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"When You Got Friends in Low Places, You Stay Low:" Social Networks and Access to Resources for Female Methamphetamine Users in Low-Income Suburban Communities

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Abstract

To examine access to needed resources among low-income methamphetamine-using females, we conducted interviews with 30 women living in poor suburban communities of a large southeastern metropolis. As an invisible population in the suburbs, underserved by social services, the women remain geographically and socially anchored to their poor suburban enclaves as transit, treatment and education remain out of reach. The longitudinal study included three interviews over a two-year period. Resources needed by the women were identified in the first interview and a list of available services was provided to them. In subsequent interviews we asked how they accessed the services or barriers encountered and discussed these further in focus groups. Using a social capital framework in our qualitative analysis, we identified three processes for accessing needed resources: formal, informal and mediated. Implications for policymakers and social service providers are suggested, and models for future development proposed.

Methamphetamine (MA) was proclaimed an epidemic as it crossed from the western coast of the United States, settled in the heartland and continued eastward, impacting primarily urban populations of young people and men who had sex with men (MSM), and rural populations in an increasingly poorer countryside (Halkitis & Shrem, 2006; Klitzman et al., 2000; Reding, 2009; Sexton et al., 2008; Shernoff, 2005; Weisheit & White, 2009; Worth & Rawstone, 2005). As dire warnings of the dangers of this potent drug became a media sensation, and increased regulations of precursor ingredients curtailed national MA production in makeshift laboratories, (Boeri, Gibson & Harbry, 2009a; McKetin, 2008; Sexton et al., 2006), use of MA by suburban housewives went relatively unnoticed. Two concurrent trends exacerbated the problems associated with MA use: the suburbanization of poverty (Kneebone & Garr, 2010), and the rampant social exclusion of drug users networks due to increased criminal justice repercussions. The first trend was made worse by the economic slump that started in 2008, called the "Great Recession" (Grusky, Western & Wimner, 2011); the second was aggravated by the "institutional quagmire of state-mandated social agencies" (Bourgois, 2003, 243) and the repressive hegemony of the new social control mandate (Beckett & Herbert, 2008; Cohen, 1985), which made accessing the limited

social services available in the suburbs dangerous for mothers who used drugs. Drug epidemics rise and fall (Reinarman, 2005), and by the time the MA epidemic discourse began to wane, many suburban women who used MA were living at the margins of society. In this paper, we examine the lives of low-income suburban women who used MA to discover how they obtained needed resources. First we provide a brief review of the social determinants of health that impact the poor in general and suburban poor in particular. Next we present our findings on how women associated with methamphetamine user networks navigate the suburban landscape to meet the basic needs of living. Lastly we discuss implications for policy and future research directions.

BACKGROUND

The literature on social determinants of health disparities highlights the social exclusion that results from racism, discrimination, stigmatization, unemployment and addiction (Marmot, 2005, Wilkinson & Marmot, 2003). Drug use and addiction has also been associated with difficulty attending appointments, caring for basic health maintenance needs, and poor relationships with healthcare providers (Krüsi et al., 2010). Nevertheless, drug users often turn to public social services to meet their daily survival needs, such as food and housing, as well as treatment and employment. Previous studies identified many barriers to shelter and housing services, such as unavailability of beds and long waiting periods (Redko, Rapp & Carlson, 2006). Barriers to accessing employment services include transportation issues, and for women who have children, child care inadequacies (Boeri, Tyndall & Woodall, 2011; Livermore & Neustrom, 2003). Studies on drug users reveal barriers to accessing services due to time and costs involved in traveling to medical care and not having an address or phone number (Bairan, Boeri, & Morian, 2013; Neale, Thompkins, & Sheard, 2008). Mothers who use illegal drugs also fear accessing social services because of the potential to lose child custody (Jessup, Humphreys, Brindis & Lee, 2003). These factors often result in increased isolation of women who use drugs and the segregation of suburban drug user networks, leaving the poorest of them without sufficient resources

While our well-documented knowledge of urban poverty has resulted in increased social service infrastructure in the inner cities, the suburbs have been viewed as less needy of a government funded social safety net (Lawinski, 2010). According to recent studies, we know that low-income people living in suburban communities are suffering from the longest recession in recent history, called by some the “suburbanization of poverty” (Kneebone & Garr, 2010). Although poverty rates remain higher in inner city urban areas, by 2008 the suburban poor exceeded the number of poor in the cities (Allard & Roth, 2011). The problems that ensued include increasing demands on schools, health care systems, and social services.

The suburban poor receive help largely from nonprofit organizations. The prolonged recession that started in 2008 resulted in limited funding for social services, decreased donations to nonprofit services, and increased home foreclosures and unemployment, which hit the suburbs worse than the cities (Katz, 2011). Moreover, without the public transit services that benefit city 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 studies examining the intersection of poverty, healthcare, social services, and drug use in the suburbs (Boeri, 2013; Lawinski, 2010; Tsemberis & Stefancic, 2007).

Methamphetamine (MA) is a stimulant that provides energy, produces a feeling of pleasure, and decreases appetite, which makes it an extremely desirable drug regardless of its illegal status (Lende, Sterk & Elifson, 2007). Yet, there are tremendous problems associated with MA use, including stroke, cardiac arrhythmia, stomach cramps and muscle tremor; anxiety, insomnia, aggression, paranoia and hallucinations (Barr, 2006; Shaner et al., 2006). MA use is associated with higher risks for infectious diseases; MA withdrawal can produce depression and suicidal inclination; and the MA-using social context is highly associated with injury and violence for women in particular (Boeri, Harbry & Gibson, 2009b; Compton et al., 2005; Bourgois, Prince & Moss, 2004; Sheridan et al., 2006).

In this paper we examine MA-using women living in suburban enclaves of poverty. The aim of this study is to identify how this population accesses basic resources and needed services. We use social capital to guide our analysis and direct our attention to the social determinants associated with drug use that impact social well-being and health.

THEORETICAL FRAMEWORK: SOCIAL CAPITAL

Social capital refers to social resources that are available to individuals from their social networks (Bourdieu, 1984; Coleman, 1990; Portes, 1998). Social capital has emerged in the literature as a valuable concept to help understand the inequality of status achievement based on social ties and access to resources (Lockhart, 2005; Putman, 2000; Schuller, 2007). In addition, the concept has been used to examine the unequal distribution of social resources within communities and across social networks that functions as a barrier to obtaining desired goals (Bourdieu, 1984; Coleman, 1990; Lin, 2001; Wuthnow, 2002).

Social networks are proposed to be the main source of social capital likely to profit individuals as adults. For example, as individuals become connected within their community, social relations within this community provide resources such as access to employment opportunities or social and health services (Lin, Ensel, & Vaughn, 1981). The relationship between the individual, community resources, and resources available from other social networks is part of what we call social capital. Social capital that results from relationships between individuals in the same community or network is called “bonding” social capital; whereas “bridging” social capital results from relationships across social divisions such as race and class (Lockhart, 2005; Schuller, 2007).

A robust association between social capital and health was found in an extensive literature review of international studies on the links between levels of increased social capital and better health, which was particularly strong in the United States (Islam et al., 2006). The literature suggests that the social capital concept also can be used to better understand drug use dynamics (Granfield & Cloud, 200l; Laudet & White, 2008). The concept of recovery capital, based on correlation between social capital and recovery of addiction, is used to predict cessation of drug use and sustained recovery (Granfield & Cloud, 2001; Laudet, 2008).

Social capital is sometimes referred to as the nature and extent of a person's involvement in informal and formal networks (Grootaert, Narayan, Jones, & Woolcock, 2004). Previous research suggests that these networks operate in conjunction to meet the person's needs. Informal networks are comprised of family, friends, and neighbors, while formal networks include community organizations such as schools, social service agencies, and healthcare systems (Shobe, 2009; Beggs, Haines & Hurlbert, 1996). According to Beggs, Haines and Hurlbert: "the receipt of informal support affects the receipt of formal support" (1996, p.11). A higher level of involvement in formal and informal social activities may lead to fewer negative health behaviors such as substance use (Finch & Vega, 2003).

Networks have functional and instrumental components (Vaux, 1988). Networks including relatives, kin, and friends can provide instrumental support, such as transportation, small loans, or places to stay (Briggs, 1998). Drug-using networks, though, can result in negative social capital (Wacquant, 1998). Physical and emotional risk-taking, stigmatization, and self-defeating behaviors are associated with resource allocation from drug-using networks (Rose, 1998). In addition, drug users and their social networks may utilize sub-optimal medical services, so although services may be utilized, the quality and effectiveness of use is variable (Boeri et al., 2011).

Prior research suggests that financial resources are associated with health-related behaviors (DiMatteo, 2004). Quality of life measures include individuals' perception of health, physical, psychological, and social functioning and well-being, as well as position in life, and expectations in the context of the culture in which they live (Laudet, 2011). The fact that people who are not well off have shorter life expectancies and more illnesses than the rich reveal that differences in health that are not only a social injustice but also highlight the social determinants of health (Wilkinson & Marmot, 2003). As long as lack of education, low job skills, lack of sustainable employment, and restrictions on geographic mobility stay in place, their social mobility prospects will continue to be dim (Luck, 2004). Difficulty occurs when tearing away from the sub-culture community in pursuit of upward mobility. For example, facing the loss of subculture support was found to be a barrier for sex workers creating new lives for themselves, leaving them more isolated from healthy forms of support (Trulsson, 2004).

Women more than men drug users suffer from the impact of social capital loss and negative social capital (Anderson & Levy, 2003; Bourgois, Prince, & Moss, 2004; Sterk, 1999; Wacquant, 1998). Women using drugs face double stigmatization by a society that accuses them of violating gender role expectations, especially if they are mothers (Boyd, 1999; Campbell, 2000; Dunlap & Johnson, 1996; Ettore, 1992; Sterk, 2000). Older female drug users also face narrowing social options and are more marginalized in society than their younger peers (Boeri, 2013; Anderson & Levy, 2003; Rosenbaum, 1981; Sterk, 1999). Moreover, poor substance abusing women are found to have scarce resources within their own networks (Mulia, 2008). Marginalized female users can experience a loss of social access, which is needed to pursue new social contexts (Anderson, 1993). Ultimately, when MA-using women are not receiving access to needed resources, these experiences also act as barriers to their social well-being and mobility. While studies have examined the association between social capital and well-being among disadvantaged drug-using populations

(Knowlton, 2005), there is scant research on social capital dynamics among disenfranchised drug user populations living in the suburbs.

The aim of this paper is to examine how low-income MA-using females in the suburbs access needed resources. We examine need areas including housing, legal assistance, education, employment, medical care, dental care and drug treatment. We investigate the processes involved and specifically how social capital resources are employed, using the women's subjective accounts verified by our own ethnographic fieldwork. This study advances our understanding of the social and contextual impact on social capital attainment and how this affects access to resources among this group of marginalized female drug users.

METHODS

Between 2009 to 2011, thirty active and former female methamphetamine users participated in this study, drawn from the suburban counties around a large metropolitan area in southeastern USA. Participants were recruited using a combination of targeted, snowball, and theoretical sampling methods (Glaser & Strauss, 1967; Strauss & Corbin, 1998; Watters & Biernacki, 1989). The majority of the 30 participants were recruited through targeted ethnographic fieldwork. Some referred their friends to call our study number, resulting in 11 additional participants. Based on our developing theory of recovery trajectories, we also recruited three former users with recovery experiences. Active users were defined as having used methamphetamine at least one time in the past month. Former users were defined as having used the drug for at least six consecutive months in the past but having been drug-free for the last month. 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. For this study they also had to be female. A consent form was read and agreed to before collecting data. In order to protect the anonymity of the participants, we collected a signed consent form that was not linked to the study data. Only the researchers on the study knew their identity and contact information. Participants were reimbursed for their time and given the choice of cash or gift certificate. Reimbursement for participants has been shown to be ethical and useful in collecting research on hidden and stigmatized behaviors (Wiebel, 1990). The researchers' university's Institutional Review Board approved the study methods and design.

A screening process was used to ensure that participants pass the eligibility criteria to participate in the study. Screening consisted of asking questions about age, drug use in the past 30 days, use of methamphetamine in the past six months, and the county where the potential participant resides. Interviews were conducted in a safe location agreed upon by the interviewer and participant; these included the interviewer's car, the participant's home, motel rooms, private university rooms and library rooms. Participants were offered food during the interview, such as pizza and soda or snacks.

The research team for this study included two female co-investigators who conducted the first interviews and focus groups interviews, and two female research assistants who helped with the focus groups, a few of the follow-up interviews, finding resources the women needed, data management and analysis. All research team members completed the NIH web-

based course on *Human Participant Protections Education for Research Teams*. Using ethnographic methods, we conducted fieldwork that involved finding field sites, distributing fliers, and talking to anyone interested. During the day we walked the streets of suburban towns or drove through subdivisions and trailer parks located in the suburbs. In the evening and night, we frequented bars, clubs, and 24-hour diners. We often employed a community consultant who was a person familiar with the drug using networks and could introduce us to insider settings.

The final sample consisted of 31 women but only 30 were used in this data analysis, which was conducted before the last participant was interviewed. Among the 30 women in the sample, 26 are white, 2 Latino, and 1 African American. One woman reported to be American Indian. The youngest woman was 19 and the oldest was 51 years old. A little over half (17) were active users of MA. All active users were low-income and the majority were unemployed, under-employed or employed in illegal work. The majority of former users were unemployed or being supported by relatives.

We collected data at three points in time from the same participants: (1) a first face-to-face interview; (2) a follow-up in-depth interview that was conducted face-to-face or on the phone; and (3) a focus group interview. Participants chose to join a focus group or conduct the second or third follow-up interview alone. Among the 30 women in the study used for this analysis, 5 were interviewed once; 9 were interviewed two times with an average of 5 months between interviews; and 16 were interviewed three times with an average of 7 months between the first and last interview. This represents less 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). We had a higher attrition rate by the third interview, which was largely impacted by the number of women who became homeless and left the suburban communities in search of shelter. Sixteen women participated in one of the six focus groups[*].

We used a longitudinal design in this study in order to examine changes over time. The first interview incorporated four data collection instruments: a life history matrix, a drug history matrix, a short risk behavior inventory and a semi-structured, audio-recorded, in-depth interview. The life history matrix, completed with pencil by the interviewer, is a research tool designed to focus the participants on retrospective life events during the in-depth interview. Conducted at the start of the study, this matrix data collection allowed the interviewers to develop rapport and established an additional validating strategy (Bruckner & Mayer, 1998). The interviewer then collected data on a drug history matrix with pencil. The drug history included information on first use of each drug, past six months use, past 30-day use and routes of administration. The risk behavior inventory asked about the drug and sexual risk behaviors such as syringe and condom use. In addition, we provided healthcare and medical information of drug use health risks and a list of social service resources in the area. The first interviews lasted about two hours. Participants were reimbursed $30 for their time.

[*]A seventh focus group conducted was not part of this analysis.

For the follow-up interviews, we updated the drug use matrix and risk behavior inventory and conducted a short qualitative interview, specifically to see how they used the resource list we provided. An updated healthcare, social services and drug treatment resource list developed by the research assistants was given to each participant, targeted for her specific needs. Follow-up interviews typically took about one-half hour. Participants were given $40 cash or gift certificate for their time. The increased amount was to encourage them to conduct the follow-up interview. Immediately after the focus group was completed, the participants met individually with the researchers or research assistants to update the matrices and were asked privately about their access and utilization of service resources. The women were free to discuss topics of interest to them as well. Since the data used for this paper are derived primarily from the focus group interviews we provide more details on this data collection.

The focus groups consisted of two, three or four women who typically did not know each other. We used participant's study number or a pseudonym, if they desired. We started with introductions and then conducted an ice-breaker exercise aimed to explore accessibility to risk awareness and utilization of social services and healthcare providers. The exercise consisted of placing a number of cards on the table with the names of health and social services taken from the list we provided to the women in the first interview. Women were given colored cards to place on the resource. Each card coincided with a response as to whether the resources was needed, used, or not used. Immediately after the game we discussed why certain cards were put on each resource. For example, if a resource was needed but not used we asked why not. If a resource was needed and used, we asked about the experience of accessing the resource.

We found the card game to be very effective and provided more than merely an ice-breaker. In fact, the women became so engrossed in identifying the right card that much discussion occurred during the game itself. After the first focus group we included a different colored card stating, "I would like to talk more about this service," to ensure more focused discussion.

During the focus group we employed a semi-structured interview guide that served merely as a framework on which to maximize group discussion and interaction. Main questions included areas on recent health and HIV-related awareness, prevention experiences, needs assessment, use of the resource list, and experiences in gaining access to needed healthcare and desired treatment. Resources and approaches that were found to not be effective were discussed, and suggestions for better strategies were explored. Accessibility to public healthcare services and employment opportunities emerged as the major problems.

Refreshments were available either before or during the activity at a time when a break was needed. The entire interview was recorded and the qualitative parts were transcribed. Participants were given $40 in cash or a gift certificate for their time. All of the women stated that the focus group helped them, and they hoped their discussion could help others who had problems similar to their own.

We conducted six focus groups with sixteen women. A woman could only participate in one focus group and it could be on the same day as either the second or third interview. The reasons why some women did not participate in a focus group included (in order of importance): moved too far away from the research study area; difficultly finding a two-hour slot of free-time; or preferred to conduct their follow-up interview alone. In two cases, the women were incarcerated. In five cases, our team lost contact with women who were homeless at the time of their first interview or lost their homes during the course of the study.

Ethnography is a living and dynamic form of research. An unexpected aspect of our ethnographic study was the changing involvement of the researchers. Similar to “engaged ethnography” (Sheper-Hughes, 2004), while conducting our ethnographic fieldwork, we recognized our privileged positions and did not ignore the cognitive dissonance we felt due to the knowledge that we had access to what our participants needed. Fortunately, engaged action was fitting with of our study goal, which was to better understand the availability and accessibility of healthcare and social services in the suburbs, as well as barriers to these services. Instead of remaining distant observers of the social action we were investigating, we became engaged ethnographers by applying what we found to be beneficial for the women.

Our engaged ethnography led to applied ethnography, meaning that not only did we think reflexively about what we were doing while conducting research but we also applied the “tricks of the trade” we learned while being engaged with our research participants (Becker, 1998). Applying our knowledge and better resources to help the women gain access to services they needed, we discovered further barriers we would have missed if we had relied only on the women’s limited resources. One example illustrates this point poignantly. When we learned that an initial barrier to services was lacking a phone, and therefore not having a number to leave when the ubiquitous voice mail message asked for a number to return the call, we called the service while we were with our participants and left our own study phone number. Due to this engagement in the research, we subsequently learned that healthcare and social service staff typically failed to respond to our messages (thus confirming what the women who had phones told us).

We continued to apply the resources we had available. In another example, when no one returned our phone call at a women’s shelter, we called a professional friend who we knew supported the shelter financially and within an hour received a phone call from the shelter director. Her intervention eventually led to a bed in a shelter. However, when our study participant arrived at the shelter with her children, she learned that the house was located in a drug-dealing neighborhood with crack dealers on every corner. Reluctant to expose her children to crack dealers, she did not go to the shelter and instead accepted temporary shelter from a male friend, but not without further consequences. This obstacle of having to rely on “friends in low places” would never have been revealed nor reported had we not become engaged with overcoming initial obstacles to needed services (i.e., lack of a phone) and further applied our resources to ensure a bed in the shelter. The socio-economic-geographic barriers and the women’s viewpoints on shelters located in dangerous areas were very important findings in this study. Although we did not achieve helping the women (which

was not a goal of the research), we did achieve our research goal of understanding the complexity of challenges the women faced when trying to access needed healthcare and social services.

Interviewers wrote notes on their reflections of the interviews within 48 hours. As the data were collected, we compared the responses on the data to gain a clearer understanding of the phenomenon and to inform the continuing data collection and analysis. The in-depth interviews were transcribed word for word. Data analysis began with the first few interviews using the constant comparison analysis common in grounded theory (Charmaz, 2005; Strauss & Corbin, 1998). The qualitative data analysis program QSR NVivo was used for data and coding management. The research team conducted the initial coding and research assistants trained in qualitative methods helped with second and third coding. For this paper, the first coding was conducted by the first author and reaffirmed by the co-investigators. The codes focused on what the woman discussed regarding barriers to needed resources and, for those who were successful, how they accessed resources.

VALIDITY AND RELIABILITY

The interviewer notes, life histories and drug histories, in-depth interviews and follow-up interviews were used to triangulate analysis of the data using the iterative model (Boeri, 2007; Nichter et al., 2004). The iterative model of triangulating data throughout the study by comparing information collected from various sources, and addressing issues of validity and reliability as the study progresses has been shown to provide greater confidence in understanding complex information (Pach & Gorman, 2002; Rhodes & Moore, 2001). Although research show that drug users tend to report valid information in qualitative interviews (Rosenbaum, 1981; Weatherby et al., 1994), the addition of quantitative data collected in the drug history matrix and risk behavior inventory was used as a reliability and validity check for the qualitative data (Deren et al., 2003). Any inconsistencies found were further explored through an iterative process in follow-up interviews, field observations, and focus groups.

DATA ANALYSIS

Based on the analysis of the interview transcripts, field and interviewer notes, and focus group transcripts, 34 initial codes were created to identify needed resources, the most problematic services, and the barriers to accessing services. Codes were associated with restrictions initiated by the services and limitations on the part of the participants, which were verified by the researchers during efforts to link participants with the services. The services were categorized by resource type: housing; medical; dental; transportation; education; legal aid; employment; and treatment. The most problematic services needed, but not accessible, were treatment, medical, dental, and housing, which is consistent with other research (Lawinski, 2010; Thompson, 1998). Among the most marginalized suburban woman, problematic needs also included education, employment, legal aid, and transportation services. Barrier codes included lack of transportation; service fees, waiting lists, lack of communication, disqualifying criminal histories, service use caps, identification (ID) requirements, and fear of agency intervention with children.

During the follow-up interviews and focus groups we examined how many women accessed the services they needed. Participants who did not receive the needed service in a specific category were coded “Unmet Need.” If a participant accessed at least a resource in a specified need area, she was classified as having a “Need Met.” Discussion of these coded areas revealed that social networks provided or facilitated the majority of links to needed resources. This was a turning point in the analysis. Whereas previously we focused on formal or informal processes to provide resources, we discovered that some of the women accessed resources indirectly through family, friends, extended social networks.

Two network types, formal and informal, were first identified and coded based on whether resources came directly through a formal source, the service, or through an informal source, such as their social network. A third new category captured the process of accessing resources when mediated indirectly by a formal and informal network. The three processes employed by the women attempting to obtain needed resources included: (1) FORMAL-directly from social services; (2) INFORMAL-directly from family or close social networks; (3) MEDIATED-indirectly mediated involving help from extended social networks or other contacts, including researchers. We then assessed if needs were met or not met through these processes and examined the results. The findings are presented as positive or negative results for each of the three processes. Quotes are chosen that best represent the essence of what more than one woman expressed or experienced in her attempts to access needed resources.

FINDINGS

Whereas low-income women access needed resources through formal or informal process, our findings show that suburban female MA users often are not having their needs met through either formal service providers or informal networks. Instead, many needs are met through a mediated process between their informal social networks and formal social service providers and staff. The women mentioned barriers and risks for each type of process employed, and we found both beneficial and negative results for each, whether or not they obtained needed resources. As is common of qualitatively defined categories, the boundaries of our positive and negative codes are porous. As we will point out, although one result might appear positive, since the goal of gaining a resource was achieved, it may have been accompanied by immediate or potential risks to the women. For example, a woman might achieve making an appointment to a doctor at the cost of paying her neighbor gas money to drive her there, which further depleted her precarious financial situation, or worse, indebted her to the neighbor, who is typically a man. We placed the women’s reported experiences in the context of their social environments and social capital potential. For example, when a woman obtained her needed resource although there was a potential risk, it was coded as positive unless a negative incident resulting from this process occurred during the period of the study. Due to the overlap in how women used their resources to obtain needed services, and because it is not always possible to disentangle one type of method of obtaining resources from another (formal, informal, mediated), we do not provide a quantitative assessment of the way women accessed services. Instead we provide an in-depth qualitative assessment using the women’s stories as data.

FORMAL

POSITIVE—Examples of positive formal processes of obtaining help, while assumed to be the most realistic process since this is what social services were designed to do, were actually the most difficult to document in this study. In every instance where we heard a participant had obtained help directly through a health provider or social service on our resource list or elsewhere, further inquiry revealed that either informal help or a mediator was used in the process. In one case, a woman had been trying to obtain Medicaid to treat a health issue during her entire participation in the study (21 months). We learned that she was finally successful three years later, which was more than a year after the study ended, so we were unable to document the details.

NEGATIVE—Many of the women found barriers when attempting to access services directly. The most common barriers to accessing social services were waiting list, service use caps, criminal history, fee, ID restrictions, transportation, lack of communication device, and fear. Some women were referred to other services and given wrong numbers, got only voice mail messages, or were put on the service waiting lists. As one participant stated:

> They’re either not taking new patients, closed, there’s so many criteria’s that you have to meet if you can even get on their list. And if you get on the list, the waiting time is like six months to a year. By that time god knows where you are. You wanna give up; you wanna say to hell with it.

Some of the service providers appeared not to acknowledge or care that needed services were not provided, although a few seemed to have empathy. For example, when we attempted to access a shelter bed for one of our participants in a suburban county, the social service worker told us, “The people in that county are screwed,” referring to the homeless.

Fear of legal intervention and loss of child custody were real barriers for women with young children, and some stories we confirmed showed that accessing services directly resulted in a negative experience for these women. For example, mothers are required to undergo drug tests before accessing some services, and this resulted in unwanted intervention by public child protection services. Researchers observed no danger to child welfare, but some women were frustrated with the public agency intrusion into their lives. They viewed the required oversight as a loss of privacy rights and felt that family service agencies generally did more harm than good in their experiences. Emotional barriers such as shame, guilt, feelings of hopelessness, and learned cultures of racism also deserved closer scrutiny. A few women in predominantly white social networks feared using a shelter because there were “too many blacks” there. For them, the risks of violence at the hands of a male they knew were better than the risks of unknown people they had been taught as children to fear.

INFORMAL

POSITIVE—The women quite often turned to male assistance for their needs. Relying on male relationships tended to leave these marginalized women even more at risk. Yet sometimes, their trust in a male in their network produced positive results.

We were a little apprehensive when one of our first participants, who was homeless when we met her, started a romantic relationship with a man she met at a support group meeting. In a short time, the unmet needs we had identified in our interviews were met through the help of her new male partner. He gave her a car to drive to appointments, a phone to call out and receive calls back from the services on our resource list, and money for dental work, including full dentures. “If it weren’t for him, I’d be walking around with no teeth,” she told us. As more of her immediate needs were met, she was able to contact the legal resource contact we gave her to start the divorce paperwork that she had not been able to do for years. With her boyfriend’s help, this participant obtained more needed resources than any other woman in the study. Yet her complete reliance on one person leaves her at risk for exploitation, abuse or abandonment.

Another major inhibitor was transportation. “I didn’t have a ride” was a recurring reason not to make an appointment or keep an appointment at a social or healthcare service. Unless they lived on a bus line, which most did not, they lived too far from the service to walk and needed help from someone with a car. The only hope for most of the women, who were without cars, was someone in their network who had a car. As one woman who was in treatment said:

> That’s my main thing to get a job and get a car. I need a car. I’m just trying to get me a car because I feel so bad. My sister’s taking me to meetings. My sister’s taking me to doctor’s appointments.

Likewise, another participant described how a close knit female-using network obtains food from the store or a food pantry. “We help each other; if one gets a ride, they get food for the rest of us too.”

NEGATIVE—Having help from someone with a car was necessary for many woman to access needed resources, but what was particularly problematic for these women was when it came from potentially harmful situations, including exploitative friendships, abusive male sex partners, or broken family relations. In these cases, the woman was often in danger of being harmed or exploited, which was a chance they usually took. There were no direct harmful consequences during our study, other than a few who said that someone they had relied on to go to an appointment never showed up or came hours late. Yet we heard many stories of past negative experiences when relying on close relations, especially abusive partners.

Of all the areas of need, participants were most likely to obtain housing within their network. This put them at risk for domestic violence, instability, and increased drug use. For example, one woman explained, “The power was turned off in our house, so we moved in with our drug dealer’s boyfriend. We lived over there, and that’s when all the shooting up [injection drug use] really began.”

A young homeless female who occasionally stayed with her mom provided some more insight during her interview:

> She [mom] tried suicide, but it was a cry for attention. And me and her are like Thelma and Louise. We both are party animals, you know. It is better to stay away from my greatest demon." [Interviewer] "Do you have anyone who can help you?"

No, because you're a misfit. You're no good. When you got friends in low places, you stay low. Referring to herself, her mother and her friends, this woman's response was consistent with the emotional climate we found among other poor MA-using suburban females. They are often imbedded in social networks that have very little to offer, and their communities are isolated in poor areas away from social services, forcing them to further rely on the other MA-using relationships.

We observed repeated exploitation of our participants. For example one woman's former landlord was "helping" her by allowing her to stay in a trailer with broken windows, no working utilities, and dog feces inside. Researchers visited the site and found it to be completely uninhabitable. The same woman "lost" her only form of identification, a driver's license, which she was keeping at former employer's home for safekeeping. She did not report this person because she thought she might work again for her in the future, which she did.

A few participants told us about a landlord who overworked and underpaid them to clean and manage the trailer park in exchange for free rent in dwellings that were not fit for human living. One dwelling was a trailer in the hot sun with no shade and no air conditioning. The temperature gauge inside was reported to read up in the 90s during the summer. One of the females explained what happened if they slowed down in their work:

> He was angry for us not going to be a slave some more--cheap labor. He gets everybody to do it, you know. Gets that cheap labor; does it to this house--that house, everybody. We're going to have to stay there because we don't have no place right now.

Many of the women in one extremely poor and disenfranchised social network remained in contact with us through the cell phone of one participant. The females in this entire network made use of one single phone, which provided some hope for return calls from potential job offers, caseworkers, and financial assistance organizations. The women relying on this phone explained:

> These people [social service providers and employers] want a telephone number to call you back. And you get a recording. You don't never get to talk to nobody. I called; I didn't have access to a phone number for them to call back. But they acted like they would help me if I had a number.

The price, however, was the woman with control of the phone often took it upon herself to attempt to engage in conversations and provide questionable information about other participants when we called. We wondered how she answered the phone when potential help from social services or employers was on the other end.

MEDIATED

POSITIVE—Although the women reported extreme difficulty attempting to obtain direct help from either formal services or informal social networks, they seemed to have greater success when formal and informal social networks mediated services. One of the most debilitating barriers was that of obtaining proper identification (ID). As voting requires citizens to present ID, we expected this to be a minor problem. Instead it was the main reason some of the women were living on the street without services for years. For example, we acted as mediators for one homeless woman to obtain an official ID. With no home address, and all of her personal documents long gone, she had to use the dental records of her recent trip to a dentist (that we arranged for her) to first obtain a birth certificate in order to receive a copy of her driver's license that was stolen. In this case, we provided the mediation, but it took over a week, a photocopy machine, a fax machine, one of our personal credit cards, and the use of our institution's address in order to acquire her birth certificate from another state.

Another example of mediation came from an unlikely source. One of our participants had tried unsuccessfully to enter an inpatient treatment center and finally was accepted at the emergency room when she said she was withdrawing from alcohol and barbiturate addiction and suicidal. Although she was an alcoholic, she confided to us that only by saying she was suicidal was she sure they would take her for a short stay in the intensive detoxification unit. While she was there she met another patient in the unit who was empathetic to her story. In her words:

> I didn't have anywhere to go. I was headed for the woods. I was headed for the tent city in front of the shelter because I can't go back to the shelter for six months. Because once you are there and you leave, you can't go back for six months. That's not an option. So I called my friend that I was in the hospital with, and she got into this program. I said, 'I'm just calling to tell you that I'm not in the motel. I don't have anywhere to go. I'll be in the woods. I don't know what else to do.' She said, 'Wait a minute, let me call the director of our program. Let me see if I can get you in.' We played phone tag all afternoon, and I got in without a face-to-face interview on her word—because of my friend. I got on the bus, and she met me to take me downtown. I was really amazed that I got in off the street on the word of one of their clients.

This service was located in the city, and the network contact was made during a hospital stay and not a part of her close network. But because her new contact gave her a referral to this residential treatment facility for women, she was accepted. The program included long-term case management. By her last interview one year later, she was drug-free, working and planning to leave the facility and go to the next step of the program into a rental apartment. She remained friends with the woman she had met in the hospital and who had acted as her mediator.

An informal social support group acted as a mediator for another woman in our study. She lacked the fees needed for the General Educational Development (GED) registration. She told us in dejectedly:

> God, it's the most frustrating thing I've ever tried to do because it's [GED] something that's so necessary if you want to do anything with your life. And they make it so difficult to get it. It makes me sick to my stomach; there is no help. If there is help, I can't find it.

Subsequently, a contact she met through "Twelve Step Program" offered the financial assistance she needed. This was an example of help coming from outside of one's drug-using network.

NEGATIVE—Although mediated help was usually successful, problems could arise when social services were obtained from relationships outside the women's immediate social network, especially when it was from positions of power. Participants reported unethical practices of service providers who used their connections, although their intentions were often respectable. In one example of a negative mediation, a nonprofit director promised a set of dentures for one of the woman, saying he would make her "a poster girl" for the reduced dental services program he ran. When she arrived for her appointment, all she obtained for free was a consultation, with a dental plan showing she would need nearly a $1,000 to complete needed dental work. When asked why he did not do as promised he explained that he was: "out there trolling for money every day," and donations were dwindling.

In another example, a woman in the study overcame her fear of withdrawal and faced the threat of losing her children by attempting to enter a detoxification unit through the emergency room. Homeless, she finally obtained transportation from a male friend to a detoxification facility, only to be released 12 hours later. She later tried to take barbiturates to qualify for detoxification but was also denied long-term admittance. We intervened and called the emergency room only to be told that once stabilized, uninsured patients are legally allowed to be discharged. This failure of the social service system to connect an MA user, who also used barbiturates and methadone, directly with treatment resulted in this participant resorting to taking a dangerous combination of methadone and barbiturates to self-medicate and ease her discomfort with withdrawal.

DISCUSSION

Participants in this study were low-income women who used methamphetamine, although their greatest difficulties stemmed from poverty and not drug use. They tended to experience many psychological, social, and organizational barriers when trying to access needed healthcare and social services through formal processes. Additionally it seemed that many social workers treated participants in inappropriate ways, by hanging up on callers, failing to return their calls, displaying negative attitudes, and making disparaging remarks about them. Social research should investigate ways to resolve these negative attitudes and behaviors, particularly toward vulnerable populations.

When women experienced continuous barriers to accessing resources, they tended to rely on their social network for help. Informal network access to services increased their chances of successful attainment of these services. But these networks often had little social capital and sometimes failed to be of assistance or kept them embedded in a life involving exchanging

sex for services, exploitation, feelings of shame, and self-defeating behavior, all of which potentially ties them in a cycle of drug use and poverty. Relying on these tight network bonds, further binds the women to their MA-using networks. And for some poor female MA users, utilizing one's social networks to gain formal resources was not an option. They often place themselves at risk for injury, exploitation, and abuse at the whim of uncaring strangers, which reduces their chances of recovery and social mobility.

There were no significant differences between women who were active or former users of methamphetamine in their experiences of barriers to services or access to resources. The only significant difference in barriers to services found was among those who had been incarcerated and therefore lost most privileges to government services. We also found differences in access to resources among those who participated in social programs, such as 12-step or church groups, and therefore received help from people outside their immediate social networks. However, due to the lack of transportation, most of the women were unable to continue attending any type of social program that was outside their immediate geographic location. Except for a few of the younger women, all of the participants in the longitudinal study were in socially disenfranchised circles of family and friends who could offer little more than emotional support. As the woman who told us the illustrative quote used in title of this paper described so expressively, and to paraphrase here, when your friends and your family are in the same poor and marginalized situation as you, there are few resources available to help change your social-economic status.

Our study revealed that both formal and informal processes for obtaining needed resources resulted in positive and negative outcomes. Although this was a small study and no definite conclusions can be made, the mediated process of achieving resources appeared to be most successful. Whether the mediation involved close or extended informal networks with formal sources of help, the women typically achieved their goals along with increased social capital. We suggest further focus on mediated processes needs to be explored among poor drug-using populations. Models similar to mediated help for achieving needed resources already exist in case management that helps patients move smoothly through the healthcare system. Patient navigation, which is a form of nursing care individualized to each patient's needs was conceptualized by Harold Freeman specifically for poor cancer patients (Freeman, 2004). The patient navigation model was used successfully among pregnant women in drug courts (Holsapple, 2011). We suggest a similar model is needed to mediate healthcare and social service navigation for women with few social resources that involve their informal social networks.

LIMITATIONS

The limitations of this study lie in its small sample size and exploratory nature. Further research is needed regarding the processes we examined to obtain needed resources. Also, a larger study is needed to understand how some processes might be more harmful or successful than others. For example, reliance on family members or friends often include reciprocity that could put the women at further risk, such as the women who relied on unlicensed "rides" from neighbors with cars, who were usually men. In addition, mediation by informal groups (e.g., 12-step or church services) also demands some commitment to the

group, and women who have children to care for or lack transportation cannot always fulfill these commitments. We found that the failure to commit to these groups placed additional stress and guilt on the women, which is another area that needs to be further studied.

The present study does not claim to fully capture the daily challenges associated with unmet resource needs. For example, although we knew that not having transportation was a reason why some of the women stopped going to a 12-step support group or religious service as well as the reason for missing an appointment, they often did not mention this unless we asked specifically. Moreover, many of the participants did not want to discuss how many times a day they are negatively affected by other daily barriers, such as not having someone they could trust to watch a child, or not owning decent clothes to wear to church. These were sources of shame and further stigmatization that some of the women discussed, but others did not, and needs to be further examined. Finally, what we consider a barrier may be accepted as part of normal life. For example, as the women become accustomed to not having certain resources, they learned to live without them and may no longer consider having to rely on a neighbor as a barrier to services. They also felt that in comparison with some of the women in their social networks, they were better off. We often found that the women did not like to talk about their lack of resources and failures to access needed services because they did not want to seem as if they were complaining. Likewise, we acknowledge that our participants were perhaps less likely to mention positive outcomes of directly accessing healthcare and social services. Finally, our category of mediated processes is limited and involves primarily mediation conducted by members of the research team. However, we did not conduct the study with a mediated resource in mind; instead this emerged as a result of the analysis. The process of mediation applied by engaged researchers needs to be examined more thoroughly as a research topic in a future research study.

CONCLUSION

This exploratory study found that low-income suburban female MA-users are blocked by long lists of bureaucratic restrictions and other limitations from the formal social service network. Our data reveal that time after time, many female MA users in these southern suburbs remained unable to obtain basic resources from the social service and healthcare systems designed to help them. While bureaucratic inertia and apathy towards the needs of the poor is not a new finding, this is one of the few studies that looked at how disenfranchised women living in the suburbs with few resources access needed services. What we found is that many of the public resources available to women living in the cities were unavailable to women in the suburbs. When they resorted to getting help from their social networks, they remained anchored to marginalized members of disenfranchised communities with low or negative social capital, leaving little hope for a better life.

We know that social exclusion plays a large role in health disparities across the life course (Marmot, 2005), and that social services and safety nets for the poor have not kept pace with the increasing dispersion of the poor from the cities to the suburbs (Felland, Laeur & Cunningham, 2009). In a seminal article written in 1976, Syme and Berkman wrote “rather than attempting to identify specific risk factors for specific diseases …it may be more meaningful to identify those factors that affect general susceptibility to disease. Of particular

interest would be research on the ways in which social and familial support networks mediate between impact of life events and stresses of diseases outcomes (p. 27).” The medical field made long strides to incorporate the social determinants of health in research and practice since then. We suggest that today, rather than merely attempting to break down the barriers to access healthcare and social services, we instead identify the process by which the poorest and most disenfranchised are obtaining needed resources. Mediated processes were generally successful in our small exploratory study; however the consequences of mediation from different sources remains largely unexamined. Our findings suggest that mediated processes need to be incorporated into formal healthcare and social services, such as shown in the patient navigation care model (Freeman 2004; Holsapple 2011), and mediated processes using informal social networks need to be further explored.

The findings highlight the success of employing a type of research design that is actively involved with the participants in the study. Similar to what has been known by various names, including “participatory research” (Cornwall & Jewkes, 1995), “rapid ethnographic assessment” (Carlson, Singer, Stephens & Sterk, 2009), or “engaged ethnography” (Sheper-Hughes, 2004), the dynamic nature of our research produced an unintended *applied ethnographic* design. We found that as compassionate women studying women, we could not simply watch our participants struggle when some of the solutions to the challenges they faced were within our reach. By becoming engaged in the process, we applied our resources and found that structured mediation is needed. Our finding suggests that mediation should be incorporated more often as part of healthcare and social services. Moreover, mediation must take into account the challenges presented in suburban environments and especially for the suburban poor.

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