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Risk Behaviors Among Suburban Women who Use Methamphetamine: Social Harms and Social Solutions

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Abstract

We propose that female methamphetamine users who live in suburbia experience risks for disease transmission stemming from their social environment that remain under the radar of public health surveillance networks. The data analyzed in this paper were collected from 2007 to 2011 and were drawn from two sequential studies on methamphetamine use. The studies were conducted in the suburbs of a southeastern United States metropolis. We analyzed a total of 65 qualitative interviews with former and active methamphetamine-using women. Data from focus groups also were included in the analysis. The participants' ages ranged from 18 to 51 years. We identified three major themes with regards to risk behaviors and transmission of infectious diseases: (1) setting risk behaviors, such as sharing syringes and homelessness, lack of transportation and unemployment; (2) sexual risk behaviors such as condom use and having multiple partners; and (3) service-related risks, such as risk awareness and prevention behaviors as well as utilization of social services and healthcare. Our findings point to the pervasive nature of social influences on the risk for infectious disease transmission. We suggest that harm reduction programs be implemented in suburban communities to increase access to these services. Secondly, our data support the concept of social recovery for drug users to better their health and social lives holistically.

Methamphetamine use remains a serious health concern in some areas of the United States (Substance Abuse and Mental Health Services Administration, 2010). Trend data show an increase in first-time use of methamphetamine, and in some rural and suburban areas the incidence of methamphetamine-related hospital visits increased dramatically (Substance Abuse and Mental Health Service Administration 2012a, 2012b, 2012c; Gruenewald et al., 2012). Epidemiological data since 2005 show an increase in females using methamphetamine (Barr et al., 2006; National Institute of Drug Abuse, 2007).

Methamphetamine is known to result in long-term negative health effects including memory loss, learning deficiencies, psychosis, delusions, auditory and visual problems, malnutrition, dental decay (a.k.a. meth mouth), depression and anxiety (National Institute of Health, 2006; Shaner, Kimmes, Saini, & Edwards, 2006). Among females, the continued use of methamphetamine appears to have substantial long-term effects. Findings from studies

conducted on gender differences among methamphetamine users show that females generally start earlier, are affected differently, appear more dependent on methamphetamine, and suffer more adverse effects than do males (Boeri, Tyndall, & Woodall, 2011; Westermeyer & Boedicker, 2000; Lamonica & Boeri, 2012). Female methamphetamine users also show more indicators of depression than male users, are more likely to use methamphetamine for self-medication and report greater human immunodeficiency virus (HIV)-related risks, such as multiple partners and unsafe sexual practices while using methamphetamine (Boeri, 2013; Dluzen & Liu, 2008; Hser, Evans, & Huang, 2005; Lorvick, Martinez, Gee, & Krall, 2006).

Little is known regarding the social context of suburban drug use since this setting has been viewed as a haven from the drug use, violence and other social problems associated with inner-city drug scenes. Yet the symbolic and structural violence that researchers have found to pervade the lives of urban drug users is present but less visible in the settings of suburban or rural homes, trailer parks, and motels where methamphetamine use occurs (Boeri & Tyndall, 2012; Sexton, Carlson, Leukefeld, & Booth, 2008). In this article, we examine the context of suburban women who use methamphetamine and how the women's social environments affect their risk for infectious diseases associated with sharing needles and/or unsafe sexual practices.

The Suburban Context for Women

Recent data show that the fastest growing area of poverty is in the suburbs, and while poverty rates remain higher in inner city urban areas, by 2008 the suburban poor exceeded the number of poor in many of the largest urban areas, a process called the "suburbanization of poverty" (Allard & Roth, 2010; Kneebone & Garr, 2010). Suburban areas, however, lack the social services needed to address such growing social problems, and suburban government coffers have seen steady decreases in income as a result of foreclosures and decreasing home values, which hit the suburbs worse than the cities (Allard & Roth, 2010). Moreover, without the public transit services that benefit urban dwellers, the suburban poor are often without a means of transportation to employment, commercial areas, and needed social services and healthcare providers. Long ignored, the suburban poor have recently attracted the attention of social economic researchers but few studies have examined the intersection of the suburban context and drug use.

Suburban female drug users are a widely neglected group within drug user studies. Because of their restricted access to social services their drug use in suburban settings often remains hidden. A key aspect of female drug users living in the suburbs is their double stigmatization as bad women because they violate gender-role expectations (Boeri, 2013; Campbell, 2000; Ettore, 1992; Zerai & Banks, 2002). In this study we acknowledge the changing landscape of poverty to examine the social determinants of infectious disease transmission and the associated risks for hidden drug-using females in understudied suburban areas.

Social Determinants of HIV/AIDS, Infectious Diseases

According to the World Health Organization (WHO), we need to address the social determinants of the conditions that give rise to diseases and their modes of transmission

(Wilkinson & Marmot, 2003). Known as the “social determinants of health inequalities” these include stress, social exclusion, access to healthcare services, unemployment, and lack of social support, transportation and housing (Marmot, 2005). We use this concept to highlight the social mechanisms of infectious disease transmission that can spread across entire communities where drug-using networks live and work. In so doing we aim to draw attention to the social implications of these infections. Transmittable diseases associated with drug use include HIV that can lead to acquired immunodeficiency syndrome (AIDS) (Centers for Disease Control and Prevention, 2008). Among women, the increase in rates is alarming, and HIV infection among female adults and adolescents attributed to injection drug use has become double the rate for men (Centers for Disease Control and Prevention, 2010).

Hepatitis C virus (HCV) is the most common blood-born infection in the United States and is referred to as a “silent epidemic” due to the lack of attention it received from the medical field, resulting in many years of untreated chronic infection (Bacon, 2011; Edlin & Carden, 2006). Comorbidity with HIV infection is common, and chronic HCV infection can lead to cirrhosis of the liver and liver cancer. Since 2002, the male to female ratio of infection has declined and was nearly 1 in 2008, showing that female risk behaviors for contracting HCV are increasing in comparison to men (Centers for Disease Control and Prevention, 2008).

We know that drug use presents a primary risk factor for transmission of HIV and other infectious diseases through injection routes as well as sexual behaviors (Page, 1990; United Nations Office on Drugs and Crime, 2007). We also know that health risks are impacted by the socioeconomic status of individuals and the social environment of the communities where they live (Singer, 2006). This study fills a gap in our knowledge of the social determinants of health inequalities among female methamphetamine users in suburban environments.

Methodology

Data for this article were drawn from two sequential methamphetamine studies conducted in the suburbs of a southeastern metropolis identified as one of the areas in the U.S. most affected by the rapid increase in methamphetamine use (National Institute of Health, 2006). The area of the study site was among the largest metropolitan statistical areas (MSA) in the U.S. and experienced the greatest numerical gain of the most-populated MSAs in the nation during the decade prior to the study. Approximately 90 percent of this population resides in suburban communities comprised of 28 counties surrounding the city. The majority of the fieldwork was conducted in the northwestern counties. Reports from law enforcement agencies show a higher use of methamphetamine in suburban and rural counties than in urban areas (National Institute of Justice, 2003), and this northwest suburban area received emergency federal funds to address the growing problem of methamphetamine abuse. What were once primarily rural agricultural communities in these suburbs have developed into an expansive hodgepodge of gated communities, new subdivisions, and small town residences converted rapidly into store front businesses flanked by fast food establishments and big box discount stores. Mega schools were built quickly to hold and educate the swelling number of children. Squeezed between the more visible communities were the less obvious trailer

parks, project homes, and single room occupancy boarding houses and motels that provide a roof for the forgotten poor and underprivileged. While we do not claim generalizability, the study sample was drawn from all levels of socio-economic communities represented in these suburbs, which by all accounts are a virtual replica of the postmodern suburbia associated with the U.S. contemporary landscape. To protect the anonymity of the participants we do not specify the exact location.

All names are pseudonyms used for this article. The university's Institutional Review Board (IRB) approved the study protocols, and the National Institute on Drug Abuse granted us a certificate of confidentiality to protect the study data and researchers from court subpoena.

The first study used a cross-sectional design that collected data from a purposive sample aimed to include 50 former and 50 active methamphetamine users. Active use was defined as using methamphetamine in the past 30 days. Former use was defined as having used methamphetamine for at least six consecutive months in the past but not using in the last month. Ethnographic methods, including targeted, snowball and theoretical sampling, were used to recruit participants from diverse communities (Glaser & Strauss, 1967; Strauss & Corbin, 1998; Watters & Biernacki, 1989). We also enlisted the help of community consultants who were familiar with the drug-using networks in each area, and we distributed fliers advertising a confidential health study with a number to call (Lambert, Ashery, & Needle, 1995).

All participants were screened by trained interviewers familiar with methamphetamine-using trends in the area. Most of the interviews were conducted in the community, such as at participants' homes, in local libraries, or in the interviewer's car. We conducted audio-recorded, in-depth qualitative life-history interviews that focused on roles, meanings and definitions of drug-using activities as perceived by the participants. For example, instead of defining dependence or addiction, we asked the users to define these terms. The qualitative data were supplemented by short quantitative drug histories of first time use, last six months and past 30 day use of all drugs, alcohol and tobacco. To be eligible, participants had to be residing in the suburbs of the city at the time of use and be 18 years or older at the time of the interview. The interview process lasted about two hours on average and participants were paid \$25 for their time. Of the 100 participants who were interviewed in the first study, 35 were women. They were interviewed once.

Based on the preliminary analysis of the first study, indicating that methamphetamine using women were at greater risk for injuries and diseases than men, a longitudinal study was designed to further examine the social context and reasons for drug use and risk behaviors among a small sample of methamphetamine using women living in the suburbs. An additional focus was on their ability to access needed healthcare and social services.

The longitudinal study used the same methods and instruments employed in the first study: (a) ethnographic participant observations; (b) drug history and life history surveys; and (c) audio-recorded in-depth interviews, with the addition of a risk behavior inventory and follow-up data on accessing needed health and social services. Each woman was asked to participate in two follow-up interviews—either two individual interviews or an individual

interview and a focus group interview. Due to social and environmental circumstances beyond their control, some of the women were unable to complete all three interviews. Reasons for this included moving away from the suburban area, incarceration (typically for parole violation), or losing contact due to a lack of stable residence. We conducted phone interviews with those who moved away but contacted us later for a follow-up interview.

Of the 30 women who participated in the second study, five were interviewed once; nine were interviewed twice with an average of five months between interviews; and 16 were interviewed three times with an average of seven months between the first and last interview. This represents a 17% attrition rate for the second interview point, which is typical in longitudinal studies of hidden and hard-to-reach populations (Corsi, Van Hunnik, Kwiatkowski, & Booth, 2006). Sixteen women participated in one of the six focus groups. All interviews were conducted by trained researchers who had built a rapport with the female participants throughout the two-year longitudinal study. In addition, we provided a list of health and social services to the participants during their first interviews, focusing on their access to services in the follow-up interviews.

The in-depth interviews were transcribed word-for-word. Data analysis began with the first few interviews using the constant comparison method commonly employed in grounded theory (Charmaz, 2005; Strauss & Corbin, 1998). Three coders independently coded the first few transcripts on paper and collaborated as a team in the development of a coding scheme representing the main categories and sub-categories of their coding work. The computer program QSR NVivo was used for storing and managing the coding of the qualitative data. Subsequent transcripts were coded by at least two coders using this coding scheme, called a “tree” in NVivo. Free codes (e.g., codes found in subsequent coding that did not fit one of the tree codes) were added and discussed as a team. This paper includes additional coding conducted by the authors.

This paper presents an analysis of the qualitative data collected from the women in both studies. Of the 65 women who participated in the combined studies conducted from 2007 to 2011, 89% were white, 3% were African American, 6% Latina and 2% American Indian. Their ages ranged from 18 to 51 years with a mean of 33.5 years. The socio-economic position of the women was based on their current residence situation and employment status, which we categorized as the “suburban working middle class” or the “suburban poor.” None of these women interviewed could be considered upper class or upper middle class at the time of the interview. In-depth analysis revealed that most of the women ages 18–25 had no residence other than living with their parents, and their income other than drug sales was dependent on their parents or extended family. While some of the women in this age group came from upper and upper middle class families, they could not be categorized as upper or upper middle class by their current economic conditions. Therefore we categorized the younger women who were still dependent on their families separately. Women in this younger age group who were not dependent on their families and living on their own were included in one of two previously mentioned categories. Our classification of the 65 women who participated in the study revealed 19 women who were “suburban working middle class” and 26 women who were “suburban poor.” Twenty were young women (age 18–25) still economically dependent on their families.

We did not categorize women according to any standard measures of dependence or addiction since these data were not collected. Instead we focused on categories of their involvement with mainstream social roles such as work, family, and partner roles (compared to unconventional roles such as sex worker), and their control of methamphetamine use in terms of not allowing their use to interfere with mainstream roles. The women varied in their ability to not allow methamphetamine use to control their lives to the point of losing mainstream roles. Among the 65 women interviewed, 27 were former users at the time of the interview and therefore had evidenced that they could control their use by no longer using methamphetamine. A few of the women continued to use other drugs but none lost social roles due to other drug use. Among the women who were active users of methamphetamine (defined as used in the last 30 days), eight were able to control their use of methamphetamine so it did not interfere with their mainstream social roles. During the time we interviewed the women, six showed signs of losing control and four had substantial trouble maintaining mainstream social roles. Two women had lost all mainstream social roles and were living through prostitution or other illegal activities. The majority of the actively using women, however, were trying to control their use but having a hard time. Past three month data showed that these women (n=18) had been in treatment or had stopped using methamphetamine on their own in the last three months but had relapsed. These women typically lost some mainstream social roles before, during or after their relapse.

Limitations

The main limitation of this study is that it cannot be generalized beyond the research sample; however as a qualitative study, a probability sample is not needed. We achieved our goal of obtaining an understanding of the social health risks among suburban women who use methamphetamine with a relatively small sample. A second limitation is that all participants in the study were living in the same southeastern U.S. geographic area at the time of the interviews, which might indicate a local bias in the findings. Thirdly, the females in this sample were predominantly white, and their experiences are not the same as the experiences of minority female drug users. Epidemiological data show that methamphetamine is overwhelmingly used by whites compared to other races and ethnicities in this area (National Institute of Health, 2006, 2007). Nevertheless, research in other regions of the U.S. indicates that many of the social findings we presented are consistent with poor drug-using female populations regardless of race or ethnicity (Lorvick et al., 2006; Sexton et al., 2008; Singer, 2006; Sterk, 2000).

Limitations to the reliability and validity of self-reported data include two forms of biases: recall accuracy and social desirability (Guest, Bunce, & Johnson, 2006). Social desirability was addressed in this study by developing rapport with respondents, and recall accuracy was increased using memory tools such as timelines with historical and cultural events targeted at specific age groups (Fontana & Frey, 1998; Shaw, 2005). Substantial research shows that multi-method designs, such as those used in the studies described here provide reliable and valid data on self-reported behaviors (Anglin, Hser, & Chou, 1993; Lambert et al., 1995; Pach & Gorman, 2002; Rhodes & Moore, 2001).

Results

The findings are organized by the themes of (1) setting risk behaviors; (2) sexual risk behaviors; and (3) access to services that are critical to awareness or avoidance of risk behaviors. Each theme is further identified by the main concerns voiced by the women. The quotes used in this article are typical of the overall findings and do not represent singular events. They are instead representative of patterns of behaviors and activities discussed by many of the women. We chose quotes that best illustrate the social and environmental risks for transmission of infectious diseases and activities associated risk behaviors.

Setting Risk Behaviors

Setting refers to “the characteristics of the physical and social setting in which use occurs” (Zinberg, 1984, p. 308). The themes that emerged from the coding on settings involved risk of disease and injury related to the social environment of methamphetamine use among suburban women, including sharing syringes.

Sharing syringes—Most of the women did not have steady access to clean syringes, and regardless of their knowledge of risks, lack of a clean syringe when methamphetamine was available was not a deterrent to sharing with a drug-using friend or partner.

Sharing syringes in a monogamous relationship was a very common theme among the women. Daisy, a 37-year-old former user explained: “Me and my husband share all the time. [...] Spoon, cotton, the whole nine yards. I don’t think about it.” When women were unable to obtain their own syringe, sharing among partners became one of their only ways to get high. Rose, a 49-year-old former methamphetamine user explained that her partner, who was diagnosed with HCV, would get her “off” first before injecting himself.

Ruth, a young woman in her early twenties who learned she had HCV while in jail, related that she “knew not to” share syringes but that she was at times “careless and unaware.” She elaborated: “Because people that use syringes, they’re going to get their fix however, whatever limits they got to go to, I don’t care what they say.”

Accessing new syringes for themselves proved difficult in the suburban community. Most of the women obtained sterile syringes from friends who used drugs, relatives who had diabetes, or from pharmacies. Not wanting to be stigmatized as a drug user, many did not attempt to obtain syringes from a pharmacy. Some women, like 24-year-old Viola, thought that they “had to have a prescription for insulin or something like that” in order to procure syringes from a pharmacy. Young women in particular lacked the experience of the older drug users for accessing syringes. One young woman, in her quest to buy new syringes “covered up all [...] tattoos” so that she would not look “shot out.” She explains:

You have to ask the right way ... You have to ask for the right gauge and you have to ask for the—it’s a certain size and I had to look it up online every time because I’d forgotten the numbers. But if you don’t say it right they won’t give it to you because they’ll think you’re an addict or a junkie.

When Ruby, a 19-year-old former user, tried to buy syringes from the local drugstore, she had to make up stories about relatives suffering from diabetes to justify the purchase. She related her encounter with a pharmacy clerk:

And they wouldn't do it. I've even gone and been like, "Look, I am either gonna go walk around the streets and like find a syringe on the side of the road and use it or you're gonna sell me these syringes, O.K.? Like please do you want my blood on your hands?" [...] And they'd still be like, "I'm sorry, I can't do it."

She resorted to reusing her own syringes over and over again to avoid having to borrow others, which increased her risks for abscesses.

The women who lived in suburban enclaves of poverty also addressed the difficulty of disposing of their syringes in a safe way in order to avoid injury to themselves and others. Nora, a 19-year-old woman who participated in a focus group explained: "Needles would be pouring out of my septic tank." She later suggested that one could "bury the damn thing in the yard" but another woman disagreed and said: "No, don't bury it in the yard cause some child might step on it barefooted or something." Of course, while most knew the danger of used syringes, children usually were not aware—especially the children in the poor area where many of the women lived.

Intersection of homelessness, lack of transportation, and unemployment

Homelessness often exacerbated the women's drug use and risk behaviors. Ruby and Daisy both independently moved in with their drug dealers when they found themselves without other options. Ruby described the following scenario: "When I was [...] homeless [...] the dealers [...] let me come live with them and just let me do all the ice [methamphetamine] I wanted." Ethel, a 45-year-old active user, was released from jail after serving a sentence for selling drugs. She was clean but had nowhere to go. She met a heroin addict who let her stay and soon thereafter she began using heroin for the first time.

A lack of transportation often stands in the way of these women bettering their lives. Ruth, who would have liked to attend a support group for her HCV diagnosis, was unable to get there because she did not have a car and she found public transportation difficult to navigate in suburbia. Daisy struggled to attend GED classes due to the lack of transportation, and it took Alexis three hours on public transit to commute to her job at a call center. Several respondents described the difficulty of applying for jobs when one lacks transportation and how public transportation can be pricey, unreliable, and time consuming. Often they were left stranded without a ride back into their neighborhoods. In Erin's words: "You got to be at a certain spot at a certain time. And then you got to wait until they get there. [...] But the hours change."

Unemployment was prevalent among the women. Ethel, for example, was college educated and before her drug use began to get out of control, she was employed in a well-paying professional setting. Currently, however, she said: "I work in a day labor place because I have a felony." Because of her low income, she considered herself "barely not homeless." Women with a felony record often did not qualify for government resources. For example, Beth explained how she felt about the barriers she faced due to her criminal record:

I'm not on anything [drugs] now. I've never, you know, I've never drawn welfare. I've never done anything like that. And I can't get food stamps because I have a drug charge. I have a drug charge. And this can be on—for the rest of my life.

Appearance was another reason women felt they could not obtain employment, with dental issues being the main esthetic issue. Alexis explained that she was unable to work as an optician despite her previous training in that area. In her own words: "I haven't even tried to get my license back because I have no teeth. You cannot get back into the optical field and be licensed again and try to sell glasses with no teeth. It just – it's not professional."

Sexual Risk Behaviors

The main areas of risks among our participants were inconsistent condom use, having multiple partners or consecutive monogamous relationships, or being involved in sex work.

Condom use—While many women were savvy to the need for using new syringes whenever possible, the same women were much less vigilant when it came to protecting themselves by using condoms. Ethel, a middle-aged former user who insisted on using clean syringes to avoid HIV and HCV infection specifically, explained: "I was careful with drugs but not with sex. [...] I know that sounds so stupid." She did not use condoms with the several partners that she had during the past few years.

The women point out that negotiating condom use was very difficult when they were with a person who had the drug that they desired. They explained that the drug is in control, or as Alexis a 50-year old active user put it: "I wanted the drugs more than I worried about catching anything."

For women who wanted to keep their new boyfriends or needed the resources provided by male sex partners, condom use was not practical in real life situations. For example, one woman said she did not use a condom because "I have one partner [and] he is faithful to me." Our study revealed, however, that most women were unaware of their partner's gregarious sexual activities while they were in what they believed to be a monogamous relationship.

Multiple partners—Molly, a 50-year-old former user, used to trade sex for drugs and had upwards of 20 partners in the past year. When asked how many of these were steady partners (serial monogamous), she replied, "None. These were people that had the dope. I'd go straight to the source. That way I didn't have to deal with the middle man." She did not use condoms that year and she later revealed that the topic of sexually transmitted diseases was never broached with any of her sexual partners.

Many of the women engaged in sex work to pay for drugs and/or to support themselves and avoid homelessness. For example, Alexis started supporting her habit with money from a client who paid for her apartment, but she later included more sex clients as her habit grew:

I was not a prostitute at that time, but I had slept with men for money—not really for money but I guess for drugs. I would sleep with anybody for drugs at that time. When I started dancing, the prostitution came in—just to support my drug habit.

By age thirty-eight, Laura had so many felonies related to drug distribution, not even the public ex-offender employment office could help her find work. She explained that all she can do to survive is sex work, “I’m not going to lie. I do drugs, you know what I’m saying. I can’t find a legal job, so if I can’t sell drugs then I do whatever you know is necessary to keep myself going.” She estimated she had one hundred sex partners in the last year.

Service Access and Related Risks

Women addressed the challenges of trying to access needed healthcare and social services, revealing a lack of risk awareness and prevention education, and little linkage to services needed.

Risk awareness and prevention education—Few of the women had been introduced to any kind of risk awareness regarding drug use, and if they had sexual education, it focused on “abstinence only” models. Their lack of any substantial risk awareness and prevention education was made clear when they learned they had contracted an infectious disease. The few who learned of their status generally were tested while in jail. For example, a 21-year-old female injector recently learned that she had HCV when she was in jail for possession and distribution of methamphetamine. When asked if she knew how she contracted it, she replied, “Hepatitis C...is very prevalent in [suburban town]. I can name at least five friends that have it.” At the time of her last interview, she was receiving no healthcare or further treatment after leaving jail, yet she continued to inject with her young drug-using network.

Deb was a 46-year-old former methamphetamine injector who suspected she had HCV when she became jaundiced and her liver swelled. With no insurance, she asked her sister to take her to the nearest suburban emergency room:

I’m so sick. [...] extremely tired. I’m talking about, you know, just worse than any, you know, I—I mean, just can’t even get out of the bed tired. Um, not functioning tired. You know, getting up and going to the bathroom and coming back, that’s how tired I was. My stomach was so swollen that it looked like I was pregnant. My eyes had a yellowish tint to it. Um, my sister was like, something is bad—you got to go to the hospital... So I went to the hospital and—you know, they didn’t check for hepatitis C. I told them all the symptoms, and I told them I had hep C. They did not check. They did not do the blood work.

Deb was released when she was “medically stabilized” with no treatment plan or health education regarding her condition.

Utilization of social services and healthcare—A lack of transportation and having felony charges were obstacles to obtaining services, but having no official identification was the major reason some of the women were without health or social services for years. Discussing the need for a government issued identification in one of the focus groups, a woman highlighted how important identification (ID) was to obtain any needed service:

They want you to have two forms of ID. Okay, I don’t have an ID. They don’t want to accept the ID that I have, you know. I have a social security card. If it wouldn’t

have been for the prison, I wouldn't have got a social security card, 'cause to get a social security card, you gotta have a birth certificate, and to get a birth certificate you got to have a social security card.

Another woman in the group described the services that were unobtainable to her due to not having two forms of identification:

Jobs, house. Not having a birth certificate and a social security card can stop you from having an ID, and the ID can stop you from having jobs and everything else. The birth certificate and the social security card [...] if you don't have those two together, you don't have nothing.

Because the local homeless shelter required official identification, women who suddenly were without a home and identification often resorted to sex work in order to pay for cheap hotel rooms, or they exposed themselves to potentially violent and unstable situations by relying on men for housing. Barriers to utilization of healthcare and social services resulted in increased risk behaviors and potential for transmission of disease among this suburban population.

Discussion

Our findings, as illustrated in the women's own voices, show that risk behaviors related to setting, sexual activities and lack of access to social services are major issues that continue to impact the health and well-being of suburban women who use or formerly used drugs, particularly poorer women with few resources. Due to the illegal status of drugs, middle-class women often became poor after an arrest that led to a downward economic and social spiral. Among the women who were already poor, many of their problems were associated with living in poor enclaves in the suburbs of this particular city, which have seen a greater increase in unemployment and foreclosures than in most cities. The "suburbanization of poverty" during the last decade and the lack of sufficient services for the suburban poor exacerbated the dire social situation for women stigmatized by drug use (Allard & Roth, 2010; Kneebone & Garr, 2010). This stigmatization is encountered not only in society at large but also within the drug scene (Bourgois et al., 2004; Sterk, 1999). As revealed in the women's stories, the lack of public health services in the suburbs increases the risk of transmission of diseases associated with injecting drugs.

Although methamphetamine can be used by other methods, such as oral, nasal, or inhalation, the most effective method is injecting. Having access to sterile syringes and injection paraphernalia is known to drastically reduce the spread of HIV and HCV infection among drug users. Many of the women were well aware of the dangers of syringe sharing, explaining to the interviewers that they did not want to risk HIV or HCV infection. Even among those who avoided sharing, accessing syringes for themselves proved difficult in the suburban community. Our data show that for many of the poorer suburban women, particularly the younger women, sharing syringes and other drug paraphernalia was often done out of necessity and lack of access to clean syringes. We heard contradictory reports of pharmacy attendants who gave syringes without asking for diabetes cards or identification, while others in the area made it difficult or impossible to obtain them. However, skill at

buying syringes at a pharmacy varied widely and depended on the women's ability to act or look like a non-drug user who was buying the syringes for medical purposes. Additionally, the women needed to know the exact product numbers in order to obtain the syringes from the pharmacist. Used syringes posed a real threat to the health of the community where the women lived, especially to children. As mentioned, syringe exchange programs (SEP) vary by state, and although technically illegal in this state, a SEP operated in the city. City officials were aware of the SEP activities but allowed them to continue undisturbed since they were conducting a needed public health service in that area. In contrast, suburban public health and criminal justice officials appeared to be unconcerned or ignorant of the need for SEPs in their jurisdictions. We suggest that rather than turning a blind eye to these issues, more risk awareness and prevention programs must be implemented in suburban areas, particularly enclaves of poverty.

Beyond a lack of access to needed health services, the women in the most marginalized areas of the suburbs expressed utter despair of ever leaving their drug-using network and environments. Many of these neighborhoods were close to the city or suburban towns that had public health and social services, but these women were so disenfranchised by years of social neglect, incarceration, or loss of employment, that they had little hope of participating in social activities most of us take for granted.

Due to our drug laws, many drug-using women acquire criminal justice records, which if it is a felony drug conviction decreases employment opportunities and access to some social services for a lifetime. This bias against drug users is perhaps most poignantly revealed when a drug user attempts to gain access to needed social services and healthcare for which she would otherwise qualify. Social and health programs funded by federal or state governments generally exclude those with a drug conviction, compounding the negative effects of law enforcement involvement. Without housing, transportation, employment and basic resources needed to survive, most of the women resorted to illegal activities to remain independent from reliance on family and friends. These activities often led to increased drug use and sexual risk behaviors.

Females who use methamphetamine are a vulnerable population for transmission of infectious diseases, especially those who inject drugs. Physical and sexual abuse and violence, exacerbated by methamphetamine use, also put females at high risk for contracting HIV, HCV and other infections and were the cause of many unintended injuries. Sexual risk behaviors among the women included having unprotected sex, multiple sex partners, engaging in sex while under the influence of drugs, and sexual relations with an injecting partner, which is similar to risk behaviors of women in the cities (Maher, 1997; Singer, 1994). The use of condoms (safe sex) reduces the spread of numerous sexually transmitted infections (STIs) such as HIV, yet for many women condom use was not a choice but dependent on a male partner's preference. Although it is rare for HCV to be spread by sexual contact, engaging in sex work with multiple partners and with injecting drug use partners is a risk behavior common to all sexually transmitted diseases.

Looking at the health of inner-city drug users, Merrill Singer (2006) used a political economy framework to identify what he called "syndemics," which are two or more

endemics that occur in clusters in society and are linked to causative structural and social conditions. Syndemics of diseases associated with drug use are hepatitis C (HCV), HIV, and liver disease. Similarly, syndemics clustered in the suburban poverty enclaves. Poverty and mental health issues intertwined with physical disease and drug use as both cause and effect. Suburban women of all classes, stigmatized by illegal drug use, were often ashamed or fearful to seek help for health problems that might expose them as methamphetamine users or reveal the stigma of prior incarceration (Bairan, Boeri, & Morian, 2013). As mentioned, some of the women who began using methamphetamine to maintain their middle-class status ended up living among the most vulnerable populations in marginalized suburban enclaves of poverty as their multiple chronic diseases progressed with little or no medical attention. In contrast to public policy focused on the poor living in urban neighborhoods, few policies are directed to implement programs for the suburban poor.

As shown in previous work, a lack of services that provide the basic necessities of humane living (food and shelter) leads to increased health risks and intensifies the motivation to use drugs (Lawinski, 2010; Sexton et al., 2008; Tsemberis & Stefancic, 2007). A lack of preventative healthcare services also leads to increased risks for serious illnesses and the transmission of diseases among drug-using networks (Bairan, Boeri, & Morian, 2013; Bacon, 2011; Wilkinson & Marmot 2003). The vast majority of women spoke of inadequate medical care and a lack of access to needed social services. Even those with an infectious disease diagnosis could not receive treatment on an ongoing basis. For example, suburban healthcare providers often lacked training to effectively provide screening or care for HCV; therefore, many of the women diagnosed received no medical attention at all. If they had a diagnosis, the women received confusing treatment information. Many of the women were not aware of their HIV or HCV status because they simply did not have any clinical symptoms and thus saw no reason to seek testing. And for those who had symptoms, these women served as a source of transmission when having unprotected sex and when sharing their drug paraphernalia with others (Lorvick et al., 2006).

While the CDC recommends HCV-positive individuals be evaluated periodically for possible development of chronic liver disease, none of the women in our study who were diagnosed with HCV infection received this type of medical care (Centers for Disease Control and Prevention 2006). After years of being ignored by medical professionals, we found that the women took the implications of these serious diseases lightly. Similar to other studies, our data show that drug users had an almost impossible time finding treatment for their HCV disease whether or not they were using drugs at the time (Edlin & Carden, 2006). They also had a difficult time finding other needed social services for various reasons beyond their control. For example, shelter workers were unable to explain the reason for requiring a government-issued photo identification.

Social environmental challenges, such as housing, employment and transportation, are often discussed separately from the health issues and risk behaviors; however we suggest that we cannot disentangle these factors for the sake of succinct analysis. Although a single focus on housing, for example, would simplify the reporting of the women's homeless situation, we found a variety of factors are so intertwined that to focus on only one or two would jeopardize the discovery of successful solutions. Similar to other literature on the

intersection of poverty, healthcare and social services in the suburbs (Lawinski, 2010; Tsemberis & Stefancic, 2007), we suggest that social factors cannot be separated from social and health risk behaviors in society's response to public health problems related to drug use. In assessing the social determinants of the health inequalities among the women in this study, we propose two solutions: (1) community based harm reduction services in suburban neighborhoods where drug-using networks exist, and (2) treatment that includes a focus on social recovery. Acknowledging that these solutions should be based on the community resources available in each location, we propose potential implementation strategies that should be common across geographic and political divides.

Harm Reduction

Harm reduction services, as the name implies, refers to the practical strategies aimed at reducing the harm caused by drug use. Founded on human rights principles, harm reduction strategies provide nonjudgmental delivery of services and emphasize quality of life for the individuals in need of services. A harm reduction approach is sensitive to individual vulnerabilities and differences but does not minimize the danger of real harms associated with drug use behaviors.

Often found primarily in large urban areas, we suggest that harm reduction services should be extended to small communities in the suburbs where poor and marginalized networks of drug users reside. Although we support the move to make syringes more easily available to drug users at pharmacies, the myriad of other benefits gained from harm reduction programs is vital to the social health of drug users.

Harm reduction programs vary by the extent of financial support received and subsequent services provided, but they are generally aimed toward drug-using populations in underserved communities. While the core of most harm reduction programs is the syringe exchange program (SEP), a harm reduction center also provides education and risk reduction programs. HRP also provide prevention, diagnoses, and linkage to treatment of substance use, HIV/AIDS, sexually transmitted infections, hepatitis, and other communicable diseases. As shown in the stories told by the women in this study, risk behaviors increase when there is a lack of access to clean syringes in the suburbs, and unsafe disposal of used syringes presents a major public health concern. Specifically, young suburban drug users are in need of risk-reduction education and testing for infectious diseases. The findings point to a need for access to clean syringes in the suburbs, as well as increased education regarding the safe disposal of used syringes and other risk reduction awareness, prevention programs, and screening for infectious diseases.

SEPs were still illegal in this state where the women lived, although one harm reduction center operated in the inner-city undisturbed by law enforcement. Only one woman in our study had heard of the city SEP but did not know where it was located. We suggest that in states where SEPs are legally permitted, funding should be allocated to extend harm reduction programs and education to suburban areas. In states where SEPs are not permitted, community leaders and policy makers should be informed of the societal benefits of harm reduction initiatives.

Social Recovery

Beyond public health concerns, harm reduction highlights the need for social inclusion of our most marginalized citizens to improve their quality of life as well as to reduce risk of injury and disease. We suggest a re-focusing of attention on the social aspects of recovery so that we can more easily identify individuals whose problems are social and not limited to addiction issues. While this might be the purview of social services primarily, health providers, particularly those in clinics and emergency facilities so often used by uninsured and stigmatized drug users, are strategically positioned to effectively provide linkage to health and social services for suburban females who are drug users (Bairan et al., 2013; Heather, 2005). Drug treatment courts also provide effective socialization mechanisms for the drug offenders under their authority (Boeri, Lamonica, & Harbry, 2011; Holsapple & Jensen, 2013). One way to do this is to include social recovery within health services and drug treatment services.

Social recovery, a concept founded on social capital theory, directs attention to the social environment that impacts social well-being and health (Barton et al., 2009; Grant, St. John, & Patterson, 2009). Social capital is used to explain the unequal distribution of social resources available to individuals within their communities and across social networks that act as a barrier to obtaining desired goals (Bourdieu, 1984; Coleman, 1990; Portes, 1998). We use the term social recovery to refer to acquiring the skills, resources and networks needed to enhance people's ability to live in society without problematic alcohol or drug use that increase risk behaviors (Boshears, Boeri, & Harbry, 2011). The key is to focus recovery on the social aspects of drug use first instead of on abstinence. A similar re-focusing strategy proved successful in addressing homelessness among the dually diagnosed (see Tsemberis & Stefanic, 2007).

Social recovery provides a more humane and less stigmatizing response to the social disparities in health associated with poverty and drug use. The data in our study indicate that for many women, efforts directed to better their social lives resulted in less problematic drug use and even cessation, but too often they met barriers to ameliorating the critical aspects of their social lives that would help with recovery. For example, Molly, the woman who experienced years of domestic abuse, homelessness and incarceration, found her social environment changed when she was given respite from living on the street by a "Good Samaritan" who gave her a room in a boarding house and employment in an office setting. Emotionally encouraged and physically strengthened by her new social context, she became involved in a church where she felt she belonged and eventually was completely drug free. Her social capital increased due to a bridge to a new social network imbedded in mainstream society, in her case a friendly church community. Some women also were helped by a relative or obtained employment that allowed them to leave their residence in marginalized neighborhoods. In most of these cases, drug treatment was not the primary goal, but their social recovery resulted in seeking treatment or gaining control of their drug use as a result of increased social resources.

Social recovery might be a more beneficial conceptualization of recovery for those who seek recovery but fail to achieve the complete abstinence from all substances that is required by our contemporary abstinence-only recovery models. We also suggest, if people were given

access to more strategies for recovery, such as education, fulfilling social relationships, and social options for avoiding former drug buddies, it could reduce the number of attempts at recovery, and, therefore, relieve the public burden of institutionalized treatment centers and the overpopulation of incarcerated drug users.

The policy implications of this paper can be addressed by state and local officials promoting and funding harm reduction services. The social implications can be addressed by private and public service providers to implement social recovery initiatives in their drug treatment programs. In many urban centers, harm reduction programs are common; we suggest that these must be extended to suburban and rural areas as well. Additionally, we propose a more focused emphasis on social recovery rather than drug abstinence only in treatment. Addressing the social determinants of health is a popular public health goal aimed to reduce global health inequalities (Marmot, 2005). Let us not forget the suburban poor in efforts to reduce the social determinants of health inequality, particularly drug-using women who are the most marginalized, stigmatized and disenfranchised hidden population.

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