neale et al. 2014; Becker and Duffy 2002).

Only 33% of those in treatment in England are women (OHID 2023). The disparity in numbers in treatment is likely to be affected by the fact that men and women experience different barriers in accessing support. For example, women often delay seeking help until later in their substance use disorder due to awareness of the gendered stigma (Lee and Boeri 2017; UNODC 2004) and often seek help indirectly via mental health or children's social services (Grella et al. 2008). In addition, once help is sought, treatment and recovery support services typically require women to leave their children and family, which is a deterrent for continued engagement in services (Whitehead et al. 2023; Wincup 2016). These factors can often lead to an underestimation of the number of women that need support, as well as a limited understanding of the dynamics operating in their pathways to recovery.

Best et al. (2020) revealed significant gender differences in the experience of substance use disorder and recovery. Specifically, their findings indicate that, during the acute phase of their substance use disorder, women reported having fewer strengths compared to their male counterparts. This discrepancy suggests that women may face unique challenges or have different resources available to them during the height of their substance use disorder.

However, during the recovery phase, women demonstrated an increased capacity for growth, reporting the largest increases in strengths. This suggests that, despite starting from a position of perceived disadvantage, women are able to achieve significant personal development and resilience in the recovery process.

Conversely, men reported experiencing more barriers than women during both the substance use and recovery phases. This finding points to the complex nature of substance use disorders and the recovery process, which can be influenced by a myriad of factors, including gender. Life in Recovery studies have also found differences between men and women in recovery (Mcquaid et al. 2017; Laudet 2013).

Abreu Minero et al. (2022) found that a significantly higher proportion of women in recovery than men report better management of general health, daily life tasks, and engagement in prosocial meaningful activities. However, women reported significantly higher rates of persistent barriers related to psychological health and domestic violence compared to men, whereas significantly higher rates of criminal justice barriers were found among men.

The effects of stigma for those in recovery negatively impact access to health, housing, employment, social relationships, and social reintegration (Livingston et al. 2012). However, research highlights the presence of a dual stigma against women. They are believed to have failed the traditional gender norms of being a woman and traditional family roles relating to being nurturing care givers (Grella et al. 2008). Women, therefore, experience distinct social and structural consequences. Therefore, it is unsurprising to find that one of the main barriers to seeking treatment for women is having care responsibilities for children due to concerns that social services may remove custody of the child from them (Best et al. 2021). However, motherhood and attaining custody of a child serve as significant factors that enhance help-seeking and the completion of treatment rates (Andersson et al. 2021; Schamp et al. 2020).

1.2. Gendered Housing Pathways

People's recovery and their support needs change over time as recovery capital is accrued (Patton et al. 2022). Access to quality housing is a priority amongst those in recovery, but research notes that it becomes more of a priority amongst those in stable (five years or more into recovery) versus early recovery (the first year in recovery) (Laudet and White 2010; Betty Ford Institute Consensus Panel 2007). The desire for, and the attainment of, stable and secure housing may be an important indicator of recovery growth.

Having safe, secure, and stable housing can aid recovery processes in various ways. Being a homeowner or person renting a home provides replacement identities for old 'spoiled' identities. The new replacement identities allow for social re-integration to occur and creates a sense of pride (Patton et al. 2022). It provides a safe and stable base from which to navigate daily life and offers opportunities to take increased control over various life domains facilitating agency and a sense of empowerment (Borg et al. 2005). It also provides a means of building social capital with local members of their community (Topor et al. 2011) and can also aid participation, contribution, and citizenship within the local community.

Issues with housing appear to impact men and women differently. Housing problems have been shown to be more prevalent among men (Straaten et al. 2016). This may be due in part to social housing sector allocations prioritising women if they have children (Malos and Hague 1997). However, intimate partner violence amongst women is a key factor that contributes to housing insecurity and homelessness for survivors and their dependents (Fraga Rizo et al. 2022; Pavao et al. 2007). Statistics reveal that there is an increased incidence of intimate partner violence among women with a substance use disorder (El-Bassel et al. 2011; Engstrom et al. 2012) and women also report more family violence upon entry to recovery than men (Mcquaid et al. 2017).

Further, violent male partners can prevent access to recovery support services and negatively impact retention in services for their female partners (Ogden et al. 2022; Gilchrist et al. 2018). Despite these barriers, recovery research shows that the accrual of recovery capital over time means that housing insecurity can be overcome with more time in recovery (five years or more) (Martinelli et al. 2020).

1.3. A Long-Term Dynamic and Nuanced Process of Change

Recovery from substance use disorder is a multifaceted and continually evolving process that exhibits a dynamic interplay of factors that shape individuals' journeys towards sustained wellness and human flourishing (Bellaert et al. 2022). The Recovery Science Research Collaborative has defined recovery as a personalised, deliberate, dynamic, and

interconnected journey marked by ongoing endeavours to improve one's well-being. (Ashford et al. 2019). Typically, recovery is perceived as a personal and individual experience. However, some view recovery from substance use disorder as a socially influenced process, where the establishment of positive social networks and involvement in community resources play pivotal roles in facilitating growth and transformation. (Collinson and Hall 2021; Best et al. 2015). The importance of social relationships in the recovery journey have been highlighted as being even more important for women as compared to men, whilst remaining important for both groups (Best et al. 2021).

Research performed by Best et al. (2021) highlighted the role of social capital in recovery. Having positive family connections in the form of close relationships with an intimate partnership and having children appear to have a positive effect on increased positive transformations in recovery strengths and notable decreases in barriers to recovery. Similarly, possessing larger social circles among individuals in recovery and having a greater amount of social capital in the form of number of confidants are linked to enhanced positive development in recovery strengths and mitigated barriers to recovery.

Recovery is recognized as a prolonged and diverse journey, as outlined by the Betty Ford Institute Consensus Panel (2007). They delineated three specific phases, beginning with early recovery (year one of recovery), sustained recovery (years two–four), and stable recovery (years five plus). These phases are crucial in understanding the likelihood of a return to use of substances, which varies significantly between phases. Early recovery has a return to use rate of (50–70%), whereas stable recovery experiences a reduced rate of 15% (Best 2019). The phases also highlight the differential interplay between a range of factors and forces and permit an exploration of how recovery capital operates, the changes it undergoes, and its significance in promoting and sustaining recovery (Martinelli et al. 2020; Cano et al. 2017). After five years, recovery becomes self-sustaining (Dennis et al. 2014).

Research shows that recovery capital levels are typically low upon entry to recovery (Best 2019) highlighting that the accumulation of recovery capital does not start at point zero as a person enters recovery. Pre-existing assets and resources, as well as the pains of recovery, enter the recovery journey with each person, all of which then go on to shape the resultant recovery journey at later stages in dynamic ways. Patton and Best (2022) found dynamic relationships between various factors to be crucial in understanding the intricate interplay of factors at different stages of a person's recovery journey. For example, the pains of a lack of responsibility, the pains of hopelessness, and the pains of unemployment and menial jobs are linked to a discovery of purpose later in recovery. For men in recovery, a discovery of purpose linked to their career, but for women, it often linked to becoming a mother. This highlights the fact that pre-existing factors, as well as those experienced in recovery, intertwine to affect the recovery journey in different ways. This is significant as it contextualizes recovery within a broader timeline, encompassing factors and influences that precede an individual's substance use disorder. Additionally, it places recovery within a wider social and structural context that acknowledges and considers various factors and forces beyond the individual.

1.4. Frameworks for Overcoming Adverse Circumstances

It is recognised that those in recovery face multiple and intricate challenges. Recovery capital has emerged as a holistic framework for measuring and evaluating the growth and transformation of individuals throughout their recovery journey. Granfield and Cloud (1999) created the term "recovery capital", which relates to the resources individuals possess and can leverage during their recovery. Clearly, the fundamental assumption underlying this framework is that increased recovery capital reduces the likelihood of a return to use of substances and fosters sustained recovery, quality of life, and well-being (Kelly and Hoeppner 2015). Non-linear and fluctuating patterns of recovery capital accumulation have been observed in research studies (Kaskutas et al. 2009; Cano et al. 2017) emphasising the significant impact of barriers and unmet needs in recovery. These negative forms of recovery capital impede progress (Cloud and Granfield 2008).

Best and Laudet (2010) present a comprehensive framework for the conceptulisation of recovery and its measurement that outlines three forms of recovery capital: personal, social, and community capital. Personal capital includes individual attributes such as adaptability, self-worth, sense of agency, and self-belief. Social capital involves interpersonal relationships, social connections, and networks. Community capital relates to local resources like secure housing, specialized treatment services, education, employment opportunities, peer-led recovery groups, and recovery-oriented programmes and champions.

This framework permits a structured understanding of how different types of capital are acquired and utilised during different phases of recovery, illuminating its complexities and the individualised nature of the process. Often, gains in one area of recovery capital or life domain produces gains in other areas, creating a positive ripple effect of growth and transformation and vice versa, with negative barriers creating setbacks and downward spirals in progress (Patton and Best 2022).

The second framework, known as CHIME, comprises connection, hope, identity, meaning, purpose, and empowerment (Leamy et al. 2011). It provides a strengths-based as opposed to a deficit-based approach to navigating the recovery journey. Pain is often regarded as a pivotal motivational "push" factor driving individuals into recovery or towards making positive choices along their recovery journey. In contrast to this push model, recovery research has highlighted a multitude of "pull" factors that promote positive change (Patton et al. 2022; Patton and Best 2022) and link to the five elements of CHIME. These forces pull individuals toward positive change and development, obviating the need for pain as the primary motivator for behavioural change. Recovery fosters a sense of community and connection. This creates a sense of hope and optimism that change is possible, including the capacity to overcome their substance use disorder. This sense of hope helps to create a vision for the new person (identity) they can occupy. This in turn promotes engagement in meaningful and purposeful activities which reinforces an increased sense of agency and empowerment.

2. Materials and Methods

This study draws on qualitative data from 30 interviews conducted with people living in the UK, in recovery from a substance use disorder. The interviews formed a component of the Recovery Pathways (REC-PATH) study, conducted across four European countries, which utilized mixed methods to explore recovery pathways (Best et al. 2018). Comprehensive details regarding the methodology employed in the broader REC-PATH study are available in Best et al. (2018). This research contributes to the growing body of literature exploring gender variations in pathways to recovery (Whitehead et al. 2023; Best et al. 2021; Wincup 2016; Grella et al. 2008).

A range of processes and measures described below were put in place to ensure the credibility, dependability, confirmability, and transferability of the study and analysis (Lincoln and Guba 1986). The research study, including the interview research instrument, project information form, informed consent form, and debriefing form all received full university level ethical approval. Informed consent was gained for all participants including, highlighting voluntary participation, the opportunity to ask further questions about the research before participation, the right to withdraw, and an explanation of how the data would be stored and used and how to make a complaint, etc. The participants were not offered any financial or other form of compensation for their participation in the research. Participants were assured of anonymity. Pseudonyms have been employed for all participants in presenting the findings, particularly when quoting directly from their statements from the interview.

Participants from the UK sample of the REC-PATH study (n = 233) were invited to participate in a follow up interview. Eligibility criteria for an invitation for an interview included the completion of a baseline and/or a follow-up assessment survey, experience of a previous struggle with illicit substance use, and participants self-identifying as being in recovery or fully recovered from a substance use disorder, aligning with the perspective that

one's self-identification determines their status in recovery (Valentine 2010). A stratified sampling method was used in relation to gender to secure an equal number of men and women in the eventual sample (15 men and 15 women were interviewed). Telephone interviews were conducted over a six-month period from September 2019 and March 2020, with durations ranging from 45 to 75 min. The interviewer noted key comments made by each respondent during the interview, and a full transcription took place after the interview. The interviews aimed to acquire understanding regarding a range of influences on critical phases of their recovery journey, encounters with different types of professional and peer assistance, and their viewpoints on the pivotal factors that positively affected or hindered their progress. This research employed a life narrative approach to gain a deeper understanding of the participants' recovery journeys. The life narrative approach is a qualitative methodology that offers a comprehensive view of the lived experiences of individuals who recount their life stories, providing insights into the meaning of events across different stages and phases of their life course (Squire et al. 2014). This narrative approach facilitates an exploration of the individual's life trajectory while considering the socio-historical and cultural contexts in which personal life events unfold (Striano 2012).

A semi-structured interview was used to guide participants to recount significant events and pivotal moments across various stages of their lives, including:

1. Period of active substance use disorder
2. Initial endeavours in recovery
3. Lasting and successful transition to recovery
4. Early and sustained stages of recovery
5. Current experiences in recovery
6. Aspirations and plans for the future

Table 1 presents the sample characteristics which shows that most respondents were of White ethnicity (27 White, 2 Asian, and 1 Black), with 29 considered to be in the stable recovery phase and one respondent classified as being in the sustained recovery phase (Betty Ford Institute Consensus Panel 2007). The sample ranged in age, with 2 respondents aged 30–39, 17 respondents aged 40–49, 8 respondents aged 50–59, and 3 respondents aged 60–69). The main substances associated with their substance use disorder were: Heroin (22 respondents), Alcohol (21 respondents), Cocaine/Crack (13 respondents, 8 and 5 respondents, respectively), and Prescription Medications (5 respondents).

The lead author of this paper conducted a qualitative thematic analysis on the interview transcripts, focusing specifically on transitions in the accommodation of the participants throughout their recovery journey. The lead author has more than 5 years' experience in qualitative data analysis and has published multiple articles on drug recovery using a qualitative method. Each transcript was read several times before emerging themes were identified and an initial set of themes were listed. After further review and reflection, as noted in the lead author's journal, the recurrent themes were identified and then grouped using a recovery capital framework. The recovery capital framework consisted of three forms of recovery capital: personal, social, and community capital. Each quotation that related to a theme was then categorised as being related to personal, social, or community capital. As part of an inter-coder reliability check, the initial themes and grouping of themes were then shared with members of the REC-PATH research team to gain their feedback on the initial codes and grouping of recovery capital themes. The presentation of multiple quotes per theme have deliberately been used in the results section below to highlight the direct lived experiences of the participants and aid the credibility of the findings, ensuring that they are accurate reflections of participants' realities (Shenton 2004). These have also been used to limit author bias in the interpretation of experiences, although it is acknowledged that theoretical and biographical predispositions by researchers cannot be fully eliminated (Smith 2004; Braun and Clarke 2006). The analysis was conducted using NVIVO, a qualitative software package designed to facilitate the organization, storage, and systematic analysis of qualitative data (QSR International 2022).

Table 1. Sample Characteristics.

Name	Sex	Age	Ethnicity	Recovery Stage	Children	Substances Associated with Substance Use Disorder
Abbie	Female	40–49	White British	Stable	Yes	Heroin, Heroin
Alice	Female	50–59	White British	Stable	Yes	Heroin, Alcohol
Amelia	Female	50–59	White British	Stable	Yes	Cocaine, Alcohol
Amy	Female	40–49	White British	Stable	No	Cocaine, Alcohol
Anne	Female	30–39	White British	Stable	Yes	Heroin, Cocaine
Dan	Male	60–69	White British	Stable	Yes	Crack Cocaine, Alcohol
Ed	Male	40–49	White British	Stable	Yes	Cocaine, Alcohol
Ellie	Female	30–39	White British	Stable	Yes	Heroin, Alcohol
Elizabeth	Female	50–59	White British	Stable	Yes	Heroin, Crack Cocaine, Alcohol
Emily	Female	50–59	White British	Stable	Yes	Cocaine, Alcohol
Eric	Male	40–49	White British	Stable	No	Heroin, Alcohol
Eva	Female	40–49	White British	Sustained	No	Heroin, Alcohol
Harriett	Female	40–49	White British	Stable	Yes	Heroin, Alcohol
Holly	Female	40–49	White British	Stable	Yes	Heroin, Alcohol
Isobel	Female	40–49	White British	Stable	Yes	Heroin, Alcohol
Laura	Female	40–49	White British	Stable	No	Heroin, Alcohol
Lily	Female	40–49	White British	Stable	Yes	Heroin, Alcohol
Luke	Male	40–49	White British	Stable	Yes	Heroin, Crack cocaine
Mark	Male	40–49	White British	Stable	Yes	Heroin, Prescription medications
Nathan	Male	40–49	White British	Stable	No	Cocaine, Prescription medications
Nathaniel	Male	50–59	White British	Stable	No	Heroin, Alcohol
Nicholas	Male	50–59	White British	Stable	Yes	Cocaine, Prescription medications
Nick	Male	60–69	White British	Stable	No	Heroin, Alcohol
Noah	Male	50–59	White British	Stable	Yes	Heroin, Alcohol
Ray	Male	60–69	White British	Stable	Yes	Alcohol, Prescription medications
Sam	Male	40–49	White British	Stable	Yes	Heroin, Cocaine
Yoel	Male	40–49	Black British	Stable	Yes	Heroin, crack cocaine
Yosef	Male	40–49	Asian British	Stable	Yes	Heroin, Alcohol
Yuri	Male	50–59	Asian British	Stable	Yes	Heroin, Prescription medications
Zoe	Female	40–49	White British	Stable	Yes	Heroin, crack cocaine

To verify the author's understanding of the participants' lived experiences of housing transitions, member checking was integrated into the process (Motulsky 2021), allowing the author to present the findings to the study's respondents and other individuals in recovery following the completion of coding and analysis. This step was taken to ensure resonance with the coding frame and the analysis of findings to check they accurately represented the experiences of the participants. Their feedback was positive, confirming the credibility of the themes identified and the analysis undertaken.

3. Results

The focus in the presentation of the results is on women's housing transitions in the context of their substance use disorder recovery journeys. The men's journeys are used as a comparison to highlight areas of similarity or difference. A wide range of accommodation

types were used by the females in the sample for example, prison, residential rehabilitation centres, recovery houses, women's refuges, homeless hostels, squats, foster homes, bedsits, flats, and houses. What is presented below are eight transitional points from one type of accommodation to another to better understand the factors and forces in housing pathways of females in substance use disorder recovery. Seven of the eight transitions or turning points relate to social capital (becoming pregnant, and motherhood, starting and ending a relationship with a partner, violent and abusive partners, 'cutting off' and removing substance using relationships with friends and family, and replacing these with new and positive relations and networks) and one related to personal capital (increased self-confidence and self-esteem). The eight themes centre primarily around the exchange of negative social capital for positive forms of social capital. The results section ends with a comparison of life and housing in early versus stable recovery to highlight what, if any, changes have been made in the housing pathways of women in recovery.

3.1. Social Capital: Pregnancy as a Catalyst for Change

Becoming pregnant and beginning their relationship with their child was a key turning point for reflection and action amongst some of the women in the sample. It seems that pregnancy became a reflection point that afforded a space for evaluating current life circumstances. Abbies describes how "*Knowing I was pregnant changed everything. It changed the way I looked at everything. I just saw everything differently. The life I had then was not what I wanted for my baby. Something in me snapped and I knew everything had to change. . . They [social services] found me a mother and baby unit in [location] and I started again with my baby*". Isobel also made a series of positive changes which contrasted with her circumstances at that key reflection point. Pregnancy was a catalyst for momentous change. She describes that after she became pregnant, she became a homeowner and "*changed so many things in my life all of a sudden for my baby. I became a proper grown up and took on responsibilities I never had before*". The sense of responsibility and purpose imbued with being pregnant and developing a relationship with their baby was a key motivational force for positive change in recovery amongst these women.

3.2. Social Capital: Maternal Motivations and Vision for Change

The desire to be an active mother and maintain parental responsibility of children was non-negotiable to the women in the sample. The women often endured accommodation types that may not have been of their own choice, but in order to facilitate caring for children they complied and used them as a stepping stone to attain their longer term vision of secure housing with their children. Ellie describes, "*When I left [location], I went to foster care with my son because social services did not want me to go straight into the community as they thought I was going to fail. . .I must say that the only thing that kept me going was my son. I didn't want to lose my son!*" Lily highlights her desire to be united with her son, "*When I was in a homeless hostel my son lived with his Dad. It was a very hard time for me. But as soon as I got my flat, I got him back. He had been with me from being a baby. I got him back. He still lives with me now*". (Lily)

The sacrificial desire to care and provide for children is clear. Emily explained how, "*When I moved, my daughter was 3, I was back working full time as she was in school although we had very little money. I furnished her room but I was sleeping on the floor*". The women had a clear vision of what they wanted life to be like as a mother with a child. Motherhood has important motivational forces which are key to positive recovery capital progression including housing. In contrast, Anne describes how her recovery capital was negatively affected when "*Social work became involved and my son got taken into care. I was heart-broken, and I felt then I had nothing to live for. I just felt that they were just punishing me. I had no responsibility and my using got worse, I felt like it did not matter what happened to me*".

Parenting did not feature in male descriptions of their journey. In marked contrast to the females, only one male spoke about the motivational role of children in recovery. Yuri shared that when "*my grandson was born something changed. It wasn't apparent at the time but*

that was the catalyst. After he was born, I re-engaged in treatment and I asked for in-patient detox and residential rehab". Males spoke about living with children in their current phase of life (in stable recovery) but it did not feature in their stories prior to this timepoint.

3.3. Social Capital: Starting a Relationship with a Partner in Early Recovery

The initiation of romantic relationships in early recovery negatively impacts accommodation, social networks and ability to sustain abstinence from substances. There appeared to be lots of relationship and accommodation transitions that occurred during the early phase of the recovery journey. Zoe described how her home and location changed when, "*Just before January 2005 I met this bloke and I just fell for him straight away. We ended up getting a flat together and within 6 months I had moved from [location] to [location] and I was married. This was a massive upheaval for me. After getting married, I found myself on my own as my husband left to work in Belgium for a year. I felt so isolated*". Several women shared how quickly their accommodation changed after commencing a relationship with somebody in recovery. Amelia shared how she "*sobered up from alcohol in November and a bloke brought me home from an AA meeting on Christmas Night. What do addicts do on their second date, they move in together*". Moving in with a partner in the early stages of recovery had significant implications for the women in the sample in relation to their social networks, return to use of substances rates, and stability.

3.4. Social Capital: Ending a Relationship with a Partner

Changing partners or ending romantic relationships was common for some of the women in the sample and often had negative implications for their accommodation. This was often a vulnerable phase, as for example, Amy came to the realization that she had never ended a relationship while sober and after leaving the country to get away from the relationship, "*when I came back I was homeless*". Similarly for Anne, "*When I left my partner, I just had a rucksack. Before I left I kept it out of the way so he wouldn't notice. When I left I slept on the beach*". Zoe shared how after starting her recovery journey she left her partner and was living in her partner's accommodation when "*I became tired of the house being full of people using drugs. I tried to ignore it for a while but ultimately I knew he would not change, stop using or ask his mates to in our home and so I left*". Elizabeth also lost her home when she "*found out my partner was cheating on me. I left him. During that year, I lost my health, my partner, and my house*". Leaving a partner, whilst a positive decision for the women to make, had a significant impact on their living conditions as it meant that they now had to find somewhere to live, often without resources or a plan of how or where the accommodation would be provided.

The males in the sample were very transactional about their partner relationships in recovery, in the sense that they were focused on whether the relationship helped or hindered their recovery progress. Yuri described how "*I had been in a long-term relationship and that person was still on the drug scene, but realised that she didn't want what I wanted [in terms of recovery] so I had to end that relationship*". Similarly for Sam, "*it was very clear to me that I was never going to stay clean going back to that environment [the marital home]—the triggers, the associations, the neighbours, the routines. I had made a decision that abstinence was the only way forward for me—at home the norm was alcohol and cannabis for my wife. I ended the marriage as I knew she would never change*". *Dan shared that his "current partner is not a user. I had a clear vision in my head that I did not want to find myself in a relationship with someone who was an addict or a recovering addict. The lovely lady I am with now has never used drugs*".

3.5. Social Capital: Overcoming Violent and Abusive Partners to Protect Children

Being involved in a negative, substance using and/or violent relationship with a partner, especially while also being a mother, was often the catalyst for change. It was the well-being and safety of their children, rather than their own, that served as the tipping point for these women to seek change. For Holly, the birth of her daughter was a key motivational factor for change. She reflected that "*My husband was on heroin, and it was a*

violent relationship. . .Looking back now, I realised I left my husband and started my recovery because of my daughter. I knew I wanted to give her something more than what I had then". Similarly, for Anne, it was not a concern for herself and her safety that was the motivation for change in her situation, but for the protection of her children. She shared how her partner had kidnapped her for three days and threatened to kill her, "*A year after I left him, he actually did end up murdering his new partner and he did it in exactly the same way that he threatened me, when he held me hostage*". She continued, "*That confirmed to me that I made the right decision in leaving. I left for the kids, not me. I didn't want them coming home and finding me*".

Low self-esteem was reported by the women in the sample. Abbie reflected that the reason why she found herself in dire life circumstances was "*because I didn't know my own worth*". Such feelings were often coupled with feelings of hopelessness. Amy stated, "*I had nothing left to live for. I was like the walking dead*". Similarly, Anne described, "*All of my hopes and dreams had gone. I felt worthless and ashamed*". Such feelings may have contributed to a lack of concern for their own safety. However, concern for their children persisted. Pregnancy, motherhood, and domestic violence permitted an assessment of life circumstances which revealed to them how their life stood in opposition to the kind of life they envisioned they would have when they became pregnant or whilst being a mum. The women were very clear that they wanted to attain a different lifestyle and environment for their children. They were motivated by the pull of the future vision they had of motherhood. This naturally had implications for their housing situation. Later in their recovery journey, in stable recovery, most of the women report that they have found new and supportive partners.

In contrast, none of the men spoke about being a victim of domestic abuse, and only one male shared that he was a perpetrator, "*I wasn't allowed at the family house as there was an injunction against me at the marital home. I was married with two children, but I had minimal contact with my children*" (Yosef).

3.6. Social Capital: 'Cutting Off' Subcultural and Substance Using Social Networks by Doing a 'Geographical'

Due to the desire to maintain their recovery, removing or 'cutting off' those who continued to use substances was seen as a necessity. To achieve this, performing a 'geographical' was a common strategy, either as a temporary or more permanent solution for some. Participants either physically moved away from their home location to a different neighbourhood in the same city or to a new city to maintain their recovery and cut themselves off from drug and crime social networks. Eva shared that "*since finding recovery I have relocated to a quiet part of town*". Similarly, Alice explained that "*something that made it much easier for me to get off drugs was because we had moved house to the outskirts of the town*". For others, the presence or absence of peer-based recovery support became a motivator for moving home and location. Elizabeth shared that at a key juncture on her recovery journey "*my meeting attendance was about once a week. But I knew in order to do healthy fellowship this wasn't enough. There wasn't the help or support I needed so I uprooted my son and moved to [location X]*". The women often moved home to new locations at vulnerable and critical junctures in their recovery journey which inadvertently created social isolation, but achieved the separation they needed from drug using and criminal networks.

3.7. Social Capital: The Power of Social Networks in Determining Accommodation Success

New friendships were formed in recovery and helped to provide much needed support at such a vulnerable stage of life and following the 'cutting off' of old relationships. The nature of social relations within the types of accommodation and surrounding environment the women found themselves in were more significant than the quality or permanence of the accommodation itself. The support of family, friends, and peers in recovery were essential in making the accommodation a safe or in many cases a healing and transformative place to live, especially when living with peers in recovery. Conversely, dysfunctional relationships

and behaviours meant that even if the accommodation type, e.g., 'returning to the family home', on paper appeared to be a good option, it did not always work out that way.

Access to stable and secure accommodation via the family was a key pathway for some of the women. For example, for Abbie, returning to the family home proved a positive move as, "*During my pregnancy, I finally got back in touch with my parents and told them I was pregnant. My mum said that I could come back home but I had to go into treatment. So, I did my pregnancy in my parents' house and I just left it all behind*". However, for Holly, returning to the parental home did not prove to be a positive step. She shares, "*after I left my abusive partner, I had to move in with my parents. It was horrendous. I moved back in with my parents who are also abusive, and my father was an alcoholic and he started abusing my daughter. I had nowhere to go and it was absolutely horrendous*".

Women's social networks were not only key to their recovery but were also key sources of providing safe places to live during times of transition and vulnerability. After Zoe decided to leave her partner, who continued to use substances, she shared how "*I turned up at my friend's door on Christmas Eve 2004 and asked if I could stay in her spare room. That Christmas was hard, but I had my friend*". Sometimes, healing and transformation occurred in the least likely of accommodation types. Harriett shared how she "*got clean in prison*". However, she explains that relationships formed in residential rehabilitation were positive and meaningful, "*It's those relationships that challenged me and my thinking. I felt like I had gained big brothers. People who saw something in me and pushed me not to take the easy option. Because of them I stayed as I thought I would be mad if I left and went back to life before because I had nothing*". It was the relationships connected to the accommodation type that determined the quality of the experience of living there, even if the material condition of the accommodation or the temporary nature of the length of stay was unstable. Amelia summed up this sense of the importance of relationships when she shared, "*I had done geographicals before but there was nobody there waiting for me. As soon as I walked through this door, this lad said to me "we will love you until you can love yourself"*.

3.8. Personal Capital: Growing Empowerment and New Identities

A progression in accommodation pathways was often accompanied by increased confidence and self-esteem. Shifting identities and new replacement identities appeared to run concurrent to this journey. As the women embarked on their journey of recovery from substance use disorder, they also experienced a transformation, gradually gaining a newfound perspective of themselves and the world around them. This often meant learning how to be and feel and navigate relationships and "*do this straight life*". Isobel shares her growth as she progressed, "*In aftercare I was in supported accommodation. This was great because I always went between boyfriends' houses, then living on my mum's couch, so supported accommodation allowed me to develop myself but still be in a bit of cotton wool. It wasn't shared accommodation. It was enough freedom and enough security for me. Personally, that was brilliant. I was there for 3 months, it was challenging. From there I went into my first council property, but I had built enough confidence and self-esteem to be able to do that*". Similarly for Ellie, "*On the 4th of July 2016 I got my own flat. When I moved in, it was a big jump and I had to phone Samaritans a few times but with time I got used to it*". Emily shared how before she became employed "*I had moved into a bedsit in Hackney. Shortly after I started working. I got out of the bedsit and into a flat and I continued to work*". The change in accommodation types is accompanied by personal growth in the women for them to successfully navigate dealing with the new responsibilities of living independently.

The males in the sample did not discuss the need to grow in confidence, nor did they describe the development of new identities before being able to manage a new form of accommodation or the move to more independent living arrangements. The focus for the males seemed to be on accruing as much recovery capital as possible. When describing his recovery, Yoel, described it as "*20% of the time it has been challenging with the stress of real-life things like buying a house and paying bills. 80% of the time was about learning about myself and how I operate in the world around me*". Similarly, Sam described recovery as "*being about*

learning and learning about myself". Yuri described the time "*when I moved out of the squat into a bedsit it was in the red-light district where I used to score, but I felt safe because something inside me had changed. I walked past the dealers, and I thought whatever*", highlighting his increased resiliency due to his recovery capital.

3.9. Life and Housing in Early Recovery versus Stable Recovery

3.9.1. Early Recovery

Return to use of substances is common in early recovery and can often signal continual changes in accommodation. Amelia shared that "*I went into a rehab. I went in for a detox first and then I relapsed. I then had to go into a different rehab detox*". After successful completion of rehabilitation, re-housing stock and offers can be very limiting. Holly shared that after leaving her violent partner she "*had support from a domestic violence advocacy worker. They helped me with housing, but I kept turning them down as I could see dealers out of the windows. I was not long into recovery, and I could not put up with that environment again*". For others, after gaining an initial period of abstinence they intentionally limit their relationships and activities to remain abstinent. Lily described how, "*after starting recovery, I went straight into solitude. I went to Crisis because I was homeless. They helped me find a place to live. I only left the house to go on their creative art course*". Here, the quality of life is reduced despite securing accommodation that can provide a basis for building a new life. Dire life circumstances were common despite successes in relation to increased control over drug use. Amy described how "*I finished my detox, but by the time I came out I was homeless, jobless and had nothing to return to*". There was also a lack of empowerment and choice available to women in relation to the types of accommodation on offer during the early phase of recovery, for example with residential rehabilitation Amelia shared how, "*the rehab was chosen for me—I didn't get a choice. It was in [location], miles away from anyone I knew*".

The pattern of chaotic and unsecure housing was also mirrored for the men. Yuri described how he was engaged in a *"quasi-residential model where I lived in a local house and went to the treatment centre seven days a week. The house was across the road from a 24 hour off license. The warm glow used to shine in my bedroom window every night. It was particularly problematic at Christmas. It was a second-rate house, a shithole"*. Eric also described his journey through a series of transitory housing situations in early recovery, *"I ended up in a homeless service, a block of flats for addicts who were homeless. Prior to that I was staying in a B&B for a while but couch surfing was easier and cheaper because I was dealing, it was really easy to find a place to sleep because it meant people got drugs if you were dealing from their place. Whilst at the homeless shelter I started engaging with the drug services and about 9 months later I got into rehab"*.

3.9.2. Stable Recovery

When asked to describe their life at present, respondents stated that *"l have a life beyond what I ever thought possible"* (Elizabeth). Amy contrasted, *"I am not the same person as I was back then…recovery works and my life is unrecognisable now"*. In this phase, life surpasses what the respondents could have imagined during the early stages of recovery. In relation to housing, almost all female participants indicated that they currently had secure housing during the stable phase of their recovery. Life, and the nature of and type of accommodation, in the stable phase of recovery in the women's journey was very different to the early phase. Access to high-quality, stable housing imbues respondents with feelings of pride and achievement, self-esteem, and a genuine replacement identity, one that aligns with societal norms and integrates them into everyday life. Abbie shared that she used to live in a squat whilst in active substance use disorder, but now lives in her own home. She continues how, "*In the morning, I can sit there and think if I had not found recovery, I would be dead. It is better than my wildest dreams*". Again, it is noticeable how the women quote their accommodation type in their descriptions of what life is like now, but importantly, they also link it to their relationships with children, friends, and neighbours. For Anne, her home environment of "living in a flat" is connected to positive relationships with her neighbours

and "great" relationships with them, as well as engagement in her local community through events such as *"the gardening competition"*. She continues, "*I am doing all of these things I never thought I would do". For Ellie, her accommodation was linked to having her children with her, "I have my son with me now. I have a flat…It is a better life"*. Finally, Amelia celebrates where she is now in her life by sharing that, *"when I look at what I have in my life now: I own this lovely house and I have my family and great friends nearby. I have this amazing career I never thought I would be having with lovely colleagues. Recovery seems to be working"*.

Males were also more likely to be living in secure housing. Many were now homeowners with the remainder renting accommodation. Nick now "*owns a very small two-bedroom house just outside [location]*". Sam shared that he owns a "*nice home, I have a nice car, all that material, but basically, I am able to do anything that I want to do that gives me a sense of value or self-worth*". Home ownership was expressed more as a marker of material success as opposed to being linked to relationships connected to their accommodation in the same way that it was for the females.

4. Discussion

This article adds to a small but growing body of evidence regarding gender differences in recovery (Abreu Minero et al. 2022; Collinson and Hall 2021; Best et al. 2020), particularly highlighting variations in housing transitions of women during the recovery process (Martinelli et al. 2020; Straaten et al. 2016). The research question explored the application of a recovery capital framework to better understand their housing transitions. What this revealed was that housing insecurity was not resolved by focusing on accommodation type alone. Instead, adopting a more holistic framework (recovery capital) proved to be beneficial. What this article highlights that has not been found elsewhere to date, is that housing transitions are essentially a social process for women in recovery. Seven of the eight housing transitions or turning points related to forms of social capital. It was not always the accommodation type or duration of residence that determined the safety, stability or security of the accommodation, or the nature of the experience whilst residing there, but rather the presence or absence of positive forms of social capital. What emerged from the findings is how housing is intrinsically related to social relationships. The nature and quality of the relationships at the accommodation often trumped the accommodation type. The findings here emphasize the social aspect of recovery as an embedded process (Teruya and Hser 2010; Price-Robertson et al. 2017).

Three types of relationships appeared to be especially key to the housing transitions experienced. Firstly, terminating negative, substance using, and/or violent relationships with partners. Homelessness rarely occurred amongst the females in the sample because they were unable to maintain their home, pay bills, nor did they face eviction due to their drug-related issues. In line with previous studies, the main cause of homelessness amongst the women was due to having to escape negative, substance using, and/or violent relationships with male partners (Fraga Rizo et al. 2022; Pavao et al. 2007). Fleeing their home to escape a partner led to a series of ongoing temporary housing transitions.

Secondly, the maternal relationship with children was an essential motivating force for many women, as observed in previous studies (Andersson et al. 2021; Schamp et al. 2020; Best et al. 2020). The disparity between their idealised or envisioned maternal roles and their current life circumstances served as a catalyst for change, influencing not only their recovery journey, but also the dynamics of their romantic relationships, their living environment, and housing.

Thirdly, eliminating drug using friendships and forming new friendships and support networks was commonplace. A process began for many of uncoupling themselves from subcultural drug and/or criminal social networks after entering recovery (Maruna and Roy 2007). Once they decided to give up their substance use they felt this meant also having to leave their home environment or 'do a geographical', at least temporarily for some, but for others, this was a permanent move. New friendships emerged during their recovery, initially with others in recovery and then later with people in the workplace, in

education settings, and the wider community. These new relationships were instrumental in providing positive forms of social capital and sometimes housing stability. It seems that a person's relationships in recovery undergo significant levels of change and transformation which has considerable implications for their accrual of recovery capital and housing stability. This aligns with the work of Jetten et al. (2012) on 'social cure' which posits that increased well-being and flourishing occurs when a person has greater links with positive pro-social networks and people.

Eliminating negative forms of social capital and replacing these with positive forms of social capital were fundamental throughout the process of change and transformation that the women experienced. What occurred as a result of the exchanges made to their social capital was a re-construction of their lifestyle, roles, and identity predicated on positive relationships, connection, and community. Meaningful relationships with children, peers in recovery, and friends provided a sense of meaning and purpose that fostered increased agency, liberation, and empowerment as they embraced new roles. These new roles helped to replace 'old' identities and low self-esteem. Many of the elements of this process of change relate to the CHIME framework. Although CHIME is not the focus of this work, future research should explore the applicability of this framework to better understand housing transitions amongst women in recovery.

The women in recovery faced a range of complex and interconnected issues related to their recovery and housing. Many of the women in the sample struggled with housing insecurity, instability, and experienced multiple and frequent moves and changes in their accommodation type. Some moved several times within a twelve-month period and then had several more moves within the following few years. Some were evicted, became homeless, were housed in a prison, lived in squats, homeless hostels, were housed in women's refuges, one-bedroom bedsits in risky parts of a city or other low quality temporary accommodation, they couched surfed or lived with friends or family members, with peers in recovery, or lived in temporary supported accommodation. Their substance use disorder and initial attempts at recovery contributed to an instability in their housing situation, primarily due to a return to use of substances and repeated visits to rehabilitation and detoxification centres.

Several structural barriers were evident from the findings in terms of obtaining stable and safe housing during their recovery. Firstly, the women had to identify and navigate a confusing web of support services, including those related to substance use disorder treatment and recovery, housing assistance, welfare, etc. This was challenging and presented a key barrier to change (Lee and Boeri 2017). Second, there is a lack of gender-sensitive services designed to meet the unique needs of females in recovery (Wincup 2016). Gender-specific support, and trauma-informed care is crucial, but was not discussed by any of the women as being part of their experience during their recovery or housing transition journey. Thirdly, females in the sample faced stigmatization and discrimination when seeking help (Livingston et al. 2012). This further hindered their ability to access stable housing and recovery support. Many females in the sample were mothers, who were conscious of the stigma associated with women and especially mothers recovering from a substance use disorder when seeking help and housing assistance. However, despite the barriers, all females in the sample were able to overcome many of them by the time they reached stable recovery in line with other studies highlighting the resiliency of women in recovery (Best et al. 2020; Patton et al. 2022).

There is a clear need for the current generation of drug recovery and housing policies to incorporate specific and explicit gender approaches to supporting women. There is a pressing need for comprehensive, gender-sensitive approaches in policies, practices, and interventions that recognize and address the diverse and often intricate needs of women in recovery (Becker and Duffy 2002). Such approaches are crucial, especially considering their absence from the lived experiences of the women included in the sample. Greater awareness and utilisation of the positive window of opportunity during pregnancy needs to be understood amongst the practices of professionals working in recovery and support

services with women in recovery. Specific support is also needed to help women transition from violent and abusive intimate partners that include plans for rehousing them and their dependents. Further, a broader approach is needed within housing policy that acknowledges the need for the cultivation or presence of positive forms of social capital and networks. The findings here underscore the significance of evaluating and bolstering individuals' social connections, considering the nature and extent of these relationships, particularly when exploring housing alternatives for individuals in recovery, especially women. What also emerged from this research is, given the prolonged periods of temporary and supported forms of accommodation, for some, the move to long term independent living posed a challenge. It is, therefore, suggested that a scaffolded approach is developed to support the transition to independent accommodation types. Finally, there needs to be greater awareness amongst professionals in their practice that a single, direct focus on an issue that needs to be addressed, in this case a person's need for housing security is limited in its effectiveness. As observed in the findings, a more holistic approach is required, as improvements in one aspect of life are interconnected with advancements in another area. Here, gains in social capital aided housing security amongst the women in the sample.

Despite the strengths of this study, it is important to acknowledge several limitations that could impact the findings. Firstly, the respondents self-identified as being in recovery (or recovered) (Valentine 2010) and volunteered to participate, potentially introducing a bias towards those who feel comfortable discussing their recovery experiences. Doukas and Cullen (2009) highlight that not everyone associates with 'recovery' to describe their status as overcoming a substance use disorder and, as such, may have excluded some from participating in the study. Additionally, there might be a perception among participants that their recovery is relatively successful, influencing their willingness to engage in the study. In addition, considering the life course perspective used in the interviews, the findings presented in this study are based on the retrospective recall of life course events, which may be susceptible to inaccuracies due to recall errors regarding past events in the respondents' lives. Despite this, the strength of gaining a life course perspective which has enabled a long-term perspective to be gained of the changing nature of accommodation types over time and how other life factors impacted upon this study is highly valuable. Drug policy, treatment, and research need to be reoriented to prioritize long-term processes and outcomes, particularly considering the extended duration required to overcome substance use disorder or extricate oneself from harmful and violent interpersonal relationships. Future research needs to prioritize the study of females and at different stages of recovery to gain a deeper understanding of their evolving support requirements over time, and how recovery capital interacts with housing.

5. Conclusions

This article highlights the potency of social capital amongst females in recovery during their housing transitions due to their choices to exchange negative forms of social capital (negative substance using and/or violent partners and subcultural friendships and social connections) for positive forms of social capital (new supportive partners, children, friends and social connections in education, employment, and the community). The women overcame tremendously dire life circumstances which were further exacerbated by systematic and structural barriers. This highlights the power, capacity, and resiliency of the women. Recovery capital was a key framework which aided the understanding of the changes occurring within their housing transitions and allowed for situating these within a wider process of transformation. The utilisation of recovery capital (and CHIME) as frameworks may provide a basis upon which to map out holistic and sustainable pathways to housing stability and security for women in recovery due to their addressing of interconnected and related life domains that produce change and transformation.

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