UNENDING MAZES: GENDERED INEQUALITIES, DRUG USE, AND STATE INTERVENTIONS IN RURAL APPALACHIA

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UNENDING MAZES: GENDERED INEQUALITIES, DRUG USE, AND STATE INTERVENTIONS IN RURAL APPALACHIA

Dissertation

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the College of Arts and Sciences at the University of Kentucky

By
Lesly-Marie Buer

Lexington, Kentucky

Director: Dr. Mary K. Anglin, Associate Professor of Anthropology

Lexington, Kentucky

2018

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ABSTRACT OF DISSERTATION

UNENDING MAZES: GENDERED INEQUALITIES, DRUG USE, AND STATE INTERVENTIONS IN RURAL APPALACHIA

Prescription opioids are associated with rising rates of overdose deaths and hepatitis C and HIV infection in the US, including in rural Central Appalachia. Yet there is a dearth of published ethnographic research examining rural opioid use. The aim of this dissertation is to document the gendered inequalities that situate women’s encounters with substance abuse treatment as well as additional state interventions targeted at women who use drugs. These results are based on ethnographic fieldwork completed from 2013 to 2016 and centered around one county seat in rural Central Appalachia. Data are ascertained through semi-structured interviews with women who have experiences with at least one of three types of substance abuse treatment offered in the area. Additional interviews were completed with program staff, institutional administrators, and community leaders. These data are supplemented with the collection of program documents, informal and follow-up communications, and participant observation in Eastern Kentucky communities, substance abuse treatment programs, and funding agencies. Social locations based on gender, income, access to quality health care, and place of residence contextualize women’s participation in illicit economies, entrance into and maintenance of drug use, particularly but not limited to opioids, and efforts to limit deleterious use. The state’s responses to drug use are manifested in these women’s lives through child protective services, incarceration, and substance abuse treatment. The sociopolitical and financial limitations on institutions often create instances in which policies exacerbate women’s marginalization. These policies are based on specific cultural understandings of women who use drugs, motherhood, Appalachia, and care. Women develop strategies, often based on care networks, to make it through these programs. Despite their navigations of marginalized and marginalizing programs, clients and institutional staff are materially and discursively constrained in their actions.

KEYWORDS: medical anthropology, Appalachia, substance use, gender, the state
UNENDING MAZES: GENDERED INEQUALITIES, DRUG USE, AND STATE INTERVENTIONS IN RURAL APPALACHIA

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For those who led me down this path, but are gone and sorely missed.

“I’ve learned something about times like these. In times like these you have to grow big enough inside to hold both the loss and the hope.”

– Ann Pancake, *Strange as this Weather Has Been*
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I wish to thank the participants in my study, may they continue to “Pray for the dead, and fight like hell for the living,” in the apt words of Mother Jones. I sincerely hope that all are able to find some sort of peace in this life.
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LIST OF ACRONYMS

AA (Alcoholics Anonymous)
ACADA (Adams County against Drug Abuse)
ACA (2010 Patient Protection and Affordable Care Act)
ADHD (attention deficit hyperactivity disorder)
ARC (Appalachian Regional Commission)
ASAP (Kentucky Agency for Substance Abuse Policy)
CHEK (Community Health Eastern Kentucky)
CMHC (community mental health center)
CPS (child protective services)
DADA (Douglas against Drug Abuse)
DUI (driving under the influence)
EKSAC (Eastern Kentucky Substance Abuse Coalition)
FDA (Federal Drug Administration)
GED (general equivalency diploma)
HUD (US Department of Housing and Urban Development)
KASPER (Kentucky All Schedule Prescription Electronic Reporting)
K-TAP (Kentucky Transitional Assistance Program)
NAS (neonatal abstinence syndrome)
MAT (medication-assisted treatment)
MCO (managed care organization)
NA (Narcotics Anonymous)
NPO (nonprofit organization)
ORT (opioid replacement therapy)
PTSD (post-traumatic stress disorder)
SAMHSA (Substance Abuse and Mental Health Services Administration)
SNAP (Supplemental Nutrition Assistance Program)
SSDI (Social Security and Disability Insurance)
SSI (Supplemental Security Income)
SSRI (selective-serotonin reuptake inhibitor)
TANF (Temporary Assistance for Needy Families)
USDA (US Department of Agriculture)
WIC (Women, Infants, and Children)
Chapter One

Weaving through the Mazes of the State: The Value of an Ethnographic Compass

Aspects of US opioid use remain widely misunderstood. Embellished narratives are born from preconceived notions of place, poverty, and the ingestion or injection of certain substances. Yet I do not think it is an exaggeration that it is difficult to find a family untouched by substance use in Appalachia or the US more broadly. The mixture of drug use as cultural spectacle as well as the very real pain associated with abuse drew me to this research. The media coverage of the region where I was raised enticed me to return home in an effort to better understand the complexities of where I come from. As I completed preliminary studies, I focused my dissertation research questions on how women talk about their experiences with substance abuse treatment programs in rural Central Appalachia. Most treatment in the area is regulated and funded by the state, giving an opportunity to examine how the state interacts with those characterized as both vulnerable and aberrant. Neither state institutions nor the people who inhabit them work within a vacuum. I thus focused much of my research on the political and socioeconomic contexts that situate those involved. In this ethnography, I aim to explore drug use and treatment by unpacking women’s stories of what it means to use, recover, and at times, relapse, within state institutions, care networks, cultural ideologies, and social systems.

Marginalized populations experience increased state surveillance as compared to populations that are economically and racially privileged. Yet state surveillance among and between marginalized populations differs. The women in this study qualify for and at times are coerced to use particular state services because of their gender, race, class, and
motherhood status. Through state and quasi-state institutions, the state offers services that are punitive, rehabilitative, and therapeutic. Women differentially find particular aspects of state programs helpful and harmful, indicating the need for a variety of programs. The vast majority of women agree that these programs are needed, but do not adequately address substance abuse or gendered inequalities. These programs are constrained materially and discursively by structural inequalities that are situated within neoliberal processes.

I focus on three treatment programs. All local program, county, and individual names in this dissertation are pseudonyms. Statewide program names and the names of agency directors or politicians making public claims are not pseudonyms. I refer to the first treatment program as “Horizons.” The Horizons program provides intensive outpatient substance abuse treatment along with case management to approximately 110 women a year in my field site. The program is located within the nonprofit non-governmental community mental health center, Community Health Eastern Kentucky (CHEK). Horizons was created in an effort to address substance abuse and child maltreatment. Child protective services (CPS) refers the vast majority of clients to Horizons because women who use substances are at risk of losing permanent child custody. The second program, drug court provides intensive outpatient substance abuse treatment along with case management to women and men who have had their criminal cases deferred to drug court. The drug court I focused on served nine women during my fieldwork. Lastly, buprenorphine programs are located at private clinics that vary dramatically in what services they offer and how many clients they have. All clinics in
my field site prescribe buprenorphine with naloxone to women and men. They have drug testing as well as behavioral modification components.

All three of the currently available substance abuse treatment programs in the study counties are regulated by state or federal governments and are dependent upon government funding streams, whether through direct grants or Medicaid reimbursement. Yet there are fractures between programs, particularly in regards to buprenorphine. Some agencies, gatekeepers, and treatment program clients view buprenorphine as just as harmful as illicit drugs such as heroin. They thus do not support the use of buprenorphine. Other agencies, gatekeepers, and treatment program clients view buprenorphine as therapeutic and a harm reduction strategy. Women are often placed in the middle of this conflict.

The lens through which I examine women’s narratives is informed by intersectionality, which provides a means of analysis that avoids glorifying or demonizing individuals or places as homogenous, fixed, or inherently pathological (Collins 2000; Daniels and Schulz 2006; Harris 1990; Mullings and Schulz 2006; Weber 2006). I take seriously suggestions to examine how various domains, from the structural to the disciplinary to the linguistic, engender oppressive material realities as well as opportunities for resistance (Collins 2000; Wolf 1999). In this chapter, I provide a theoretical framework for this dissertation drawn from anthropological examinations of the state, of our current economic system, and of health policy. Appalachian studies offers understandings that root the current project in a particular, albeit not unique, place.

I want to make clear throughout that women do not encounter broad trends homogenously or without action. Women differentially experience oppression and
privilege due to their unique social positions (Abu-Lughod 1990; Butler 1993; Collins 2000; Crenshaw 1991; Crenshaw 2012; Harris 1990; Weber 2010). They thus face divergent opportunities as well as consequences to actions. The main pathways women utilize to successfully navigate the unending complexities of drug use, institutions, and marginalization involve forming close alliances with friends, family members, and other women in treatment. These alliances often involve intense care work and at times erupt violently. Nonetheless, they are an avenue to resistance and change. By examining these strategies, I build on anthropologists’ conceptualizations of agency as a means to cope with and challenge socioeconomic inequalities and state intrusions (Aretxaga 2003; Das and Poole 2004). Agency involves knowledge production and the development of survival strategies, yet individuals remain limited insofar as their strategies are tied to unequal power relations and access to resources (Collins 2000; Gunewardena and Kingsolver 2007; Maskovsky 2001; Mullings 2006). Drug use itself may be a constrained survival strategy. A focus on women’s survival strategies and their constraints reveals the inequalities women navigate, contests depictions of certain women as incapable of knowledge production, and provides a platform to make systemic changes in social services and treatment programs.

Notes on the state

States are not monoliths with uniform effects, but represent cohesive and conflicting forms that differentially affect segments of the population using particular techniques. States exercise governance through multiple programs that “manage” populations without necessarily addressing needs or changing the structures that produce
inequalities (Aretxaga 2003; Crenshaw 2012; Das and Poole 2004; Davis 2004; Lyon-Callo 2004; Raffaëta and Nichter 2015; Weber 2006). The state enters these women’s lives through a number of pathways, including through carceral, therapeutic, and rehabilitative institutions. While political discourse and research around substance use encourages a spread of therapeutic and rehabilitative services in order to replace the carceral, carceral technologies nonetheless bleed into the therapeutic and rehabilitative or the therapeutic and rehabilitative may only be offered in prisons (Campbell 2000; Cunha 2014; Viterbo 2016). The state’s use of rehabilitation and therapy is problematic as governance is often enacted to not just heal, but to reeducate according to elite ideals that may be impractical for non-elites (Steveson 2014). Notwithstanding the issues with state provision of rehabilitation and therapy, relinquishing these aims can be more harmful. When states exclude segments of prisoners from rehabilitation, for instance, then the prisoners are less often paroled and more likely to lose any benefits, such as education (Viterbo 2016).

State policies often intensify inequalities. Since the 1970s, the US government has used the War on Drugs and stereotypes of social welfare recipients as “unworthy” of aid because of presumed drug use to justify reductions in government welfare spending. Punitive drug policies are targeted towards poor people and people of color, creating a situation in which the US has the highest incarceration rate globally (Gillmore 1999; Gordon 1999; Huling 2002; Maskovsky 2001; Mullings 2003; Roberts 2012; Schneider and Schneider 2008; Wacquant 2009). Alternatively, state policies may respond to vulnerability and fund programs that women advocate for, such as substance abuse treatment. Yet such programs have mixed effects on women’s lives (Dahl 2007; Rai
2008). For instance, programs may provide wanted counseling services, but may require women to work in low-wage jobs that women find undesirable. Due to these complexities, the current study answers the call for more research on the “how and why” of state policy implementation in local contexts to reveal the layers of governance embedded across various institutions (Jaffe 2013; Raffaetà and Nichter 2015). State interventions that do not address larger social patterns ultimately represent certain populations as pathological and exacerbate the harm done by structural violence (Daniels and Schulz 2006; Farmer 1992; Hedges 2015; Mullings and Schulz 2006).

How state surveillance is targeted and the ways in which people interact with specific state programs reflect histories of inequality based on gender, class, ethnicity, and geography (Aretxaga 2003; Das and Poole 2004). Individuals’ inclusion in culturally and historically marginalized populations influences health and health care by shaping socioeconomic conditions as well as representations utilized in political mobilization, state interventions, and constructions of the self (Collins 2000; Das 2008; Mol and Law 2004; Mullings and Schulz 2006; Schulz et al. 2006; Weber 2006; Weber 2010). Some populations may be deemed wholly violent and thus the state’s suppression or expulsion of these “ever-present enemies” is viewed as ridding the nation of rot (Aretxaga 2003). At the same time, in the midst of austerity measures (Raffaetà and Nichter 2015), people attempt to use their vulnerabilities to demand rights in the form of state funded health care and social welfare services (Biehl 2006; Koch 2013; Trundle 2011). Individuals are required to document their marginalization and trauma to make claims on the state for these programs (James 2010; Petryna 2010a). Clinicians and administrators become gatekeepers of services as they have the power to approve this documentation (Petryna
Rights discourses are perilous because they allow situations in which the rights of groups are pitted against one another (Morgan and Roberts 2012). The rights of children are seen to conflict with those of parents, where children are viewed as “innocent” victims and parents as possible criminals (Krause and De Zordo 2012; Viterbo 2016).

State surveillance is gendered. In our society, through reporters, commercials, movies, and a litany of additional sources, women are dichotomized into “good” and “bad” mothers based on social locations of class, ethnicity, place, education, and religion. State policies have made determinations over which reproductive practices are “respectable” or “pathological” in order to regulate and pathologize women “who challenge dominant American trends and ideologies around childbirth” (Craven 2005, 195). Ideal US motherhood is defined by white, middle-class, heterosexual, norms of respectability where women are supposed to place fetal health above all else. Good mothers should be “sexually virtuous, self-sacrificing, nurturing, and drug-free” (Bourgois and Schonberg 2009, 207; Flavin 2009; Oaks 2000).

The state’s use of biopolitical governance techniques is fundamental for these women in this study as they are caught in mazes of institutions that attempt to configure their reproduction and caregiving strategies. Political theorists such as Thomas Robert Malthus have long analyzed populations, whether viewing high fertility as hampering the success of the poor or as a prerequisite for capitalist growth based on surplus labor (Krause and De Zordo 2012). Through these analyses as well as innovative monitoring techniques, the body and life itself is opened to politics (Foucault 1980; Rabinow 1984; Rose 2007). The state utilizes expert knowledge and moral regimes to regulate bodily norms. Moral regimes consist of the privileged standards of morality in terms of such
values as care that are used to govern reproductive and sexual bodies (Morgan and Roberts 2012). Individuals may both internalize and modify norms, indicating the various roles the state has in people’s lives but also contestations of state intrusion (Krause and De Zordo 2012; Singer 2017). Women’s reproduction in particular is held to be under the purview of the state because women are responsible for reproducing children who will protect the nation and for caring for the bodies of all family members (Craven 2005; Das 2008; Goodwin 2011; Krause and De Zordo 2012; Rose 2007; Singer 2017; Whiteford and Vitucci 1997). The term reproductive governance refers to the ways in which governmental, quasi-governmental, and non-governmental organizations, enact biopolitics through legislation, financial and physical coercion, and moral arguments to monitor and control reproduction (Ginsburg and Rapp 1995; Morgan and Roberts 2012).

Due to the perceived unique relationship between women and children, the state makes women who are mothers eligible for particular services and simultaneously places all women under suspicion for harming children. Although access to substance abuse treatment is particularly limited in rural Appalachian Kentucky (Leukefeld et al. 2007), state agencies advocate treatment as an alternative to the states’ permanent removal of children from women who use drugs. Through these efforts to keep mothers and children together, women who have children may be eligible for programs that are not available to men or women without children under the age of 18. Some women want to be involved with treatment and thus view access positively, even if it is state mandated as a diversion from incarceration or child removal. Yet other women experience state mandated treatment as coercive and intrusive and comparable to incarceration or child removal because the state is controlling their behavior.
Despite calls by medical providers and epidemiologists to end alarmist reports and policies regarding prenatal drug exposure, women’s reproductive rights may be suspended because all women, whether pregnant or not, are seen as possible vectors for the spread of neonatal abstinence syndrome (NAS) or fetal alcohol spectrum disorder (FASD) to their newborns by using drugs or alcohol while they are pregnant. These conditions are often exaggerated and assumed to produce costly, disabled children who are burdens to families and society (Flavin and Paltrow 2010; Hedwig 2013; Knight 2015; Paltrow and Flavin 2013; Reagan 2010; Singer 2017; Stewart 2016).

The exact effects of maternal substance use, particularly opioid and methamphetamine use, on long-term child health outcomes remain an open question. To date, few longitudinal studies have been conducted to address this question, and it is difficult to parse the effects of prenatal drug exposure from other factors that affect neonatal, child, and maternal health (Kaltenbach et al. 2018). The latter include poverty, homelessness, state violence, and interpersonal violence. Prenatal opioid exposure can lead to NAS in neonates and may negatively affect some child health outcomes. For example, in their review of available studies, Behnke and Smith (2013) show that prenatal opioid exposure is associated with long-term effects on behavior, but there have been no documented long-term effects on physical growth. The most recent research on the effects of opioid exposure on neonates through age three shows no poor effects of opioid exposure at age three (Kaltenbach et al. 2018).

Some studies have found that cocaine and methamphetamine exposure negatively affect neonatal health by increasing rates of prematurity and low birthweight (Behnke and Smith 2013; Oro and Dixon 1987; Smith et al. 2003; Smith et al. 2006). In one data set
that has been analyzed by various groups of researchers, prenatal methamphetamine exposure was associated with anxiety, depression, and attention-deficit hyperactivity disorder problems in children aged three to five (LaGasse et al. 2012). Reporting on this same data set, Smith et al. (2011) note that methamphetamine exposure was associated with poorer fine motor skill performance among one-year-olds, but all effects had disappeared by age three. Yet these studies do not control for some confounding factors that could be important, such as housing status, food security, and parental incarceration (see LaGasse et al. 2012; Smith et al. 2011). Another analysis of these data suggests that serious negative neonatal health effects are not due to methamphetamine exposure, but to confounding factors, such as lack of prenatal care and poverty (Shah et al. 2012). Much remains unknown about the effects of maternal drug use on long-term child outcomes and how these effects interact with experiences of structural and interpersonal violence. A mythology that stereotypes pregnant women who use drugs, especially poor women and women of color, and blames them for harming children and society has nonetheless emerged.

Policy makers, media sources, and CPS workers focus on individual drug use and ignore the effects of structural inequalities, such as housing instability and poor nutrition, on the health of women, infants, and children (Flavin 2009; Flavin and Paltrow 2010; Knight 2017; Whiteford and Vitucci 1997). Women who use drugs and are under state surveillance through the criminal processing system and CPS are more likely to be poor, sick, physically abused, and to lack prenatal care (Goodwin 2011; Roberts 1997). If women are in jail while pregnant or are incarcerated because they are pregnant women who use drugs, they are exposed to the generally violent, overcrowded environment of
correctional facilities where there are few if any health care resources (Flavin and Paltrow 2010; Goodwin 2010). Policies that separate fetal from maternal health treat women as risks to the fetus, dismiss the complexities of women’s experiences, and ignore the efforts that women have made throughout time to take care of their own health as well as the health of fetuses and children (Flavin and Paltrow 2010; Oaks 2000; Reagan 2010). Further, efforts to constrain reproductive rights are rarely applied evenly across a population, with poor women and women of color facing the harshest infringements (Morgan and Roberts 2012; Singer 2017).

Epigenomics is one of the more recent innovations that has, in some cases, intensified biopolitics. Epigenomics is the study of epigenetic modifications, or alterations due to mechanisms other than changes in DNA, on cellular genetic material (Lock 2015). Epigenetic research can be used to combat festishization of DNA and genes, but, at the same time, may be used to further disentangle bodies from social and political contexts in order to blame undesired behaviors on faulty biology (Lock 2015). Some epigenetic research focuses exclusively on the intrauterine and young childhood environments, placing the locus of change on pregnant women and new mothers and families to implement healthy behaviors and limit possible risks (Geronimus 2013). This focus may promote state programs that target pregnant women for behavior changes that are unattainable in their social environments, invariably producing maternal frustration and reiterating belief systems that blame poor mothers and families for poverty (Geronimus 2013; Lock 2015). Epigenetic research risks individualizing inequalities as simply a product of problematic familial and personal behaviors that can be changed with education and market-based approaches instead of the state encouraging population-wide
programs, such as reduced incarceration and more investment in equitable economic development and infrastructure (Geronimus 2013; Lock 2015).

**Quasi-state institutions**

The provision of substance abuse treatment in Appalachian Kentucky reflects current politico-economic trends of partially privatizing social services where governments fund, and in the current study, mandate some clients to attend programs that are implemented locally by quasi-state institutions. In the current study, this partial privatization does not signal a retreat of power, but rather a blending of the state with civil society (Wies 2013). I intentionally use the term quasi-state institutions here instead of the more common non-governmental organizations (NGOs). While some of the programs I examine may consider themselves NGOs, I question the accuracy of the term. All of the treatment programs I discuss are privatized to varying degrees, but all are solely or primarily funded by the state. Federal and state policies heavily regulate all of these treatment programs. The degree of program engagement with the state shifts in intensity in terms of funding and regulations. Some institutions are for profit while others are non-profit. Programs and their staff are thus beholden to corporations or board executives as well as state bureaucracies. NGO or quasi-state program ideals may differ fundamentally from the state (Kingsolver 2012). These fractured loyalties lead to frustrations among staff who often feel lost in miscommunications between the multidimensional bureaucracies. Clients are at times trapped in competing organizational agendas and may be unsure of who is an ally as they attempt to make their way through programs. With multiple sources of power influencing programs, it becomes unclear who
is responsible for which decisions. With inconsistent and at times conflicting leadership, staff and community members are often quick to solely place the blame of program failures onto clients.

Institutional practices often serve as methods of surveillance that attempt to regulate and alter women’s behaviors (Craven 2005; Dewey 2014; Ginsburg and Rapp 1991; Martin 1987). In their entrance into treatment, individuals are asked to accept a stigmatized identity of a drug user (Cain 1991). Therapeutic governance is enacted in treatment programs as the state intrudes in people’s lives through the provision of care in particular ways, based on treatment goals and implementation (Bourgois 2000; Carroll 2016; Hunt and Barker 1999; Hyde 2011). Programs often reify socially constructed gender roles by emphasizing the role of motherhood and demonizing mothers who use drugs (Carr 2011; Cox 2013; Hansen 2012; McKim 2008; Prussing 2007; Skoll 1992; Zigon 2011). Most treatment programs in the US are based on an Anglo-American middle-class Protestant culture that emphasizes self-control, spirituality, and personal responsibility (Frankel 1998; Prussing 2007; Skoll 1992).

In areas with strong and large faith-based communities, partial privatization of some social services has equated to Christianization and thus played to neoconservative agendas (Farmer 1992; Kingsolver 2012). Christianity is heavily pushed on drug users in these Eastern Kentucky communities, especially if women have experience with drug court or any of the regional inpatient facilities, which are all Christian-based. Christian centered discourses present treatment as a process of working on the self in order to remake a “moral personhood” that represents a new, more responsible community member (Hyde 2011; Zigon 2011:2). The allowance of a Bible-based program that is
mandated in a state funded and regulated program, such as drug court, reflects moral understandings of addiction among local judges and court staff.

Despite the governance enacted within these programs, communities and those who use drugs within them request additional substance abuse treatment services. Yet how treatment shapes women’s drug use and whether it meets women’s needs is unclear due to a dearth of analyses on substance abuse treatment for women, in rural areas, or for prescription drugs and methamphetamine (meth), which are the primary drugs of choice for most women in this ethnography. Quantitative data indicate that rates of relapse for those who complete treatment programs are high, but additional treatment effects have not been fully explicated. In one meta-analysis of post-treatment studies with a variety of US client populations, 40 to 60 percent of clients began using drugs within one year of leaving treatment (McLellan et al. 2000).

Treatment programs themselves face heavy surveillance and marginalization. Substance abuse treatment staff are situated in multiple discursive systems and may be heavily stigmatized for the services they provide (Harris 2015). They must frame programs in particular ways so they become politically and culturally acceptable enough to maintain funding and legal status (Agar and Reisinger 2002; Campbell et al. 2008; Carr 2011; Lovell 2006; Prussing 2008; Saris 2008; Zigon 2011). This framing may encourage programs to focus on remaking the individual, which prevents group solidarity, may not address women’s most basic concerns, does not change the environment in which women live, and ignores the association of drug use with increasing poverty and homelessness among women (Biehl 2010; Chavkin and Breitbart 1997; Morgen and Maskovsky 2003; Skoll 1992; Sun 2007; Singer 2017; Zigon 2011). When clients
critique social service programs, their living conditions, or service provider instructions, staff and other clients may dismiss these critiques as being emblematic of an individual’s noncompliance with program rules or denial of their addiction (Carr 2011; Lyon-Callo 2000; McKim 2008). Poor health or program outcomes can thus be blamed on individual lack of motivation or education (see Chiplis 2010; Krause and De Zordo 2012; Singer 2017; Smith-Nonini 2009; Whyte, van der Geest, and Hardon 2002).

While participants’ actions through these state funded programs should not be discounted, solely focusing on patient compliance serves to “pathologize the behavior of the poor” (Das and Das 2006, 171). Structural violence and poverty bleed through quasi-state institutions as workers and clients must contend with these issues outside of institutions (Kalofonos 2014). Programs exist within defunded spaces where they must operate spartanly to survive, which equates to decreased wages and fewer available services. In the end, organizations often lack the politico-economic power to change inequalities and are left to help people cope with inequalities (Kalofonos 2014; Kingsolver 2012).

I describe throughout how women are caught in frictions within and between state or quasi-state institutions, healthcare providers, and those who they care for and care for them. These spaces provide opportunities for resistance, but also space for harm, as women may be unclear as to what is considered “progress” through treatment. The women who are most successful in taking the least harmful paths through this labyrinth of institutions do so by forming or reforming relationships with others who are sober or only using drugs to a limited degree. Yet these relationships can be difficult to maintain. The complexities of these institutions and programs are important to understand. Not
only are quasi-state institutions ubiquitous in our world, but examining how program policies are actually enacted in a particular context gives insight into how these programs may fail or succeed (Harris 2016).

*Neoliberalism, care, and categorizing the poor*

Neoliberalism represents specific systems of domination that nonetheless have a long trajectory within the history of oppression. I write this to avoid alluding to a mythical past through critiques of the present. It is of importance to note, for instance, that social welfare programs have always focused most resources on white working males and their families (Dickinson 2016; LeBaron and Roberts 2010). For these data, I am interested in analyzing neoliberalism as an ideology and mode of governance that discursively and materially enters women’s lives. While the concept of advanced capitalism describes economic relations, I take the concept of neoliberalism to more thoroughly frame the organization of social, political, as well as economic relations between the state and its defined citizens; between global corporations, people, and the environment; and, between different sectors of society. Analyzing governance systems that create inequalities grounds research in pragmatic strategies for specific changes, rather than relying on understandings of forces as invisible, timeless, and unchangeable (Kingsolver 2012; Roberts 2012; Singer 1996).

Neoliberalism is in part comprised of processes that enforce surveillance of the poor and other marginalized populations while deregulating those in power. The state utilizes coercive techniques and auditing of individual behaviors through such institutions as private insurers, prisons, and social services to support self-regulation and limit
“unhealthy” risks. Risk is manipulated as a “political and moral construct” that may be overblown or undervalued for political needs that are tied to powerful dominant cultural constructs as much as or sometimes more than research that may subvert these constructs (Geronimus 2003; Kaufert and O’Neil 1993, 43). The state justifies spending reductions for safety net services through these techniques and emphasizes individualized private solutions, such as marriage, child support, adoption, high-interest loans, and low-wage work, as the only answer to social problems (Becker 2007; Crenshaw 2012; Jaffe 2013; Kalofonos 2014; LeBaron and Roberts 2010; Raffaètà and Nichter 2015; Roberts 2012; Wacquant 2009).

Work on the political economy of health and structural violence demonstrates that such processes as decreased government health spending and diminishing availability of jobs that pay a living wage underlie health inequalities (Becker 2007; Braveman 2012; Briggs and Mantini-Briggs 2003; Farmer 1999; Maskovsky 2001; Pfeiffer and Chapman 2010; Smith-Nonini 2009; Susser 2009). Structural violence is a system of exploitation where those in power prevent the marginalized from reaching their potential, in some instances causing death, primarily through inequitable resource distribution (Galtung 1969; Galtung 1990). Economic, political, religious, cultural, and legal social structures uphold these distribution patterns (Farmer et al. 1996). For example, most overdose deaths may be attributed to structural violence. These deaths could be prevented by an adequate distribution of resources where all individuals have access to quality employment, housing, and education and those facing addiction are able to seek quality substance abuse treatment and harm reduction services (e.g. access to medications that rapidly reverse overdose). In order to curtail negative health outcomes, systems of
exploitation must be worked against and the illness itself must be treated (Farmer 2005). When the state does not address structural violence, but solely focuses on limiting individual health outcomes or personal violence through such actions as incarceration or anti-violence education campaigns, then inequalities are upheld and violence is continued (Farmer 1999; Galtung 1969).

Structural violence bleeds through institutions, families, and care networks. Structural violence is partly articulated as an everyday violence that is experienced as shame, stigma, and physical harm or the threat of harm within interpersonal relationships. This everyday violence occurs in interactions with representatives of the state, creating distrust of state institutions among the marginalized (Farmer 1999; Scheper-Hughes 1992). Everyday forms of violence become normalized and commonplace. The poor and marginalized come to expect interpersonal, state, and police violence. Those in privileged social positions accept the existence of structural violence because they view the marginalized as deserving of suffering. The elite do not react against violence until it is occurring among the privileged (Scheper-Hughes 1992). In the current context for instance, public discourse about opioids, which is characterized as an ethnically white and middle-class drug, is more empathetic to users than is the rhetoric about crack cocaine, which has been characterized as a drug used by poor African-Americans.

The everyday violence with which those who use drugs must constantly navigate limits actions, where people knowingly take risks because there are either no other options or all of the available options pose risks (Bourgois 1998; Farmer 1999). A primary iteration of everyday violence in the women’s lives in this ethnography is domestic violence. Women’s strategies in dealing with domestic violence are limited
since the same relationships that produce violence, also produce care and support. Part of structural violence is depriving people of their ability to organize against their own marginalization (Galtung 1969). Yet women develop strategies to make it through. As structural violence comes into individual lives, care networks, and homes, it is often in these spaces where structural violence is confronted.

The institution of substance abuse treatment is rooted in neoliberal ideals of personal responsibility because “The notion of addiction is only meaningful in a culture where the self-control of individuals is valued above all” (Radcliffe and Stevens 2008, 1006). A focus on individual risk ignores the risks that women who use drugs must take to survive, such as desperate income generating strategies that may increase experiences of sexual and physical violence (Bourgois 1998; Epele 2002). Women’s gendered economic marginality may instigate involvement with illicit economies and limit the ability to cease deleterious drug use.

With gendered social roles, personal responsibility often becomes articulated as burdens of care for women cycling through programs. To be clear, I argue that women’s social positions, not some genetic predisposition, situate them in particular care networks (Tronto 1987; Tronto 1995). On the other hand, when they need support, women must place that burden on their family because care through state or quasi-state institutions may not be available. If women do not have a support system, it becomes difficult to navigate the labyrinthine assortment of state and quasi-state programs. Even mostly female lay workers outside the family who increasingly provide social services, from community health workers to peer support, generally face a lack of respect and remuneration, as do the programs in which they work (Collins 2000; Kalofonos 2014).
Due to structural violence, care provided by or to women is limited. Further, care is not uniform. There are a plethora of moralities that define acceptable forms of care within institutions, social interactions, and oneself. While these moralities often support one another, there are conflicts as well as subversions (Zigon 2011). In previous research that focused on active drug users rather than women’s encounters with substance abuse treatment, I document how women who use drugs are entrenched in intensive caretaking responsibilities and cycles of violence and care (Buer, Leukefeld, and Havens 2016). I thus take an expanded definition of care, an understanding that care is far messier than good intentions or positive outcomes and may be entwined with oppression (Stevenson 2014; Tronto 1987).

Receiving and providing care can be nothing less than joyous, but also tedious as well as emotionally and physically draining. Depending upon care from those who are obviously strained, whether family or non-family, may lessen individual’s feelings of worth and dignity (Biehl 2013). What feels like violence from the inside may look like care from the outside. I find this to be most typical when care is surveillance of behaviors, whether of drug use or which people one chooses to be around. The same act may feel like state intrusion when performed by a state employee, but may feel like care when performed by a beloved family member. Conversely, what appears to the outsider as violence may feel like a declaration of love or intense care from within. Violence can at times be a demonstration of care and solidarity, as when it is used against a mutual enemy (Karandinos et al. 2014). At other times, what looks like violence feels like violence, but that violence is as complex as the care with which it intertwines. The complexities of violence and care have been described among those who use drugs.
While women distinguish between sober and using companions because other users may pressure them to use drugs and women experience violence within using networks (Bezdek and Spicer 2006; Fast et al. 2013), there are nonetheless dangers outside of using networks that may be more feared, such as incarceration and isolation (Epele 2002).

The ideals of personal economic risks as well as private solutions to marginality, in the form of care networks, absolve the government and industry from creating viable economic environments. Neoliberal subjects are encouraged and expected to engender economic growth by taking risks in the market, which is seen as being equally accessible to everyone (Harvey 2007; Knight 2015; LeBaron and Roberts 2010; Maskovsky 2001). Yet critiques of this model aptly note that many do not have access to the free market, and certainly do not have equal opportunities (Kingsolver 2007). Risks that are deemed “unhealthy,” on the other hand, are penalized. Defining groups as having “heightened risk” opens these populations to biomedical intervention, as well as increased surveillance from numerous state and quasi-state institutions that attempt to manage “suspect” bodies. Through understandings of risk as well as the chronicity of conditions, social categories of marginalization become understood as biological risk factors that often reify gendered stereotypes, such as women as caregivers or victims (Hedwig 2013; Sweet 2015).

Like other systems of domination, neoliberalism’s ideological success is based on particular characterizations of marginalized populations (Susser 1996). The poor have been reductively framed as dependent, immoral, irresponsible, threatening, and thus unworthy of welfare (Feldman and Ticktin 2010; Morgen and Maskovsky 2003). Welfare reform targets poor mothers whose caretaking responsibilities and marginal status in the
workforce are no longer seen as legitimate reasons for their entitlement to state services (Kingfisher and Goldsmith 2001). The expanding reach of neoconservatism adds moral undertones to individual action as well; if someone does not take personal responsibility, they are morally failed (Harvey 2007). Supposed cultural differences can become a political tool to retract government funded health interventions because culture rather than resources becomes the explanation for health inequalities (Wailoo 2011).

With limited resources organizations depend on eligibility requirements. These requirements are often based on funding streams and those who are deemed too needy may be banned. Drug courts often do not allow individuals who lack personal transportation (Chiplis 2010). Along with this transportation requirement, Kentucky drug courts generally do not allow individuals with mental health diagnoses or unstable housing. Thus, large segments of the population, arguably the most vulnerable, are ineligible for services precisely because of their vulnerability.

Yet policy makers have deemed some populations worthy enough to receive at least minimal social services. The provision of these services nonetheless subjects people to governing technologies, particularly intense surveillance (Feldman and Ticktin 2010). These categories of who is punished and who is helped are raced, gendered, and placed in complicated ways that are at times made visible in particular situations or programs (Jacobsen and Lempert 2013). For instance, I do not argue these research participants are classified as homo sacer, “that which may be killed but not sacrificed,” or even deemed entirely unworthy of life and allowed to die (Agamben 1998; Das and Poole 2004). I do suggest the state’s management occurs not because women’s lives are portrayed as worthy, but because their white children’s lives are worthy. This population is intrusively
managed, but in terms of funding, barely addressed. If women do not have child custody, they may barely survive or die because their entitlements to resources such as substance abuse treatment, health care, housing, and food are drastically cut or eliminated. Thus, access to services is tied to whether women are seen as fulfilling their caretaking roles.

Both staff and clients in institutional settings are materially and discursively constrained in their behaviors, but nevertheless have the ability to navigate policies in various ways (Bell et al. 2017; Carr 2011; Faulkner-Gerstene 2017; Lyon-Calio 2008; Maskovsky 2001; Meyers 2013; Scherz 2011; Zigon 2011). For instance, in order to lessen their subjugation to state surveillance and, at the same time, access needed services, women must participate in discourses of eligibility where they perform in a series of roles that are at times conflicting. They must be victimized enough to need services, but adequately personally responsible to justify the use of resources. These performances are rooted in understandings of Appalachia that stereotype the region as ethnically white and thus racially privileged, but also as a region that is under suspicion for its poverty.

*Situating Appalachia as part of the US*

“Growing up here, you get the message very early on that your place is more backwards than anywhere in America and anybody worth much will get out soon as they can, and that doesn’t come only from the outside.” – Ann Pancake, *Strange as this Weather Has Been*

I did not go into this research expecting to have to address Appalachian stereotypes so bluntly. This has been done repeatedly. But when I spoke to people about my research, I became engulfed in questions about incest, poverty, and violence. Stereotypical portrayals treat Appalachia as an exceptional space in the US for a variety of purposes, from deflecting criticism of exploitive industries, such as timbering and coal,
to solidifying national identity (Billings et al. 1999; Mason 2005; Massey 2007; Scott 2010). Though it was first used to attack African-American families and communities in the Moynihan Report (Collins 2000; Maisano 2017), ideas from the “culture of poverty” have plagued Appalachia for decades. Current politicians employ “generational poverty” and “cycles of poverty” to bolster similar ideology. In sum, these ideologies hold that pathological individual, familial, and cultural practices cause poverty rather than any local, national, and global political and economic forces. Government subsidies for the poor are thus seen as exacerbating poverty by supporting pathological behaviors. The culture of poverty model has too many proponents, iterations, and applications to form a monolithic whole. People learn the model through various forms that may appear fragmented, but come together in different ways to influence understandings of the poor, work, and the ideal family. These ideas are continued in current scholarly and non-academic works on the poor and Appalachia as authors like J.D. Vance characterize symptoms of poverty as causes of the problem and continue to privilege an elite narrative (Maisano 2017; see Vance 2016).

A common stereotype of Appalachia is that local people are fatalistic, doing little to contest their marginalization (see Vance 2016). This supposed fatalism is a pathway through which to blame rural culture or individuals for health problems, instead of examining the conditions that produce these conditions (Farmer 1992). Yet there is individual navigation of marginalization in Appalachia (Amason 2015; Fletcher 2014) as well as long traditions of collective activism for such issues as labor rights, land rights, alternatives to extractive industries, and better health and access to health care (ALOTF 1983; Anglin 2002; Banks et al. 2013; Bell 2013; Dean, Gulley, and McKinney 2012;
Fisher and Smith 2012; House and Howard 2009; Kingsolver 1992; Scott 2010; Scott et al. 2005). If marginalized populations continue to partake in identities, acts, and ideas unshared by the mainstream, they continue to be treated as outside of a national society (Williams 1989). If, on the other hand, populations on the margins attempt to become more like the mainstream, they are often treated as followers and not meaningful creators (Williams 1989). As Appalachians are framed as either exotic or partaking in mimicry, they may not be understood as cultural producers in their own right. Through this pathway, state and non-state actors are able to treat the region as in need of intervention, but a type of intervention that cannot be rooted in or produced from the region.

Stereotypes about Appalachians as poor, white, uniquely violent, and particularly drug addicted underlie the creation of some substance abuse treatment programs. As early literature on Appalachia erased the presence of non-whites (Trotter 1990), all Appalachians continue to be racialized as white even though the region is ethnically diverse (Amason 2015; Anglin 2004; Mason 2009; Scott 2010; Trotter 2001; see Vance 2016). Although constructions of whiteness confer privilege in the US, including in Appalachia, Appalachian whiteness is nonetheless “marked” as representing inherited violence, antiquated consumption patterns, and sexual deviancy (Hartigan 2004; Massey 2007; Powell 2007; Scott 2010). Ethnicities and races are created. This creation requires a degree of mythmaking and generally has material motivations and rationalizations (Williams 1989). Race was rarely explicitly discussed in my fieldwork, but the stereotype that Appalachia is all white and rural played into people’s pleas for funding addiction treatment in the region. The discourse of Appalachia as a place that needs saving is raced, as Appalachians are presented as all white and in need. Unlike politicians’ expected
failure of some populations because they represent people of color (Stevenson 2014), Appalachians may be expected to succeed because they are presumed white. When individuals or communities fail, it is not blamed on their race, but on a combination of their culture and class. Appalachians’ failure as whites has historically created a national anxiety, especially among the white elite (Hartman 2012).

Media portrayals, government discourses, and public health organizations have utilized stereotypes to at times disparage and at other times glorify Appalachian women (Barney 2000; Becker 1998; Dunaway 2008; Engelhardt 2003; Goan 2008; Mason 2005; Tice 1998). In the current research, women’s place in rural Central Appalachia is seen as hampering their ability to become good mothers and citizens. Part of this characterization can be attributed to understandings of rights and of Appalachia as a place trapped in time. Women’s rights or reproductive rights often become associated with “personal choice” and are pitted against some “traditional” culture that is assumed violent and isolating to women (Singer 2017).

Appalachia is shrouded in a geography of blame (Briggs and Mantini-Briggs 2003; Farmer 1992). Rural Appalachia as a place is blamed for causing poverty, substance use, and violence against women. When urban areas are considered the norm, rural areas become coded as unregulated and incomprehensible. Health inequalities and inadequate health care are naturalized as typical of the geography rather than as resulting from particular socio-political processes (Briggs and Mantini-Briggs 2003; Farmer 1992). Culture and space may be conflated and framed as the causal factor of an epidemic. As humans and their environment become fused in regional imaginings, agency is lost. Both the space and those within it are assumed to lack the ability to change (Briggs and
Mantini-Briggs 2003). Since OxyContin misuse became widespread in the region, parts of the news media as well the medical-scientific community blame Appalachia for rising rates of prescription drug and opioid misuse across the US (Buer 2014). Presumed isolation, fear of outsiders, and dependence on government services, especially Medicaid, are taken as the root causes of prescription drug misuse by these sectors rather than Purdue Pharma’s unethical marketing strategies, limited funding for primary health care and mental health and substance abuse treatment, and industrial exploitation and disinvestment.

As every place and population, this is a complex region, and I hope that by documenting the political economic environment and a brief Appalachian history as well offering lengthy vignettes of women’s lives I am able to fully demonstrate this complexity in an effort to move past the assumptions. Appalachia’s isolation is overemphasized, at times to make the region appear more exotic or trapped in time (Billings and Blee 2000; Hutton 2013; Powell 2007; see Vance 2016). I give a brief history of the area in order to show how these counties, no matter how rural, are intensely connected to the global political economy. How else could have the prescription drug OxyContin marketed by a Connecticut company and the street drug methamphetamine manufactured with materials from China taken hold of some residents?

The Appalachian Regional Commission (ARC) classifies the vast majority of counties in rural Appalachian Kentucky as economically “distressed” (ARC 2016; Billings and Blee 2000; Chubinski et al. 2014; Singh et al. 2017). This is the worst category on a five-point scale and is based on unemployment, income, and poverty data (ARC 2016). The inclusion of greater numbers of global workers into the industrial
workforce has created an industrial shift out of the US (Susser 1996). The fact that economic insecurity was at the forefront of the 2016 national elections demonstrates that these issues travel beyond Appalachia. Yet it would be reductionist to assume all those with economic anxieties are the same; there are differences based on class, location, race, and thoughts on others (Walley 2017).

As in regions globally, neoliberal forces have encouraged corporate deregulation, nonunionized workforces, decreased wages, and increased pressure on individuals and families, especially women, to take responsibility for safety-net services. Currently, employment in the formal sector that provides a living wage and benefits is limited, especially for women (Amason 2015; Anglin 2010; Fickey 2014; Fletcher 2014; Hayes 2015; Kingsolver 2011; Smith 2002). Factory jobs in Eastern Kentucky rely on just-in-time production and flexible schedules that make it difficult for women to plan for childcare or their household finances (Hayes 2015). There is at times a cloud of grief or anxiety in some counties, which certainly presents itself in many of the narratives I explore. This is felt in communities globally where lands have been lost to development, extraction, or environmental degradation (Farmer 1992). In the words of Mrs. Taylor, an older woman in Ann Pancake’s (2007) novel who experienced the 1972 Buffalo Creek Disaster in Logan County, West Virginia and now lives below a mountain top removal site, “I try to stay off of the nerve medication…But this has turned into one nervous place.” This ecological disaster driven by greed and political ineptitude in many ways mirrors the health disaster that is prescription drug abuse.

I do not intend to glorify an industrialized past through descriptions of the present. While some in Appalachia have certainly prospered through time and wealth may have
been in some periods more evenly distributed, there have always been divides, as shown in the Civil War and post-war guerilla warfare as well as the labor conflicts in the early through mid-20th century (Hutton 2013; Lewis 2004; McKinney 2004; Scott 2010; Smith 2015). The polarized class economy that persists in rural Central Appalachia is rooted in a particular political economic context where white male elites, both from within and outside the region, controlled politics and utilized local, and at times state and federal, governments to protect their material interests from the 18th through the 20th centuries (Dunaway 1995; Hutton 2013; Pudup et al. 1995). Elite land speculation and monopolization in rural Central Appalachia beginning in the 18th century, including corporate absentee ownership, prevents economic diversification, drastically decreases local governments’ tax bases, and thus limits the construction and maintenance of infrastructure (ALOTF 1983; Billings and Blee 2000; Dunaway 1995; Pudup et al. 1995). The declining ability of subsistence agriculture to support the Appalachian Kentucky population, in large part due to soil depletion and land scarcity, lead to an underemployed labor pool that could be exploited as cheap industrial labor in Appalachia as well as urban centers to which Appalachians migrated. Political corruption created public institutions that could not effectively address such issues as economic stagnation (ALOTF 1983; Billings and Blee 2000; Hutton 2013).

When stereotypes of the region do not align with what people find, they owe this contradiction to previous state intervention in the area (Hutton 2013). The state does not have a monolithic presence in Appalachia. At times it has supported industry and elite interests, going so far as to remove indigenous, black, and poor white populations from lands as well as bombing workers in conflict with coal operators (Awiakta 1993; Boyd
2004; Dunaway 2008; Lewis 2004). Through the ARC, the federal government has invested billions of dollars in the region. Much of this spending has gone towards infrastructure such as sewer systems and broadband internet, but the ARC is a consistent funder of socially progressive programs, including those focused on media arts, drug use prevention and recovery, and community wellness (ARC 2017a). Yet humanitarian efforts are often linked to neo-colonialist “civilizing missions” that assume a universal humanity where urban, Euro-American elite are at the apex (Feldman And Ticktin 2010, 8; Spivak 1988). In Appalachia as elsewhere, Christian missionaries have often predated or accompanied state economic development endeavors as they are associated with social uplift and rehabilitation of criminals (Becker 1998; Hutton 2013).

At the local level, those working within state programs may follow state guidelines, or deviate from those rules in ways that help or harm participants. Local communities often fight or support the state in unexpected and seemingly conflicting ways that may have more to do with the local face of an elected official or program rather than state policies. While those in this five county area often expressed to me hostile feelings towards the government, sometimes this hostility was because they do not think the state is doing enough to curb substance use. These divergent feelings towards the state have a long history in this particular area, where arguments for law and order to cease illicit markets and substance use are cyclical, dating to at least the 19th century, when the media asked law enforcement to control alcohol sales and use (Hutton 2013).
The ACA and Medicaid Expansion

Health care reform is at the center of current debates in the US as to whether such programs as Medicaid are part of the state’s responsibility for its citizens or create a corrosive dependence upon the state (Bell et al. 2017). Health reform policies may be predicated on ideals of health coverage for all, but are often tempered by limited resources, reliance on private markets, and understandings of personal choice (Bell et al. 2017; Dao and Mulligan 2016). Thus, health policies are embedded in a complex web of politics that organizes the relationships between people, health care providers, health intuitions, NGOs, and governments (Dao and Mulligan 2016, 9). Examinations of contested health issues in a moment of policy change and turmoil offers a unique lens in which to view the zone between medical, legal, and political anthropology (Biehl 2013).

President Obama signed the Patient Protection and Affordable Care Act (ACA; HR 3590) in 2010. ACA expands health coverage to US citizens who previously did not have private health insurance, did not qualify for public health coverage under Medicaid, or were underinsured. States have increased health coverage in different ways, including expanding access to Medicaid and providing a marketplace to buy private insurer health plans (Dao and Mulligan 2016). ACA expands access to forms of health care that often were not covered by previous private or public plans. Substance abuse and mental health treatment are now deemed “essential” and must be included in some form (Cassidy 2013). Insurance coverage offered through ACA marketplaces and Medicaid must cover these benefits, but the requirements do not apply to health plans outside of these systems. If states offer benefits that extend beyond the essential benefits, the states and not the federal government must pay for the services (Cassidy 2013).
Individuals with incomes from 100 to 400 percent of the Federal Poverty Level are eligible for subsidies to purchase health insurance in Kentucky marketplaces (KCHFS 2013). Kentucky decided to implement Medicaid Expansion and to create its own state-based marketplace, “kynect”, as part of ACA, but it did not affect health coverage in the state until January 1, 2014. Kentucky Medicaid only covered substance abuse treatment for pregnant women and youths below the age of 18 prior to 2014. As of January 1, 2014, substance abuse treatment is covered for all Kentucky Medicaid members and those in ACA insurance exchanges (KCHFS 2013). This coverage has dramatically changed how Kentucky programs fund services.

Kentucky’s Cabinet for Health and Family Services supported Medicaid Expansion because they said it would lead to improved health outcomes, provide new local health care employment, and be cheaper to expand Medicaid rather than not due to federal financing of Expansion. One of the primary reasons they were concerned with Medicaid’s expense without federal support was due to new requirements for availability of substance abuse treatment (KCHFS 2013). Kentucky Medicaid, both prior to and after Expansion, is provided through managed care organizations (MCOs). Through kynect, Kentucky’s state-based marketplace, Kentucky had arguably the most successful ACA implementation. This success is due in part to strong marketing efforts, a state-based and streamlined eligibility system that determined both marketplace and Medicaid eligibility, and an expansive and varied network of enrollment assistance (Artiga et al. 2016).

Overall, Medicaid Expansion in Kentucky has had the most dramatic impact on health care in recent history. Kentucky has seen more health coverage, reductions in uninsured, and increases in health care access and utilization (KCMU 2016). Expansion,
along with mental health parity, has increased access to substance abuse treatment, especially buprenorphine. The 2008 Mental Health Parity and Addiction Equity Act prevents health insurers from imposing stricter benefit limitations on mental health care and addiction services as compared to medical and surgical services. The uninsured rate for opioid-related hospitalizations in Kentucky dropped 90 percent from 2013, the year before Expansion implementation, to 2015, the year after implementation. During this same time period in Kentucky, there was a 700 percent increase in Medicaid beneficiaries utilizing substance abuse treatment (Broaddus, Bailey, and Aron-Dine 2018).

Despite the success of kynect and the system wide problems with the federally supported marketplace, healthcare.gov, the governor elected in 2015, Matt Bevin, is transitioning away from “kynect” to “healthcare.gov” (Artiga et al. 2016). Governor Bevin, who campaigned on a platform of ending Medicaid Expansion, instead successfully requested to modify Medicaid Expansion in order to institute sliding scale monthly premiums, work requirements for adult Medicaid recipients, and up to six month coverage lock-out periods if an adult fails to renew their enrollment or to pay their premiums. There is also a removal of eligibility for non-emergency medical transportation to adults. Out of 462,000 Kentucky Medicaid enrollees, 95,000 are estimated to be disenrolled due to failure to pay or not meeting employment requirements (KCMU 2016; Musumeci, Rudowitz, and Hinton 2018).

Despite the ability of the ACA and Medicaid Expansion to increase health insurance coverage, in her work in Central Appalachia, Rebecca Adkins Fletcher (2014) notes that these efforts do not address expanded cost-sharing within insurance plans via deductibles and co-pays that often make health care unaffordable even when individuals
and families have coverage. Health insurance companies justify shifting costs to the policyholder by claiming that insurance coverage induces moral hazard, or unnecessary risk-taking and overuse of health care because the policyholder is no longer financially responsible for all medical costs (Dao and Mulligan 2016; Fletcher 2014). Health plans, both public and private, may not cover needed medical care, as seen in Fletcher’s (2014) Central Appalachian urban research site as well as the more rural setting of my fieldwork. There are often extra administrative duties and more restricted formularies associated with Medicaid as opposed to strictly private insurance plans, which may result in fewer providers who accept Medicaid (Bell et al. 2017). Further, some people are marginalized from the health systems for reasons beyond economic, transportation, or time issues. People on Medicaid and those who use drugs receive poorer quality of care, are more likely to have negative interactions with providers, and thus may avoid seeking care (Bell et al. 2017; Harris 2016; Room 2005). Overall, if health policies do not consider the factors beyond the individual that affect health and health care, including poverty and environmental degradation, then these policies will not effectively address health inequalities (Hedwig 2013; Inhorn and Whittle 2001; Janes and Corbett 2010; Krieger 2011).

In the context of the ACA, Kentucky passed another piece of state legislation in 2015 that has affected substance abuse treatment and harm reduction services. Harm reduction programs are meant to decrease the dangers associated with substance use by providing such services as syringe exchange programs, supervised injection facilities, and basic health services. SB 192, nicknamed the “Heroin Bill,” was passed in an effort to curb increases in opioid abuse and overdoses. Ten million dollars was distributed in 2015
and 2016 for substance abuse treatment, neonatal abstinence syndrome, and rocket docket, or rapid, prosecutions in controlled substance cases. The bill increases funding for ASAP to distribute monies to CMHC’s and jails to provide substance abuse treatment. SB 192 reiterates that Medicaid must cover services for substance abuse disorders, including residential and intensive outpatient treatment. It also changes what is allowed for reimbursement for peer-mentors when programs are in negotiations with managed care organizations. This reimbursement alteration has increased utilization of peer services. Lastly, pregnant women are given priority for substance abuse treatment. In 2016 in my fieldwork area, this bill had not resulted in increased accessibility to treatment, and statewide data are not yet available to speak to SB 192’s effectiveness.

SB 192 allows for some progressive measures, including a provision for local health departments to operate syringe exchange programs. Unfortunately for issues of over incarceration, SB 192 provides for stiffer criminal penalties for trafficking and drug paraphernalia (e.g. syringes, cookers). Those facing trafficking charges can now also be charged with homicide if drugs they sold aided in the overdose and death of a person. Penalties are increased for women who miscarry if the woman tests positive for drugs. She can then be charged with fetal homicide. Also in relation to women’s reproduction, a woman’s parental rights can be terminated if she tests positive for drugs during pregnancy, does not accesses prenatal care, and does not enroll in and remain compliant with a substance abuse treatment program.

Women’s marginalization directly influences their health. I conceptualize participants’ continuing encounters with inequalities and trauma, which are exacerbated by underfunded state programs, as what Arline T. Geronimus (2001) calls “weathering.”
Weathering moves beyond genetic determinism in analyzing the complex mechanisms by which inequalities become written in and on the body (Geronimus 2013). Marginalized women’s health progressively worsens and the gaps between health based on social locations often expand through the aging process as women face consistent stress caused by socioeconomic inequalities, lack of access to quality health care, intense caretaking work, precarious income generating strategies, and loss of family and friends to death and incarceration (Geronimus 2001; Geronimus 2013). The causal pathways between inequalities and health may be conceptualized as embodiment or, even more specifically relating to stress, allostatic load, whereby continued stress can result in physiological damage, such as hypertension and psychological concerns (Geronimus 2001; Krieger 2011). While in these positions, women are limited in their self-care strategies and one of the only available coping mechanisms may be substance use (Buer, Leukefeld, and Havens 2016; Fuentes 2011; Geronimus 2001). This is not to say that inadequate coping mechanisms are the cause of marginalization. Importantly, even coping mechanisms that the dominant culture considers “healthy,” such as time intensive work in the formal sector and fulfilling caretaking responsibilities, may exacerbate women’s stress and accelerate weathering (Geronimus 2001).

State services are spread unevenly across populations according to such social locations as class, gender, race, and place. Health care falls within these services. Health policies along with socioeconomic conditions contextualize women’s health. Within these constraints, women develop survival strategies that may get them through complex mazes, but not without damage to themselves or their families.
Organization of the dissertation

I discuss methods and ethical dilemmas in fieldwork in Chapter Two. I utilize analyses of the state, the political economy of the US and Appalachia, and health care reform to examine how our current economic system, ACA, and Medicaid Expansion are articulated in the five county area of Central Appalachia where I completed fieldwork. Through Chapter Three, I explore the networks of pharmaceuticals, illicit drugs, and replacement therapies in which women and their counterparts find themselves. Although these networks are expansive, crossing national, ethnic, and class-based lines, there are wide disparities between those who are simply fined for their network roles compared to those who are heavily sanctioned.

Having provided a broad background, I spend the remainder of the ethnography paying attention to the ways in which women navigate impossible identities, underfunded programs, and complex relationships. In Chapter Four, I analyze the treatment mazes in which women find themselves. Whether women more successfully navigate these mazes within which they find themselves or not is often predicated on the social conditions and care networks where women are embedded, which is explicated in Chapter Five. Issues of relatedness, reproduction, and interactions with CPS dominate many narratives, and I examine these in Chapter Six. I move to six women’s stories in Chapter Seven. I highlight these narratives, not as ultimate representatives of women in Central Appalachia or even the participants I spoke with, but as contextualized examples of themes that emerge throughout the stories I hear and see. I conclude in Chapter Eight with recommendations as well as pleas for further research and action.
Chapter Two:

Navigating the Familiar Unfamiliar: Political Economies of Home

My fieldwork takes place among women who are marginalized in an area that is impoverished materially but steeped in a rich tradition of theoretical ponderings from those across the disciplines as well as outside academia. Entering a field as contested as this, especially in my home region, presents a series of dilemmas that must be worked through. I situate my data collection and analyses within these contexts. The five counties in which my fieldwork takes place have trajectories that are differentiated based on such aspects as ecology, community power structures, and history dating back to at least indigenous removal and Euro-African settlement. While health care reform was implemented on statewide, population density and availability of health care institutions shape how reform is experienced locally. These shifts in place generate survival strategies that may differ from those utilized in, for example, more urban settings.

Entering the field

My decision to conduct fieldwork in rural Central Appalachia was in part based on the epidemiological course of prescription drug misuse as well as the lack of available treatment options. More importantly to me, I have an interest in Appalachia as an East Tennessean with an academic focus in Appalachian studies. I share some of the ambivalences about the mountains with the women I interviewed. I could not wait to leave when I turned 18, and could not wait to return almost as soon as I left. I located my dissertation fieldwork in Eastern Kentucky because at the beginning of research, I had a
working knowledge of the key organizations and health care providers in the local area due to previous research, which includes two projects conducted in 2011 and 2012. I completed 77 interviews with people who use drugs in a rural Appalachian Kentucky county located outside of the current research site. The first study found that prescription drugs remain the drug of choice in the area even after a reformulation of the notorious OxyContin and that particular social contexts surround misuse, such as high rates of occupational injuries and physical pain (Buer, Havens, and Leukefeld 2014). The second project showed how users are situated in social networks that are primary sources of financial and emotional support as well as violence (Buer, Leukefeld, and Havens 2016). Those studies do not focus on responses to drug use, as this ethnographic research does.

As part of preliminary fieldwork for the current research, in 2013, I spent several days at three women’s treatment facilities in Eastern Kentucky, one of which was Horizons. I interviewed 13 gatekeepers who work on substance use and treatment, including the regional administrator for Horizons. Horizons is a treatment program that became a focus of this ethnography. The additional gatekeepers administered drug court, opioid replacement therapy (ORT) programs, and behavioral health substance abuse treatment programs for either incarcerated or civilian populations at the Kentucky state level. I spoke with local treatment providers, law enforcement, and community activists in several Eastern Kentucky counties. These interviews are included in discussions of data from gatekeeper interviews. During this time, I volunteered at a shelter for domestic violence survivors that serves women and their children from Central and Eastern Kentucky. I also performed a content analysis of Appalachian newspapers regarding
prescription drug misuse and found that journalists and elected officials publicize prescription drug misuse as the primary problem for Appalachian Kentucky (Buer 2014).

Three women who have grandchildren the same age as my young children helped me gain entry into the community of Adams County. Doris is the local volunteer director of the non-profit organization (NPO) Adams County against Drug Abuse (ACADA) and a former grade school teacher. With one email and an explanation of my research, Doris encouraged me to come to all ACADA meetings and events, found me an apartment to live in through her family, and introduced me to numerous local political and church leaders and treatment providers. Sandra is a local pastor who organizes for churches outside of Appalachia to donate money, resources, and labor to building and rebuilding local people’s homes. She has been another friendly face at community events and gave my information to several participants of substance abuse treatment programs whom I interviewed. Finally, Gail was the director of operations for Horizons in 2013, but retired later that year. Gail introduced me to the Horizons’ staff in 2013. Although I did not see her once in person during my primary fieldwork, she told me to use her name to let other gatekeepers know she had referred them to me. I cannot overemphasize how important this connection has been. The mention of Gail’s name instantly made several respondents more comfortable not only with the interview, but with my presence in the community.

In terms of gaining entry to participants in treatment programs, the target study population, three additional women were key. Emily is the program manager of the tri-county drug court located in Adams County. Naomi and Jane are peer support specialists at Horizons. Both graduated from Horizons and are now paid staff who facilitate women
graduating the program. All three of these women gave program participants my information and briefly explained to them my research.

As I entered the field, my research was focused on Horizons. I quickly realized that many of the participants I spoke with also had encounters with buprenorphine clinics and drug court. Many women are sent to Horizons by other treatment programs as well. I thus decided to re-focus my research on the three local forms of substance abuse treatment for women: Horizons, drug court, and buprenorphine clinics.

*Knowledge sources*

Ethnographic data are from semi-structured interviews and participant observation in Eastern Kentucky communities, treatment programs, and funding agencies. These methods are supplemented by informal conversations, collection of local newspaper articles, and collection of local government, community organization, and treatment program documents that are publically available, such as program brochures. All research activities are centered in the place I refer to as “Adams County, Kentucky.” County names are pseudonyms. These counties have small populations, and I want to limit the negative consequences of this research to treatment clients, programs, and staff. I interviewed women in the surrounding Kentucky counties of Douglas, Teller, Eagle, and River because women often cross county lines to access services and most programs in the area serve multiple counties. The community mental health center (CMHC), for instance, provides programming to women in Adams, Douglas, Eagle, and River counties. Because there are no buprenorphine programs in Adams County, county residents generally drive to Eagle or River counties to obtain buprenorphine. All five counties have
a county seat where most services and businesses are located. Yet someone may live in Adams and regularly travel to the River County seat because they live closer to that town.

The combination of interviews and participant observation has allowed this research to move beyond quantitative analyses of treatment outcomes to reveal an in-depth understanding of the specific contexts that situate how women actively navigate state policies and inequalities, such as tenuous government funding for health services, and a program that may offer hopefulness and frustrations when dealing with difficult circumstances (Borneman and Hammoudi 2009; McGlotten 2012; Prussing 2007).

Focusing on women, particularly women utilizing programs generally targeted at low-income individuals, was a political decision to treat the experience of others, including women who use drugs, as legitimate (Hesse-Biber 2012; Nielson 1990). Focusing on rural women challenges “knowledge that excludes, while seeming to include” (Hesse-Biber 2012, 3), such as research on substance use that may lead to assumptions that urban males define all experience or that all women have generalized drug encounters, despite differences in social positions. Yet the aim of this ethnography is not to authoritatively “give voice to the voiceless,” but to highlight the ways in which women’s narratives reveal the circumstances in which their lives and actions are embedded (Anglin 2013).

I began my primary fieldwork in the early summer of 2015, which provided an opportune time to enter the community as the summer is marked by a series of holiday celebrations and festivals (see Table 2.1). These are free community events that provide easy entertainment on the weekends for families. Although I did not recruit any women for interviews at these events, they provided an easy talking point when seeing women at treatment programs. At one school event in Adams County, I volunteered to work the
ACADA table giving away school supplies. Overall, my presence throughout Adams and surrounding counties at these activities during the first few months made my face more familiar as fieldwork intensified, and allowed me to have dozens of informal conversations with people before I began interviews. State and local agencies often have tables at these events, and I used these moments to introduce myself to possible participants for gatekeeper interviews. Through these introductions, people encouraged me to attend other events, see other county sites, and even drove and guided me through forests as they explained to me their love for the place and visions for the future. These encounters removed any inclination to view Adams County or the region as a stagnant snapshot, something national and international journalists have been apt to do as photographs of abandoned homes are printed aside headlines proclaiming the area one of the poorest in the US. Instead, I saw the histories of the region written in the landscape and was drawn into various scenarios of the future, whether they included climbing a rock wall or learning how to kill, clean, and preserve your own chicken.

Most of my participant observation occurred at community events in Adams and Douglas counties, with program clients in their homes as well as public spaces, and at treatment programs. Although I performed participant observation in several counties, I focused my efforts in Adams and Douglas in order to gain a better understanding of a few counties instead of fragmenting my efforts across a region. I initially began observations at community meetings and events in Adams due to my previous relationship with Adams County Horizons and the warm invitation I received from ACADA to attend monthly meetings. The ACADA meetings are combined with local Kentucky Agency for Substance Abuse Policy (ASAP) chapter meetings. They are regularly attended by seven
to nine community members representing the school system, drug court, family court, the county health department, a local newspaper, CHEK, Eastern Kentucky Substance Abuse Coalition (EKSAC), and a public Kentucky university that provides funding to local organizations. I began attending the Douglas against Drug Abuse (DADA) monthly meetings, which generally have twice as many participants as ACADA and include more participation from parents of schoolchildren and the wives of law enforcement, who seem to represent their husbands for the purpose of the meeting.

Table 2.1. Types and counts of participant observation conducted, 2013-2016

<table>
<thead>
<tr>
<th>Type of participant observation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Completed in communities and treatment programs</strong></td>
<td></td>
</tr>
<tr>
<td>Community volunteering</td>
<td>16</td>
</tr>
<tr>
<td>Festival or local attraction</td>
<td>14</td>
</tr>
<tr>
<td>Local drug prevention coalition meeting</td>
<td>10</td>
</tr>
<tr>
<td>Tour of treatment program facility</td>
<td>7</td>
</tr>
<tr>
<td>State or regional economic development meeting</td>
<td>4</td>
</tr>
<tr>
<td>Drug court event</td>
<td>3</td>
</tr>
<tr>
<td>Local pastoral meeting or church service</td>
<td>3</td>
</tr>
<tr>
<td>Community education workshop</td>
<td>2</td>
</tr>
<tr>
<td>Local government meeting</td>
<td>2</td>
</tr>
<tr>
<td>State level drug prevention coalition meeting</td>
<td>2</td>
</tr>
<tr>
<td>Free dental care clinic</td>
<td>1</td>
</tr>
<tr>
<td>Job fair</td>
<td>1</td>
</tr>
<tr>
<td>Neighborhood reunion</td>
<td>1</td>
</tr>
<tr>
<td>Treatment program staff meeting</td>
<td>1</td>
</tr>
<tr>
<td><strong>Completed with treatment program participants</strong></td>
<td>13</td>
</tr>
<tr>
<td>Participating in everyday activities</td>
<td>6</td>
</tr>
<tr>
<td>Accessing local resources</td>
<td>2</td>
</tr>
<tr>
<td>Drug court programming</td>
<td>2</td>
</tr>
<tr>
<td>Attending parenting class taught by participant</td>
<td>1</td>
</tr>
<tr>
<td>Buprenorphine clinic</td>
<td>1</td>
</tr>
<tr>
<td>District court</td>
<td>1</td>
</tr>
</tbody>
</table>

Through ACADA, I met Sandra, who asked me to attend the Pastoral Association meetings in Adams County since their group wanted to provide substance abuse services.
In order to get an understanding of Adams County’s political environment, I attended city council meetings, and to gain a broader regional and state-level perspective, I attended a regional EKSAC meeting, state ASAP board meetings, and two ARC conferences on Appalachian health and economies in Eastern Kentucky and East Tennessee. While not the focus of this research, this ethnography is nonetheless informed by the work I have done in East Tennessee since leaving the field. My current position is focused on a variety of issues that affect health in Appalachia, from transportation to food systems and housing. I do some work around syringe exchange programs, increasing access to and success of substance abuse treatment, and hepatitis prevention in county jails.

Community members invited me to attend events that provided particular services, such as job fairs, dental clinics, and workshops for new mothers, and smaller community gatherings, including neighborhood reunions and evangelical revivals. I volunteered at two local food banks as well. Those observations, along with my own somewhat economically privileged experiences of buying food and finding affordable housing, gave me glimpses of the socioeconomic contexts with which women must contend. Rental housing is expensive and hard to find without personal connections. Women who lacked personal connections became homeless or lived in dilapidated conditions. Several women I spoke with paid at least $200 a month for a trailer with no electricity or running water and large holes in the flooring, ceiling, and walls. These encounters helped me think about how I wanted to focus my participation observation with women.

My observation of women’s lives outside treatment is somewhat limited. Many have active or recently closed cases with child protective services (CPS). Prior to every observation conducted with women, I read them a thorough consent form that
emphasized their ability to refuse any questions, their right to stop the interview at any point, and my duty to report suspected cases of child abuse or neglect. I read through this same consent form prior to every interview and secondary interview as well. Although all brushed off this disclosure, it created uncomfortable moments when women proceeded to spend the next minutes emphasizing how their homes are suitable for children and they are “good” mothers. Several interviewees showed initial enthusiasm for doing participant observation, but then never returned phone calls after I discussed my duty to report. This is not to say that there would have been anything to report had they participated, and I empathize with their wariness of any additional forms of surveillance entering their lives.

I completed participant observation with 13 women. I entered the homes of 11 women. Very often, I simply observed and helped as they completed everyday caretaking and household chores, including helping children with homework, running after toddlers on the playground, preparing food, cleaning, fighting with a kerosene heater, planning a summer garden, dealing with a litter of puppies, and enjoying nice weather on the porch at the end of the day. At other times, we scheduled specific activities, such as attending an open twelve-step group meeting, a class on parenting taught by a participant, a children’s Christmas celebration, a buprenorphine clinic, and district court. I spent one day driving a woman to multiple local food banks where we tried to figure out how she could survive on juice and seafood broth for two weeks.

My observation in treatment programs was restricted, due to administrators’ as well as my concerns over confidentiality. This was an obvious limitation but also forced me to focus on the places outside of the clinic where treatment interacts with everyday life or, in other words, the therapeutic “afterlife” (Meyers 2013). I toured treatment
program facilities at Horizons, drug court, and two buprenorphine programs. Horizons welcomed me to attend regional Horizons and CPS team meetings. These meetings were supposed to occur quarterly, but they were consistently rescheduled and only one meeting took place during my fieldwork. I became familiar with the Horizons location and room, but did not attend group meetings. As I got to know staff and clients, women often asked me to meet them for interviews in the Horizons lobby or in the outdoor smoking area. We would then find a private place for an interview. If women saw me around Horizons, they would often stop me to schedule an interview, follow-up interview, or participant observation. My only observation of buprenorphine clinics occurred in the lobbies when I was waiting for a client who brought me, Maggie, and when I was contacting service providers. Even with the legal regulations stipulating what I was allowed and not allowed to see, I was able to conduct the most observation at drug court. Drug court participants, the program manager, and the counselor invited me to observe two group meetings. I attended drug court graduation and a recovery rally for one of the women I interviewed. Although by law I was not allowed into drug court meetings with the judge, I did have a chance to attend district court, which is considered a public setting.

These participant observation experiences provided topics to be explored in interviews and helped situate the information provided by interviews in cultural contexts and social relationships (Agar 1996). Participant observation in the local community allowed me to examine aspects of the broader socioeconomic contexts in which women experience treatment and the services available to meet women’s various needs, including those for housing, food, and health care. In community meetings, I observed how local leaders, whether they were in county government, the county and district court systems,
or the school system, discussed national and state policy initiatives, including those focused on substance use. These conversations were fraught with particular understandings of rurality, Appalachia, femininity, motherhood, and poverty. They provided an important juxtaposition to women’s own narratives because it is through relationships with these local leaders that women experience the state.

Participant observation among women helped me understand interpersonal roles and strategies as they performed daily activities, such as household maintenance and caretaking (Mullings and Wali 2001; Pattillo-McCoy 1998). These everyday practices revealed how people navigated their health concerns, substance use histories, intimate and kinship relationships, housing and financial situations, and income generating strategies, as well as how these practices affected their current engagement with substance abuse treatment and additional state institutions. Through these research activities, I saw how program services and requirements often supported women while at the same time, undermining their efforts to maintain a life outside of the drug economy. For instance, women’s caretaking responsibilities and time-intensive engagement in treatment often prevented them from obtaining employment. However, the latter is often a requirement for certain phases of the treatment programs. Participant observation in treatment programs and staff meetings allowed me to better understand how program staff and administrators talked about women’s substance use and needs in treatment as well as how therapy, case management services, and drug testing were implemented.

This research abides by feminist research methods that frame interviews as occurring in specific contexts and thus resulting in a particular kind of knowledge that is coproduced by and often reflects the power relations between the researcher and
participant (Grenz 2005; Visweswaran 1994). I recruited substance abuse treatment program participants via flyers placed throughout the community in Adams and Douglas counties, in the Adams County newspaper, and in program facilities. I also recruited interviewees through an information sheet provided to clients by program staff and a presentation of my research project at the beginning of group therapy sessions. Snowball sampling was used to recruit additional participants. I gave my information to participants and asked them to pass the information to anyone they knew who was a current or former client. Snowball sampling not only allowed me to reach populations hidden from programs and program staff, but also shows how social groups form at treatment programs and through different counties and neighborhoods. For instance, I spoke to four clusters of women who all knew each due to geography or encounters with particular programs. Three women had attended drug court in Teller County together. I spoke to three clusters who had all been through Horizons, but one group lived in Adams County, one in Eagle County, and the last group resided in River County.

I interviewed 40 women who are over the age of 18 (see Table 2.2; see Appendix B for detailed description). All but three of the women identified as non-Latina white. The remaining three identified as biracial. At the time of my study according to staff, neither drug court nor Horizons were serving any women who identified as an ethnicity other than non-Latino white or biracial. Of the 40 total participants, 33 had experiences with Horizons, 17 with buprenorphine clinics, and 14 with drug court. All but two women had encounters with CPS. Half of the women live in Adams County, six each live in Douglas and River counties, five live in Teller County, and three live in Eagle County. Although women cited primary counties of residence, many moved between counties
based on their housing situation and sought services in different county seats according to preferences and conflicts of interest with local agencies. For example, a woman may be switched to another CPS county office if family members work in county agencies.

Interviews were semi-structured, audio-recorded with consent and transcribed, and occurred in a location of the clients choosing. The interviews lasted an average of 87 minutes. Several clients asked me to come to their homes, often because they lacked transportation. Others felt more comfortable meeting in, and had transportation to, public spaces. I paid clients $40 for each interview, which was meant to compensate women for their time and transportation. I noticed that this payment became, for a short time, a part of Horizon’s and drug court’s case management. Program staff saw the interview as an economic resource they could provide clients if the client wanted to speak with me. From what I witnessed, I do not think this caused staff to coerce women into this study. The payment may have encouraged women to participate, but I think the option of asking women to give me hours of their time for no compensation is more problematic.

I asked participants for contact information, if they consented, in order to locate them for secondary interviews three to six months after primary interviews. I interviewed 10 women for secondary interviews. Secondary interviews were generally warmer, less awkward, and less formal than primary interviews. At times women steered the conversation in new directions to pursue questions or topics they wanted to discuss in terms of substance use, treatment, or CPS. As a consequence, I had some of my most rewarding conversations regarding drug policies in these interviews. Though I followed up with 10 participants, I informally had multiple conversations with roughly half of the participants, generally when I saw them at Horizons. For six women, I saw them
repeatedly through my fieldwork, both through my formal research as well as stopping to chat when we saw each other in public or texting occasionally.

Table 2.2. Treatment program client characteristics, 2015-2016

<table>
<thead>
<tr>
<th>Characteristic</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of women interviewed</strong></td>
<td>40</td>
</tr>
<tr>
<td><strong>Treatment program experiences</strong></td>
<td></td>
</tr>
<tr>
<td>Horizons only</td>
<td>13</td>
</tr>
<tr>
<td>Drug court only</td>
<td>4</td>
</tr>
<tr>
<td>Buprenorphine only</td>
<td>2</td>
</tr>
<tr>
<td>Horizons and buprenorphine</td>
<td>11</td>
</tr>
<tr>
<td>Horizons and drug court</td>
<td>6</td>
</tr>
<tr>
<td>Drug court and buprenorphine</td>
<td>1</td>
</tr>
<tr>
<td>Horizons, drug court, and buprenorphine</td>
<td>3</td>
</tr>
<tr>
<td><strong>Housing status</strong></td>
<td></td>
</tr>
<tr>
<td>Homeowner</td>
<td>8</td>
</tr>
<tr>
<td>Renter</td>
<td>14</td>
</tr>
<tr>
<td>Homeless</td>
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<tr>
<td>Live with family</td>
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</tr>
<tr>
<td><strong>Highest level of completed education</strong></td>
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</tr>
<tr>
<td>&lt; High school or GED</td>
<td>9</td>
</tr>
<tr>
<td>High school or GED</td>
<td>14</td>
</tr>
<tr>
<td>Some college</td>
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</tr>
<tr>
<td>Associate’s degree</td>
<td>6</td>
</tr>
<tr>
<td><strong>Race</strong></td>
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</tr>
<tr>
<td>Non-Latino white</td>
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</tr>
<tr>
<td>Biracial</td>
<td>3</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>5</td>
</tr>
<tr>
<td>25-29</td>
<td>8</td>
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<td>30-34</td>
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<td>35-39</td>
<td>6</td>
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<tr>
<td>40-49</td>
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</tbody>
</table>

I completed 19 gatekeeper interviews in 2015 and 2016, for a total of 32 interviews completed between 2013 and 2016 (see Table 2.3; see Appendix C for detailed description). I recruited five CHEK staff, three drug court staff, and two buprenorphine program staff by asking if they would be willing to participate. I found it particularly difficult to recruit buprenorphine program staff, probably because the programs are under
intense surveillance from local law enforcement and media. I did find one local counselor willing to speak with me, but the provider I spoke with is based in an urban area outside of the field site. She nonetheless provides services to individuals in Eastern Kentucky.

I recruited 10 additional respondents based on my participant observation and interviews with program clients who were asked about the state institutions with which they had contact. I interviewed five local leaders from Adams County, including individuals in local government, at the county health department, and a former drug court judge. I made multiple attempts to recruit a law enforcement representative or a jail administrator, but was unsuccessful. This may be due to a local judge’s admonishments directed towards law enforcement for allowing inmates to attend court while intoxicated. Multiple legal cases were being brought against law enforcement and the jail for use of excessive force and not providing health care to ill or overdosing individuals who died.
Table 2.3. Gatekeeper characteristics, 2013-2016

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of gatekeepers interviewed</td>
<td>32</td>
</tr>
<tr>
<td>Gatekeeper organizational affiliation</td>
<td></td>
</tr>
<tr>
<td>Horizons</td>
<td>6</td>
</tr>
<tr>
<td>Drug court</td>
<td>6</td>
</tr>
<tr>
<td>Treatment provider outside of Horizons, drug court, or buprenorphine</td>
<td>3</td>
</tr>
<tr>
<td>Kentucky college/university</td>
<td>3</td>
</tr>
<tr>
<td>Buprenorphine provider</td>
<td>2</td>
</tr>
<tr>
<td>City/county government</td>
<td>2</td>
</tr>
<tr>
<td>County health department</td>
<td>2</td>
</tr>
<tr>
<td>CPS</td>
<td>2</td>
</tr>
<tr>
<td>EKSAC</td>
<td>2</td>
</tr>
<tr>
<td>State government</td>
<td>2</td>
</tr>
<tr>
<td>County housing authority</td>
<td>1</td>
</tr>
<tr>
<td>Kentucky Department of Corrections</td>
<td>1</td>
</tr>
<tr>
<td>Time at position&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>2</td>
</tr>
<tr>
<td>1-4 years</td>
<td>2</td>
</tr>
<tr>
<td>5-9 years</td>
<td>5</td>
</tr>
<tr>
<td>10-14 years</td>
<td>5</td>
</tr>
<tr>
<td>15+ years</td>
<td>5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>32</td>
</tr>
</tbody>
</table>

<sup>1</sup>This measure was only collected for gatekeepers interviewed in 2015 and 2016, N=19.

I interviewed a bi-county and then regional CPS representative due to women’s extensive encounters with the agency. I spoke with the executive director of the Adams County housing authority that also provides monthly food boxes to low-income individuals. Due to women’s at times extensive experiences with religious settings, I formally interviewed three religious leaders, had informal conversations with a half dozen others, and attended several church services or events in Adams and Douglas counties. For one interview, I traveled a few hours away to another state in Central Appalachia to interview a woman whose name I continued to hear because she has been providing substance abuse treatment for decades in the area.
All 32 gatekeeper interviews completed from 2013 to 2016 were semi-structured, audio-recorded with consent and transcribed, and occurred in a location of the participant’s choosing. Interviews lasted an average of 64 minutes. Prior to every interview, I read gatekeepers a thorough consent form that emphasized their ability to refuse any questions and to stop the interview at any point. The purpose of these gatekeeper interviews is to provide multiple viewpoints on the broader socioeconomic and political contexts that situate women’s experiences. Gatekeeper interviews reveal how women who use drugs are viewed and how state policies are implemented. This information is not meant to override or supersede women’s narratives (Hesse-Biber 2012), but helps explain the multiple contact points women have with the state and the institutional practices and services women are navigating.

I collected or examined three types of documents throughout my fieldwork. First, I read archived newspapers and several histories of Adams and Douglas counties that were published by small county organizations and are housed at special collections libraries at the University of Kentucky. In order to stay current with news in the county, it was vital for me to read the two local Adams County newspapers, which also provided news from surrounding counties. Lastly, I collected program documents as I attended meetings and toured treatment program facilities. I thus have pamphlets, meeting agendas, and program forms from Horizons, CHEK, drug court, additional treatment programs, ASAP, ACADA, DADA, EKSAC, ARC, county food pantries, and city counsel meetings.
Analyses

I began data analysis in the field as I transcribed interviews and reread field notes. This data analysis helped triangulate data from interviews and participant observation so I could examine similarities and differences and discuss such comparisons in interviews (Agar 1996; Borneman and Hammoudi 2009). Emergent codes from the data, guided by the research questions and my theoretical perspectives (Patton 2002; Strauss and Corbin 1998), were used to develop the initial coding framework. All data were analyzed using the ethnographic analysis software program ATLAS.ti.

I initially coded the data line-by-line to examine general themes. I then organized coded materials into more specific themes according to the three research questions addressed by this study. First, I was interested in issues concerning state interventions in women’s lives. I organized data from female participants to analyze how the state funded treatment programs as well as additional state institutions met women’s needs and in some ways perpetuated their marginalization. I further organized data to examine how state employees talked about women in these programs, how the treatment programs were implemented, and the financial and political constraints placed upon programs.

Second, I sought patterns as to the primary intersecting inequalities that situated women’s experiences, such as unemployment and physical violence, how women’s encounters with treatment affected these situations, and how these patterns affected women’s needs in treatment. Finally, central to my analysis are comparisons of women’s survival strategies. I organized data to examine how women talked about navigating identities, substance use and treatment, socioeconomic contexts, and interactions with state institutions. These examinations lead to broader understandings of how individuals
experienced a state funded program, how the state engaged with institutions and citizens, and how contexts based on the intersecting processes of gender, class, ethnicity, and place may affect health and treatment.

_Dilemmas_

Words matter. This is not a revolutionary statement. I want to explain my decisions and terminology as I attempt to limit the ways in which this research can be used as a form of surveillance and to advance policies that harm women. I find the terms “drug-using women,” “addicted,” and “women who use drugs” all problematic for those I spent time with. “Drug-using” for me is the most reductionist in defining women as first and foremost an embodiment of one stigmatized behavior. I thus limit usage of the terms. I do not consistently use the term “addicted” in order to highlight that some women in the current study explicitly do not identify as being addicted, are not labeled as addicted by their service providers, and are caught in state systems because of drastically varying levels of drug use. Yet I write the term “addicted” when I discuss other literatures where the authors and their participants explicitly use the term or when I write about the women I interviewed who described themselves in this way. Overall, I primarily employ the term “women who use drugs,” while acknowledging that this term may appear sanitized, divorced from material and political realities, and reifying a category based on one individualistic behavior (Garriot and Raikhel 2015; Knight 2015).

I take from those examining women’s imprisonment a shift in terminology from “criminal justice” to “criminal processing.” Their work and mine shows that the “just” qualifier is deceptive (Jacobsen and Lempert 2013). Although the vast majority of those
with whom I spoke refer to buprenorphine with naloxone as “Suboxone,” this is a brand name and not the most accurate term. Thus, I refer to buprenorphine with naloxone when I write “buprenorphine” because the vast majority of people who speak of buprenorphine are referring to buprenorphine with naloxone. If I am writing about buprenorphine that does not have naloxone, I make this explicit.

What to call study participants is tricky. The connotation of “informant” as someone who helps law enforcement in prosecuting others removes the usability of that term. “Key informants” appears to privilege some narratives over others. The term “clients” is fraught with reductions of individuals to the status of consumers of state services and of agency to the realm of consumer choice (Craven and Davis 2015; Steager 2015). I nonetheless use this term, especially in discussions of Horizons and buprenorphine clinics, because both those who attain program services and providers continuously say “clients.” I most often write “participants” and attempt to limit any confusion of whether an individual is a participant in my ethnographic research or a participant in a substance abuse treatment program. This term is also problematic in that it does not indicate the level of coercion most of these women feel as they process through these programs (McKim 2008). When referring to the group of service providers, administrators, local leaders, and researchers I interviewed, I write “gatekeeper” because I think this most accurately describes the power they wield over programs, policies, and knowledge production. To be clear, this power varies dramatically between gatekeepers and changes through time, even during the relatively short period of my fieldwork.

I make a note on sources here. I take from Lisa Stevenson (2014) an embracement of uncertainty, and at times knowledge from outside of academia lent more understanding
to women’s experiences. So much of being in a place, ingesting a substance, and caring for others is felt in a complexity of ways that cannot be easily translated through sterile language. Artists often create more fruitful methods of transmitting these moments of being. While I use few sources to lessen the feeling that this is simply a collection of disparate narratives, I draw from one novel more than others. In *Strange as this Weather Has Been* (2007), Ann Pancake pulls together the anxiety and hope I continue to witness in Central Appalachia. While Pancake focuses on mountaintop removal in West Virginia, there are parallels to the counties that I studied though they have not had coal ever or for decades. From my previous research in counties where coal mining is a more common occupation, I found there are certainly direct casual pathways between the injuries workers sustain in extractive industries and misuse of prescription opioids. I think the connections between mountaintop removal and drug abuse extend to the strain they put on individuals, families, and communities. Pancake has a way of making situations clearer by unearthing the complexities of many of those involved. She successfully illustrates the dynamics of structural violence through accounts about individual experience. Most importantly, Pancake reveals the messy ways in which people navigate structural violence in their daily lives that are not as polished or as seen as collective action. I attempt to do similar work here, though of course without the literary skill or eloquence of those I quote.

I attempt to self-reflexively explore which “values, attitudes, and agenda[s]” I bring to this research (Hesse-Biber 2012, 10). Following feminist research methodology, I agree that disinterested and positivist research is impossible (Haraway 1989). My location in Adams and surrounding counties and substance abuse treatment programs
certainly blurs the imagined boundaries between “insider” and “outsider.” As a white, Appalachian, woman in her early to mid 30’s, I share several important characteristics with the female participants with whom I spoke. I have personal stories of loss related to substance abuse that are in line with women’s stories. During my fieldwork, I was pregnant, and my growing belly provided an easy conversation starter with people, especially other pregnant women and new parents.

Despite these similarities, the chasm between our experiences due to differences in housing, access to food, transportation, and status with state systems created instances of frustration, embarrassment, fear, and mutual support. I agree that although the insider or quasi-insider ethnographer may have initial advantage in language or local common knowledge, we must unsettle assumptions, making the familiar unfamiliar, in order to reach an understanding of research questions that move beyond an insider status (Hammoudi and Borneman 2009, 271; Harrison 2007; Wagoner 2008). Furthermore, the gap between my experiences and the interviewees differs across participants and through time. In my fieldwork, I wove between speaking with treatment program participants, political leaders, community activists, and tenured academics. These jumps across social locations require me to move in and out of worlds and integrate multiple perspectives simultaneously, sometimes more successfully than others (López 2013).

Understandings of being an insider or outsider in part makes researching drug use contentious. Most people have some sort of experience with drug use, either personally or through family or friends. Experience has led some to develop intricate explanations of abuse that are difficult to articulate, while others become reductive in their logic. This simplification is understandable. These women’s stories and the stories of those who
provide services demonstrate the messiness and just plain exhaustion of drug abuse. Perhaps being able to reduce is therapeutic in its own right. Though understandable, simplification is not helpful. State agencies, state-funded programs, as well as community members may overlook and thus support the structures that produce the very behaviors they aim to fight. Who does get to be an expert? The ex-alcoholic preacher who has been counseling drug users for ten years and maintains that the devil sent buprenorphine? The woman in recovery who says she owes her life to buprenorphine? Or, the anthropologist who draws on her research and personal feelings of loss? I do not pretend to offer definitive answers to that here, but through explanations of my own position and the narratives I heard, hopefully I can offer contextualized insight.

Within treatment programs, I walked an uneasy line between staff and clients because I was neither. This balance, or lack thereof, has a presence in a spectrum of institutional research, including ethnographers in substance abuse treatment programs who struggle with identifying themselves as well as others identifying them as having particular program roles (Meyers 2013; Raikhel 2009). In order to enter these treatment programs, I had to first meet with administrators and earn approval through formal or informal processes. I came into the programs tied to high-level, regional administrative staff. My presence may have thus felt like surveillance to both local staff and treatment program participants. I initially had the strongest camaraderie with former clients turned paid staff members in the form of peer mentors and case managers at Horizons. I think this was because they also occupy a liminal space between client and staff. However, these relationships cooled late in my fieldwork due to two peer mentors and a case manager being terminated, which made everyone uneasy. Due to my overall friendly
relationship with peer support at Horizons and the program administrator at drug court, several clients told me that some women feared speaking with me because they did not want to threaten their status within the treatment program or possibly with CPS.

In Horizons and drug court, staff never seemed threatened by my presence. When I entered two buprenorphine treatment programs, staff treated me as if I was a form of surveillance, or as one of my participants said, they thought I was a “rat.” Since both the media and law enforcement have placed buprenorphine programs under intense scrutiny because they disagree with this form of treatment, this is not surprising. However, I was surprised when staff at a similar program to ACADA in Douglas County, DADA, treated me as a “rat” as well. Though some older individuals in the DADA meetings were friendly, the staff refused to speak to me. I never found out why.

A concentration on the harms drug use could have on children led to frustrations in my fieldwork when it seemed like every time I told community members about my research, they would ignore everything I said, and immediately begin talking about the children as “innocent victims,” in the words of the Adams Housing director. I hopefully hid my indignation well as I sat through a CMHC class on healthy pregnancies that explained that women needed to get help for domestic violence when they are pregnant, not because it harms women, but because it might harm the fetus. These were the only deep tensions I felt during participant observation. More minor tensions arose with gatekeepers as some disregarded questions I asked or critiqued my accidental use of vernacular I heard from treatment clients in interviews. An early gatekeeper interview went completely awry, for example, when I referred to buprenorphine as Suboxone.
With program participants, the tensions that arose with our interactions revealed differences in our social positions and my own understanding of what it means to use drugs and have addiction concerns. Program participants assumed I would be uncomfortable meeting in their homes and often apologized for their housing conditions or dogs’ excitement. I was rarely uncomfortable in these situations. Yet when I did feel uncomfortable, I was embarrassed by this feeling, and linked it to societal stigma placed on the poor and drug users, particularly female drug users. Looking back, I think I should have felt uncomfortable when I did. The instance that stands out clearest in my mind was when I was supposed to meet a participant at the Douglas courthouse for our second interview. She called and said she would be late. She then drove up with an older man, and told me to follow her to his house. I obliged the request and became increasingly nervous as we drove further from town, ending up at a remote farm with a few other men in the driveway. I followed her into the living room, the others in the house removed themselves to an out building, and we spoke for a few hours. I became relieved after a few moments. During the interview, this participant relayed her deteriorating relationship with her mother, who worked at the courthouse. She did not want to meet at the courthouse because she did not want to see her mother. This was not the first or last time I found myself in the middle of complex relationships.

These tense and sometimes fearful situations never led to harm to myself or those whom I interviewed as far as I know. I further realized my privileged position where I used women for their stories. At the same time, I became for a short while incorporated into women’s survival strategies. Participants could ask for rides and gain compensation for interviews. Several women asked me to go with them to attain resources, from jobs to
grocery boxes from food banks. In these situations, I provided moral support, but I also looked like an authority figure to program staff who were gatekeepers to resources. Ultimately, I think I played a somewhat contradictory role. In some ways I was an arm of these treatment programs, but in others, I was a co-conspirator in navigating these programs as well as the inequalities that situate women’s lives.

In Adams County, I at times became an unwitting intermediary between people who use drugs and those who said they wanted to help provide services. Women told me they desperately wanted a local Narcotics Anonymous (NA) style group, and I relayed this information to local church leaders when they asked what they could do to help. I realized this intermediary position was complex and fraught with uncertain fault lines as I attempted to advocate for services women ask for without supporting the negative assumptions and stereotypes local leaders make. In the meeting with church leaders, they dismissed the request for NA, and instead said they wanted to have a Bible-study for those who use drugs because they agreed drug use is a spiritual and moral problem. When I told several women that the church leaders were going to offer a Bible-based support group rather than NA, they were disappointed and said they would not attend.

Unfortunately, I exited the field full of concern as Adams County attempted to deal with several murders apparently revolving around drug trafficking. Within the small community, most people knew both the perpetrators and victims. Experiencing or witnessing trauma in the field can clarify the structural issues that underlie violence and blur constructed boundaries between victims and perpetrators (Maternowska 2006). I heard from several community members and through local newspapers that the primary assailant was a young person who had experienced a life of early and prolonged abuse,
had not graduated high school, and was unemployed and homeless at the time of the murders. One of the lessons of this research has been the importance of documenting the multiple and intricate repercussions of structural violence, where people suffering from economic inequality and physical abuse may, in turn, harm others.

*The five counties*

The five county fieldwork site is more rural than Kentucky or the US, and is decreasing in population through time with massive out-migration that has been documented for decades (ALOFT 1983; US Census Bureau 2017). The population density was just 34 persons per square mile in 2015, compared to Kentucky’s 109 and the US average of 91 (US Census Bureau 2017). Although River and Teller counties both have one fairly population dense town and the remaining three counties have small county seats, the rest of the five county area is rural and the topography ranges from foothills and river valleys to mountains. Adams and Douglas counties are the least accessible in terms of road systems, both requiring travel via two-lane, narrow, curvy roads to enter the counties.

Coal has historically been somewhat important in the five county area, but it was not and is not the primary employer. Currently, there are three small coalmines and parts of two mines in the five counties (KMMIS 2018). However, extractive industries have dominated the counties, including those focused on the extraction of timber, oil, salt, and iron. The land speculation and absentee ownership that has accompanied these industries is present in the counties (ALOFT 1983; Hutton 2013). According to locally produced historical documents and county historical centers, the area has an agricultural history,
including livestock and tobacco. All of these extractive industries, as well as tobacco farming, have decreased sharply in the last half-century. One resource that continues to provide, albeit minimally for the marginalized families I spoke with, is the forest, where people hunt and collect and sell geodes, ginseng, and other roots. At this time, most employment is located in the retail, education, and health care sectors (US Census Bureau 2017). Most retail jobs are in small chain stores or fast food, resulting in low-wage employment. Jobs in health care run the gamut from low-wage, physically intense, entry level positions at nursing homes to high-wage medical providers. Education jobs also vary, from bus driver positions to administrators, but education is seen as offering the most solidly “middle-class” employment in the counties. Overall and through time, unemployment rates run higher for the counties as compared to Kentucky and US. In a 2013 to 2015 estimate, the unemployment rate was 10.4 percent in the counties, as compared to 6.7 percent in Kentucky and 6.3 percent in the US (ARC 2017b).

The dire employment situation in the counties was highlighted at a local job fair. When I arrived, half of the tables where employers were supposed to present stood empty. A group of young men were trying to find those in charge of the fair to ask them why employers who they advertised as being there did not attend. The vast majority of the staffed tables represented government agencies, telemarketing, or job placement agencies. For the government jobs through CPS or the Department of Corrections, people who have any criminal or civil record are not qualified. The telemarketing jobs are flexible hours, pay minimum wage, require certain telephone and internet connections, and are unstable. The job placement agencies focus on temporary work and most place people at least two hours away from my fieldwork area. I asked all employers if they accept those with past
felonies or misdemeanors. Most said they tried to be flexible, but a few said no felonies, a few more said no violent crimes, and some said the person could not have any sort of record. Most of the women I interviewed would not have qualified for any of these jobs because of their records, their lack of internet connections, or their inability to leave the counties for months on end because of their family, court, or treatment obligations.

Attaining more jobs for the counties is the primary directive of all the local politicians I spoke with. I had the most insight into Adams County because of my more extensive participant observation there. Community leaders are working on economic development in the form of tourism and call centers that may perform telemarketing or serve as help desks. Yet both of these industries offer low paying and unstable employment (Colias 2002). In my experience seeing tourism in the area and speaking with community members, those who live outside the region often control tourist endeavors and generally employ college age students who are on summer break from universities that are hours away. Tourism, including in Appalachia, relies on “flexible labor systems” based on service work that creates economic uncertainty for workers, who are often seasonal (Amason 2015). Despite the problems with these industries, I think the efforts of local leadership are important. They have seen what coal, prisons, and factories can do to a county. These industries may bring in employment for a little while, but the jobs are low paying, and controlled by those who have no interest in the community. When they leave, the county is devastated. A natural gas fracking company was attempting to enter Adams County during my fieldwork and most community members are against the company. They did not cite environmental concerns, but concerns that the jobs being advertised are temporary and low wage. Leaders desperately want locally
owned small businesses that take the community into consideration and if they fail, only a few jobs are lost. This has lead to wide support of an entrepreneurship business model.

The five counties have poor economic indicators. The median household income was and remains well below the Kentucky and US median (Figure 2.1). The percentage of persons below the poverty line in the counties has been above the Kentucky and national averages since the measure has been used (Figure 2.2). There are variations across and within the counties. The percentage of persons below the poverty line in 2015 hovered around 30 percent in Adams, River, and Teller counties, while it was close to or surpassed 40 percent in Douglas and Eagle counties (US Census Bureau 2017).

Other factors tied to income, such as food and housing are primary stressors for women in the area. For the five counties, 37 percent of households utilize Supplemental Nutrition Assistance Program (SNAP) assistance, as compared to 17 percent of Kentucky and 13 percent of US households (US Census Bureau 2017). Despite qualification for SNAP, 20 percent of residents in the counties lack adequate access to food, compared to 17 percent of Kentuckians (University of Wisconsin Population Health Institute 2017). Food remains difficult to access due to lack of local availability and to the fact that SNAP often does not cover everyone in the household who needs food assistance.
Figure 2.1. Median household income.¹

Policies that have criminalized poverty along with decreased availability of affordable housing and stable employment have resulted in a homelessness surge in the US beginning in the 1990s (Lyon-Calio 2008). Lack of affordable housing is a long-standing issue in Appalachia (ALOTF 1983). Data on homelessness are sparse. Point-in-time estimates calculate homelessness based on a count of homeless people on one night in January each year. These estimates are problematic in rural areas. Homeless individuals spread across larger geographical spaces may be more difficult to count. Many estimates rely on counting those who are utilizing particular services, such as soup kitchens, that are not available in some rural areas. Point-in-time estimates from the previous ten years show that homelessness was at a high during the 2007 to 2008 global financial crisis and have slowly but steadily decreased across the US, in Kentucky, and in the five county area. According to these measures, rates of homelessness in Kentucky are lower than in the US. In 2015, 178.4 persons per 100,000 were homeless in the US, while

¹American Community Survey, US Census Bureau.
103.2 persons per 100,000 were homeless in Kentucky (US HUD 2017). Homelessness rates fluctuate dramatically from year to year in the five county area, most likely due to its rurality and small population size, but hover around 100 per 100,000 (KHC 2017).

Figure 2.2. Percentage of persons below the poverty line.¹

![Percentage of persons below the poverty line](image)


In terms of affordable housing, the expense of rental housing in the fieldwork area is equivalent to more urban areas in central and northern Kentucky due to low availability. Housing affordability is exacerbated by the low median income in the five counties. Most state agencies as well as NPOs who work with housing with whom I have had contact consider housing unaffordable if households must spend more than 30 percent of their gross income on rent or a mortgage. The percentage of households who live in affordable housing is decreasing through time in the entire US and in the five county area. Yet between 2011 and 2015, 56.6 percent of households who rent faced unaffordable housing in the five counties as compared to 51.8 percent of US households and 46.7 percent of
Kentucky households (US Census Bureau 2017). During the same time period, unaffordable mortgage trends are comparable for those who own their home. A greater percentage of residents in the five counties live in households where the mortgage is unaffordable (37.4 percent) as compared to Kentucky residents (25.9 percent) and US residents (32.5 percent). Overall, while housing affordability is less of a concern in Kentucky as compared to the US, affordability is even more problematic in this area of Appalachian Kentucky when compared to countrywide trends. Affordability is more of a concern for renters as opposed to those who own their home.

The counties remain primarily non-Latino white, with 97.4 percent identifying as such in 2015 (US Census Bureau 2015). Although I witnessed no direct personal conflicts over race or immigration, these issues haunted the area, just as they do the entire US. The proliferation of Confederate flags in late summer 2015, and in one moment, a Nazi flag, after the white supremacist church shooting in Charleston, South Carolina and increased visibility of the Black Lives Matter social justice movement is a demonstration of racial tensions in the area. Implicit discussions of race occurred at state level ASAP meetings and regional economic development conferences, where funding for increased treatment in rural areas was justified with pictures of young whites who had overdosed and racialized speeches about Appalachia as having “Scots-Irish” roots, a common myth across the region.

Despite the white privilege bestowed among a large swath of the population, those in the five counties may have more frequent contact with punitive aspects of the state compared to Kentuckians and others across the US. In examining jail admissions in 2014 per 1000 persons, the rate in the counties was 122, compared to 98 in Kentucky and
53 in the US (Vera Institute 2017). In terms of the percentage of all children in cases of suspected child abuse or neglect, 14 percent of children were reported to CPS in the five counties in a 2011 to 2013 estimate, while just 10 percent of children were reported in Kentucky. In the same time period, 2.8 percent of children were found to be victims of abuse or neglect in the five study counties, while only 1.6 percent of children were confirmed to be abused or neglected in Kentucky (The Annie E. Casey Foundation 2017). Thus, it is not clear if there is actually more abuse and neglect in the counties, or if just more cases are confirmed due to increased surveillance. To be clear, CPS is extremely understaffed in the area, so these cases do not generally originate from the CPS office. Instead, they begin when a community member or service provider calls CPS and makes a report, indicating that the community is utilizing the state to survey families. When I refer to “families,” I primarily mean women with children, because men rarely face the same consequences from CPS that women do.

*Local health care reform*

The treatment programs operate and women navigate healthcare in an area that is designated medically underserved and health professional shortage areas for primary, mental health, and dental care (HRSA 2016). The counties have some of the highest rates of premature death, or death prior to 75, in the state (Givens et al. 2017). Depending on county of residence, people living in this area can expect to live six to nine years less than average US life expectancy (IHME 2016). When asked about their health concerns or health concerns in the community, participants in the current study cited hepatitis C virus, tobacco use, mental health, and car accidents. Kentucky had the highest rate of acute hepatitis C in the country from 2010 to 2014 (CDC 2016a). “Deaths of despair,” or
deaths due to suicide, alcohol, and drug abuse have received media attention, especially now that rates are climbing among whites (Walley 2017) and among Appalachians in particular (Meit et al. 2017). From 2006 to 2015, the suicide rate in the five counties was 19 per 100,000, compared to 15 in Kentucky and 13 in the US. In the same time period, deaths due to drug overdose in the counties more than tripled the national rate of 13 per 100,000 at 42 per 100,000 (CDC 2016a).

Women in this ethnography face major health concerns at alarmingly high rates. The most common issues women talk about are depression and anxiety. Women connect depression and anxiety to poverty, intense care work, both paid and unpaid, domestic violence, and grief from death. Six women had attempted suicide, four within the year previous to our interview. Some women are constantly worried about living in poor housing conditions and how contact with such toxins as mold and indoor air pollution negatively affect their health and their children’s health. About a quarter of the women in this study experience chronic pain from occupational injuries, car accidents, or injuries from domestic violence. Several are prescribed pain medications, and a few talked about selling some of their medications to survive financially. There is little access to non-opioid pain management in the area, such as physical therapy.

Almost a quarter of women I interviewed say they test positive for hepatitis C. All say they contracted the virus via injection drug use. While all of the women who test positive are concerned about having the virus, most attempt to ignore their positive status because there is no locally available treatment and women do not think they can afford the treatment that is accessible an hour away. At the time of fieldwork, a new hepatitis C treatment, Zepatier™, was in the news for costing $85,000 for a treatment course.
Insurance providers were arguing that they should not have to pay for such a drug, especially for people who may become reinfected with hepatitis C, such as injection drug users. Women make do with no treatment, attempt to use new needles when they inject, and use bleach to clean their house to keep those they live with from becoming infected. These strategies may be changing, as new syringe exchange programs opened through the health departments in two of the five counties in my fieldwork site in 2017.

From gatekeeper interviews, I learned that because Kentucky Medicaid coverage has not traditionally included substance abuse treatment, state government agencies developed a network of treatment programs to serve uninsured clients. This treatment program network provides uneven coverage across Kentucky and the existence of collaboration between programs varies between counties. Programs differ in the services they provide, from offering a range of options to only having one program geared at a particular population, such as pregnant women. Women in this study accessed substance abuse treatment at a unique moment. ACA and Medicaid Expansion were just being implemented in Kentucky. Political and social activism around the “opioid epidemic” culminated in passage of SB 192 in Kentucky in 2015, otherwise known as the “Heroin Bill” earmarking millions of dollars for treatment. Additionally, due to a combination of physician prescribing and Medicaid coverage, there has been an enormous increase in the use of buprenorphine in the treatment of substance abuse in the last five years.

While ACA is federal and 32 states adopted Medicaid Expansion, local differences in application are important in terms of “access to care, social inequality, and the role of government” (Dao and Mulligan 2016, 6). While drug court is directly funded by the state, the bulk of funding for Horizons and buprenorphine clinics comes from
Medicaid. Prior to ACA and Medicaid expansion in Kentucky, two Kentucky state
departments distributed Temporary Assistance for Needy Families (TANF) and
Children’s Bureau block grants monies to Horizons. Currently, most Horizons
programming is billed to Medicaid, with TANF funding some transportation and drug
screening efforts. Thus, Horizons is no longer beholden to TANF program guidelines, but
only offers services that Medicaid reimburses.

Table 2.4. Uninsured rates before and after ACA implementation.  

<table>
<thead>
<tr>
<th>Location</th>
<th>Percent of population uninsured</th>
<th>2012</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five counties</td>
<td>16.9</td>
<td>12.6</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>14.1</td>
<td>11.4</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>13.9</td>
<td>12.8</td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>14.9</td>
<td>13.0</td>
<td></td>
</tr>
</tbody>
</table>

1American Community Survey, US Census Bureau.

Several providers who I spoke with argued that Medicaid Expansion has not had
the full impact that it could have on substance abuse treatment because the managed care
organizations (MCOs) that enrollees must choose between when signing up for
Expansion are limiting reimbursement for particular services. For example, a
buprenorphine provider said she could get the MCOs to pay for buprenorphine and other
medications, but she and other providers are having difficulty being reimbursed for
physician time spent in appointments or counseling services.

Even if women qualified for Medicaid before Expansion, their partners often did
not. Thus Expansion has affected most participants’ households. With ACA and
Medicaid Expansion, uninsured rates in the five counties dropped from above the
national average in 2012 five-year estimate data to below the national average in 2015
five-year estimate data (Table 2.3). Yet uninsured rates remain above the Kentucky rate. I include Tennessee in the table as a comparison state that did not expand Medicaid. Of 40 female participants in this study, 34 have either Medicaid or private insurance through the ACA exchange. Only three have private insurance through their partner’s or parents’ insurance and one woman has Medicare. Only two women are uninsured. Horizons staff assured me that, had my fieldwork been completed before implementation of Medicaid Expansion and ACA, at least half of the women I interviewed would have been uninsured.

Despite being insured, health care access remains a constant problem according to treatment clients. This lack of access is due in part to few providers and overburdened systems in rural areas. Mental health services continue to be difficult to attain due to lack of providers and case management is severely underfunded. There have been efforts to expand access to substance abuse treatment and behavioral health in the form of contracting with individual providers in addition to Kentucky’s CMHCs, but those individual providers may not exist in rural areas (Artiga et al. 2016). In terms of obstetric care, women have to drive a few hours away to get anything but a routine prenatal exam. Some women cannot afford the co-payments for health care or prescription medication, which has been shown in other recent research in Appalachia (Fletcher 2014).

Women in this study often reported that they rely on “free” health, dental, and eye clinics. At the dental clinic I attended, people do not receive pain medications, even when they have multiple teeth pulled. This is because the administrators of the program fear drug use. While a few drug court graduates I spoke with refuse any type of medication, several other women said they fear receiving surgical dental work without pain medication. Further, the clinic is set up in a gym with no privacy. Often, “free” health
care involves expenses, as shown in this study and others (Foster 2010). These include fees for transportation, taking time off work, and paying for childcare while attending dental clinics that are hours away. Despite the success of these policies, Medicaid Expansion and ACA contain rather than solve the problem of poor health. While women now have a form of insurance, they do not have full access to quality health care.

The purpose of this chapter is to contextualize the participants and researcher. The remaining chapters more fully illuminate how this context is articulated in women’s lives and how my position provided pathways but also limitations to data collection. The combination of economic inequalities, healthcare reform, and changing substance abuse treatments created a particular, but not entirely unique, moment to examine women’s experiences as they worked through addiction and state inroads into their lives.
Chapter Three

Gendered Subjectivities of Pharmaceuticals and the Criminalization of the Poor

OxyContin and buprenorphine are the drugs people talk about in my field site, whether it is community members, clinicians, or women who use drugs. According to my interviews, some “street” drugs have been available in rural Eastern Kentucky for decades, especially cannabis and methamphetamine. Despite increasing use of meth, OxyContin remains at center discursively. During my research, most people had not used OxyContin for nearly five years. The pill was reformulated in 2010 to make it harder to break down for inhalation and injection. People who used prescription opioids illicitly quickly replaced the controlled-release OxyContin with instant release oxycodone pills (Buer, Havens, and Leukefeld 2014), which continue to be the main drug of choice for most women in this ethnography.

In this chapter, I outline anthropological understandings of pharmaceuticals as well as epidemiological and public health research on opioid use in Appalachia. I tie these literatures to data from interviews to briefly describe the illicit drug environment in the five counties. Interviews from women who use drugs show how drug use began for them. Both previous research as well as data from this ethnography indicate that prescription drug misuse is linked to health care inequalities and the pharmaceuticalization of health or the institutionalized practice of treating many physical and mental health concerns with medication (Biehl 2013; Dumit 2012). In this setting, people have limited access to employment. The available employment is often physically and psychologically straining, whether people are being hired as caregivers in nursing
homes or correctional officers. Women do not have adequate access to environments that promote health or medical care for common health concerns or occupational injuries. When they are able to seek health care, women are generally prescribed pharmaceuticals and offered no other health or social services. Their health, and in many ways, their poverty, is treated as an individual issue needing medication, and represents a form of structural violence where inequalities are ignored. The onus of change is placed on individuals who are expected to solve their own problems by participating in a capitalist market where pharmaceutical companies often exploit bodies and suffering for profits.

Through analyses of OxyContin, oxycodone, and buprenorphine, I show how women’s drug use is connected to understandings of health and pain, access to health care, and corporate misconduct. Anthropological literature on the development and marketing of pharmaceuticals, including ORT, is critical here. I bring Appalachia into this discussion via my own study as well as research from clinicians and investigative journalists who critique pharmaceutical companies’ actions in the region. The societal response to opioids in the US is revealing of how state surveillance is targeted. Individuals may face grimmer responses than corporations. Some individuals have more access to therapeutic state services rather than incarceration based on their social locations, yet the criminalization of drug use affects all women in this study.

**Overview of prescription drug use and misuse**

Prescription drug misuse differs from illegal misuse of so-called “street drugs” because pharmaceuticals more often obscure the line between licit and illicit (Nordstrom 2007; Quintero, Petterson, and Young 2006; Schlosser and Hoffer 2012; Whyte, van der
Pharmaceuticals have lead to new imaginings of what it could mean to be human. While pharmaceutical imaginings may have positive connotations for those looking for enhancement, control, or amelioration of suffering (Jenkins 2011), for others it has led to new monstrous patterns of addiction. Though service providers with whom I spoke categorically define street drugs as harmful, they view pharmaceuticals as things that may be healing or harmful, reflected in the concept of pharmakon (Whyte, van der Geest, and Hardon 2002). Health care providers’ ambivalence towards pharmaceuticals has resulted in patients, especially those with pain, becoming suspect because they may become addicted (Crowley-Matoka and True 2012).

Misuse of OxyContin was particularly problematic in early 2000s Appalachia. Higher rates of prescriptions for OxyContin and increased misuse of OxyContin resulted from Purdue Pharma’s intensive marketing of their drug (Chubinski et al. 2014; Cicero et al. 2005; Kobak 2012; Passik 2003; US GAO 2003; Van Zee 2009). Currently, Kentucky’s estimates of illicit drug use, nonmedical use of prescription pain relievers, and illicit drug dependence reflect national trends (SAMHSA 2013; SAMHSA 2014; SAMHSA 2015). Yet prescription drug misuse continues to be an important public health concern in Kentucky, with overdose rates nearly double that of the US (CDC 2016a). The five counties in this research fall within the US areas that have the highest morphine milligram equivalents (MMEs) prescribed per capita. MME prescriptions increased from 2010 to 2015, demonstrating that medical services are contributing to this public health issue (Guy et al. 2017). These calculations do not include buprenorphine used for ORT. But this is a problem for the US, not just Kentucky or Appalachia. US overdose deaths have increased fourfold from 1999 to 2015 (Sarpatwari et al. 2017). Opioid misuse is
associated with drug overdoses, acute hepatitis C, and HIV infection, especially in rural areas, including rural Appalachia (CDC 2011a; CDC 2011b; CDC 2016c; Conrad et al. 2015; Chubinski et al. 2014; Havens et al. 2013; Havens et al. 2011; Paulozzi and Xi 2008; Rossen et al. 2013; Zibbell et al. 2017).

Prescription drugs are widely abused in the US due to a number of factors, including individual misuse and inappropriate clinician prescribing (Butler et al. 2013; US DHHS 2013; Levy et al. 2015; Mack et al. 2015). Several studies have indicated a variety of reasons why people might begin or increase misuse of prescription drugs, including to self-medicate for and assert control over their stress, addiction, mental health disorders such as anxiety and depression, and physical or emotional pain. These conditions are exacerbated by the lack of access to quality health care (Quintero, Petterson, and Young 2006; Schlosser and Hoffer 2012). In a study in Appalachian Kentucky, prescription drug misuse included both overuse and underuse of prescription drugs because prescriptions are expensive (Anglin and White 1999). Beyond self-medication, decreasing access to psychotherapy and other forms of mental health treatment may mean that psychopharmaceuticals are the only option for treatment in clinical settings as well (Jenkins 2011).

Service providers and activists in other rural Appalachian studies have connected prescription drug misuse with geographic barriers to health care, the cost of health care that is available, and aggressive pharmaceutical advertising and prescribing (Anglin and Collins White 1999; Kobak 2012; Leukefeld et al. 2007; Van Zee 2009). According to a treatment provider I interviewed, and to others who have written on the issue (Anglin and White 1999), prescription pain relievers have been misused for decades in Appalachia.
Coal company doctors would give miners pharmaceuticals to keep them working instead of addressing underlying health concerns, which may have required more expensive and extensive treatment. This indicates that prescription drug abuse may simultaneously be tied to lack of access to certain types of medical care, but overutilization of pharmaceuticals.

No women in this study had adequate access to mental health care even though most discussed having depression or anxiety due to their social conditions and experiences with interpersonal violence. Four of the 40 women attempted suicide in 2015 or 2016. No women had stable and quality access to medical care. Nearly a quarter of those I interviewed had chronic pain due to physical injuries, primarily from occupational accidents and domestic violence. Structural violence is articulated in these women’s lives as anxiety, depression, and physical pain, often caused by gendered inequalities and hazardous working conditions. Self-care via drug use was their primary strategy in dealing with the effects of structural violence.

With pharmaceuticalization, health is equated with access to pharmaceuticals in societies where everyone is framed as being at constant risk of becoming sick (Biehl 2013; Dumit 2012). Joseph Dumit (2012) partially attributes the rise in prescription drug use to this ethos of being at risk and personally responsible for managing that risk through medication. Drug companies promote the pharmaceuticalization of health to increase profits for existing and future drugs, as a market is being created for all medicines (Biehl 2013). A focus on prescribing and consuming pharmaceuticals downplays the effects of housing, food insecurity, and economic inequalities on health.
Both gatekeepers and treatment participants said that prescription drugs, primarily prescription opioids and benzodiazepines, have been the main drug of choice in the five county area for at least 15 years. While these drugs are created licitly, they travel through underground networks just as illicit drugs. The women I interviewed argue that as the number of increasingly expensive prescription drugs dwindles due to tighter regulations, they begin using other drugs they can obtain through illegal and legal networks. Those other drugs in this time and place are either meth or buprenorphine. Literally all treatment program clients, program staff, social workers, and community leaders view meth as being worse than opioids because they think it changes people’s physical appearance and mental state more quickly. This is not to say that women who use prescription drugs do not think pharmaceuticals can be addictive or dangerous, women just view meth as more harmful. They also view heroin as more harmful, but only a few women had seen it in the area. Women who used heroin did so in areas outside of Eastern Kentucky, as heroin was rarely seen in the counties.

In terms of acquiring opioids, there are certainly situations in which people feign pain to acquire pills. Both in this and previous studies, people who use drugs have told me stories of paying prescribers large sums of cash to obtain pharmaceuticals. They offer tales of lengthy, adventurous road trips driving around the Southeast and Midwest to find profuse prescribers and loosely regulated pharmacies. More often than those stories, though, are narratives of car accidents, surgeries, occupational accidents, injuries from domestic violence, and un- or mistreated mental health issues, which lead to women’s use.
In terms of drug use history, there are common threads in women’s narratives demonstrating how drug use intersects with the body as well as relationships with others. The stories most rooted in the body belong to seven women who did not begin using until their late 20s or early 30s. They were prescribed opioids as pain medication following surgeries, car accidents, or occupational injuries. Beth, for instance, was a firefighter who fractured her leg in several places while battling a fire on a mountain ridge. She failed to successfully make a jump and was then prescribed opioids for pain. Lizzy was a paramedic who broke dozens of bones when she was crushed by an ambulance. She took opioids as prescribed for over a year. When her physician told her she could never return to being a paramedic due to her injuries, she began abusing opioids.

Relationships with family or friends led others into use in their preteens. The fact that this was the beginning story for only three of the women I interviewed goes against the narrative favored by a few gatekeepers. Namely, that all drug use results from a dysfunctional family with parents who have mental health issues and give their children drugs at a very young age. Almost a quarter of women began using in their early 20s, and they usually started taking prescription drugs with an intimate partner who was also using. Over a third of participants started experimenting with cannabis, alcohol, or benzodiazepines with friends in their mid to late teens. Their use did not progress past experimentation on weekends until they were in their mid-20s. Women attributed this progression to being in physical or emotional pain, experiences with intense domestic or sexual violence, and being around others who were using more, especially male partners. Emotional pain was most often associated with children being removed, loved ones dying, or intimate partners leaving.
I asked women about their primary drugs of choice, and they reported:
prescription opioids (N=28), methamphetamine (N=7), cannabis (N=5), benzodiazepines
(N=5), alcohol (N=4), cocaine (N=3), heroin (N=3), and crack (N=2). Of the 40 total
women, 22 named multiple substances and 18 had injected drugs at some point. Five did
not name a substance because they said they were never addicted to anything, but only
used cannabis or prescription opioids occasionally. Several continue to use cannabis,
primarily because it helps with their anxiety and they see it as a drug that should be legal
in Kentucky, as it is in other areas of the US. No women I talked to said they were
currently taking illicit prescription opioids. Three were taking meth and two were
injecting illicit buprenorphine at the time of our interview.

It is clear that pharmaceuticals in the form of prescription opioids and
benzodiazepines remain a primary component of drug use in the area, but in some ways
their past use is as important as the current market. Even those who primarily prefer meth,
cannabis, or other drugs still use pharmaceuticals from time to time. Most of those who
identify as meth, cocaine, and heroin users ingested pharmaceuticals long before they
moved to these drugs. Cindy exemplifies how OxyContin changed people’s addictions,

What really got me, when I was taking just the Percocet [acetaminophen/
oxycodone], I took them as prescribed for three years straight. If I missed one, I
wouldn’t even realize I missed it. One day I was out of [Percocet] and me and this
person went and got an OxyContin. We snorted it and ever since, I was pain free
for three days, my body was numb, I had energy, I couldn’t sleep. I was like a
wired animal. When I crashed, I crashed. That pill made me feel so good. I was
like, I need that today. When I look back, if I had never done that, I might not
have gotten on those pills.

Several women who had started using meth say they do not actually like the drug, but as
prescription pills became scarcer, meth was the only drug available to help with
withdrawals. Although community members were concerned about heroin and fentanyl
becoming a problem, the only women I spoke with who consistently used heroin lived in non-Appalachian urban areas when they used. No treatment participant I interviewed mentioned fentanyl.

The most unrecognized part of drug use for these women is underuse of prescribed medications. Kim is prescribed a SSRI that is not covered by her insurance, so she does not take the $600 a month medication. Charity is prescribed over a dozen medications, and she goes without the most pertinent ones when she cannot afford them. Anna was prescribed the antidepressant bupropion, but she does not have transportation to renew her prescription with a clinician or to a pharmacy. Instead, she takes her neighbor’s bupropion, which he does not use. Despite the rise in misuse with the industries’ push of OxyContin and other prescription opioids and benzodiazepines, these narratives illustrate the longstanding practice in health care shortage areas, such as rural Appalachia (Anglin and Collins White 1999), of sharing prescribed pharmaceuticals to get by.

**Marketing pain and pills**

Beginning in the 1980s, there was a serious move by patients, clinicians, and researchers to address issues of undertreated pain in the US, especially non-malignant chronic pain, in the US. Through the 1980s and 1990s, a series of letters to the editor and opinion articles as well as recommendations from the American Pain Society shifted the medical culture in the US to view prescription opioids as beneficial to all pain patients, regardless of pain intensity, and unlikely to be abused. In the context of opioids being viewed more favorably by US physicians, health insurance companies stopped funding
more holistic pain treatments, such as occupational and psychological therapy, and increasingly covered opioids as opposed to non-opioid pharmaceuticals (Knight et al. 2017; Quinones 2015; Sarpatwari et al. 2017; Thomas and Ornstein 2017). Due to changing prescription patterns for pain, the milligrams of opioids prescribed in the US increased dramatically due to more people being prescribed for longer periods of time and with greater doses (Guy et al. 2017).

With hindsight, but even with a lay understanding of addiction, this process of pain pharmaceuticalization seems problematic. The World Health Organization had been warning about the addictive capacity of oxycodone since 1957 (Sarpatwari et al. 2017). Why were clinicians eager to increase opioid prescriptions when evidence of addiction far outweighed the few opinion pieces and letters to the editor that stated otherwise? Part of this has to do with chronic pain being a complicated complaint that may require multiple forms of intervention, which is frustrating to patients as well as clinicians who were increasingly being given less time to work with patients by administrators and MCOs during this time period. There are few other options for chronic pain treatment in resource poor areas (Knight et al. 2017; Quinones 2015). But drug companies cannot be left out of this equation. Pharmaceutical companies may have close relationships with clinicians where companies bestow economic rewards, produce clinical knowledge through directed research and randomized controlled trials, and provide access to this knowledge (Dumit 2012; Lakoff 2006; Oldani 2008). Overall, pharmaceutical development may have little to do “with the realities of disease and treatment demand” or drug effectiveness (Jain 2010; Petryna 2010b; Petryna and Kleinman 2006, 7). Companies are more inclined to create new and expensive products focused on such
issues as chronic pain because their treatments present increased economic opportunities for sales to patients with a chronic condition who may be able to pay for pharmaceuticals (Dumit 2012; Jain 2010; Petryna and Kleinman 2006). Beyond development, there is marketing.

Modern pharmaceutical advertising began in the 1950s with Arthur Sackler, whose family later bought Purdue Pharma (Quinones 2015). With Sackler’s marketing of the first billion-dollar drug, Valium, drug companies heightened their sales of diseases, risk factors, and stages of life, such as menopause, that can be treated by current and future medications, which is more effective than simply selling one drug (Padamsee 2011). One danger of pharmaceutical marketing is displacement, which occurs as pharmaceutical companies and sales reps downplay the possible side effects and risks of prescription drugs to clinicians and patients in order to increase sales (Etkin 1992; Martin 2006; Oldani 2008; Petryna and Kleinman 2006). Exacerbating this phenomenon is that drug companies generally recommend the highest tolerable dose as the best standard of care (Petryna 2010b). Beyond clinicians, direct to consumer advertising has created an environment in which taking pharmaceuticals becomes a matter of personal choice where individuals demand and expect prescriptions when they visit their provider (Jenkins 2011). In terms of prescription opioids, lack of regulation for pharmaceutical development and marketing both served as an impetus to exploding opioid use as well as an exacerbation of abuse once began (Sarpawari et al. 2017). The stories of Purdue Pharma and buprenorphine make this clear.

I want to start this analysis of Purdue Pharma and OxyContin with a narrative from Hessie. Hessie is a substance abuse treatment provider in Central Appalachia who
was at the forefront of legal actions against Purdue with a coalition of substance abuse
treatment providers, physicians, people in recovery, and families of people who died of
drug overdoses:

Already Purdue Pharma was targeting, looking at communities where they could
market OxyContin. And of course if you look at the way they were going to
market it, they were going to market it right to communities like ours with a high
Medicaid rate, a lot of legitimate pain because we have logging and the coal mine.
So there was legitimate pain. Well they were making hand over fist with money.
They wanted to profit, profit, profit. So they were so upset about us that they flew
in there, the director of Purdue, the medical director, the attorney, everybody on
their staff came and asked if they could meet with a few of us here. So we did
meet with them and of course their whole purpose was to sell their drug; like how
important this was and so forth. They thought they would manipulate us and get
us this and they were going to offer money to the community and they were; oh, it
was just crazy; it’s just like everybody else does for us. And anyway we met with
them just to listen and of course they realized when they were with us, they were
against a brick wall with us. Because we weren’t going to, they weren’t moving
us at all. We just kept challenging them because we were so angry.

Purdue Pharma surpassed all marketing norms with OxyContin (Sarpatwari et al.
2017). Drug companies, exemplified by Purdue Pharma’s actions, exploit human bodies
for profit thus treating patients as “tools that can be used, depleted, and thrown away”
(Martin 2006, 284). Purdue aggressively marketed OxyContin to clinicians in the US by
paying for over 5,000 physicians, nurses, and pharmacists to attend all-expenses paid
trips to resorts to learn about OxyContin. The company set up another 20,000 free
educational programs for physicians between 1996 and 2002, where Purdue continuously
dismissed the addiction risk of OxyContin (Meier 2003; Van Zee 2009). Purdue Pharma
provided physicians with over 34,000 starter vouchers and coupons for OxyContin to
give to patients (Van Zee 2009).

According to their own research with OxyContin, Purdue knew the addiction risk
to be higher than they alluded to in their marketing (Meier 2003). The company could be
confident from a history of weakly enforced regulation that their illegal marketing would be met with fines that could be considered part of business in relation to the size of their profits (Sarpatwari et al. 2017). Purdue knowingly spread the falsehood that OxyContin lasts 12-hours. This lie is what gave the drug a competitive edge over non-extended release options. As part of this myth, Purdue encouraged prescribers to not decrease the time interval between pills, but to increase the dosage of pills (Sarpatwari et al. 2017).

Ultimately, researchers, clinicians, law enforcement, and prosecutors agree that the entrance of OxyContin onto the market changed the context of drug use in Appalachia, where there were higher rates of OxyContin prescriptions as compared to the US average (Cicero, Inciardi, and Muñoz 2005; Inciardi and Goode 2003; GAO 2003; Passik 2003; Van Zee 2009).

Moving on to the ORT buprenorphine, the most commonly available form of buprenorphine in rural Appalachia according to buprenorphine providers and program clients is mixed with naloxone in a sublingual strip. From a pharmacological perspective, ORT involves three phases: induction, or switching from illicit opioids to the replacement; stabilization, or consuming replacement doses after withdrawal has subsided; and, maintenance, or the tapering down of ORT (Meyers 2014). Naloxone is supposed to produce withdrawal symptoms if injected. Thus, the addition of naloxone theoretically encourages individuals to swallow or dissolve buprenorphine in their mouth rather than injecting the substance. Both health care providers and program participants in this ethnography question the effectiveness of naloxone as prevention from misuse of buprenorphine because they know people who inject buprenorphine with naloxone to feel
euphoria. Buprenorphine injection may not only produce euphoria, but also increase the risk of blood-borne pathogens if contaminated syringes are used (Stoller et al. 2001).

Unlike methadone, another ORT, buprenorphine is supposed to be less addictive than heroin and methadone, less likely to depress the respiratory system compared to other opioids, and less likely to cause overdose (Harris 2015; Lovell 2006; Meyers 2014). Still both methadone and buprenorphine are associated with overdoses when combined with benzodiazepines or alcohol (Lovell 2006; Unger et al. 2010). These pharmacological aspects of ORT are one place where this idea of pharmakon arises. The legality of ORT becomes tied to its intent. Is it intended to be used for euphoria or therapy (Meyers 2014)? Through research, development, and production, drug companies try to define the intent of ORTs by making them materially different than street drugs because they are formulated to be consistent, pure, and efficient. Yet what is evidently clear to service providers in the current study, which underlies many of their concerns with ORT, is that the efficacy of ORT is not over-determined because these medications may be used against indications and they do affect people differently (Lovell 2006). The literature on methadone demonstrates that its detractors view methadone as just another illicit drug that is connected to increased rates of crime and social upheaval (Agar and Reisinger 2002). Buprenorphine detractors take a similar view in this ethnography.

Beyond pharmacology, the method of buprenorphine Federal Drug Administration (FDA) approval and formal distribution differs from methadone. The Controlled Substances Act (1970) and the Narcotic Addiction Treatment Act (1974) heavily regulated MAT. In 2000, the Drug Addiction Treatment Act allowed buprenorphine to be prescribed in less surveyed physician offices (Harris 2015; Meyers
At the same time, increased usage of buprenorphine in some ways parallels the rise of methadone in the 1970s, with factors both pushing and pulling people into ORT treatment (Agar and Reisinger 2002). Heightened surveillance of prescribers and distributors of prescription opioids has resulted in fewer opioids being available in illicit markets. Prescription opioids’ changing formulations that are increasingly difficult to manipulate for inhalation or injection has made them less popular among those who use drugs in Central Appalachia (Buer, Havens, and Leukefeld 2014). The lack of available and desirable opioids has pushed users to enter buprenorphine programs. With mental health and substance abuse treatment parity in Medicaid, several Medicaid insurers now cover buprenorphine. More people also have access to Medicaid through Expansion. Thus, more clients are pulled into buprenorphine programs because they have insurance that will cover the medication and counseling sessions. Yet in Central Appalachia, buprenorphine has never garnered the support from some law enforcement and policy makers that is described with methadone (Agar and Reisinger 2002).

In Central Appalachia as well as across the US, methadone is only available in heavily regulated public clinical spaces where clients are required to dose in front of staff on a daily basis for years before they earn privileges for take home doses. Buprenorphine is distributed through private physicians and is immediately available to be consumed privately, offering more flexibility in provision (Harris 2015). In Kentucky, clients at both methadone and buprenorphine programs are subject to random urine drug screenings to test whether they are taking the ORT and if they are consuming additional substances. Still, from my interviews with gatekeepers, I learned that buprenorphine’s less structured method of distribution has drawn criticism among the public, law enforcement, and
politicians in Kentucky. In rural Appalachia, as in France (Lovell 2006) and Baltimore (Meyers 2013), the diversion of buprenorphine from formal networks where it is coded as “medicine” to informal networks where it is coded as a “dirty” commodity is the location of much of the conflict over buprenorphine. Yet informal distribution networks may help create formal networks as people who use drugs experiment with buprenorphine on the street and then enter formal networks through clinics if they decide they want to continue use (Lovell 2006; Saris 2008). Buprenorphine’s diversion is not unique considering that formal and informal networks of pharmaceutical distribution are intimately linked. The importance of informal networks is rarely discussed in analyses of pharmaceuticals (Lovell 2006; Whyte, van der Geest, and Hardon 2002).

Buprenorphine is controversial in the five counties. Most gatekeepers I interviewed who have no experience with buprenorphine, either personally or through close family or friends, are deeply skeptical of the drug for two main reasons. First, many hold a puritanical view of drug use, and see all use, from alcohol to psychopharmaceuticals to buprenorphine as harming the body, revealing some underlying weakness in the individual, and preventing people from performing social roles. To be clear, they extend their focus on the dangers of prescription opioids and benzodiazepines to all medications that can be seen as treating mental health issues, from SSRIs to antipsychotics. According to the drug court staff member, Ben, women on ORT are not fulfilling their roles as protectors of their children because children can find ORT in the home, ingest the medication, and overdose. Second, gatekeepers and community members with whom I spoke are justifiably wary of prescription drug companies and
high prescribers. They think makers of buprenorphine are just capitalizing on the opioid epidemic that the companies created in the first place.

Buprenorphine represents the primary conflict between different treatment models in the area. The drug court administrator Emily “hates” buprenorphine because people still withdraw and may continue to participate in illicit economies, as they buy buprenorphine off the street or sell their own prescription. She would not allow a drug court participant to work as a peer mentor at Horizons because they allow buprenorphine. Emily perpetuated rumors about buprenorphine at ACADA meetings. Community members take her assertions seriously because Emily is considered an expert on all issues relating to substance use. Emily said that a local clinic is offering “lifetime prescriptions” to buprenorphine and does not have a licensed clinician on staff, neither of which is accurate according to my participant observation and discussion with several Adams County gatekeepers.

Buprenorphine providers and clients claimed that these conflicts have lead to the seemingly constant surveillance of clinics by law enforcement and the media. This surveillance has stoked fear among providers, who pass this fear to clients. Some providers, such as Eagle Health, have chosen to downplay the fact that they offer buprenorphine. The Eagle Health prescriber is reluctant to speak to anyone about providing buprenorphine, including myself. He couches the buprenorphine program within the full range of services he provides from cradle to grave, which is shown in the Eagle Health waiting room. I spent 30 minutes in Eagle Health’s waiting room before I interviewed the counselor, Molly. The waiting room feels community oriented. Most patients are seniors, with a few middle age patients and parents with children. Cartoons
are blaring for the kids and many folks are engaged in conversations about the community or their family.

Other providers, such as River Buprenorphine, create a punitive clinical landscape. When I attended River Buprenorphine with Maggie, I was in the waiting room for over an hour while she saw her counselor and attained her prescription. A security guard walks through every 20 minutes. In my field notes, I described all the signs posted through the small and overcrowded room, “All the signs seem like they are yelling at you. ‘Don’t be late, don’t go anywhere while you’re waiting or we will skip you, no children in appointments, no pets in the waiting area, you must make appointments yourself and no one can make them for you, you have to wear shorts and shoes.’” These are different strategies providers utilize to protect themselves from losing their business and possibly their freedom to law enforcement and prosecutors who view buprenorphine prescribers as dangerous. Providers also employ these techniques to dampen media critique of buprenorphine. In this instance, state criminalization of drug use and societal stigma against ORT comes into clients’ lives through their interactions with health care providers.

Tensions arise between health insurance MCOs and clients in regards to buprenorphine. Debbie argues that MCOs are trying to lessen their spending on buprenorphine by requiring programs to administer drug tests and then ceasing payment for buprenorphine when people test positive for additional drugs, even those that do not dangerously interact with buprenorphine, such as cannabis. When MCO payment is ceased, the programs cut people off of buprenorphine instantaneously if they do not have the ability to pay for buprenorphine as individuals. This represents the spread of the
carceral state into the private as MCOs are utilizing intense surveillance, examinations, and sanctions to control costs.

Service providers who are ambivalent about or even fundamentally support the use of buprenorphine agree that programs can simply be moneymaking schemes. According to them, in order to prevent that, programs must take insurance to become legitimate and offer counseling and additional services, such as job placement. This shows that the providers care about the community, not just money. Michelle, a university researcher, relates lack of counseling in a buprenorphine program to the program being fraudulent,

What we are seeing in many of these rural communities is doctors who come in, who understand there’s a problem in the community, set up shop and it’s a money-making scheme. It’s not altruistic in any way, shape, or form. They’re not there to treat folks and get them clean and send them on their way. They’re there to make as much money as possible, which is giving Suboxone potentially a bad name. It’s actually a very effective drug when used in conjunction with counseling and all of these other services, including primary care, sometimes mental health services. But from what I’m hearing of those providers in that area, there’s not a lot of that going on. It’s bring in cash, we don’t take any insurance, and come and get your prescription, you may or may not even see the physician. They may or may not do any drug tests.

In one of the counties where John, a research project director, works, some of the same physicians who misprescribed OxyContin are now prescribing buprenorphine.

Phil attributes the lack of counseling to diversion of buprenorphine from licit to illicit use,

But Suboxone is an effective tool. My only concern is that the physicians, office based Suboxone clinics, are not very well regulated. The feedback that I’m getting off the street is say if they typically need four to six milligrams of Suboxone, well what they’re doing, is they’re selling half of it, taking half, selling the other half to pay for treatment, so they get a free ride. And that’s where the diversion is. And subsequently, if you’re opiate naïve, you can get high on Suboxone. So that’s an issue too. So that’s a lot of people’s drug of choice anymore.
For these gatekeepers, buprenorphine is beneficial if it does not produce euphoria, but becomes harmful once pleasure is introduced because pleasure is equated to addiction. I heard Phil’s story about diversion more times than I can count from community members, gatekeepers, and clients, but it was usually told as people are prescribed three buprenorphine strips, take one and sell the other two. While Phil is concerned about diversion, other providers like Debbie see buprenorphine diversion as indicative of a lack of access to treatment programs. People are sharing prescriptions because they do not have individual access.

Again, this debate over buprenorphine goes far beyond Eastern Kentucky, becoming a source of contention for state-level, national, and global organizations. NA does not consider members “sober” if they are on ORT. Debbie thinks the stigma against buprenorphine and other medication-assisted treatment (MAT) will subside. In a state-level ASAP meeting, my field notes reflect this possible shift,

The new Secretary of the Justice and Public Safety Cabinet, John Tilly, came to introduce himself. A treatment provider in the meeting asked Tilly about MAT and he said “it has got to be available.” According to Tilly, MAT is effective when combined with treatment. He also said that diversion is a major problem. The man who had commented then complained that providers were not on board with making MAT available.

To be fair to the people who question buprenorphine in this area, women’s and gatekeepers’ experiences with or knowledge of the actions of Purdue Pharma, pharmaceutical distributors, and overprescribing physicians underlies their current concerns with all pharmaceuticals, including ORT. According to my research, buprenorphine is being diverted and injected. Further, the pharmaceutical companies that manufacture ORT are suspect. Mallinckrodt is the primary manufacturer of methadone in the US and worldwide (Covidien 2013; Karch 2011). Mallinckrodt is also the maker of
one of the most diverted and misused prescription opioids in rural Central Appalachia, generic instant release oxycodone (Buer, Havens, and Leukefeld 2014). Methadone is used to treat dependence to instant release oxycodone. Pharmaceutical companies are part of the systematic industrial disinvestment in Appalachia, as when Mallinckrodt closed a plant in Appalachian South Carolina in 2012 to move 595 full-time jobs to a facility in Costa Rica (Siddiqui 2012). Reckitt Benekiser, the primary global maker of buprenorphine, started producing Suboxone as a sublingual dissolvable film and ceased production of Suboxone tablets because the company said that the film is less likely to be accidently taken by children (Silverman 2012). Some medical providers and generic drug makers have criticized Reckitt for this move stating that they changed the Suboxone delivery method because the patent on the tablets expired in 2010 while the patent for the film does not expire until 2022 (Silverman 2012). In a country with already inadequate substance abuse treatment, Reckitt has exacerbated this lack by extending their control of the market and thus maintaining high prices for buprenorphine (Sarpatwari et al. 2017). Private insurers and Medicaid have been reluctant to cover buprenorphine because of its expense (Thomas and Ornstein 2017; Sarpatwari et al. 2017).

I have my own reservations about buprenorphine. I share the distrust of pharmaceutical companies. Buprenorphine assumes a stable brain, a diseased brain, but nonetheless stable. The medication ignores stress that is outside of the body. This is not a novel idea. This is what counselors, providers, and community members are saying; we cannot rely on a magic pill solution. But, they are seeing education, therapy, and changing social networks as the required services. These are often different ways to fix the individual. What they usually ignore is the context. Buprenorphine programs are
repeating the problems with methadone clinics, failing to address socioeconomic marginalization (Bourgois 2000; Lovell 2006). These debates over buprenorphine, whether originating from concerns based on actual events or misunderstandings, prevent women from utilizing ORT and were present in women’s discussions of buprenorphine.

Who is nominally fined and who is heavily sanctioned?

Thus far, Purdue and its top three executives have paid $654.5 million in fines for downplaying OxyContin’s risk for diversion and abuse; their OxyContin revenues have been around $31 billion (Kobak 2012; Sarpatwari et al. 2017). Kentucky, along with other Appalachian states, sued Purdue. Purdue has not been alone in these lawsuits. Pfizer paid $2.3 billion in fines in 2009 for illegally marketing another prescription pain reliever (Quinones 2015). As of early 2017, two large drug distributors, Cardinal Health and McKesson Corporation, along with several small distributors, have agreed to pay hundreds of millions of dollars in fines to the federal government and Central Appalachian states for failing to report suspicious pain medication orders to the Drug Enforcement Agency (DEA) (Ornstein 2017). Pharmacies and doctors have also been closed and jailed for over or misprescribing prescription pain relievers. These actions are not unique to Appalachia as evidence continues to appear to indicate similar pharmaceutical company and drug distributor misconduct occurred in Maine and on Cherokee Nation lands in Oklahoma (Higham and Bernstein 2017). Yet these fines pale in comparison to profits. Individuals outside of the pharmaceutical industry are those who are truly criminalized. Drug users themselves are seen as the problem, whereas pharmaceutical companies are seen as having a problem drug (Knight et al. 2017).
According to my gatekeeper interviews and participant observation at local and state drug prevention meetings, Kentucky policy makers responded to OxyContin misuse with a number of initiatives, including the introduction of Kentucky All Schedule Prescription Electronic Reporting (KASPER), EKSAC, and ASAP. EKSAC and ASAP abide by Kentucky’s law enforcement, treatment, and prevention/education three-pronged approach to substance use. All of these responses are focused on the individual, whether through incarceration or educating grade school students on the dangers of substance use. In prior research, located in the same region but not in the same counties as the current study, a number of key informants argued that KASPER had ended drug users eliciting prescriptions from multiple Kentucky doctors simultaneously. Still those who use drugs find ways to actively navigate around KASPER by driving out-of-state to obtain and fill prescriptions (Buer, Havens, and Leukefeld 2014).

Intersecting social positions based on drug use, class, gender, race, and place shape the options women have in navigating state institutions. All individuals are not treated equally. Who the public considers addicted and morally deviant and who society frames as utilizing personal enhancement in order to succeed in an overstressed environment reflect understandings of economic class, division of labor, and body norms where working-class drug use is blamed on individual failure and upper-middle-class drug use is blamed on a broken system (McKenna 2011; Pine 2007). Yet the poor and minorities face the brunt of punishment for their supposed individual failures, while almost none, with perhaps the exception of monetary fines on the manufacturers and distributors of OxyContin, are punished for creating and perpetuating a broken system.
Ethnographic research completed among female drug users, primarily in urban areas or on illicit street drugs, shows how gender and class-based inequalities affect experiences of substance use. Women more often face sexual and domestic violence, may begin using or injecting drugs because of their relationships with men, become involved in drug economies because of their lower wages in the formal sector, and face more sharply critical public opinion and interventions assigned to those who are responsible for childbearing (Baker and Carson 1999; Bourgois and Schonberg 2009; Campbell 2008; Epele 2002; Flavin and Paltrow 2010; Garcia 2010; Goodwin 2011; Knight 2015; Kushner 2010; Whiteford and Vitucci 1997). Women differentially experience gendered oppression based on their class, ethnicity, and role in the drug economy (Campbell 2008; Carr 2011; Epele 2002). Women of color are more likely to be arrested, charged with drug-related crimes, and serve more time as compared to white users (Crenshaw 2012; Fuentes 2014; Rhodes 2001). As opioids have reached more and more white people, treatment has increasingly come to be seen as the answer to drug use rather than incarceration (Knight 2017; Meyers 2014). White bodies become the bodies that matter in discussions over the state’s role in defining the boundaries of the pharmakon.

State intrusion may feel differently according to place because of a lack of resources in some areas. Service providers and some clients say that the intensive outpatient model available through Horizons, drug court, and buprenorphine programs is not intense enough for many women when they are just becoming sober. It is really better as a maintenance model after women have sought detoxification services and inpatient treatment. Detoxification services are located two to three hours away from the five
county area. According to Horizons staff and women who have tried to access such services, waitlists vary from a few days to a few months.

The closest inpatient substance abuse treatment is located two hours away from Adams County. Local and state level service providers as well as women who use drugs claim that Kentucky facilities generally have multi-month waiting lists and many programs do not accept Medicaid due to low reimbursement rates or prolonged reimbursement for services. In Kentucky, there are only two treatment programs where women can bring their children. Several providers said that women were not willing to leave their county to seek inpatient treatment. Several women said they would leave if they could get into a treatment program that accepted their insurance and allowed them to bring their children. Others choose to access services outside of their home community so neighbors and family do not see them going into particular clinics.

State intrusion may be felt to be more individualized in small communities. While neighborhood location, race, and ethnicity are the primary determinants of state surveillance and intervention in urban areas (Gillmore 1999; Gordon 1999; Mullings 2003), women and service providers in rural Central Appalachia say that stigma is attached to individuals based on their reputations, which often begin construction in elementary or middle school, and their family’s reputation, which may go back generations. Women argue and service providers concede that CPS, law enforcement, and judges repeatedly target certain individuals because of their family’s “bad name” or because of their past. Community employers refuse to hire women based on the reputation of themselves or their families, even if they do not have a criminal record and have been in recovery for years. From the women I interviewed, Louise cannot get away
from the police, because her ex-husband is chief and his deputies regularly pull her car over while she is driving. Ellie said once you are arrested, you are more likely to be arrested again because you are consistently harassed, “There for a long time, after I straightened up, I kept getting pulled over every time I came to town because I have a bad name. And it was constant. The police down there have certain people they just hate.” On the other hand, Kim said she did not have to worry about the police because her uncle is an officer. A few service providers, including Abe and Ellen, critiqued local police departments for keeping heavy surveillance on a few people in the community, while ignoring the crimes of others.

Beyond targeting certain individuals, some gatekeepers, community members with whom I spoke, and participants in meetings I attended often blamed opioid use on individual behaviors and Appalachian cultural values they saw as problematic. The local CPS administrator, Karen, connects drug use with individual laziness and reliance on disability as well as a loss of the cultural values of hard work and noble suffering. This creates a situation in which the harm that emanates from cuts to government services are dismissed, such as when I asked Karen about diminishing government welfare programs, “Yeah, you know what? People know how to survive, with limited income that they have. They just know how to survive. They’ll come out on top.”

Others link drug use to lack of individual education and an Appalachian culture that does not value education. When I asked Jennifer, a CHEK clinician, if education level is an issue for women, she said that lack of education causes poverty and drug use. She went on to blame individuals, families, and “Appalachian” cultural values for lack of education,
They don’t have a GED [General Equivalency Diploma]. Some of them don’t even have you know the intellect to pass a GED so you have got people dropping out of school early because of the poverty; because of you know their families probably not encouraging them to go. They don’t have any kind of degrees or education and they’ll tell them, I’ve heard it more than once, several, a whole lot of times; you know, “Go out and get your own check now. You’re 19, 18, you need to get your own check now.” And so it’s a generational thing of staying on disability or Social Security.

Karen partially blames women’s marginalized positions on their lack of intellect. Another Horizons clinician complained that women are poor and have a lack of education because they live in a “culture that doesn’t respect education.” Women are seen as lacking because they live in a harmful Appalachian culture, make poor personal decisions, and have intellectual deficiencies.

This idea that education in itself will save Appalachia is not new (Billings 2007). While strands of public health have analyzed social factors in health for centuries, other strands have a history of focusing on education, rather that social or environmental factors (Anderson 2006; Braveman 2012; Trostle 2005), including in Appalachia (Barney 2000). Every single woman I spoke with except one wanted an education and all hoped their children would make it to college. The one woman, Nicole, who does not have and does not want her GED has severe dyslexia and, at the same time, is one of the few women I interviewed who consistently has full-time employment with benefits. She does not see the use in a GED for herself. Overall, education is important for these women and their families.

Gatekeepers characterized drug use in other individualized ways, at times playing into stereotypes of Appalachians as uneducated and violent. Service providers and most female clients agree that lack of available jobs that pay a living wage is a large motivator for entering the illicit drug economy. On the other hand, local Adams County politicians
with whom I spoke blame drug users for industries not relocating to the area because the
employers do not think they can find enough local workers to pass drug tests. Blaming
certain sectors of the community for lack of private investment is certainly not unique to
Appalachia (Maskovsky 2001). One employer I talked to in a non-Appalachian urban
area said she no longer hired anyone from Eastern Kentucky because of their supposed
drug use. Others connect drug use to the stereotyped inherent lawlessness of
Appalachians. Horizons staff members showed clients the film *The Wild and Wonderful
Whites of West Virginia*, which outlines members of a family who are all involved in
illegal behaviors, in an attempt to explain drug use in the area.

These individualized understandings of drug use are present throughout the US
and have consequences. Representations in US popular culture often equate drug use with
addiction and symbolically mark drug users as “others” who harm themselves, their
children, and society (Singer and Page 2013). Howard Becker (1963 [cited in Singer and
Page 2013]) argued over 50 years ago that deviance is not about individual behavior, but
about how those in power publicly label other’s behaviors as wrong and act upon those
labels. This othering process is a form of symbolic violence, where at times drug users
themselves internalize society’s harsh stigma (Singer and Page 2013). Policies based on
stereotypes of women who use drugs that do not acknowledge the context in which they
use serve to further isolate women through application of stigma (O’Hare 2015). Stigma
threatens people’s abilities to engage in activities that support their understanding of what
makes them a moral person, such as caretaking, employment, and religious experiences,
and thus stigma threatens an individual’s personhood. At the same time, rebuttals to
stigma often include people attempting to remain engaged in those activities (Yang et al.
2014). Women may not seek addiction services in order to avoid stigma (Radcliffe and Stevens 2008). In the context of stigmatized drug users, substance abuse treatment is underfunded and often overlooks inequalities clients face, such as unemployment and homelessness (Bourgois 2000; Carr 2011; Prussing 2008; Zigon 2011).

All of the women I spoke with are stigmatized because they have used drugs and are going through a program for it. This indicates to the community that they must have been using enough to get into trouble. Women embody the stigma associated with female drug use and are further stigmatized because of the marks inscribed on their bodies. Addicted bodies become marked, which serve as histories of criminal behavior (Biehl 2010). In the sociopolitical context of women’s lives, family, communities, and the state scrutinize women’s bodies. Non-injection drug user female participants continually degrade women who inject and have track marks for wearing long-sleeves in the summer to cover marks. Susan, who swallowed prescription opioids, said that injecting is simply not acceptable for women in particular. Since the local jail uniforms are short-sleeved, Anna describes the “walk of shame going to court with track marks” when inmates are walked from the transfer vans from the jail into the courthouse. Once you take that walk, the entire community knows you inject. Ashley feels like she is treated differently by health care providers, particularly when her arm is used as a teaching tool,

I’m thankful I ain’t got track marks, but I tell you what, I went to the hospital right after I stopped using and I had track marks. There was a nurse who asked if she could bring a training nurse in so she could look at my track marks and see what they looked like. And one of them was actually just a sore where I had scratched you know, I told you I get nervous and scratch, and she had thought it was a track mark. I just let her do her thing because she was trying to teach and I’m totally for teaching, but yeah, I think people treat me different.
Most detrimentally, law enforcement and CPS use track marks as a pseudo-drug tests. Several women are pulled over frequently, just so the police can examine their arms. CPS threatens women with child removal if they notice track marks on mothers or pregnant women, even those marks that have scarred. Ashley was again examined, this time by her CPS caseworker at Horizons, “[The caseworker] showed up today and I had to show her my arms, like, ‘Look, there ain’t no marks, I promise you, I’m not doing it.’ But I had to take my socks off and show her my feet and everything. You talk about embarrassing.”

In this place, women are incarcerated based on their drug use as well as their class and reputation. Yet their gender and ethnicity often turn encounters with the state from incarceration into encounters with CPS and substance abuse treatment. Their positions as mothers to white children qualifies them for this shift. This is not to say criminalization does not matter for these women, which is why I outline incarceration below. One of the state’s most damaging responses to substance use is the criminalization of users. Though my research and interview questions were centered on substance abuse treatment, women at times recentered the conversations on law enforcement, incarceration, and CPS.

Encounters with law enforcement and CPS not only serve as precursors to experiences with treatment, but I suggest that the techniques refined in penal institutions have bled into the additional state programs that are explicated here. All of these state responses have several characteristics in common. They are all intrusive, focused on personal responsibility, and profoundly underfunded and understaffed. The rhetoric of personal responsibility and noncompliance forecloses the possibility of women explicitly and openly critiquing programs. Yet these programs are productive in a plethora of ways, such as helping create underground and often unorganized networks of resistance. In a
Foucauldian sense, the power in these programs is productive as it creates the desire to become “normal” through examinations, or judgmental observations, that reveal gaps between what is deemed abnormal and normal (Foucault 1977).

The US War on Drugs is linked to moral arguments that allow the state to confirm its authority over criminals, while, at the same time, granting the state the ability to relinquish provision of social services. Increased incarceration rates in the US are not in response to more crime, which actually decreased, but are in response to the marginalization of populations through the withdrawal of state welfare services and the restructuring of work (Beckett and Western 2001; LeBaron and Roberts 2010; Rhodes 2001; Wacquant 2009). Thus, the disappearance of many social services does not signal the retreat of the state, but the restructuring of the state to spend public dollars on penal institutions and welfare entitlements for the rich rather than services for the poor (Crenshaw 2012; LeBaron and Roberts 2010). Techniques of the prison, including intense surveillance, interrogation and confession, and the implementation of sanctions, have spread to welfare offices, and in the current study, beyond (LeBaron and Roberts 2010; McKim 2008; Wacquant 2009).

The prison, and I argue, all the forms of state intervention I explicate here, “symbolize material divisions and materialize relations of symbolic power” (Wacquant 2009, xvi) as those who are already marginalized are most likely to face intrusion, and these intrusions exacerbate poor material realities. Increasing imprisonment rates and welfare reform simultaneously remove entitlements from families, attempt to push adults into exploitive wage markets, and are justified by discourses that paint the poor as moral derelicts (Davis 2004; Wacquant 2009). Incarceration creates debt, as inmates accrue
court fees and child support arrears (LeBaron and Roberts 2010). Mass incarceration strains the care networks of vulnerable communities, limiting navigations of economic and social inequalities (Roberts 2012). Prisons and jails produce poor community outcomes through numerous pathways, from providing low-wage and dangerous employment to stressing local infrastructure (Huling 2002).

Most women I spoke with have been imprisoned at the regional jail that is located in Adams County and serves women in all the counties except Teller. Teller has a separate county jail. The regional jail, according to women who have been incarcerated at various facilities, is comparable to other county jails. Women are sent to the regional jail during pre-trail and pre-sentencing periods if they have not posted bail. Generally, if they are sentenced to less than one year of incarceration time, no matter the charge, they are kept at the regional jail. For sentences greater than one year, they may be sent to state or federal facilities, depending on the charge.

The gatekeepers to the jail are local police. Like other programs in the area, law enforcement departments are underfunded and continuously have positions cut or remain unfilled after a retirement. Reflecting trends across the US, these police departments are controversial. The Douglas County police department paid hundreds of thousands of dollars for a police brutality case the year before my fieldwork. During my fieldwork, the Douglas fiscal court judge had an editorial published in the Douglas newspaper critiquing the police department for using excessive force on inmates when the police were bringing them into court. But when Lizzy attempted suicide via her car, she thanked the police officer who responded to the car accident for saving her. He worked to keep her out of
jail and to put her in treatment. She was charged with one felony, but she could have been charged with multiple felonies, and the officer is helping her expunge her record.

Only two clients I spoke with, Hazel and Barb, and one Horizons peer support, Naomi, had been to prison. All three had also been to county or regional jails. Of the 40 clients interviewed, fourteen had served time at the Adams regional jail and eight were incarcerated at another county or regional jail. Hazel and Naomi said that prison has better conditions than regional or county jails because you receive more medical and substance abuse treatment services and are allowed to be outside. At the Adams County regional jail, female prisoners are locked down in their cells almost 24 hours day. Inmates have no outside time, and are only allowed out of their cells for brief visitations with family and occasionally friends. Male inmates are allowed outside for work release. Service providers, especially those in drug court, talk about incarceration as a moment that can be a “rock bottom” for women that forces them to change. However, only three women talked about incarceration in this way. April said incarceration positively affected her life. Her family, who lives a few hours away from her, discovered she was on drugs because of her arrest and rallied to support her recovery as she entered Horizons.

For most women, however, the regional jail exacerbates their marginalized positions in numerous ways. Women lose housing and income streams while incarcerated, must pay booking and drug screening fees, and live in crowded and unhealthy conditions. Lela, who eventually entered drug court, lost a factory job that paid a living wage and her house went into foreclosure when she was incarcerated. Like other women with jail experience in this study, she was disenrolled from SNAP when imprisoned and had difficulty reenrolling. Lela called the regional jail “nasty” and has insisted on being
regularly tested for HIV and hepatitis C since she was released. Several women living in her pod disclosed their hepatitis C status to the other inmates with which they shared close quarters in an effort to prevent disease transmission. Lela practiced tattooing within the jail as an economic survival strategy in an effort to pay for her court fees and needed toiletries and food items in the jail commissary. She remained concerned that such activities as tattooing would lead to hepatitis C infection.

At the county level, the jail utilizes most of the local budget. Cas, the Adams County fiscal court judge, said, “The jail has killed us.” Adams County government has had to reduce budgets for every program funded through the county to pay for inmates, including the budgets for county roads, parks, and schools. Cas said he would like the county government to do more in terms of substance abuse treatment and housing, but they do not have the funding. According to drug court staff, women, and the local newspapers, the Adams County regional jail generally has a quarter to a third more inmates than it is built to house. None of the women I spoke with received any substance abuse treatment, psychiatric services, or job training or placement while in Adams County jail. The most extensive health care I heard of being regularly applied is women being given the medication they were already prescribed prior to incarceration. Some women, if they know the guards, may receive acetaminophen, clonidine, and the antihistamine diphenhydramine to help with withdrawal symptoms. Yet women are often prevented from taking their prescribed medication, like medication for hypertension. During my fieldwork, the local newspaper reported that a man died at the jail because he did not receive timely medical care for a ruptured spleen. Most women are scared to go to the regional jail because they fear they will die or at least get sick there.
Hazel, who had a court date approaching with almost certain jail time following, was visibly shaking when talking about going back to the jail. She listed a number of deaths at the jail, including two women who died of overdoses. Her father died at the jail in the early 1990s. He was in his early thirties, and jail officials told Hazel and her family that he died of a sudden heart attack. Hazel was later told by several people, including a former corrections officer, that her father was injected with something and then died. She remained convinced that a jail staff member murdered her father. Elizabeth, a research assistant who works with many individuals incarcerated in county and regional jails throughout Eastern Kentucky, said that women simply do not get health care at jails until they are dying. She attributed this lack of care to inadequate funding as well as general disregard for inmate wellbeing. She worked with several women who had hysterectomies because they had infections that went untreated for years while incarcerated, despite their complaints of pelvic pain. Elizabeth worked with another woman who had complained about being sick for well over a year before she received health care. The woman was diagnosed with stage four cancer and died within two weeks of diagnosis.

The focus on incarceration is changing, perhaps more so rhetorically than materially, but drug court represents a move away from solely incarcerating those who use drugs. Drug courts have primarily evolved in the US because state and local governments are concerned about rising incarceration rates and costs. Policy makers have begun to understand addiction as a medical disease that requires rehabilitative and therapeutic services, not incarceration (Klag, O’Callaghan, and Creed 2005). Kentucky policy makers from the federal level, such as Senator Rand Paul, to the county level, including politicians interviewed for this ethnography, talk about reducing incarceration
rates and increasing alternatives to incarceration, like drug court. At a state ASAP meeting in Frankfort, Kentucky, John Tilly, the secretary of the Justice and Public Safety Cabinet, described overdose deaths and overpopulated prison populations as a “public health disaster.” He said the state must treat addiction as a disease and not a crime because incarceration is not working in Kentucky.

The spread of a drug court model has occurred simultaneously as an increasing interest in restorative justice, which focuses on personal responsibility, remorse, and attempts to have offenders resolve negative deeds (Chiplis 2010; Wenzel et al. 2007). Drug court does incorporate rehabilitative and therapeutic components, but it nonetheless continues a focus on punitive measures through threats of incarceration and child removal if someone fails to progress through the program. Efforts to funnel those who use drugs into treatment rather than jails still represents an individualized response to drug use that does not address the social conditions in which use occurs (Crenshaw 2012).

Race comes into arguments for refocusing responses to drug use. I often saw an allusion to Appalachians’ whiteness at regional or statewide meetings. In a state ASAP meeting, a local administrator contended that we must increase funding for treatment and naloxone because now opioid use affects everyone, including rural young people. Though he did not mention race, every picture he showed in the presentation was of white young people. Amy, a local nurse, blamed the spread of drug use on urban areas, “In the past, you thought you didn’t get exposed. If you raised your children here, you didn’t get the exposure to bigger city problems. That’s not the case anymore. You thought if you were in a small town, that you didn’t have the problems that the bigger cities have, but it’s in
the small towns now.” In combination with her discussions of crack, I take “bigger city problems” to be coded as being located in urban communities of color.

Prescription drug misuse in rural Central Appalachia is situated in a particular socioeconomic and political context that shares similarities with some other regions nationally that have seen dramatic increases in opioid use and overdoses, namely areas where pharmaceutical marketing and distributing was intense and where there is a depressed economy. Yet pharmaceutical misuse has increased across the US, which may be in part due to larger trends in how pain is treated, the power of pharmaceutical companies, and the pharmaceuticalization of health. Nationally, responses to prescription drug misuse have focused on individual and at times cultural failures, relying on punitive models. Yet how these responses are experienced differ according to such factors as gender, geographic location, race, and class.

Criminalization comes into substance abuse treatment, which I will detail in Chapter Four. Yet treatment blurs lines between sanction and access to desirable and useful services. Mass child removal has similar effects on communities as mass incarceration, hampering meaningful family connections and collective social action (Roberts 2012). I will further explore the entry of CPS into women’s lives in Chapter Six. In the end, women who are mired in inequalities are swept into institutions that are marginalized and marginalizing. Even when women accept the discourse of personal responsibility, they nonetheless feel stuck in these systems, as expressed by Lela when I asked her about experiences with government agencies,

Well, I done everything to get myself in the messes I’ve been in. You know it’s nobody’s fault than my own. But my God, it seems like once you’ve been through this, where do you go for help? Like right now, I’m clean, my husband, he could
pass a drug test, but how do I go about getting my kids back? [crying] I mean I just don’t know where to pick up and go.

Women in this study are subjected to an “exclusionary regime” which includes a “dense coalescence of punitive forces” that emanate from modes of governance, both within and beyond the criminal processing system, and discrimination based on the stigmatization of women who use drugs (Dewey 2014, 1139). Yet they do their best to get around these regimes, which I hope to demonstrate in the following chapters.
Chapter Four

Strategies in Therapeutic and Rehabilitative State Iterations

There are three substance abuse treatment options available in the five county area that reveal therapeutic and rehabilitative state aspects. All are government funded and regulated. Horizons is usually court-ordered through the family court system. Women are unlikely to retain or receive child custody if they fail the program. Drug court is court-ordered through the criminal processing system and those who fail are incarcerated. Funding streams and government regulations constrain program operations, but staff navigate these limitations in order to provide what they think are the best services.

There are areas of discordance and confluence between programs, communities, and clients. These gaps provide opportunities and complications, as women in treatment are required to navigate multiple mazes that have contradictory overlays. Most importantly, the state is not monolithic, and neither are people’s encounters with it. The vast majority of women agree that these programs are needed, but do not adequately address addiction or inequalities. These services in some ways meet women’s needs, and in others provide more “hoops to jump through,” in the words of several participants.

Through this chapter, I present an overview of each of the treatment programs using program documents as well as staff interviews and participant observation. I utilize gatekeeper interviews to outline their hopes and concerns for treatment. For each type of treatment, I take interviews with clients to reveal what they understand to be the benefits and problems with specific programs. Stepping back in the last section, I utilize
interviews with women show on a broader scale what they hope to get out of substance abuse treatment and what ultimately makes programs beneficial or problematic.

*Treatment for mothers*

The intensive outpatient Horizons program is housed within CHEK. According to Horizons and CHEK staff, treatment consists of group therapy, individual therapy, at times, NA style support groups, and random drug testing. Group sessions include a range of activities, from learning about parenting, coping skills, trauma, addiction as a disease, nutrition, relationships, and job readiness. Individual therapy deals with substance use, mental health issues, domestic violence, and parenting. Case management is focused on poverty and domestic violence. It aims to assist women in accessing transportation, education, employment training, legal services, and medical care. Clients must participate in groups and case management throughout the program. Although not described by Horizons staff, clients talked about watching movies, coloring, and doing errands with case managers during group session times. From my own observation of being at CHEK, there are numerous smoke breaks and informal moments to talk.

Program documents and staff said that clients are expected to attend the program three to six hours a day from one to five days a week depending on the program phase. The program is divided into three phases and women have access to aftercare once they graduate from phase three. Each phase lasts approximately two to three months. Some clients may take substantially longer in each phase, due to individual circumstances. Phase one is the most intensive in terms of the time spent in counseling on a weekly basis. Participants must attend three group-counseling sessions per week. In phase two,
participants must attend two groups per week. Participants only have to attend one group per week in phase three. In all phases, clients must attend two hours of individual counseling sessions per month. Aftercare lasts six months, where the number of group and individual session requirements is lessened every two months. Through the phases, the overall programmatic focus of group sessions is constant. However, clients’ individualized program plans, which they create with Horizons staff, may change. For example, staff may ask clients to focus on passing drug tests in phase one, require clients to create a resume in phase two, and ask clients to apply for employment in phase three.

“Graduation” from a specific phase is based on attendance records, drug screenings, and staff ratings of client progress. Women must attend at least 90 percent of group and individual sessions and must have negative drug screens for 30 days. Staff said their rating is generally based on women’s attitudes in treatment, including whether they speak in counseling sessions, are pleasant to other clients and staff, and attempt to reach goals outlined in the individualized plans. Three-quarters of clients who graduate all three phases remain in the program for at least one year. Graduating phases is important to women because graduating a phase may positively effect their CPS case and increase child visitations if they do not have custody. Alternatively, if they do not graduate a phase or are demoted a phase, they may lose visitation rights or permanent custody.

According to Horizons brochures, the program has the following goals for participants, in no particular order: 1) attaining education and employment; 2) ceasing criminal activity and increasing positive community engagement; 3) learning self-care and coping; 4) accessing needed health care; and, 5) moving through the program in under one year. If participants complete Horizons, their children are supposed to be
placed back in the home if they have been removed. The most often repeated goals in program documents are to place children back in the home and “Reducing [participants’] dependence on public assistance by addressing barriers to self-sufficiency.” Horizons service providers repeated these goals, saying that after completing Horizons, participants should be returned or retain child custody, should remain sober, and should become “self-sufficient,” meaning they do not have to rely on Horizons programming or social services, such as SNAP and Kentucky Transitional Assistance Program (K-TAP).

Gail, the former Horizons regional administrator, said that one of the program’s focuses is parenting. The TANF block grant that initially funded the program required this focus. Horizons is sometimes referred to by women and those in the community as the “parenting classes.” Staff utilize parenting books as a primary source of program materials. The group counseling room is set up with a large table and a side area with children’s toys, cribs, and bouncers. According to the current counselor, these items are used to help women practice parenting techniques and they may bring young children to Horizons while completing certain program requirements, such as drug testing.

Horizons has locations in Adams, River, and Eagle counties, and also serves women in Douglas County. Program documents reveal that Horizons provides services to approximately 50 women a year in Adams, 40 in River, and 20 in Eagle. Staff said these numbers generally reflect the capacity of the programs, rather than the need, where women are put on waitlists for services. Most staff work at multiple programs or switch from one county to another based on need. Clients said they seek services from multiple Horizons sites if they move, think they cannot seek treatment in the same county in which
they used, or if they have a conflict of interest in their home county Horizons or CPS offices. These conflicts most often occur when a close relative works for the CPS office.

The relationship between the state and Horizons is defined by shifting funding and differing understandings of best treatment practices. When Horizons relied on the TANF block grant, their funding was continuously cut at the federal and state levels. Currently, if they cannot bill Medicaid for a service, they have difficulty offering that service. Of the different groups of providers I spoke with, Horizons staff are the most keenly aware of how structural inequalities affect health and drug use. Gail knows her clients have unmet needs, but feels like, “We’re doing as much stuff as we can.”

Decreased funding has limited case management the most, resulting in inadequately available services. Brittany complained that she did not receive case management when she was a client, and now that she is peer support, she has nothing to offer clients. Horizons does not have funding and neither do other safety-net programs in the area. Becky framed her case manager position as being sometimes irrelevant because she has no budget. Her job then becomes about encouraging responsibility among clients,

Technically a case manager is there to help a client find resources to cover their needs, but when you don’t have any funds, there’s not a whole lot you can do to help them other than fill out applications and take them to the store. We do transportation some. We try to help them to be responsible. When they first get in here, try to encourage them to keep their doctors’ appointments.

Becky received $2000 for case management in 2014, and $100 in 2015 to help 20 clients. One client, Sissy, commended Becky for being handy with duct tape and super glue, fixing air conditioners and car engines. There are some things you cannot fix with this.

Although women may be targeted for state intervention and have access to particular resources because they are socially designated as primary caregivers, treatment
programs nonetheless fail to provide resources for this social function. Horizons staff and administrators are frustrated by the absurdity of asking mothers to choose between treatment and working to house and feed their children. Yet Horizons and other programs do this as they make demands for therapy and drug testing that do not accommodate work schedules. Women often miss treatment because they do not have access to childcare.

Horizons administrators ensure that they work within state guidelines and structure the program to survive in a changing financial landscape, but they push these guidelines as best they can to serve women in ways they see as progressive. For instance, when distributing gas cards for transportation to Horizons, they do not examine how clients use these gas cards. Most staff have nuanced understandings of sobriety and the usefulness of treatment. Horizons staff and administrators support women entering buprenorphine and methadone clinics. Becky considers a substantial decrease in use, even if women continue to, for example, take a prescription pain reliever every night before bed, a success, especially if women can be cognizant enough to take care of their children. Yet Horizons staff ultimately have to report to CPS and at times drug court, which creates tensions both between the programs and between Horizons and their clients.

There is a strained relationship between Horizons and the communities where the programs are located as every person I spoke with, whether pastor, local government, or school teacher, has an opinion about Horizons. While those who have personal experience with the program or know someone who has have generally favorable views, from my participant observation in the communities, Horizons is seen as being too lenient. This in part lends to the community stigma of the program. Becky said the negative characterization of Horizons keeps women from the program, “Now it’s so stereotyped
that if you’re in this program you’re a ‘loser mother’ and you’re in trouble with the social worker. To the point that for some people, even if they wanted help, they wouldn’t come into the program because they were nervous about [Horizons].”

Horizons and CHEK administrators said that staffing is an issue. According to a CHEK administrator, I was seeing Adams County Horizons at a turbulent time. From spring 2015 to spring 2016, the program had five different clinicians. This turnover is important because Horizons has one clinician at a time. That clinician not only runs individual counseling sessions, but directs programming by creating rules and deciding on how group and individual counseling sessions are implemented. When I spoke to them, these clinicians cited a number of reasons why they quit. Some of these reasons have nothing to do with the program. Gail simply retired after a decade’s long career with CHEK. Judith was diagnosed with late stage cancer and was no longer able to work. Two other clinicians cited the very low wages at CHEK, compared to other employers both within and outside of the area. One of these clinicians did not like the rural geography of Adams County, and quickly moved to a small city in Eastern Kentucky.

Former CHEK staff maintained that the chaos I witnessed is not unique, but a longstanding issue at CHEK, where communication between administration and staff is poor and the wages are so low that there is constant turnover. Administrators claimed Horizons loses clients when they do not have stable and quality personnel. As Brittany noted, if you have staff turnover, women will just leave, because they are tired of retelling their story, which “retraumatizes” them. CHEK does not have the funding to pay people competitive wages and many health care providers are not willing to relocate to a rural area, where their partners may be unable to find employment and their children may
not have access to quality schools. What my interview with Becky, a current CHEK case manager and former client, made clear is that peer support and case managers are in similar if not the same marginalized positions clients are in. Most have criminal records, and although they have a job, it is low paying and emotionally stressful. Becky, for instance, is managing her own sobriety while living with a partner and son who still use.

In response to changing Medicaid reimbursement, Horizons has shifted from offering more individual counseling services through a licensed clinician who is better paid to offering more group counseling through peer support who are less trained and paid less due to Medicaid reimbursement. The role of peer support and other lay providers has been widely debated. Efforts at biomedical professionalization have served to delegitimize women’s non-biomedical knowledge (Barney 2000; Reagan 2010). Yet service providers argue that having professional resources, such as credentials, assist them in serving their clients and maximizing their acquirement of resources for the program and clients (Hall, Baldwin, and Prendergast 2001; Wies 2013). Health care settings can be intimidating, especially when services are coercive, so peer support offers a bridge between the setting and the community (Harris 2016). In Horizons, peer support are former clients who have at least their GED and six months of training through CHEK. Their jobs include leading some group sessions, checking in with clients on a daily or weekly basis, and trying to provide some case management services, such as clothing and food boxes. Peer support is a relatively new position and administrators are excited by the prospects of peer support being role models to clients, serving as a liaison between clients and clinicians, and offering former clients a method of employment. For Gail and another administrator, Bill, peer support offers a new avenue of surveillance. They hope peer
support will be able to “call out” clients in ways that clinicians cannot or be able to tell when clients are trying to “con” staff because they have experience with drug use.

Almost a third of clients whom I interviewed agree that peer support are helpful because they have been in the same situation as clients in the past. Several said they only stayed at Horizons because one peer support staff member, Naomi, cares about clients. Yet other clients, such as Katie, become annoyed with peer support because they need resources, such as childcare, and peer support seem to be there only for emotional support. Katie, Maggie, and Theresa complained that peer support are too untrained to be helpful, because they do not seem to know how to connect women with resources or how to lead NA or other group counseling sessions. Other women had previously used with Horizons staff and cited this as a difficulty in working with peer support especially.

During my fieldwork, there was a scandal with Horizons peer support. Two peer support staff were being coercive to clients in ways that clients found uncomfortable and inappropriate. Horizons addressed these concerns by demoting one peer support. The other peer support resigned. Both clients and staff alerted me to these incidents. Two women dropped out of the program following the scandal because they felt they could no longer trust peer support or CHEK more broadly. In many ways, I see this as another instance of structural violence bleeding into women’s lives through underfunded health care. Peer support are not paid a living wage and face similar barriers to accessing adequate substance abuse and mental health services as clients.

CHEK and Horizons staff find themselves in tight situations, becoming constrained mediators between the state government, various state agencies, communities, social understandings of drug use, and clients. While self-identified progressive
organizations may offer spaces to contest oppression, administrators and staff are
discursively and materially limited in a system that espouses self-regulation and creates
institutions where staff earn below the living wage. It is hardly fair to expect staff in such
positions to resist the systems of power that marginalize their programs, their clients, and
themselves (Lyon-Callo 2008; Uzwiak 2013; Wies 2013).

Clients are well aware of Horizons’ economic marginalization and become
frustrated that staff members have to make do with few resources. Some women are in a
constant state of panic because they do not have housing or food. Yet when women
complained about lack of services, they were rarely complaining about the staff per se.
When I did hear women’s complaints about staff, it was because some offered
inappropriate resources. For example, women with felonies would ask for housing help,
and be handed applications for places that do not take felons. They would not find out
about their ineligibility until they went through the application process. When clinicians
left Horizons, clients were quick to justify their departure, stating that clinicians were not
paid enough at Horizons. Still, a third of participants said staff turnover negatively
affected their experience with Horizons. Every time they had a new clinician, they had to
retell their story, build rapport with another person, and learn a new set of program rules.

The loss of confidentiality harmed women. Women blamed staff as well other
clients for these breaks. A third of those who had been through Horizons had problems
with information leaking from the program into the community. For these clients, they
said they only felt comfortable talking in individual sessions. This is problematic since
clients only receive two individual sessions a month due to Medicaid reimbursement.
Three women found sharing difficult not only because of confidentiality issues, but also
because they have intense social anxiety, which group sessions exacerbate. Several agreed that talking in individual or group sessions is only helpful up to a point. Sarah quit Horizons because she was tired of talking about and reliving the past, without looking to the future, “I didn’t feel like talking. I wanted to talk about things that would help. The past is the past, it can’t change. I want to talk about the future.”

Overall, treatment program clients cited inadequate case management and breaking of confidentiality as their primary problems with Horizons. There was one aspect unique to Horizons that the vast majority of clients cited as beneficial. Some women credited Horizons for helping them regain child custody and other women hoped that Horizons would assist them in regaining custody. Additional issues elicited more nuanced responses. Approximately half of women with Horizons experiences appreciated the program’s flexibility. They valued their individualized program plans for outlining their specific needs. Women felt as though staff treated each person as coming into the program with a unique set of experiences that required various staff responses.

The other half of clients equated this flexibility with a program that was biased and too lenient. This group more often expressed concerns that some women are treated more harshly than others. The program confused some of these women, because they would hear different rules and policies according to which client or staff member they were speaking to. They could not discern which aspects of Horizons are reported to other agencies. For some clients, Horizons just felt like another unorganized maze they had to wander through because they happened to get caught using and were not wealthy enough to afford a lawyer who could get them out of the program, “I just jumped through the hoops you know, played their game so to speak, I mean it’s really not that hard to do
what they ask and get your child back and still be an addict” (Sissy). Five women said the program is unstructured and that they have never understood the point of Horizons even after graduating or being in the program for months. Several called Horizons a “joke” after they were asked to color and watch fictional movies during group sessions.

Women take issue with particular aspects of Horizons. While some find the parenting modules helpful in giving them ideas, like making child bath time enjoyable, over half of clients said the parenting materials are useless because parenting is not their problem. The consequences of substance use are their main concern. Some make fun of the parenting modules, saying it is a “waste of time.” Others are offended, saying that program materials are so basic that it makes them feel like staff think they are “stupid.” Others argue they do not agree with how the materials define what a “good” parent is.

Heather was annoyed with the material because she thinks it promotes consumerism and middle-class norms that she cannot and does not want to meet,

The textbook it was like, if your kid is good you can take him out to McDonald’s and buy him that. I’m sitting here looking at them saying, “I don’t do that.” And they say, “You have to reward your child for being good.” You can look at them and say, “Good job.” To me, it made me feel as if they were telling me to go out and buy, buy, buy. You can’t do that for a child and that was one of my problems. I can’t buy my 13-year-old video games after he mows the grass. Daddy has a good job but he still doesn’t have it that way. You don’t do things like that.

Criminalized treatment

Two state drug court administrators explained that the yearly drug court budget comes through the state and staff are trained through state offices. The state budgets enough to cover drug court basic services, but specific drug courts can apply for federal grants to offer expanded services. Adams County did not have a grant for expanded services. Similarly to Horizons, drug court treatment consists of group therapy, individual
therapy, and case management. Drug court and CHEK staff lead mandatory twelve-step
group therapy sessions for participants. The twelve-step model considers alcohol or drug
addiction a chronic illness. According to the model, sobriety occurs when individuals
change themselves to become more honest and display this honesty in public narratives
of their addiction (Cain 1991; Carr 2006; Garcia 2008; Prussing 2007).

At the time of this research, drug court participants attended one twelve-step
group session per week at CHEK. Yet Emily, the local administrator, referred few
women to CHEK’s Horizons program because she does not agree with their tolerance of
buprenorphine. Buprenorphine created factions among those in the counties. The rift
between Horizons and drug court is just an example of this larger debate. Participants are
required to attend a self-help group session outside of drug court and CHEK as well.
Since there are no local options for self-help groups, drug court contracts with a local
pastor, Ben, to provide twelve-step Bible-based group therapy sessions once a week.
While belief in a higher power is part of traditional twelve-step programs, the Bible-
based program focuses on this point and defines the higher power as the Christian God.

In terms of individual therapy, drug court contracts with CHEK to provide
counseling services. Participants regularly meet with Emily to discuss individual
treatment goals. These meetings vary in frequency depending on where someone is in the
program and if they are facing a current crisis, but at least occur weekly. Since Teller
County is not in the CHEK district, group and individual therapy is provided in that
county by another CMHC network. Drug court case management is focused on helping
participants meet program requirements. Drug court has random drug testing and
attendance policies, as well as specific requirements for housing, transportation, and
employment. Participants pay restitution and court fees. Neither Horizons nor buprenorphine programs have housing, employment, or court fee requirements.

Like Horizons, drug court orientation materials reveal that the program is broken into three phases and programming is based on creating an individualized program plan. Drug court graduation has more requirements than Horizons. Participants must make such accomplishments as attaining employment as well as completing drug screens and participating in treatment. Drug court is designed to last 18 months for felonies and 15 months for misdemeanors. Phase one is deemed the “stabilization phase,” phase two the “education phase,” and phase three the “self-motivation phase.” Drug court is more time intensive and stricter than Horizons. Participants must call drug court every morning to find out if they will be randomly drug tested that day. They have daily curfews requiring a call-in to drug court staff. For those living in Douglas County, participants must drive to Adams County to have a drug test. When participants are late for a screen, cannot produce enough urine, or drink too much water and have diluted urine, it is counted as an automatic positive, and they are sanctioned, which generally means jail time.

While client progression through Horizons affects CPS cases, progression through drug court affects both CPS cases and incarceration. If women have an open CPS case, moving into higher or lower drug court phases affects visitation and custody. If participants fail certain drug court requirements, they can be sanctioned with jail time or terminated from the program. If terminated, participants are incarcerated for the entire time that was deferred from their criminal cases when they entered drug court. Drug court may allow someone to forego incarceration, but they may still be charged with a felony that remains on the record and can negatively affect housing and employment options.
According to drug court documents given to participants in their orientation, the program has multiple goals, listed here in order from those most to least often mentioned: 1) attain and maintain employment; 2) reduce criminal activity; 3) sobriety; 4) pay restitution and child support; 5) perform community service; 6) earn at least a GED; 7) attain and maintain housing; 8) learn the disease concept of addiction and coping skills; 9) learn personal responsibility; 10) build self-esteem and confidence; 11) become honest; 12) maintain own transportation; 13) have drug-free babies; and, 14) learn how to be a “productive citizen” who is self-motivated and can budget their time and finances.

Service providers’ listed goals for treatment are shortened, and all said about the same thing, so these are listed in no particular order: 1) sobriety; 2) attaining and maintaining employment; 3) having drug-free babies; 4) learning personal responsibility; 5) learning how to act appropriately in the community; and, 5) filling your life with the Bible instead of drugs. Ben said that drug court is about learning that “life is hard” and beginning to work industriously without focusing on negative life events. Drug court staff often focus on relationships. Drug court, more than any other program, encourages participants to disengage from family and friends who continue to use drugs. If drug court staff hear that a participant is with other drug users, the participant is sanctioned and sent to jail. Particular understandings of morality bleed through these goals and interventions, not only in the Christian discourse, but in understandings of what it means to be a productive member of families and of these communities.

Several drug court staff agree that the goal of drug court is for people to become and remain sober, with fear of incarceration as incentive. For this fear to work according to them, drug penalties have to remain stiff. Emily, Ben, and two state level drug court
administrators thus lamented the passing of Kentucky HB 463. They said the bill made penalties so easy on drug users. Those with a criminal conviction could spend less time incarcerated than it would take them to process through drug court. Those eligible for drug court decided to serve their jail time rather than enter drug court. The legislature passed HB 463 in 2011 to curb the number of inmates coming into prison and jails. This effort included reducing sentences for minor drug crimes unrelated to trafficking. Andy, a now former drug court judge, disagreed with this analysis, saying he had seen more people through drug court with the passage of HB 463. Emily complained that she had not had a new person enter the Adams County drug court for over 18 months. Although she blames HB 463 at local ACADA meetings, she later told me that the relatively new Adams County drug court judge is not allowing enough people to enter drug court. For her, publicly chiding a local judge is dangerous for her own employment as well as for the drug court program, which he can shut down at any moment.

The drug court I focused on is located in Adams County and serves Douglas and Teller counties as well. Drug court brochures and orientation documents show that approximately 700 women a year enter Kentucky drug courts. Program sizes vary dramatically across the state due to population size and the drug court administrative team. The drug court team helps the judge to decide which cases should be admitted to and terminated from the program. The team generally includes the prosecutor and defense attorney, as well as representatives from CPS, CMHC, and law enforcement. Eligibility for drug court is based on medical, criminal, and drug use histories. All participants must be non-violent, non-sex offenders who have committed drug or drug related crimes and admit drug abuse.
Participants cannot have chronic conditions that require medication that interferes with drug screenings. Thus, according to Rose and Diane, drug court does not admit people who have co-occurring substance use and mental health concerns because of drug screenings as well as their inability to provide participants with appropriate care. Rose and Diane said that they do not want to “set people up to fail,” especially in rural areas where there is a lack of mental health care. This policy leaves those who are arguably the most vulnerable to languish in local jails, where they also receive no services.

Much like Horizons staff, drug court staff are mediators between the state government, local governments, communities, and clients. In Adams County, both funding issues and the judge threaten drug court’s viability. Prior to the beginning of fiscal year 2016, Emily, as well as other community members and drug court participants, were panicked that drug court would be defunded due to low participant numbers. At the last moment, state officials notified Emily that Adams County drug court would be funded for at least two more years. Emily blamed the smallness of the program on the new judge who is reluctant to send anyone charged with a property crime from district court to drug court. Apparently, the judge deems people ineligible if they have a past or current theft or burglary charge. As when a new clinician enters Horizons, when a new judge enters drug court, the program can drastically change.

The relationship between drug court and local pastors complicates ties with the state. Ben is a local evangelical pastor. He leads the mandatory weekly twelve-step Bible-based group. In my one observation, drug court participants barely spoke in this session. Ben said this was customary. The textbook for the group presents addiction as a moral failure where those who are addicted have decided not to follow God and must thus seek
forgiveness through Christ. In the group I attended, Ben repeatedly equated Kentucky and US law with God’s law, arguing that it is good that everyone in drug court has troubles with the criminal processing system. These troubles show how drug court participants are sinning against God. Another pastor, who works closely with Ben, told me that this model is important because “there is only a spiritual solution to addiction.” This belief makes Ben and Abe, both pastors counseling drug users within and outside of drug court, and the Pastoral Association wary of any government programs that attempt to address substance use because there is supposed to be a separation between church and state. This separation is obviously absent in Adams County drug court.

According to Emily, community buy-in of drug court wanes, because although some participants permanently succeed, others fail. No law enforcement are currently involved in Adams County drug court, which is an anomaly for Kentucky drug courts. This is because they “have lost interest” (Emily). Andy attributes this loss of buy-in to a misunderstanding of drug use in the community and among certain service providers,

Drug court has successes, drug court has failures. I learned a long time ago, success isn’t always a black or white situation. When I first started this, I thought I could if not save the world, at least save the county. And now I don’t know if I can save one individual because you have so many setbacks. Sometimes if you just keep them alive, you’ve made a win. And you’ve got to accept the cliché, relapse is a part of recovery. So I try not to get too high on a success or too down on a failure, I just try to live with it. And we’ve had a number of drug free babies. And my job is to yell and scream and hold people accountable. Most people come into drug court, if not virtually all of them, come in to get out of jail. That is reality. We are not going to turn their lives around. Only they can turn their lives around when they decide to do it. But we give them an opportunity, we give them the education and the treatment if necessary and some of them do see the light.

Along with a nuanced definition of success and failure, Andy delicately talked about the context of drug use as well as individual accountability, as further highlighted below.
Sometimes service providers outside of drug court view the program as harsh. This is why they stop supporting the program, not because relapses offend them, as the Adams Housing director indicates, “And I just really get so frustrated that it’s easier for these individuals to get their drugs than it is to get help. Programs make it so difficult to get their help. They’re like, ‘Well if they get out here and work for a pill, they can work for their sobriety.’ But I think it should be a little easier than getting a pill.” A few Horizons and CPS staff agreed with this assessment. Even Rob, a former drug court judge, said requiring participants to have their own transportation and pay court fees makes drug court difficult. The highly involved nature of drug court may create situations in which it becomes more costly in terms of time and finances than incarceration (MacLeish 2015).

Andy characterized drug court as an imperfect system, but nonetheless offering the best opportunity for recovery. This was a common sentiment expressed by drug court staff. At the time of our interview, he was the judge for drug court in a county that bordered River County, but is not in the five county area I describe. He said he was not wed to the drug court model, and would do whatever he could to help his community. He thinks drug court is the best option the county government has to address substance abuse, I’ve seen results of some studies that show drug court has higher degrees of success than other things. I think of all the things I’ve seen, drug court is the best thing going, with all its imperfections. Tell me what’s better, and if anybody wants to complain and wants to come talk to me with a better idea, I’ll listen to any idea that may do it better, and if it sounds like it might, I’ll try it if it’s within my capabilities to do it. And I’m not sure what’s best; this appears to be. I can tell you one damn thing though, it ain’t best just to do nothing and just ignore the problem and pushing it under the table. And that was one of the earlier problems.

Andy highlighted one primary imperfection he saw in drug court. He heavily critiqued the lack of funding at the state and federal levels. Andy claims his drug court was more successful than others when he applied for and received a Substance Abuse and Mental
Health Services Administration (SAMHSA) grant to provide additional resources in drug court that are not funded by the state. These resources primarily include wrap around services, such as paying for utilities, transportation, or an apartment deposit. Andy repeatedly said that drug use is a symptom of poverty and marginalization, not the cause. He recognizes that drug court participants should be assisted in attaining resources if they are expected to succeed. Yet Andy’s drug court lost the grant, and he was no longer able to provide those services. He saw this as a great hindrance. Like other programs, drug court faces a similar cultural and economic marginalization as its clients.

Women cited the highly structured program as one of the most useful aspects of drug court, especially in helping them make it through the first several months of sobriety. Those who had encounters with both Horizons and drug court said that drug court helped them more because of the structure. Compared to Horizons, drug court required more random drug screenings, curfew checks, housing, transportation, and either employment or volunteer work. Further, unlike Horizons, drug court sanctions are tied to incarceration. Star praised drug court for forcing her to earn her GED and her driver’s license. She learned how to be a social person without drug use, particularly fulfilling her roles as a “mother, wife, friend.” Brittany appreciated drug court for teaching her how to be accountable for her actions, to both her peers and the judge. Overall, these activities help women stay busy so they do not think about their drug use or “running” lifestyle.

Nicole values drug court for teaching her to be “normal.” Her children are her motivation in this quest,

[Drug court] is a place for you not only to get clean and for you to learn how to live without using, but it is a program to stabilize you. To teach you how to live from what you’re used to living. It teaches you the norm. Now, I work a full-time job. I work 40, 60 hours a week, I go to school, I do my NA meetings, I do my
group, I do my individual counseling sessions, I do my court appearances, and I do my drug screens. I understand why drug court is so strict, because a lot of people laugh it off and they try to fake it to make it. There’s not a day that goes by when I’m having a bad day that I know that you can take a pill, and you’ll feel okay for a few minutes. The whole world will disappear and all your problems and cares will go away. What keeps me from it is my children.

I had contact with Nicole three times over one year, and she repeatedly spoke warmly of drug court, including its strictness. Women’s only problem with the structure comes when drug court ends and that structure is instantaneously removed, without any support in the form of self-help groups or other transitional programs in the rural communities.

Clients experience some fissures in the relationship between rural drug courts and the urban-centric state guidelines. The obligations, outlined by the state level, seem to be made harder by living in a rural area, especially requirements that all participants have their own transportation. The transportation requirement was one of Alisha’s largest hurdles. Getting transportation to and from Teller County was so difficult and she did not have a car, that she “almost slipped back to bad behaviors to manipulate someone to give me a ride to drug court.” While Nicole was never sanctioned for having a positive drug screen, she was sanctioned multiple times for being late to a drug screen due to her extensive driving across rural areas. Nicole has to work second shift so she can make it to her drug screens on time. On the days she works, she drives 80 miles to work, works for at least 12 hours, drives 80 miles back home, rests for an hour and a half, and finally drives 30 miles to her drug test. When we completed our interview, she had been awake for several days due to her job and drug court obligations.

Kentucky drug court orientation literature explains the importance of attending self-help groups and finding the group that works for each individual, since not every group is successful for every person. While this sounds conducive to meeting individual
needs, drug court participants in every county except Teller have only one option for group. In Teller, they have two options. In Adams, Douglas, and Eagle counties, the only group is Bible-based, to which some women take exception.

I felt the preeminence of Christianity at drug court graduation, where there were prayers and hymn singing. Speakers in recovery called addiction not a disease, but a “sin problem,” which contradicts explicit drug court goals. When a pastor from an inpatient facility stood to speak, Katie, Heather, and several treatment program participants whom I had interviewed left. I heard someone say, “I didn’t come here to get saved.” I asked Heather about it later, and she told me that she left because she felt uncomfortable with the heavily Christian ceremony. Only two women found the Bible-based group session through drug court helpful. As Jarrett Zigon (2011) argued, religious practices may offer hope in redemption and methods of navigating stress. While most think the Bible study is simply boring, others are offended, as demonstrated by Alisha, “Because I felt forced into religion and I have peace with my faith and I didn’t think it was something people should be mandated to go to. I thought it was pushing religion. I didn’t feel like God was the cause of it so why should he be the sole fix of it?” I am not suggesting an elimination of such programs, but argue against situations in which these programs are the only available and are forced upon women, as is the case for Adams County drug court.

The most fundamental complaint women expressed about drug court was how staff treated relationships. Clients thought staff deemed relationships positive or negative based solely on drug use, yet women felt these relationships to be more complex. Alisha, for example, relied on her father and son’s father for emotional and financial support. Both of these men continued to use while Alisha was in drug court. Rob, a former drug
court judge, told Alisha he would send her to jail if she did not stop seeing these men. Alisha nearly quit the program over this order and she found her remaining time in drug court to be almost unbearable. At the same time, drug court can force others who used drugs together but are now in recovery to remain with each other through the program. The program is run for both men and women without separation. When partners are asked to complete drug court together, sometimes the program forces former drug using partners to spend all of their time together, instead of coercing them to cut ties. Heather and her husband went through drug court simultaneously in Adams County. Heather’s husband was abusive and competitive. He made drug court a twisted game, where he would become violent if he thought Heather was doing better than himself.

_Buprenorphine_

At the time of my fieldwork, being able to pinpoint a buprenorphine program’s structure was nearly impossible due to constant shifts. Some programs opened and closed repeatedly without warning. Requirements at other settings changed sporadically. According to providers and state level administrators, this chaos was caused by consistently changing reimbursement rates and federal and state level buprenorphine regulations. They were unsurprised by the chaos considering buprenorphine’s relative novelty and quick uptake across the country.

Debbie, a buprenorphine provider, spoke extensively of federal and state buprenorphine guidelines. Prescribers must undergo SAMHSA training and be specially licensed with a DEA number to provide buprenorphine. Providers may only have up to 30 patients at one time in their first year of prescribing. In the second and subsequent
years, providers may apply to SAMHSA to qualify to have up to 100 patients. The DEA can audit a provider at any time to ensure they are only serving 30 or 100 patients at one time and are prescribing legitimate dosages. All Kentucky clinics have drug testing and a behavioral modification component as mandated by the Kentucky board of licensure. This mandate reflects federal clinical guidelines. Some clinics hold twelve-step groups to meet the behavioral modification requirement. Others provide individual therapy sessions, billing either individuals or insurance companies for these sessions.

One of the clinics I visited in River County requires clients to attend individual counseling sessions and provides case management services, such as assistance in finding housing and enrolling in the local community college. The Eagle Health buprenorphine counselor, Molly, spends about 30 minutes with each buprenorphine client from once a week to once a month, depending on how long and how successful a client has been in the program. She mainly provides cognitive behavioral therapy. Cognitive behavioral therapy asserts that such mental health concerns as anxiety and depression result from particular negative thought and behavior patterns within the individual. These negative mental paths are disordered in that they are not changed, even when presented with contradictory information. Thus cognitive behavioral therapy is focused on making implicit ways of thinking explicit, analyzing thought and behavioral patterns, and altering mental models to result in more positive thoughts and behaviors (Beck 2011; Leahy 2017). This type of therapy can be practiced in many types of ways, and Molly said she focused on relaxation techniques to prevent anxiety and negative thoughts. She also performs marriage and family counseling when she thinks that is necessary.
None of the buprenorphine clinics that I encountered or about which study participants had experience has formal program phases like drug court and Horizons. Instead, providers said that counselors, prescribers, and clients work together to discuss appropriate amounts of time spent in outpatient counseling and buprenorphine dosage. During my fieldwork, there were no buprenorphine programs in Douglas or Teller counties. One buprenorphine program for women was open in Adams county for a few months, but closed due to financial issues that I could never specify with gatekeepers. There was one program in Eagle County and two programs in River County. Women in Douglas and Adams generally drove to Eagle or River to receive services and women in Teller generally drove to Central Kentucky for services.

Some buprenorphine users argue that the drug has stabilized their lives. For users and providers who largely celebrate buprenorphine, they focus on the ability of the drug to turn them into “normal” people who can have jobs and care for their families. This connection between buprenorphine and desired normalcy has been found in other settings (Harris 2015). Katie said buprenorphine allows her to fulfill her motherhood and citizenship roles, “[Buprenorphine] keeps me a functioning human being in society and I can live my life and pay my bills and take care of my daughter and provide for her. I’ll stay on it the rest of my life if that’s what I have to do.”

Some in buprenorphine programs find them useful, but also characterize them as moneymaking schemes. Ellie wants the buprenorphine, but said the program is otherwise inadequate. She only sees her counselor for approximately ten minutes a week in order to receive her prescription. Lucy, who contends that buprenorphine saved her life, nonetheless sees problems with buprenorphine,
Most people trade their shit for dope, which frustrates me. My biggest thing is that I had so many people say that I couldn’t stick with this and get clean, but it really frustrates me. It would bring the fight out of me to watch people abuse it because it changed my life. It’s not easy to get and it’s a battle every day. I hate seeing people who go and get that and take it and trade it, and abuse it in one way or another. It changed my life and it would change anybody’s if they would take it. You have to do it on your own account.

Others find buprenorphine to be as or more addictive than their drug of choice and to produce unacceptably harsh withdrawal symptoms. Those with drug court experience have the most negative connotations. I spoke with a few women who have injected buprenorphine. Other treatment participants use that as evidence that it may be just another drug. Some women are concerned about withdrawal symptoms in trying to come off of buprenorphine. They ask why not just withdraw from opioids if you are going to have to withdraw regardless? Stacey does not want to go on buprenorphine because for her to stay sober, she thinks she needs to feel the pain of withdrawal.

After taking buprenorphine, four women vowed never to take the substance again because it made them extremely sick. Anna and Susan offered conspiracy theories about buprenorphine where they think the government is making vast sums of money off of the drug and utilizing the pharmaceutical to slowly kill drug users via damage to people’s kidneys, livers, and bowels. Through conversations with women about these conspiracies, they are obviously rooted in the very real damage Purdue Pharma did to Appalachia and in knowledge of the US Central Intelligence Agency’s (CIA) role in distributing crack in urban US neighborhoods in the 1980s (Mullings 2003; Van Zee 2009).

The majority of women I spoke with are ambivalent about buprenorphine. Lela was preparing to graduate from drug court when I last spoke with her. Her husband is enrolled in a buprenorphine program. Lela has seen drastic improvement in his drug use
and overall demeanor. She is still concerned that he is “substituting one drug for another,” will be on buprenorphine for life, and will lose access if buprenorphine is outlawed, which she sees as a possibility.

My interview and participant observation with Maggie exemplify a buprenorphine stigma. She wanted to enroll in a clinic for a year before she was able because she lacked transportation. She had to convince her mother to take her, because her mother thought buprenorphine is “just substituting one drug for another.” When I was interviewing her, Maggie kept telling me how terribly she is treated in the community because she is on buprenorphine, especially by the local pharmacists,

The stereotype of when I take my prescription to the [pharmacist], they look at you like, “Oh, hi,” and then they look down and they’re like, “Oh,” which I would rather see somebody on Suboxone any day than getting a prescription for Lortabs or Xanax. Before, I stereotyped the same way. I thought if somebody’s on Suboxone, they’re just a piece a crap. They’re just getting it to have drugs to resale, but gosh, no, for me, it levels me out.

Maggie asked me to come to the buprenorphine clinic and then pharmacy with her so I could see for myself.

We left Adams County in the early afternoon to drive to the buprenorphine clinic in River County. After her appointment, Maggie and I drove back to her pharmacy in Adams County. When we went in, no one was there and the pharmacy tech was sitting behind the counter restocking a display. Maggie was overly nice. She is a photographer and brought an envelope of horse pictures for the pharmacist to give to his daughter. She handed these pictures, along with her prescription, to the tech.

As soon as the tech looked at the buprenorphine prescription, her face fell. She said she did not know if she could get the prescription ready before the pharmacy closed in three hours. Maggie was polite, but obviously infuriated. She told the tech that her
doctor said they had to have the prescription for her that night because she would run out of buprenorphine the next day. The tech said she could only get the prescription ready if no one else came in for the rest of the night.

Maggie said okay, and pulled me aside. Her face was bright red and she complained that she was there first, and should be served first. She was really worried because she lives 30 minutes from the pharmacy, and did not have enough gas money to come back the next day for her prescription if they could not fill it that night. Another customer came to the pharmacy, and they were promptly told their prescription would be ready in 20 minutes. I thought Maggie would explode, but she sat there patiently. Almost two hours later, her prescription was ready. She texted me later that she made it back home sometime after eight in the evening. It took her almost eight hours to obtain her weekly prescription. Another participant, Sissy, defined addiction as having your life centered around an object. In this way, Maggie is in some ways addicted. This is not necessarily because of a physical addiction, but because several days of her week every week are focused on filling her buprenorphine prescription.

These tensions and stigmas complicate women’s experiences with programs. Program eligibility requirements are shifting and unclear to clients in part due to policy chaos, and in part due to differing understandings of the feasible uses of buprenorphine. According to service providers, existing clients, and women seeking services, some providers adhere to FDA guidelines for buprenorphine. Others alter their prescribing practices to match their own clinical experience. Some clinics only accept people who are actively using opiates and nothing else. Some accept people who are currently sober but fear relapse. Others accept people who are using methamphetamine, despite
buprenorphine’s intended purpose to treat opiate addiction. Four women I spoke with entered a program and said the program helped, even though they used meth.

A buprenorphine provider, Debbie, claimed that programs are financially insecure due to low Medicaid reimbursement rates for office services. Office closures leave women without prescribed buprenorphine. If they do not want to start withdrawals, they must quickly find another source, which may not be legal, as Ashley demonstrates:

I was going to [a clinic] in Lexington. Dude! I go to my doctor’s appointment, and there’s a sign on the door that says, “Sorry, we’re shut down, please call [another doctor] at this number.” But [the other doctor] charges $300 a month, and so I couldn’t go there. I’ve been buying Suboxone off the street, but I’m in [Eagle Health] right now. I have to go to four counseling sessions and then they can start writing Suboxone because that’s the insurance policy. So I’ve got two down, I’ve got two more, and then they’ll start writing Suboxone for me.

According to Ashley, the doctor she was referred to does not accept Medicaid, which is why they charge $300 a month. Ashley said it is difficult to find buprenorphine programs that accept any kind of insurance. Overall, accessibility is limited.

Women reported that both Eagle Health and River Buprenorphine staff are quick to terminate clients because the clinics are afraid of public scrutiny. This runs counter to understandings of relapse in addiction and to efforts by Horizons and drug court to utilize sanctions rather than termination. Three women were terminated from Eagle Health when they tested positive for cannabis. After they lost their prescription, they either began buying buprenorphine illicitly or began using their previous drug of choice.

Yet in women’s lives, diversion and illicit buprenorphine use does not seem to be as detrimental as some service provides and politicians portray. Several women, including Sissy, entered a buprenorphine clinic after using illicit buprenorphine to see if the medication would work for them. Other women, like Beth, do not enter the clinic
because they do not think they need a full prescription of three buprenorphine strips a day. Instead, they buy half a strip illicitly to help with withdrawals and other physical pain. Other women use their prescriptions in particular ways. Katie and Star only take a portion of their prescribed dosage on a daily basis. They occasionally take the full prescribed amount when they are experiencing intense anxiety. Otherwise, they stockpile their buprenorphine in case their clinics close and they need a backup supply.

Once women enter buprenorphine programs, they noted several positive attributes. Three women said that being prescribed buprenorphine as opposed to buying buprenorphine or other drugs illicitly is helpful because the prescription keeps them from drug using networks and drug dealers who are selling various substances that may be more harmful and may interact dangerously. Women also gain access to clinical services they want, such as counseling and drug testing. In the words of Isabel, “I now stay at home and take care of what needs to be taken care of. Suboxone’s helped me with all of that.” But learning how to stop running can be hard, as Sissy demonstrates,

And that’s a whole other thing, learning not just the physical, you know not having withdrawals with that, but you also have to learn to stay home. You get up and run after [drugs], every morning. That first morning when you take Suboxone and you don’t have to get up and leave, it’s kind of confusing. You get used to go around people all the time and you get used to going from house to house and making all these stops and going out and being in the middle of a crowd. Whether you want to do it or not, you’re still used to it. The running is addictive too. You have to relearn your daily grind. You had to learn to sit and watch a TV show rather than get and run to the car and zoom, zoom all over the place. I mean I can’t stress enough, how hard that it, to get used to not being around. And there are a lot of really good people that are on drugs too that you have to give up. They do have a good heart, and there’s a lot of bad ones too, but there’s some friends that you got to give them up because they’re still living the life. And they will not even meaning to, drag you into it.

This ties back to the helpfulness of structure in other programs, but it is a more self-imposed structure that occurs in the home. Women must structure their lives to take
buprenorphine in the morning rather than driving to find drugs when they awake. Then they must change their social relationships, which I will expand upon in Chapter Five.

Being able to implement the change at home can be a more drawn out process, which may be appropriate for some. Many are in the program for years, much longer than in Horizons or drug court. For Hannah, the buprenorphine program is helpful because it has allowed her to slowly change her life, including her routines and social networks. This is opposed to an inpatient or outpatient program, which she has utilized in the past, that forces her to quickly change for 90 days or so. After treatment, she immediately returns to her previous life.

Meeting needs and jumping through hoops

I asked women what they were hoping to get out of treatment in interviews. All who had lost child custody said they wanted to regain custody. Almost a third said they want to maintain recovery. A few talked about going back to school, getting better housing, and learning coping skills, which they equated with learning how to be “normal.”

Hattie exemplifies some of the things women want out of programs,

Hattie: I want to be done with [drugs]. I don’t want this life because it hurts. It really does.

Lesly-Marie: Okay, and I guess what else would be included with that? With being sober?

Hattie: Joy. You know you can’t enjoy life because you’re like how do I find my high? Do you know what I’m saying? I like to get up, fix breakfast, which I still do, but you know what I’m saying? Not worry about that. Not go out and hunt stuff down. I don’t want that. It’s just a life that nobody needs because that’s just, when you’re in that kind of life you know it’s different, it’s not just like being normal people, you know what I’m saying.
Lesly-Marie: So I know through this program you’re hoping they’ll help you find housing, is there anything else you’re hoping to get out of it besides that?

Hattie: No. I mean I’m doing it to get my young’un back, I’m doing it to be sober, I’m doing it for three things.

If women do make it through treatment, they are more likely, at least in the short term, to be reunited with their children, most women’s primary goal. According to program documents, of all the women who enter Horizons, about half regain child custody when they graduate, while just over a third regain custody if they do not enter the program.

The vast majority of women found individual and group counseling sessions helpful overall. Women cited learning coping strategies as the most beneficial aspect of counseling. These coping strategies have to do with changing the individual self, as when they discuss self-esteem, as well as navigating marginalization, exemplified by talks about overcoming stigma. Nancy outlined the helpfulness of learning “coping mechanisms to stay sober,” which several women reiterated. These included methods of working through trauma, like domestic and sexual violence, using cognitive behavioral therapy and relaxation techniques. Sissy especially appreciates the breathing techniques, which help reduce anxiety. Counseling is not equal across programs. Maggie, who was simultaneously in Horizons and River Buprenorphine, found the individual counseling available through the buprenorphine clinic more helpful where she received more time. She felt more comfortable opening up because she does not think what she says will be repeated to CPS since the buprenorphine counselors do not have regular meeting with CPS as Horizons counselors do. All participants appreciated case management services. The only issues women had with case management was its inadequate funding.
Women noted several characteristics that help them successfully process through treatment. Those who had previously been through treatment said the experiences aid their current navigations because they know what to expect in terms of program goals, counseling sessions, and drug screening. If women were in a more intensive program before entering Horizons or in another program concurrently with Horizons, especially a buprenorphine clinic, they seemed to find staying sober and passing Horizons drug screenings easier. This indicates that more access to residential treatment is needed. Women in rural Central Appalachia have little access to services that are not court-ordered, and it is unclear how services, such as residential, would be used.

Women whom I interviewed find aspects of treatment programs emotionally and at times materially supportive. They find other parts pointless. As I begin to discuss the ambiguities and at times destructiveness of treatment, from my research, I think women, staff, and policy makers are often doing the best they can in the circumstances. Programs offer support, but at times they nonetheless reproduce marginalization.

One of these ambiguities is tied to relationships. A constant tension in the programs is whether being around other women who use(d) drugs is helpful or harmful. Other participants are a source of support, but women are being asked to expend more of themselves to care for each other. Seeing other participants ahead of them in the process can serve as a source of inspiration, and seeing other participants who are still using can show what they do not want to do again. Dealing with the other users can help them practice being around people with different personalities, while also showing respect. Most importantly, women see other people going through similar struggles and they are provided a space to talk about these problems. These conversations help build empathy as
well as connection and allow women to collectively create strategies for navigating the mazes of addiction, relationships, trauma, and treatment. Yet when others come to the program high, this can be a trigger that makes women want to use. As women share their hopes and wins, they also share their frustrations, which can exacerbate everyone’s stress. Group can also be a place to find other people to use with.

Some women find the greatest support in treatment staff as they usually offer more stability. For several women, the treatment staff are somewhat irrelevant; the other women in the program are important. Katie, Maggie, and Beth grew close as they processed through Horizons and decided to start their own NA style support group with regular meetings, a Facebook page, picnics for those in recovery, and regular lantern releases at a local park to remember those who have died from overdoses in the community. They wanted to start NA because the closest regular meeting is roughly an hour and a half away. When I left the field, they had momentum and seemed like they were reaching people in the community who wanted to get clean but did not have access to or want to go to other types of treatment. Beth wants to find funding to have more intense outpatient and even inpatient programs, but the granting process is so complicated, that she does not know where to begin. While much of treatment in the US is based on grassroots models that began over a half-century ago, these models are difficult to begin today with few resources and complicated granting and insurance procedures. Once again, Appalachians, even those facing substance use issues, are striving for collective change, but these strivings are materially and bureaucratically constrained.

Gatekeepers interviewed cite stigma as a major barrier to accessing treatment. Hints of this appeared in women’s narratives, especially concerning buprenorphine. Yet
lack of material resources and poor quality of care represent the major issues women have with treatment. This is not unique to this setting, and stigma of marginalized health issues has been used as the primary explanation for low uptake of services, even though clients may be more concerned about quality of care (Farmer 1992). I am not arguing that stigma is not a felt problem for women, but it often presents as small cuts. Lack of resources has the ability to eviscerate more quickly and wholly. Lack of resources is undoubtedly affected by stigma, but economic marginalization is what is primarily felt, as I demonstrate in the next chapter. No one ever said these programs should not exist. The feelings towards treatment reflect a Horizons and buprenorphine client’s statement, “They should have done more.”

When women were discussing the benefits of counseling, they talked about how counseling helps them reach normalcy. But who defines “normality”? And does treatment become inapplicable if it is attempting to define a normal that appears abnormal for its clients? Ellie rejected the inpatient program she was in because she said program staff kept telling her they were trying to teach participants to be normal. Ellie does not think it is normal for people to wake up, be showered, have eaten breakfast, and have a bedroom and bathroom cleaned by six in the morning. When clinical interpretations of addiction and treatment do not fit with client definitions, clients may reject aspects of therapeutic governance. They may instead develop their own strategies and definitions of success, which may or may not mesh with program objectives (Carroll 2016; Hejtmanek 2016). Women in Central Appalachia repeatedly said they wanted to return to a “normal” life through treatment. Yet women contest strict notions of normal, arguing instead for a range of normalcy (Zigon 2011).
The connection of Horizons and drug court with CPS complicates women’s navigations of therapy. What pieces of information Horizons staff report to CPS is unclear to staff and clients. According to duty to report laws, staff are supposed to notify CPS of anything that could immediately harm children, but this leaves room for staff’s personal judgment. In our first interview, a Horizons client Ashley said that you have to be “smart” about what you say in treatment, but you still want to be “open and honest,”

You don’t want to say something and have them get wind of it and it and them see it the wrong way. And then you don’t get your kids back. These people have control over whether you have your kids or not. So you just gotta be smart about stuff...I’m still open. I’ve always been an open and honest person. Secrets don’t make friends and you know secrets end up eating at you. And I don’t want to live that kind of life, I did that when I was using.

In our follow-up interview, Ashley was even more reticent in therapy because she had gotten in trouble with CPS when she told peer support she had injected her buprenorphine, “And that’s something I shared in class and they’re not supposed to tell that stuff. So I don’t know if I’m going to talk in class anymore.” With Ashley’s children out of her custody and living hours away, whether or not her injection of buprenorphine at this time would harm her children is uncertain.

Katie said that other clients were nervous about talking to me because they did not know if I reported to CPS. But other women said they are honest people, so they do not try to hide anything, like Ellie, “Some of the girls told me when I got here, only say what you want them to hear. But it’s one of my things, I’m an honest person. I don’t have nothing in my life right now to hide. Every move you make, they’re watching you. But I don’t feel like I have to hide nothing.” In twelve-step models, becoming sober involves a transformation of life from someone who is supposedly arrogant, deceitful, and suspicious to someone who is humble, honest, and trusting (Cain 1991). “Honesty,
openness, and willingness,” along with the idea that “secrets keep you sick,” are mantras where addiction becomes a disease of denial and therapy is about parsing the truth. This focus on denial may foreclose critiques of program and therapy methods (Carr 2011).

Like programs’ connection to CPS, drug court’s connection to incarceration complicates what women feel they are allowed to say in counseling sessions, which makes healing from trauma more difficult, according to Cindy. Alisha felt betrayed when her counselor at CMHC, who is contracted to provide services through drug court, broke confidentiality to inform on her to drug court,

Alisha: I felt uncomfortable sometimes when [the counselor] shared things I had shared in confidentiality with him. I had signed a waiver that he could share, but it made me uncomfortable, so I stopped my individual [counseling sessions] at that point. I removed myself from drug court. I didn’t attend as many NAs and AAs as I had been attending. I just did the bare minimum to get me by.

Lesly-Marie: Did you not understand that he could share that?

Alisha: No. He said that unless it would harm myself or another person, it would not be shared with drug court.

Every woman I spoke to with substance use concerns agreed that treatment needs to be more widely available. This does not mean they uniformly think currently available services are helpful or adequate. They make do with these programs. Sometimes, they find enough mutual support with peers to attempt to create their own program. Staff also make do. From interviews with staff, clients, and my participant observation, Horizons administrators and staff were the most understanding of women’s marginalized positions and made the most effort to address women’s concerns. Yet Horizons has very meager funding to tackle such issues as housing, transportation, and unemployment. Some buprenorphine clinics also attempt to offer case management services, but fickle policies and insurance reimbursement create an unstable environment. Drug court is the strictest
of the programs, but the women I spoke with who processed through drug court did not see this as an obstacle. According to a former drug court judge, when drug court has extended funding to offer housing and transportation assistance, the program is more successful. Ultimately, this research indicates that there is need for greater access to better quality treatment. Women did not necessarily agree over which treatment aspects or models are best or worst. This shows that a variety of treatment models should be available as well. At the same time, it may be unlikely that any substance abuse treatment program could, on its own, address the gendered and economic inequalities women face in Central Appalachia.
Chapter Five

Making It to Recovery: Care, Violence, and Violent Care

There are differing definitions of care. What one person expects out of someone who cares for them does not equate to others’ expectations or wants. When people are wedded to specific notions of what care should look like, then those who demonstrate care outside of these boundaries may be sanctioned if they do not have the power to define care. As with all actions, how one cares for another is constrained. When state agencies and treatment programs ask women in this study to change their patterns of care, they must find how that change can occur within the interpersonal and organizational mazes in which they are embedded. For some women, sobriety can equate to loss of relationships, resulting in experiences of isolation.

Women’s survival through these mazes can be supported or crushed by care provided through the state and interpersonal networks, usually heavily involving family in this setting. Family members are fundamental in providing material and emotional support for women who have few resources. While care is necessary for navigating life, it can also be precarious and even dangerous. Care has the ability to exacerbate the pains people experience. Most of the women I spoke with were domestic or sexual violence survivors. Family members or intimate partners were most often the perpetrators of this violence. Women connect trauma to their drug use and wanted trauma informed counseling services. Yet solely focusing on women’s victimhood may not be the answer. A programmatic centering on victimhood may prevent efforts to alter the inequalities and structures of power that contextualize violence. Through encounters with inequalities and
violence, women show resilience. In this study, that resilience more often equated to making do in the household, rather than collective action.

*What is care?*

These people who can see right through you never quite do you justice, because they never give you credit for the effort you’re making to be better than you actually are, which is difficult and well-meant and deserving of some little notice. – Marilynne Robinson, *Gilead*

What do you want from the liquor store? Something sour or something sweet? I’ll buy all that your belly can hold, you can be sure you won’t suffer no more. I’d swim the ocean or the deepest canal to get to you darling just to make you well. – Ted Hawkins, “Sorry You’re Sick”

So if you wanna burn yourself remember that I love you, and if you wanna cut yourself remember that I love you, and if you wanna kill yourself remember that I love you. Call me up before you’re dead, we can make some plans instead. – Kimya Dawson, “Loose Lips”

I start this section with three quotes from literature and music because artists may be the most able to recreate the affect of this complicated and perhaps chaotic care. Sometimes care is as simple as recognizing that another is there and is trying to imagine as well as live a future that is better than the past or present. Taking further actions and removing sickness or withdrawal from alcohol or drugs in the short term may inadvertently prolong long-term suffering. Ultimately, the care that pervades these communities is limited. This is not well-resourced everyday care, but deeply constrained care that is attempting to keep people and communities from death.

Some service providers in this study question whether active users can have any type of care for others. A state level opioid treatment administrator claimed that drug users do not have the ability to differentiate between right or wrong or to have stable relationships due to their addiction. In treatment programs, those who use drugs may not
be seen as having “real” relationships, because these relationships are framed as fake and based on the acquisition of resources (Skoll 1992). In this vein, a few providers, including Claire, Jennifer, and Debbie, exclusively focused on what Debbie called “toxic relationships” with friends and family members as preventing women from attaining sobriety. At the same time, other gatekeepers find glimpses of care from those who use drugs, which they see as emblematic of the addiction as a disease construct. When discussing the possibility of a syringe exchange program at a DADA meeting, the Douglas fiscal court judge said he thinks the exchange will be successful among those who use drugs because most needles he finds on the ground are capped. This shows that people care for their community and do not want others being stuck by their needles.

When people who use drugs are portrayed as uncaring or immoral, this justifies withholding resources, including societal care. When resources are provided, they must be framed as strict or for someone other than a drug user. The following instance demonstrates this framing, as well as the gaps in what service providers and community members view as appropriate methods of care for people who use drugs. At a DADA meeting, the fiscal court judge and a longtime CHEK provider began talking about the importance of naloxone availability and training for first responders to prevent overdose deaths. A few in the meeting began grumbling that if users know first responders have naloxone, then addicts will simply increase drug use without fear of overdose. The judge and CHEK provider immediately began telling stories of the harshness of receiving naloxone, where those overdosing are immediately sent into withdrawal, to justify its provision. They thus justified access to health care for those who use drugs, but defined this care as unpleasant.
When lack of care for others is characterized as one of the primary symptoms and at times causes of addiction, changing care patterns is seen as vital to recovery. Both providers and women in Eastern Kentucky associate recovery with a return to or novel embrace of caregiving, which aligns closely with research among Native North American women (Prussing 2007). Yet the question of whether those who use drugs can provide care reveals fractures in women’s understandings of care. Some contest stigmatizing portrayals of addicts and argue that even though they use or used drugs, they can provide care as moral actors. Ashley claimed her care for the community by saying that she does not and has never stolen anything. In my previous research (Buer, Leukefeld, and Havens 2016) and in discussions about active drug use in the current study, women demonstrate care for others when they provide or share drugs with close family and friends who are in withdrawal. Other women eschew the idea that active users can be involved in care networks and categorize friends they use(d) with as “drug buddies,” who do not really care about them. They see recovery as a time to begin or renew ties to sober individuals and the community, especially by volunteering in the schools with their children and helping others with drug issues. Recovery is framed as a shift in or beginning of care.

Substance abuse treatment programs in Eastern Kentucky ask women to reimagine their past relationships and modes of care as faulty, to construct new forms of care, and to create new imaginings of future relationships that exclude people who were previously important to them if those people use drugs or are abusive. Service providers emphasize the importance of having stable family and friends, but also portray interpersonal relationships as posing the most risk to women’s sobriety and success. If women cannot form new relationships and cannot imagine a future in which their modes
of care change, then recovery becomes a harder thing to render clear. Program aspects that help women build new communities are thus in demand.

Participants greatly value the events drug court holds outside the program to bring together current participants, alumni, their families, and community members. These include picnics, recovery rallies, and graduations. I attended a recovery rally and graduation where I witnessed alumni and current participants mingling, laughing, and hugging each other with their partners, parents, and children. Women feel like this is a time when they can reconnect with their families and community, as well as form new relationships with others who are in recovery. These events provide them a reimagined social group outside of people who are currently using. When I asked women what helped them complete treatment programs, most said the emotional and material support from sober family members, friends, and at times, program staff. Women in Teller County also have access to sober living apartments, which helps tremendously by providing stable housing as well as another source of community support. Women are able to live in the apartments by themselves, with their children, or with their children and partner. Group sessions are held daily in a room below, creating a sense of community among apartment residents and with others in recovery who attend the groups.

Although women may be able to start building a new community through treatment events, they are restricted from doing this on an everyday basis because they are not allowed to see other participants outside of Horizons and drug court. Treatment participants view this rule as unreasonable because staff are asking them to relinquish social relationships where the other person is actively using, but then prohibiting them
from trying to find emotional support from others who are trying not to use through a program.

When women do not see drug use as ever having conflicted with their ability to be a caregiver, whether they are caring for children, siblings, other family members, or the community, their transition to recovery is less abrupt in terms of who they are connected to and how they see their roles in relation to others. Women whose use increased to the point where they could not function in their social roles as caretakers or who do not think anyone could provide care while using face more abrupt transitions in recovery. They understand sobriety as involving a complete reversal in their networks and caregiving strategies. Although this understanding is certainly influenced by treatment rhetoric, it is not unilaterally imposed and women talk about how being around others who are in active use triggers them to want to use. The first step women take is delinking themselves from who they term “so-called friends,” or those they used drugs with. Drug court takes the hardest line when it comes to breaking past relationships, or shifting “people, places, and things,” in AA and NA terminology. When I spoke to drug court participants collectively, they argued that you have to cut ties with those who continue to use drugs to be successful in drug court. According to the groups of drug court participants I spoke with, this is no real loss because those people are just “pill” or “drug” friends, not “real” friends.

Women provide more complex views in interviews. Lela felt like she had to cut connections with fellow users in order to be successful in drug court and to abide by their policies to end contact with any drug users. She still struggles with how she navigates this loss, as do other women I spoke with. At times she mourns the loss of friends and family
she no longer sees. In some ways, Lela relinquished people who supported her emotionally and helped her develop strategies to survive addiction in the fringes, “I had to cut ties with them. And it’s hard because, but most of them, I have to say, are really supportive. They see me, and they’ll be like, ‘I’m so proud of you, I wish that I could get clean.’ But then you still got the occasional one that tries to be like, ‘When we going to get out and run around.’”

Yet throughout our interviews and informal conversations, she characterized her relationships with other drug users as exploitive and uncaring. When I asked Lela if it matters that she had to shut former friends out of her life, she said,

It didn’t really bother me because they were only around pretty much when we were using together. You know, if I had what they wanted or if they had what I wanted. I mean whenever I sat up there in jail for seven months, I didn’t hear from nobody. I mean didn’t even offer to write a letter. Didn’t even offer to send word with my family or nothing, “Tell her hey. Tell her I’m thinking about her.” I ain’t got no use for anybody like that.

Angela Garcia (2010) is apt in highlighting that drug use rarely occurs in isolation. I argue that recovery in this setting more often occurs in isolation than drug use. Women I interacted with only talked about isolation while using when they were in abusive relationships. As they alter their “people, places, and things” in recovery, some women find themselves alone without any means of emotional or material support. This is especially the case if they do not have family members they can rely upon. Women cited feelings of loneliness and isolation once they were sober. Alisha termed her time in drug court as “devastating” because of the loss of connections she experienced. Stacey fanaticized about suicide because she “felt so alone in the world, I couldn’t tolerate it anymore.” Cindy thinks that part of her recovery is coming to terms with the idea that she
may “die alone.” For her, relationships with those who are using are not worth attempts to escape this possible fate because they risk her sobriety.

Women who are alone may not have any living, sober individuals in their network. They may have strained their relationships with others, particularly family members, to the point of breaking. Ellie spoke extensively about her connection to her husband, who has never used, but also of the pain she has caused him, “I love him so much and it’s so hard sometimes because I just want to be home with him so bad. Other times I know I can’t because it just don’t work. I know that me and him will never find anyone we love more than each other. So much damage has been done, I don’t know if it can be repaired.” She claimed her husband was supportive, but her drug use had destroyed their relationship to the point where he had separated from her. This is why it is vital for these women to have service providers who seem like they care and why they find program activities that encourage socializing outside of counseling, such as cookouts, important. It is unclear from my research what happens to those still using when their friends or family enter treatment. Do they become more isolated, approaching the mythical isolated addict? Does this become harmful to their trajectory?

_Surviving_

Most clients said they could not make it through these treatment programs without the support of family members, partners, and friends, who provide emotional support, childcare, housing, and food. To a lesser extent, state agencies make some resources available. Women spent considerable time outlining the daily socioeconomic struggles they face as well as their methods for navigating these hardships. The only services
women regularly utilized directly through the state are Medicaid, discussed previously, and SNAP. Three-quarters qualify for and receive SNAP, referred to as “food stamps” by all participants. About a third who receive food stamps say that it provides enough food for their families. The other two-thirds say food stamps last about two to three weeks, and then they pay for the rest of their food. Those who had larger numbers of people in their household were more likely to have to spend out-of-pocket money on groceries. Food stamps are unlikely to be enough if women are homeless, because they are relegated to buying expensive individually packaged items due to lack of access to storage and refrigeration. Not having transportation out of the county to buy better quality and cheaper food is problematic.

Women struggle if they lose food stamps, even if just for a few months. They are most often disenrolled due to administrative issues when they are incarcerated or become homeless, and are then unable to recertify with SNAP because they do not have a valid address. One Horizons clinician, Judith, said she did not know how people reenlist with SNAP without professional help, because the enrollment process is grueling in terms of paperwork and time spent in encounters with administrators. SNAP has instituted delays that turn a cycle that used to be 30 days into 35, forcing them to stretch these benefits even further. While state services are cut, they are simultaneously made more difficult to use for those who still manage to qualify.

Women very rarely use K-TAP, Kentucky’s cash benefit TANF program. Only one participant was enrolled in K-TAP, while two others owed the state for their K-TAP enrollment. Ashley was on K-TAP after she lost child custody and thus K-TAP eligibility, so she now owes the system $400. When Alisha was incarcerated, her mother sued her
for K-TAP to provide for Alisha’s child. She now owes the state $6000. Many never attempt to enroll because they think K-TAP provides too little resources to be worth the time consuming processes of enlistment or completing program requirements.

Several community leaders and service providers, especially Karen, scoffed at food stamps for supposedly being heavily abused. Bill said he could not care less if families used food stamps “creatively” because, no matter what, food stamps get resources into people’s homes. People have told me that they do use food stamps in unintended ways. While Karen and others equate this with trading food stamps for drugs, women rarely said this was the case. If they are being used to buy drugs, more often than not in my experience, it is cigarettes, nothing illicit. The violation of SNAP policy that I saw most widespread was people using their SNAP benefits to try to feed more people than actually qualified for SNAP. If Star, her husband, and her kids are enrolled in SNAP, for example, then those SNAP benefits are also being used to feed Star’s sister and at times her mother. Punitive state actions, such as incarceration, affect entire systems of care. State support filters through these systems in similar ways.

Those gatekeepers who scoff at SNAP or claim food is not an issue for poor women assume that the private sector ensures people in the counties are fed. Some women do not have access to food banks in their county. For others, the cost of transportation to the food bank and the limited food given make the bank not worth going to. Ashley asked me to drive her to multiple food banks, where she has to provide a license with an in-county address, social security card, and proof of income. My field notes from that day document some of the limitations of food banks,

When the front office lady gave her the bag, Ashley looked surprised and said they sure were ‘slimming down.’ The front office lady shrugged, smiled, and said
‘Yes.’ Ashley said they used to give big boxes, but now it’s only a small bag. She immediately started eating some chips out of the bag and said she hadn’t eaten in a few days. The bag contained eight small containers of snack size food, crackers, a jar of peanut butter, two protein drinks, and a large bottle of apple juice. She couldn’t believe how small the bag was, so she asked to go to another place.

At the next food bank, she received a larger bag, but it had items neither Ashley nor I knew what to do with. How can you fix a meal from canned cranberry sauce, turkey gravy, and seafood broth? People are only allowed to access these banks once per month. When women and their children do not have food, they usually rely on women’s parents and grandparents to buy them food or in the summer, to provide produce through their gardens.

As state support has dwindled, so has private investment in rural Appalachian Kentucky. Women cite lack of employment as their largest concern. The five county area shares the “uncertain and shifting” economy that Fletcher (2014) describes in Central Appalachia, where deindustrialization coupled with increases in service sector employment results in fewer jobs that have benefits and pay a living wage. The two largest private employers in Adams County left in the last five years. An apparel factory that employed over 100 people, primarily women, closed about five years ago, some of the jobs being lost to mechanization and the others to a Kentucky town closer to an interstate. A private prison closed in 2015 that employed mostly men. As populations lessen when these jobs are lost, the local tax base suffers, resulting in poorer county-level services as well as decreased employment through the school system, health care, and service sector. Cas, the fiscal court judge in Adams County, said several large employers had considered moving to Adams County in the last few years. Companies decided against moving because the county is not close enough to an interstate.
At the regional and national level currently, politicians seem enthralled with the idea of entrepreneurship as *the* answer to “save” Appalachia. At an ARC conference, Congressman Hal Rogers, who represents the majority of Appalachian Kentucky counties, then Kentucky Governor Steve Beshear, and Earl Gohl, the ARC Federal Co-Chair, exclusively championed entrepreneurship as the economic model for Appalachia (ARC 2015). The poor are expected to not rely on leaders to create policies that help the region, but to help themselves by creating their own jobs, all within the context of a history of economic, political, and environmental marginalization where infrastructure and social institutions remain eroded. Rural Appalachia has a history of governmental and industrial disinvestment (ALOFT 1983; Dunaway 1995; McKinney 2004), which is why hearing Jared Arnett, the executive director of Shaping Our Appalachian Region, say that we need “innovation, not investment” and Senator Mitch McConnell arguing that economic development is “not my job” is frustrating to myself as well as to those with whom I spoke.

When I asked Becky, the Horizons case manager, about this focus on entrepreneurship, she dramatically rolled her eyes and said, “You can’t expect people on the bottom to be entrepreneurs.” This is not to deny that those “on the bottom” are entrepreneurs. Many of the women I interviewed as well as their family members and friends are entrepreneurs within underground or illegal markets. Maggie is the only person I interviewed who had started a small, licit business involving her artwork. Although she enjoys having an income from a legal enterprise, she cannot earn enough to support herself and her children. Maggie is constantly anxious over whether or not she will be able to pay her monthly bills. The only way she survives financially while running
this small business is by relying on her parents, SNAP, and Medicaid. Asking women without a college degree who are processing through substance abuse treatment, are responsible for intensive caretaking work, who often have criminal records, who do not have access to the banking industry, and who do not have access to quality infrastructure to take risks to start a small business ignores the risks they must navigate daily.

When women move to more urban areas, they do have better access to some employment, but the jobs they can take are still low paying and often temporary. This is usually because of criminal records, low education levels, gaps in employment records, and lack of connections in a new area. If women are working temporary or part-time jobs, they are quickly fired if they must miss work for caretaking responsibilities, illness, or pregnancy. The working conditions are demanding. Nicole commutes one and a half hours one way to a meat packing factory that has benefits. She works 12 to 14-hour flexible night shifts with two 30 minute breaks in a room that is kept below freezing. Further, many of the factory or service jobs that are available require standing for hours on end. This is not possible for the several participants I spoke with who have chronic pain or occupational injuries that prevent them from standing.

Even in urban areas, women who have felonies said they rarely get called in for an interview because of their record. Child abuse, neglect, or dependency charges through CPS can hurt women’s employment prospects as much as or more than felonies. With CPS charges, women are placed on a central registry that prevents them from working in schools, day cares, peer support, or many health care positions. People with felonies can still work in peer support and a broader range of health care positions that require licensing through the state. The vast majority of participants with some college
education specialized in nursing or early childhood education, due to the positive prospects for these occupations in the area. They can no longer use those course credits or degrees because of CPS-related charges. Many who enter Horizons hope to become a peer mentor after graduation, but CPS charges remove that possibility. Horizons touts peer support as the best employment option for clients. In Kentucky, misdemeanors are supposed to be removed from one’s criminal record in five years, thus not being revealed in criminal background checks for employment or additional purposes. Yet study participants said it had been longer than five years. Although charges may be deleted from their official record, they still appear on online-based searches of women and on other court documents other than their official record. While having a record does hurt women, so do gaps in the work record due to time spent incarcerated and in treatment. If women can obtain employment with their records, for these participants, the jobs are almost exclusively minimum wage in fast food.

If there is little formal employment that pays a living wage, then how do women survive? Women do utilize state services. Six women collect SSI or SSDI disability, which they use to provide for their entire family, and two women’s families are kept afloat by their child’s disability payments. Ashley has been attempting to enroll in disability for five years and a few participants qualified for disability at one time, but had not reenrolled since they had been incarcerated and refused disability. Most women survive because of family members. About a third of participants rely on income from their male partners or parents, who may be informally or formally employed. Two women survived through family members who qualify for SSI or SSDI. This reliance results in some situations where women remain with abusive partners or partners who
continue to use drugs because they control household resources. Yet most partners’ incomes are unstable or from seasonal work. Other women live with extended kin in order to pool resources. For example, Lela and her husband live with her father in a house that they rent together. Nicole lives with her mother and four children in her mother’s house. Nicole’s mother owns the house, but Nicole helps take care of the house and her ailing mother.

Women talked about “hustling,” especially when they are actively using. Hustling may involve under the table untaxed odd jobs, like providing transportation, cleaning houses, agricultural work, home tattooing, taking care of children, or collecting and selling abandoned items and natural products, such as ginseng and geodes. Illicit forms of labor include sex work, stealing from family, shoplifting, drug trafficking, or connecting people with drug dealers. Moneymaking schemes may be successful because of family support, or can be the source of familial tensions when people steal from or cheat family members. Ten women said they were involved in drug trafficking. The majority who self-identified as addicts said they would connect friends with drug dealers, and then obtain either money or drugs for making the connections.

Treatment program clients and service providers alike associate lack of access to jobs that pay a living wage with women entering into the drug economy. Stopping “the hustle” can be a hard transition for participants when entering recovery because they go from “run, run, run” to “nothing,” in the words of Sissy, a treatment program client. Thus entering recovery is a shift in social as well as economic relationships. Ultimately, though, most of women’s work is unpaid and involves caring for their children, other children in their extended family, elderly family members, and for others in treatment as they lead
self-help groups. While this work is crucial for families and communities in the context of global economic restructuring and social disinvestment, it goes undocumented on resumes and limits women’s ability to control household resources (Anglin 2010; LeBaron and Roberts 2010). Families are a source of economic support, but women also spend much of their time supporting their families.

Most women said lack of affordable, stable, and sober housing is the primary inequality they face, second only to lack of employment. Seven out of 40 women who participated in this study are actually homeless, living in spaces not meant for human habitation, such as in cars and in forests. Nine are technically homeless, usually moving from one family member’s or friend’s home to another on a nightly or weekly basis. Two women permanently lived with family members. Having access to a place to stay through family or friends is fundamental to survival, but others may be using drugs in the house or violent partners may be present. Fourteen women rented and eight women owned their own homes. Due to an overall lack of housing in the area, women may have extended family members or friends relying on them to provide housing. There are lower rent apartments and trailers available where those with poor credit are accepted, but even these are hard to find and the living conditions are difficult. Several times I walked into dark, small, rodent and insect infested trailers and apartments without heat or air, and sometimes without running water. Housing instability and poor living conditions produce stress, which may be manifested through anxiety and hypervigilance (Knight 2015), which women talked about and I witnessed through our interactions.

I was able to find housing in the area after looking for a little over one month. I had several advantages in the search. I had time to look for an apartment because my
husband and daughter were living in Central Kentucky about a one-hour drive from Adams County, which allowed me to commute for a short time. Since the apartment was just for me, I was able to live in a cheaper studio apartment. For most women in this study, if they are under CPS supervision and want to live with their children, they must have a residence large enough to have one bedroom for the parent(s) and one bedroom for each child gender. For example, if a woman lived with her two daughters and son, she would have to have at least a three-bedroom residence. Lastly, I would not have known about or been able to rent the apartment if not for a positive personal connection who vouched for myself and my work. My connection to the University of Kentucky and lack of a criminal record helped as well.

Each county has at least one apartment complex that supplies government subsidized low or no rent housing. Yet these complexes are stigmatized by those in the larger community as having drugs, are highly surveyed by the police, have multi-month waiting lists, and those with felonies do not have access. Getting into the apartments is usually predicated on having child custody, and parents are evicted if child custody is lost. In Adams County, applicants are required to show all of their children’s birth certificates as well as their own birth certificate, which can be difficult to access if the woman or her children were born in states where people have to pay for birth certificates. Ex-partners and others use this requirement to prevent women from accessing additional housing or to bribe women when they steal their birth certificates or identification. Also in Adams County, the same person has managed the one subsidized apartment complex for years, and if they decide they do not like someone, they will evict that person or not even let
them apply. Anna said the only way her sister was able to sign an apartment lease at the subsidized housing in Adams County was by intensely flirting with the manager.

Although Adams Housing, the local housing authority, assists those in Adams and Douglas counties find housing, programs and program eligibility requirements vary through time. Their programs are determined by federal US Department of Agriculture (USDA) and Department of Housing and Urban Development (HUD) funding streams. Adams Housing originally focused on home ownership per specific USDA no to low-interest loan programs, which is beyond the reach of many participants I spoke with. Temporary housing assistance is focused on women with child custody who have not had a drug charge in the last year. Most people wait on their lists for years. Lela had just heard back from Adams Housing at the time of our interview. She estimated she had signed up for the program three to four years previously. When Kim finally received a Section 8 Housing Choice Voucher allocated through Adams Housing for rent assistance, she could not find a landlord who would take the voucher. Hattie, who was living in her car at the time of our interview expressed her frustration,

It’s horrible. Living like this. [Adams Housing] said they can’t help me unless my children are in my home. And so they said it’s not an emergency case because my children are ok. I’m like, it’s not an emergency? It ain’t to them but to me it is. They can’t help me because I don’t have my children in my custody and we’re not literally sleeping outside on the ground. They said you have to be outside before they can put you in the homeless shelter. There is no emergency housing. But that makes no sense to me because I need a home, too, and I’m a person. I’m not a stray dog. I should get help too, I think.

There is no local access to a homeless shelter in the five counties. The two closest shelters are one hour away and have under ten beds. Some community members take advantage of this by charging people who are homeless ten dollars to take a shower in
their homes. Others, especially Sandra from Pastoral Association, are working to start a homeless shelter, but face resistance from city council members. One city council member compared homeless people to “wild dogs” who will be drawn by the shelter and will remain in the community to steal. The owner of the local conservative newspaper joked at a city council meeting that they should put the homeless shelter at a dilapidated house in a cemetery, because “people wouldn’t stay too long.” Although women think a local homeless shelter would be beneficial, and several utilized shelters when living in more urban areas, the strict rules and sometimes harmful living conditions nonetheless enact another form of violence, as Ashley demonstrates,

I lived in a homeless shelter for about nine months, me and my son did. I was pregnant with my daughter. There was no air conditioning for like three weeks. It would get to like 109 degrees in there. You had to do chores and I actually went into labor because they had me mopping the stairway. And it was a three story shelter, so it put me into premature labor and they had to give me some kind of shot to stop it. But I remember waking up at like eight o’clock in the morning and getting my son and going to the library so we could be in air-conditioning and then I’d go out job hunting.

While those who work with homeless populations discuss how inequalities produce homelessness, shelter rules may nonetheless be directed at inspecting and disciplining individuals who are homeless in an effort to train self-governance. These rules are supported discursively with understandings of “denial” in addiction and self-help, which individualize and explicitly ignore the social factors of homelessness and drug use (Carr 2011; Lyon-Callo 2008; Susser 1996). This is once again an example of how characterizations of people who use drugs are employed to justify decreased or increasingly harsh social services. While the existence of programs for poor women who use drugs is vital, whether they are homeless shelters or substance abuse treatment
programs, the implementation of these programs may nonetheless further marginalize participants.

Women outlined how their lack of transportation prevents them from going to jobs and job interviews, community college, court dates, and social gatherings. Participants may have temporary access to cars through partners and family, but these arrangements are unreliable. According to service providers, transportation has become more of an issue in the last 15 years as county health departments and other agencies no longer have funding for mobile clinics and as community services become dispersed through counties instead of being centralized in a county seat. In Adams County, five years ago, an elementary school, the library, the health department, the extension office, and the CPS offices were located within a few block radius. People only had to acquire one ride to the county seat to access all services. Now, the elementary school, the library, the extension office, and the CPS office are in different locations throughout the county, so women have to obtain multiple rides to access different services. A few programs help with client transportation, such as Horizons, but this has a time cost, increasing the amount of time women have to spend on Horizons by a few hours every day. Public transportation takes people to medical appointments but only if they have Medicaid, schedule the ride 72 hours in advance, have a referral if the service is out of county, and do not have a car titled in their name. Several women have cars titled in their name that do not work, but they cannot pay the fee to junk the car and remove their name from the title. Once again, family and friends must help, or women do not get transportation.

Women develop strategies utilizing kin for making it through the criminal processing system as well. Most women have family members transfer money into the
commissary while they are jailed, so they have access to better foods and toiletries. If women know they will not be allowed to take their prescribed medication, especially buprenorphine, they or their family will smuggle the medication in. Once released, women must find housing and employment, often through their family. Coming together with statewide social justice organizations and other felons is also a strategy after release. Frustration can motivate larger scale social action beyond individual navigation. When I asked Alisha about convicted felons not having the right to vote in Kentucky unless they petition the governor for the restoration of that right on a case by case basis, she said,

I disagree one hundred percent. So what I feel doesn’t matter? I have never missed a vote until I became a felon. It really bothers me. Now you can apply for your voting rights back. I will go to the steps of Frankfort and picket for my rights to vote. When I asked about [getting back my right to vote], they laughed and gave me a form and said, “Good luck.” When I called Frankfort, the lady told me it was a procedure like having a child, but none of the good things. She said, “It’s all of the bad things.”

When I spoke with her a few months later, Alisha had joined a statewide social justice organization to campaign for felon voting rights. In 2017, this organization successfully convinced groups of legislators in the Kentucky House of Representatives and Senate to draft bills to restore felon voting rights more easily. As of 2018, these bills are being processed through the legislature.

The violence and necessity of care and caregiving

Women in this study experience intense violence, usually from the same network that provides support. Many participants want therapeutic services that address trauma, and all want access to material resources that could mitigate their marginalized positions. Claiming women’s victimhood can be a way for program staff to gain additional
resources for their clients through grants that are focused on survivors of domestic violence or sexual assault (Carr 2011). However, state agencies are assuming victimhood in targeting women for intervention. Focusing on victimhood is not important to some women I interviewed. Experiences of personal violence should be understood as producing a variety of responses and not solely creating a state of victimhood. Personal violence can be intertwined with care and is embedded within structural violence. An assumed intrinsic violence in Appalachia, along with other stereotypes, creates discourses in which leaving Appalachia becomes the answer for mitigating all types of violence women face. Yet women often do leave, and escape is not necessarily what they find.

When people are categorized as victims, either through their own or other’s efforts, they often come under the purview of the state. People may not receive the state intervention they seek. If women are being abused and still have custody of their children, then they themselves can lose child custody for not leaving a situation in which a child may witness domestic violence or become a victim of violence themselves. CPS required several women to complete Horizons because their husbands, boyfriends, or sons abused them. The husbands and boyfriends generally did not have to do anything through CPS. Yet when women wanted the state to intervene because they were being beaten, they feared calling law enforcement because they thought CPS would also intervene. CPS removed multiple women’s children because the mothers were experiencing domestic violence. Anna was charged with neglect because she suffered abuse while her children were in the house.

The fear about calling law enforcement can be on more personal terms. Susan’s husband was beating her, but she knows her husband’s family is friends with the sheriff.
She thus called the state police instead of the sheriff, but the state police and sheriff communicate, so the state police brought the sheriff to her home. When the sheriff arrived, he told Susan he was going to call CPS and have her drug tested. She tested positive for cannabis. CPS asked the husband to get drug tested, he refused, and CPS accepted that refusal. Susan presumed this acceptance was due to her husband’s connection to the sheriff. CPS removed her children and placed them with her mother and then her husband’s mother. She was able to live with her children the entire time they were removed from her custody, because the grandmothers allowed her to do so without the CPS caseworker’s knowledge. Susan said she will never call the police again for domestic violence. She was charged with misdemeanor neglect and had to complete Horizons as part of her CPS case plan. Her husband received probation for domestic violence.

Overall, CPS and treatment programs focus on women as primarily victims of interpersonal violence who need to learn appropriate coping skills and need to remove themselves from violent situations where their children may be at risk. They do not view women as part of families and care networks who all consistently navigate structural violence. Shallow examinations of interpersonal violence that do not consider the broader contexts in which violence takes place risk depoliticizing and pathologizing poverty as something that happens among violent “others” because of criminal personalities or cultures. The depoliticization of violence, rather than eliminating the category of victim, essentializes the category of victim and perpetrator rendering them as objects rather than subjects (Fassin 2010; Han 2012; Hutton 2013; Karadinos et al. 2014; Malkki 2010). If programs do acknowledge the environment in which women live, it is often through a
blaming and stereotyping of Appalachian culture that harkens back to culture of poverty arguments. This blame of rural Appalachian culture for domestic violence can be seen in academic literature on the area.

Neil Websdale’s (1995) analysis of woman abuse in rural Appalachian Kentucky is helpful as he shows how domestic violence reinforces gender roles and how gender roles in turn are used to support domestic violence. Still he ignores the structural violence that has been perpetuated in Appalachian Kentucky and the effects that violence may have on domestic violence. Websdale instead relies on stereotypical understandings of the rural without unpacking those stereotypes. He says rural areas are unique because they supposedly have stricter understandings of gender roles, are more suspicious of outsiders, are more religious, and have a gun culture that is not present in other areas (Websdale 1995). I suggest that by ignoring the effects of structural violence on interpersonal violence, those who benefit from a hierarchical social organization are absolved from responsibility for perpetuations of violence. The context in which women experience violence is ignored and the structural barriers they face in cooperating with the state to reduce domestic violence are made invisible (Crenshaw 1991; Jacobsen and Lempert 2013). Society, family, and community members may then blame women for continuing to endure the abuse (Crenshaw 1991; Hautzinger 2007).

Substance abuse treatment programs may dismiss webs of power and women’s agency. Staff, administrators, and policy makers seem to only grant women who use drugs agency as perpetrators. CPS and drug court staff framed women as having agency only when they harm their children. Treatment program staff from various programs characterized women as taking action when they refused to follow treatment rules or
continued to have positive drug screens. The primary positive evaluations by staff of women who use drugs come from client’s constructed roles as victims of sexual or domestic violence, where they are framed as having no agency. When women were doing well in treatment, staff generally owed this to the treatment program or women’s stable and strong family. Thus, female clients are often seen as being unable to make decisions for themselves. Women take action, but the strategies they develop to survive remain unsupported and unacknowledged within programs. The inability of program staff to speak to women about certain types of violence because of their duty to report to CPS hinders the possibility of supporting clients in surviving these types of violence or understanding how these necessary strategies may be harming women through such processes as embodiment and weathering. Women must navigate violence. Sometimes women perpetrate crime. In my interviews with women, the most common crimes they cited committing involve drug use and trafficking, stealing in order to buy drugs, and neglect of children due to drug use. These crimes reflect women’s drug use and roles in illicit economies. But other women talked about assaulting people over drug and money disputes.

Sometimes women remained in violent relationships because they needed the material support or were afraid if they left, they would also be leaving their children. More often, women left these violent situations. Few women I spoke with said they were currently in violent relationships. Women generally left of their own volition. CPS told a few women that they would close the woman’s CPS case, as long as they did not get reunite with their abusive ex-husband or ex-boyfriend. Although these actions by CPS may be seen as reducing violence against women and children, they are paternalistic and
are another instance of pitting women’s interests against their children’s (Hanna 2010). Further, this abusive ex may be the person providing housing, clothing, and food. From women’s narratives, CPS never offered an alternative source of support.

Protective strategies also include extra vigilance and precautions to protect oneself. Anna was the first woman I interviewed whom I had not previously met and was not referred to me by someone I knew. She told me that she saw a flyer about my study in her uncle’s truck and decided to call me. I do not know how the flyer made it to the truck. We met at her house and drove to a park to talk. As I was driving her back home, we discussed how we were both a little anxious about meeting each other. She thought I might be the police or would not give her the stipend for the interview. After having talked for a few hours and becoming comfortable, we were laughing about this. Then we started talking about how we keep ourselves safe. I told her that on days when I was going places that were unfamiliar, I let my husband track my cell phone. Anna regularly checks in with a cousin and an aunt, so they know each other is safe. She amiably pulled out a pocketknife, “Yeah, I always pack one of these. I usually like the box cutter knives better because they let you cut people just a little. It lets them know they’re alive and they usually stop.” I admitted that I have carried a pocketknife for years as well. These methods reflect strategies, but also the gendered violence Anna has experienced. She was raped in two different episodes. In one situation, both she and her female cousin were unknowingly drugged at a party and raped by two men. At another time, her male cousin brought Anna to a drug trafficking deal. The two men they met raped Anna and severely beat her male cousin.
There are models for understanding violence against women that take into account political and socioeconomic contexts. Anthropologists and feminist theorists connect gendered violence in the US to neoliberal policies, racism, xenophobia, and poverty (Anzaldúa 1987; Conwill 2007). As men perpetuate transgenerational cycles of violence, they are not simply copying past instances of domestic violence, but drawing on violence to exert their dominance in a world where they are limited by poverty, addiction, and social marginalization (Bourgois and Schonberg 2009). In connecting interpersonal with structural violence, I am not trying to apologize for interpersonal violence (Anzaldúa 1987; Hautzinger 2007). Further, simply saying that poverty and unemployment are connected to domestic violence may still serve to hide power relations (see Grama 2000; Sweet 2015).

Instead, I am advocating for an understanding of how structural violence bleeds into the home and familial relationships through interpersonal violence and of the overall context in which interpersonal violence takes shape. Recognizing interpersonal violence as situated in multiple systems of power, including those based on gender as well as class, race, and location, limits reliance on a biased criminal processing system to protect women. This recognition moves beyond criminalization to changes that can be made in hierarchical systems to lessen instances of abuse, as well women’s vulnerability to abuse (Crenshaw 2012; Jacobsen and Lembert 2013; Roberts 2012).

In this dissertation, I have documented the ways in which structural violence comes into women’s lives, and here I make clear how interpersonal violence is experienced. I limit detailed descriptions to avoid voyeurism, but at the same time, I feel as though naming brings these events to light. Over a third of the women I spoke with
had been molested or raped, generally by family members or other people they knew. This percentage matches very closely to both US and Kentucky data (Smith et al. 2017). This indicates that rape and molestation is not an Appalachian Kentucky issue, but a national issue. Women face sexual violence in other ways as well, such as when they have to deal with the molestation of their children or rape of their family members or friends. These moments are not rare, as demonstrated in my interactions with Star when she was assisting her sister after her sister’s rape.

Sexual violence led to rifts in families and further physical or emotional violence, as explained by Lizzy,

I had the nervous breakdown in ninth grade and the social worker came to our house, mom went off because she said I was lying about everything. I mean here I am, I’ve already been raped numerous times. She made me get down on my hands and knees and crawl to this man and beg him for forgiveness for me lying. I refused to do it, so I got knocked around. She put me out of the house. I had nowhere to go. I called my grandmother and my grandmother raised me from that point.

Of the 40 women I interviewed, 25 were domestic violence survivors. Women were not just beaten by their boyfriends or husbands, but by parents and siblings. Heather miscarried twins when her younger brother, whom she was raising, beat her. Roughly half of participants who faced sexual violence continued to experience these traumas as post-traumatic stress disorder (PTSD), depression, anxiety, and suicide attempts. Women with histories of domestic violence talked about both depression and anxiety and the chronic pain associated with fractures and breaks. Participants connected various traumas, including the deaths of loved ones, loss of child custody, domestic violence, and sexual violence committed against themselves and their children, with their drug use.
Although not felt to be as extreme as instances of rape, molestation, or domestic violence, stigma based on portrayals of women who use drugs become another type of embodied interpersonal violence. Cindy explained the pain of this judgment and the connections she made with her increasing drug use,

People you truly love, you find out they’re saying [negative] stuff about you and you’re like f- [sic] it, I’ll show them. I’ll make it reality. After you hear that so many times, it’s like, you start to really believe it in your head that I’m not good enough and I am a bad mother. I might as well do what a bad person would do. They want to sit and talk about you but the time they’re talking about you, why aren’t they trying to help you? Pull you out of the dark hole you’re in. In my addiction, the more I was alone, the more I wanted to use. I felt like no one cared about me. My kids did, but they didn’t know what to do with me in my addiction. There were so many times I was trying to call out for help but so many people I knew the most were saying the most negative things about me. I was trying to tell them that I needed help but they weren’t listening to me.

As this quote demonstrates, judgment becomes embodied as frustration, depression, and feelings of abandonment. Cindy linked these feelings to her drug use.

The overall violence women experience in their social networks is exhausting, bringing a “tiredness, an about-wore-out-ness” to families and communities (Gipe 2015, 85). I have heard many people who use drugs, in this study and others, appropriate Fanny Lou Hamer’s quote, “I’m sick and tired of being sick and tired” to describe their wariness of a situation that differs significantly from the Jim Crow South Hamer fought against (Brooks and Houck 2010). Weathering encompasses the embodiment of social inequalities and limited resources as well as subjective feelings of loss (Geronimus 2013). The murders, overdoses, and suicides of fathers, brothers, aunts, and uncles became defining moments to the women in this study. The people lost to death turn to bones or ash, but they remain fleshed in people’s minds, a presence not easily lost. When living in a small community, every overdose, stabbing, shooting, and house fire in a neglected
tenement is felt because the victims and perpetrators or their families are known. During my fieldwork, in the week before Thanksgiving in Adams County, five people overdosed and died, two people were shot to death, one person was stabbed to death, and a major fire destroyed part of the main street. Interviews that took place after this week for the next several months often turned into hearing different people’s sides of the story or how they were connected to everyone who died that week. One effect of this violence was that women had difficulty finding support from others because many were consumed in coping with their own grief.

Living with this violence can be crushing, but also give people a sense of their own seemingly miraculous resilience. Some frame having a past as a drug user and a survivor of violence as significant in their ability to provide certain types of care, especially to drug users. Alisha sees her experiences, including physical and mental scars, as attributes that allow her to care for her community in ways that others cannot. She is empathetic and has been in similar situations as others who are entangled with CPS or the criminal processing system. She thus takes issue with programs she sees as attempting to alter her, more than just helping her remain sober. In Alisha’s words, “I think I was resentful of a program to try to fix me. I think that I’m broken, but I’m not sure I can be put back together. I think it helps me more to be broken than to be fixed.” I asked her to expand on this, and she said, “scars make be beautiful.” Alisha found strength and a deeper understanding of humanity in her navigations of violence and drug use. Further, it helps Alisha, and others, to provide care to those in recovery because it makes them feel like they have some success and connection with others. In these ways, drug treatment
may be empowering. Those going through recovery may claim that they are tough survivors who possess a unique understanding of life (Frankel 1989).

Taking these instances of violence as primary examples, six gatekeepers whom I interviewed blamed geography and supposed isolation for violence and drug use in Appalachia. Jennifer, a CHEK clinician originally from non-Appalachian Kentucky, sustained the idea that Appalachian women are always abused and downtrodden throughout our interview. She said this level of abuse is unique to Appalachia. When I asked her about the largest health concerns for women in the area, she immediately said, “Sexual abuse. I’ve probably got two out of every three girls in the Appalachia area I think has been sexually abused.” She went on to say that sexual abuse rarely occurs in non-Appalachian Kentucky. This subset of gatekeepers often foreclosed the possibility of anyone in Appalachia changing. Michelle, a university-based researcher, stated, We knew people weren’t leaving the community to get treatment and to make, if you will, better lives for themselves. That’s when something like a drug epidemic can more easily take hold because we’ve got a constant. People in recovery in rural areas have to leave because it’s such a small insular community that it’s hard for them to change their behaviors because there’s so many negative influences on them.

Although from the region, Elizabeth, a research assistant in Eastern Kentucky, views rural Appalachia as particularly harmful for poor women, “Especially women. I wish that they could see that there’s so much more than staying here and marrying the boy up the road.” In the context of rearticulations of Appalachian stereotypes, state administrators, politicians, and service providers from outside the region particularly argue that individuals must leave Appalachia in order to change their lives. Most make two assumptions: that Appalachians never leave their home community, and that leaving will solve people’s problems.
The women I interviewed pushed against these ideas of leaving in several ways. First, over half have moved to different areas, leaving their home county for another county or state for months or years at a time, primarily to search for employment. Other women desire to leave, but feel like they cannot because they will be leaving their children as well, for whom they do not have custody. Although Maggie has custody, her family currently provides childcare while she works. Maggie does not want to move to where she has to pay for childcare she does not trust. Ashley wanted to go to an inpatient treatment program, especially since her children are already living with their father in another state. She did not go because she would have lost her stable housing situation. Hazel, Louise, and Sarah were attempting to save enough money to leave, but they had to save thousands of dollars for rent and transportation. This seemed like an insurmountable goal.

Second, when women do leave their home counties, it does not change their marginalized positions. Whether they left for urban Central Kentucky, Texas, Ohio, or Alaska, they were nonetheless ensnared in similar mazes of homelessness, unemployment, incarceration, and drug use. Further, leaving did not change the stigma they felt. Women may be stigmatized because of their reputation and former drug use in their hometown. When they left, they were stigmatized for their drug use and birthplace in rural Appalachia. Women in this study reasoned that if they were going to be treated poorly regardless of place, then perhaps being in the place where they have some support is more advantageous. When women moved to different areas several times and did not find better conditions in terms of housing, employment, and educational opportunities, they saw no point in attempting to move again. Theresa, Alisha, and Hazel said they would
never return to inpatient treatment that removed them from their families because there are as many drugs in inpatient as there is in their networks. Star and her family moved to another county with better jobs, but her children were miserable in the school system that has poorer outcomes than Teller County’s. She quickly returned to Teller County and vowed not to attempt to move again until her youngest child has graduated high school.

Theresa and Katie moved to urban areas where they found low-wage employment, expensive and substandard living conditions, and heroin, which its cheapness compared to prescription opioids financially allowed them to increase drug use.

Documenting the grounding of individual experiences in particular cultural and political histories is vital in understanding the symbolic and material realities of addiction. Assuming regional isolation and inherent violence serves to deem an area pathological. In fact, these regions that are stereotyped as having high rates of drug use and overdose deaths are intimately tied to exploitive global capitalism (Garcia 2010). Women’s placement in a marginalized region materially constrains their lives and symbolically frames their interactions with state agencies, yet these limitations do not disappear when they leave. Leaving Appalachia does not provide an escape from gendered inequalities, punitive discourses and policies regarding people who use drugs, or state surveillance. Further, leaving threatens systems of care that are vital for women’s survival.

Some of the women I interviewed are proud to embrace an Appalachian identity that they also see as stigmatized. This shows that they do not care what others think and have little concern about being “proper.” Lela said that coming to love Appalachia is like coming to love yourself. Both Appalachia and herself, as a woman who has used drugs, are looked down upon. In a bell hooks talk, she noted that a sense of belonging to a place
may be the greatest asset of the marginalized (hooks 2015). Others reject Appalachia. Female treatment clients, generally those who have spent substantial time outside the region, blame other clients for treatment failures because as Appalachians, they are supposedly too lazy to work hard. A few women asked me what Appalachia is when I mentioned it, indicating that this regional identity is meaningless to some. Most, however, are more ambivalent. They love the beauty and their community, but they feel like they cannot move out of their marginalized positions. One of the character’s observations from _Strange as this Weather Has Been_ exemplifies this feeling, “Because for a long time, I’d known the tightness of these hills, the way they penned. But now, I also felt their comfort…I understood how when I left, I lost part of myself; but when I stayed, I couldn’t stretch myself full” (Pancake 2007, 10).

Ann Pancake successfully displays how the pain and hope of this place can live through its residents, “This place not pure, and how that somehow makes him more tender for it, makes him love it deeper, for its vulnerability, for its weariness and its endurance. This place so subtly beautiful and so overlaid with doom…Killed again and again, and each time, the place rising back on its haunches, diminished, but once more alive” (2007, 239). I do not take this quote to be as disheartened as it might seem. I connect this to Alisha’s understanding of her scars as beautiful aspects of herself that give her might. Some of the women in this study are arguably the most marginalized county residents in an area with poor economic and health indicators. Yet they find ways to make do.

Women’s resilience against inequalities has a long history in Appalachia. Women have been fundamental in labor disputes. This was most popularly displayed in the 1976
academy award-winning documentary *Harlan County U.S.A.*, which highlighted women’s support of the United Mine Workers of America strikers through the Brookside Women’s Club (Ward Maggard 1999). Women, including Maria Gunnoe and the late Judy Bonds, have been at the forefront of protests against mountaintop removal and the negative consequences of the coal industry (Bell 2013; House and Howard 2009).

Women of color have demanded inclusion in an Appalachian region that is stereotyped as all white (hooks 2009; Wilkinson 1999). Appalachian communities have come together to respond to opioid use and overdose deaths (Kobak 2012; Mullinax 2012). In the five counties in this study, women have organized anti-drug coalitions such as ACADA and DADA. Yet a select few gatekeepers attend these meetings. When I asked women in recovery if they would go to these meetings, none said they would feel comfortable attending because of their status as a former drug user.

The resilience I describe among the women in this study more often takes place in the home or the family, rather than collectively in the community. For example, when women said, “I’m sick and tired of being sick and tired,” this was not used in the same way Hamer originated the term when she was rallying support for the Voting Rights Act of 1965 to combat Jim Crow voter suppression. Women I spoke with said this to indicate they were tired of addiction and their individual marginalization. Of the 40 women I interviewed, only five took part in collective action. Alisha joined a statewide social justice organization. Star worked with other drug court participants to advocate for a drug court drug screening site that is located in their home county, as opposed to a neighboring county. Katie, Maggie, and Beth came together to start a community lead substance abuse treatment program. I think women’s struggles with addiction, other health issues,
caregiving work, and material deprivation are limiting the energy it takes to organize. Their discomfort with attending anti-drug coalition and additional community meetings indicates they may be prevented from organizing in the public sphere through shaming of drug users. A next step for this research could be to think through ways to support the efforts of women like Alisha, Katie, Maggie, and Beth.

Women’s survival strategies for navigating socioeconomic inequalities as well as gendered violence are constrained and may represent the best choice out of several poor options. But these strategies represent creative ways of generating a life primarily based on care networks that are undetermined by a capitalist labor market (Gibson-Graham 2014). In areas with uncertain or wavering economies, care networks may provide more predictable assistance than labor economies (L’Estoile 2014). Perhaps building onto understandings of care is a starting place for treatment programs to support women’s navigations. This may be a more helpful and less isolating path as opposed to sanctioning women for how they engage with care or encouraging clients to enter low-wage and exploitive employment. Yet any investigation into how to build upon care networks should avoid reinforcing gendered categories of who can provide care and gendered burdens of care work. These gendered understandings of care are most embedded in discussions of and policies targeted towards mothers, as explicated in the next chapter.
Chapter Six

Relatedness, Reproduction, and CPS: Intervening in Systems of Care

I did not intend to focus on mothering or motherhood when I began this research. Several factors brought this identity into focus. State surveillance of those who use drugs is gendered through the unique provision of some services to women who have children. At the same time, state sponsored sanction through CPS is particularly leveled at women who have children. Thus women’s relationships with the state are often experienced through a mother identity. In these ways, being a mother can carry risks of state intrusion, but through time and place, women have also used this identity as a source of power to challenge marginalization.

I witnessed negative characterizations of women who use drugs among community members and service providers. These characterizations were often articulated through discussions of NAS and generally intersected with stereotypical understandings of Appalachian women. Ideas surrounding women who use drugs, Appalachian women, the culture of poverty, addiction as a moral failure, and addiction as a brain disease culminated to produce characterizations of Appalachian mothers who use drugs as genetically and morally flawed beings who are chronic victims of trauma and perpetrators of addiction and poverty. While I do not deny women’s experiences of trauma, simply treating women who use drugs as victims or as “bad” mothers is reductionist.

Substance abuse treatment programs in the five county area, some state services outside of treatment, and CPS target women who have children. Yet these programs,
particularly CPS in this chapter, are limited in the quality of services they can offer. These limitations are rarely acknowledged when women fail. When women are sanctioned or terminated from programs, they are stigmatized as drug users and “bad” mothers who do not love their children enough to cease drug use. Treatment program clients face further complications when programs are at odds with each other. In Adams and Douglas counties, the CPS office’s bias against buprenorphine creates harmful fissures for women and their families. Women’s attempts at making do can at times lead them to worse entanglements than they were experiencing previously.

Understandings of motherhood

Despite the focus on individual autonomy in Western neoliberalism, this does not accurately describe the lives of most humans (Sahlins 2011; Tronto 1987; Tronto 1995). I analyze relationships and care partly for this reason. I focus on motherhood because most I spoke to did, whether treatment participants or the variety of gatekeepers. By focusing on the construct of motherhood and analyzing it from the vantage point of ethnographic data, I hope to complicate it. I do not want to harken to bioessentialist understandings of kinship or care, as these have been soundly critiqued by David M. Schneider and the work that has built on his analyses (Carsten 2004; Schneider 1972; Wilson 2016). “[Kin] partake of each other’s sufferings and joys, sharing one another’s experiences even as they take responsibility for and feel the effects of each other’s acts,” but this mutuality often grows from intricate combinations of natal, as well as performative, connections (Sahlins 2011, 14). More recent scholarship blurs the lines between social and biological in attempting to consider both (Berman 2014; Sahlins 2011). I do not let go of biology
completely because the act of pregnancy as well as cultural understandings of the biological body infiltrate women’s lives. Having or appearing to have a uterus opens women to a host of state and societal surveillance that is concerned with fetal health. Women who use drugs thus face more complicated stigma than men who use drugs, as well as a subjective reality that induces anxiety when they find they are pregnant. Yet even physical processes that appear purely biological include social understandings (Berman 2014). For instance, while pregnant women are connected to fetuses via umbilical cords, how the public and those in power perceive this connection has as much to do with policies towards pregnant women as the umbilical cord itself.

I observe characterizations of women who use drugs as bad mothers continuously, whether it is in the local or national news, at community or state policy meetings, in health care settings, or at academic presentations. In his 2018 “State of the Commonwealth,” the Governor of the State of Kentucky, Matt Bevin, lamented the purportedly astronomical social and familial cost of children born to addicted women. Conversations at ACADA and DADA often revolved around concern over the number of “babies born addicted every year” and the young children who are supposedly already “lost” because they live in households where drug use is present. When I was volunteering at an Adams County thrift store, a woman came in to get a car seat. The two proprietors immediately began lecturing the woman for using drugs, having too many children by different fathers, and not being able to find the fathers to pay child support. The woman quickly left. My premature daughter was placed in a neonatal intensive care unit during my fieldwork. I talked to the nurses about drug use and NAS. I heard sighs, saw eye rolls, and one nurse told me that she was tired of seeing babies prenatally
exposed to drugs because of “a series of personal and generational decisions.” Women said they felt the juxtaposition of “good” versus “bad” mothers from family members and the community long before they enter treatment. Alisha compared how women are treated in the community versus men, “I think they put that label like she doesn’t care about her kids. Dads get off easy. So I always feel like the mom’s judged more than the dad is. I think they put it on us like we can’t make a mistake. Dad can make up for that lost time.”

Another identity that intersects with that of poor mother or mother who uses drugs is that of Appalachian. I observed instances of this ideology that women who use drugs, particularly Appalachian and poor women, harm their children in practice. A presentation by two clinicians based at a Kentucky university at the state ASAP meeting blamed Appalachian women’s drug use and promiscuity for creating children who are overprescribed ADHD medications. They said that mothers get their children prescribed these medications because the mothers do not want to take care of their children, but just want to use drugs and hang out with their “boyfriend or boyfriends.” They went on to describe their program. They take children to a summer camp where they are baptized and put in contact with “positive” male role models, generally law enforcement. In an academic presentation focused on teaching children with learning delays in Appalachia, the presenter blamed maternal drug use for all disabilities in the school system. All presenters made clear these assumptions did not come from program evaluations or data collection, but from what they imagined children’s home life to be.

In these examples, drug use and assumed prenatal drug exposure become framed as a culture of addiction that supposedly creates a genetic underclass of children. Like the
culture of poverty model, values, reproduction, and when taken further, genetics, are used to explain poverty or addiction instead of acknowledgement of structural forces. In the rhetoric I have witnessed in communities, despite vast amounts of data to the contrary from social science and biomedicine, some community leaders and policy makers continue to view addiction as a moral failure. What is most concerning is that people are taking small pieces of biomedical research on epigenetics and addiction as a brain disease, combining biomedical with moral failure understandings of addictions, and using this combination to frame addiction as a moral failure that has a basis in prenatal drug exposure, neurochemistry, and genetics. Moreover, as they deny the influences of structures of power, they use the chronicity implied by epigenetic, genetic, and neurochemical models to remove the possibility of drug users or their “damaged” children being able to change. Women who use drugs and the children they have while using become “lost generations.”

In her discussion of the possible effects of ongoing epigenetic research, Maurizio Meloni (2015) notes that, “Bad habits can become bad biology, and the indelible scars of past environmental exposures can give rise to ideas of specific groups being ‘too damaged’ (because of persisting bad social experiences) to be rescued.” Moral fervor when merged with shallow understandings of epigenetics creates a social environment in which addiction can be viewed as an unending moral failure that women can supposedly pass down to their children through a risky fetal environment and heredity. This view supports scenarios in which coerced sterilization, performed through such organizations as Project Prevention in North Carolina, and imprisonment of pregnant women who use drugs occur. In this understanding of addiction, the only way to change drug use and its
consequences in Appalachia is to focus services on preventing prenatal drug exposure and drug use among children. Most community substance abuse programs in this five county area, whether run by local groups, county churches, or regional organizations, such as EKSAC, only have programming for preventing substance use among children. Even though a focus on children characterizes the vast majority of community organizations, when I asked community leaders what they needed more of, they generally responded more substance abuse prevention programs for children. While this is important, I argue it should not be the only focus.

*Intervening in motherhood*

Due to the perceived unique relationship between women and children, women who use drugs have increased access to substance abuse treatment in this five county area. Pregnancy or being a mother of children under the age of 18 is a qualifier for services. Horizons primarily serves women who have CPS cases and programming is focused on parenting. “Number of drug free babies” is an outcome measure of Kentucky drug courts and reflects the prioritization of admitting pregnant women into the program. A former drug court judge, Andy, said he is more likely to admit and readmit pregnant women into drug court because he wants them to give birth to children who have not been exposed to substances in the intrauterine environment. EKSAC prioritizes pregnant women in its voucher program for substance abuse treatment. Recent Kentucky legislation, SB 192, has neonatal abstinence syndrome as a primary focus, and thus sends more money to treatment sites willing to accept pregnant women. Several program directors with whom I spoke said they are starting programs specifically for pregnant women in an attempt to
garner more grant dollars. When women are no longer pregnant, services disappear. Ashley lost access to methadone, “It was right after my daughter was born, and I couldn’t pay for the methadone. Legally, they can’t take you off of it when you’re pregnant because it can kill your kid, but as soon as I had my baby, they tapered me down five milligrams a day. I still got sick as a dog. It lasted like three months.” These programs make clear that the primary client being served is the fetus or newborn, not women.

The process of pregnancy and childbirth and the constructed role of women as primary caregivers qualifies women for services, and may be used to coerce women into treatment through such programs as Horizons. According to Horizons and CPS staff, completion of Horizons is usually part of women’s CPS case plan. The CPS case plan, developed by a CPS caseworker, involves a series of steps parents must complete to show progress with their case. CPS caseworkers in the five county area generally require mothers to complete Horizons as part of their case plan. The case plan, including any Horizons or other substance abuse treatment requirements, becomes court-ordered through family court. Horizons staff estimate that CPS refers 90 percent of the clients to the treatment program. The remaining 10 percent of clients may not have been directly referred by CPS, but usually have an open or closed case with child removal. Horizons staff think these 10 percent of clients enroll in treatment because they hope that CPS will view Horizons graduation as a positive step.

Horizons staff and clients claimed that fathers usually do not have to attend treatment at all as part of CPS case plans. When they do attend treatment, the program is housed within CHEK, the same community mental health center that houses Horizons. A CHEK clinician told me that the program fathers attend is for one hour a week for eight
weeks with no drug tests. Although CPS can request the father to complete drug tests, it is not a regular part of men’s treatment through CHEK. CHEK and CPS staff justify this discrepancy between women and men’s treatment by explaining that they had to fight for the men’s program to exist at all. Before ACA and Medicaid Expansion, the TANF grant for Horizons did not provide funding for men’s treatment. Although CHEK is now largely funded through Medicaid reimbursement, CHEK administrators are unsure of the stability of Expansion and are reluctant to begin a men’s program if they do not know if the women’s program will survive a dismantlement of ACA and Expansion. Still two CHEK staff justified the discrepancy by arguing that mothers are more important than fathers in terms of caregiving. Fathers need to spend their time working, not in treatment, “If the men are working, we don’t want to have them here three days a week; they need to be working and doing what they can” (Jennifer). This thought was certainly not universal at CHEK. Gail, the retired Horizons administrator, was disappointed they do not have an intensive men’s program. She said women resented they had to spend more time in the program, and she did not begrudge them this.

Class may intersect with gender to determine who is targeted for substance abuse treatment. Alisha, a former drug court participant who now volunteers at a community mental health center outpatient substance abuse treatment program in Teller County, says that socioeconomic status more than drug use determines whom CPS refers to treatment. Alisha works closely with CPS caseworkers, and she maintained that most of the people she counsels do not have drug problems, but live in “rundown” housing. She argues this is not their fault because they live where they can afford and the landlords do not
maintain the properties. It is nonetheless part of their CPS case plan to attend outpatient substance abuse treatment programs.

State services outside of substance abuse treatment and CPS also target mothers. Programs may give women a few material resources, such as diapers and children’s toys, as incentives for them to attend. More importantly to the organizations according to providers, services are meant to educate new mothers on how to avoid risky behaviors that may harm fetuses and newborns. A primary example of this is the CHEK community baby showers. Pregnant women or new mothers in the community are asked to attend via newspaper advertisements to acquire diapers, a diaper bag, and several door prizes. Participants are provided lunch and asked to sit through a slide presentation with a CHEK staff member.

I noticed during the baby shower I attended that the vast majority of the presentation utilizes scare tactics, such as alarming pictures of infants with fetal alcohol syndrome, to demonstrate how a mother’s behaviors can hurt their fetus, especially smoking, alcohol use, and drug use. The CHEK staff member defined pregnant women’s bodies as sites of fetal risk and possible toxicity, a word she used repeatedly. Even when discussing postpartum depression and domestic violence, the information is couched in terms of what behaviors may hurt a fetus or newborn, not how mothers may be harmed. Even though the presentation is developed by an organization that exclusively serves rural Appalachia and primarily targets poor women, all presentation images represent affluent women in pastel sweater sets with pearls. Most suggestions are urban-based. Women are encouraged to get henna instead of a tattoo and to find “mommy and me” groups, which are even difficult to find in the closest metropolitan areas to the five
county region. At the end of the presentation, women are given a “Making Healthy Choices” packet, which focuses almost exclusively on healthy choices for the fetus or newborn. For example, when describing depression and postpartum depression, the listed possible negative outcomes do not mention mothers at all,

Ongoing feelings of depression can put your baby at risk of being born too early or too small. If you are having these feelings, it is important to talk to your doctor!

Postpartum depression may get in the way of you being able to care for and feel close to your baby!

The packet explains that children should be women’s motivation to change risky behaviors. There are several pictures of babies with the caption: “Remember WHO you are making the change for!” It is implied that if women do not change, then they cannot care about children.

Beyond requiring Horizons, substance abuse treatment clients said that CPS had become a large force in their lives. In interviews, CPS administrators and caseworkers were fully aware that their presence in homes is usually unwanted, and sometimes unwarranted. Local and state administrators say they are making efforts to improve CPS’s standing in communities, yet the agency is constrained politically and economically. The federal Adoption and Safe Families Act of 1997 (ASFA) decreases chances of family reunification by encouraging swift adoption. Legal reunification timelines are relatively short in terms of how long it may take a parent to enter recovery. Parental rights are terminated if children have lived in foster care for 15 of the last 22 months (Hall et al. 2016). The combination of the ASFA with the passage of welfare reform in 1996 created a turning point from CPS focusing on child poverty and social inequalities to protecting children from parental harm (Roberts 2012). CPS policies that
focus on protecting children from parental harm reflect the bind in which caseworkers find themselves as they are expected to protect children and preserve families, which may be conflicting missions in some situations. CPS is heavily scrutinized in the media because the public expects them to accurately predict whether children are safe with their families or may come to harm (Scherz 2011).

Fay, a state administrator who coordinates services with CPS, argued in our interview that CPS’s funding structure has traditionally favored removal of children from the home. She is working on family first initiatives with Kentucky and the federal government. These initiatives are aimed at increasing the flexibility of funds reserved for foster care. With the current system, children must be placed in foster care before they receive certain services (Roberts 2012). Fay, and those within Kentucky CPS administration, want to alter those restrictions so they may use funds to garner services for children while they are still in the home, thus decreasing removal rates. The Family First Prevention Services Act failed at the federal level in 2016, but Fay continues to advocate for these changes as well as policies that acknowledge that women’s recovery may not occur immediately. As Fay contests the swift adoptions supported by the ASFA, Governor Bevin (2018) has prioritized the further shortening of adoption times.

CPS is further constrained by material deprivation. When I asked Karen, a local CPS administrator, what is preventing her office from carrying out their mission, she said, “There’s always room for improvement. I mean we’re short-staffed. I have three workers for this entire county. There are six people for two counties. We are over-worked, exhausted, and it doesn’t take long for workers to get burned out. We just want to make sure we don’t make critical mistakes.” While I was at an Eastern Kentucky regional CPS
meeting, county CPS representatives reported that several offices in Eastern Kentucky do not have Internet and may have to share cell phones between three or four caseworkers. During my fieldwork alone, two county offices were relocated because the walls of their buildings began to fall apart. In the context of limited funding, program staff feel like they must take actions to save money and cannot offer wrap-around services that they think families need. Governor Bevin (2018) acknowledged the high case load and low pay of CPS workers and promised a 10 to 20 percent pay increase for workers beginning July 1, 2018. Yet in the same budget, he eliminated 70 state programs, some of which provide the educational and in-home early childhood programs that CPS workers want to offer families.

Horizons works with CPS to attempt to keep children in the home after women test positive for drugs. Horizons and CPS are in communication daily. Fay talked about the importance of collaboration between substance abuse treatment and CPS because these two systems are “old advisories, in some ways.” She says there is intense emotion tied to CPS work because many caseworkers enter the profession to make sure “babies are safe.” Caseworkers can thus come from the perspective that parents are simply the people who hurt children,

There can be some judgment that [drug users] don’t even deserve to be a parent or if they really loved their children, they would put those drugs down. So we work really hard to build an awareness on the substance abuse treatment side that child safety is incredibly important. If we see something that’s happening from the substance abuse treatment side that might mean children are being endangered, if we have evidence that the parent is using or even suspect that the parent is using, then we need to talk with their [CPS] worker about that so that they can do a home visit and make sure the children are safe. And then we also work really hard on the child welfare side to, first of all, give [CPS] hope, to show [CPS] people in recovery so that they can see that people in addiction really can get better. That can help break down a lot of the stigma and discrimination that can come out of some of those beliefs that the parent has a moral failing. [Fay]
Despite Fay’s efforts, I witnessed some adversarial moments in an interagency meeting, with all Horizons staff seated against one wall, all CPS staff seated on the opposite wall, and administrators complaining about poor communication between the agencies. Agency personnel argued over who had better, more complex understandings of women’s lives. In the same meeting, my field notes reflect some of the tensions between Horizons, CPS, and how they understand women who are mothers and use drugs,

I accidentally walked into the CPS and Horizons joint budget meeting, which was the hour before the general meeting. CPS and Horizons share some funds for transportation and other case management services, hence the budget meeting. They were discussing how to meet clients’ needs. When I entered, they were talking about how to use funds to get things like water pumps, to make sure that people have water in their homes before children are placed back in the home. They then spent a long time talking about gas cards they provide to women to get to Horizons. They were somewhat concerned that gas cards can be sold and used for other things or that the gas cards themselves could be redeemed for things like cigarettes. The Horizons administrator said he didn't really care what the gas cards were being used for because it was still money going into the household income. But, the state CPS administrator said that she definitely did not want people trading those cards to buy drugs.

These deep connections between CPS and two of the three substance abuse treatment options in the area, Horizons and drug court, mean that child custody in addition to incarceration represent the main consequences for not progressing through treatment. When women fail a drug screen, for example, they do not advance their CPS case. Women said this accentuated frustrations with treatment. At the same time, the vast majority of treatment clients cited regaining custody after child removal as a primary motivator for entering Horizons and drug court. They see progressing through the programs as “working for your kid.” But, women face a double stigma when they receive dirty drug tests or do not show up for treatment. They are seen as not only failing sobriety, but failing their children. This stigma comes from other women in treatment, just as much
from the community and treatment staff, as shown in Katie’s conflict with another Horizons participant,

You know one day she was sitting there and she said, “Well this is just a complete waste of my time to be sitting here.” And I looked at her and I said, “Really? Well where else would you be?” She said, “Well I don’t know, at home.” And I said, “What have you got going on at home? You’ve got three children and you don’t have custody of none of them. So being here is a waste of time, so therefore you’re saying being here fighting for them is a waste of time so they’re a waste of time.” I can’t help it; stuff like that just burns me up. So she said, “Well no.” And I said, “Well then being here shouldn’t be a waste of your time.”

But staff share these sentiments as well, as noted by the Horizons case manager, Becky,

Becky: For some, the instinct of being a mother and protecting your children and needing them home will override [wanting to use drugs]. If [CPS] removes the client from the home and restricts the client from seeing the kids, that will light the fire up from underneath them. If it doesn’t, you can tell they won’t be able to take care of their kids at all.

Lesly-Marie: So you think being physically separated from the kids helps?

Becky: I think it does. It’s kind of like threatening.

Lesly-Marie: For women separated from their kids, what’s the effect on women who come through here?

Becky: After the first bit when they get in here and get started, once they get trying to clean up and trying to get sober a little bit, you can tell if they’re going to make it or not or how far they’ll go. If they want those kids, they’ll make the effort and you’ll see it.

For the women I interviewed, while their male relatives and friends are more likely to have felony records and to have come in more frequent contact with the criminal processing system, women are more likely to have interactions with CPS. Only two women I spoke with lacked experience with the CPS system because their drug use did not coincide with having children in their home.

No one I spoke with disputed that CPS is a necessary service for protecting children from harm. Yet agreement over the institution, including how policies are
implemented locally, ended here. Unsurprisingly, it is difficult to find women who have had their children removed who say positive things about CPS. Katie and Laura did not have complaints about CPS. Katie said she had a good experience because her caseworker is new and not “wore out with the system.” She felt as though her caseworker listened to her and regularly checked in on her via text message in a way that felt nonintrusive and caring. Katie doubted other caseworkers who had worked at the agency longer would do this, since she thinks they are overburdened with too many cases. Although Star has her problems with CPS, she does think one caseworker in Teller County is exceptional, “We have one good worker…but she actually quit [CPS] because of that. Because she felt that they was picking on drug addicts, instead of help them save their lives and their children, they wanted to come and take them. She wasn’t for that.” Both Star and Louise are happy with some material support they received from CPS. Star received a grant for a wood burning stove and Louise received some clothes after her apartment was driven through by a drunk driver.

Women become frustrated with CPS because they said they are under increased surveillance as compared to their male partners or husbands. Hattie exemplified this frustration: “So how’s it fair that I have to go take a drug test and have to be supervised to be around [my son], but his daddy doesn’t have to take no drug test. Shouldn’t he have to be drug tested? It ain’t fair, it’s not right. I mean I’ve raised that baby since he was a newborn. His daddy has not done nothing.” Further, three women said that their abusive ex-husbands used the threat of CPS against them. If the women threatened to contact the police to report domestic violence, their ex-husbands threatened to call CPS and tell CPS that the women were abusing the children.
The focus of CPS on women’s behaviors results in women being disciplined if they call CPS when they know their children are being harmed. Nicole called CPS because her children’s father and uncle, who did not live in the home, molested her children. CPS gave her a drug test and removed her children from her home. What concerns women the most is when they feel like their children are placed in harmful environments when they are removed. Some women trust their parents to be quality caregivers to their children, but others are not as fortunate and must rely on “kin of last resort” (Knight 2015, 173). These kin are called upon to take child custody so children do not enter foster care, but women may not trust these people and these kin may have problematic or even violent histories. Ellie’s children were placed with her mother-in-law, who is a larger-scale drug-dealer. April’s kids were placed with their father’s family, who let them see their physically and sexually abusive father.

The most intense instances of unwarranted CPS intrusion involve clinician-prescribed buprenorphine. Medication-assisted treatment (MAT) is associated with higher rates of family reunification in Kentucky. Yet MAT utilization is low among parents with CPS cases, hovering at just over nine percent in one Kentucky study (Hall et al. 2016). This low utilization rate is understandable. In Adams and Douglas counties, CPS caseworkers are removing women’s newborn children from households upon birth if pregnant women test positive for clinician-prescribed buprenorphine without naloxone. Two Adams County Horizons staff who are in regular contact with CPS caseworkers confirmed that CPS is removing newborns and older children from mothers who are prescribed buprenorphine. Although they do not think this is right, they think it is their job to try to help women navigate CPS, not to publicly and explicitly fight CPS actions.
This makes sense to them and to me. If they begin conflict with CPS, CPS can refuse to send women to Horizons. Adams and Douglas CPS has done this in the past when the local administrator did not personally like a Horizons clinician. This ultimately hurts Horizons staff, because they lose clients, and it harms women, because they are less likely to get their children back if they do not complete Horizons.

According to CPS literature and state level administrators, CPS ostensibly condones the use of prescribed buprenorphine for pregnant women and parents. Perhaps this is why Fay spent a portion of a regional CPS meeting espousing the merits of MAT. Melissa, a CPS regional administrator with geographically narrower authority than Fay, was a bit more hesitant about buprenorphine. She said that newborns who withdraw should be referred to CPS by the hospital, but this should lead to an open case, not necessarily removal. Karen, the local level administrator in Adams and Douglas counties, was the harshest. She stated “I hate Suboxone” and that if a newborn withdraws from buprenorphine or a mother tests positive for anything in addition to buprenorphine, it is an “automatic removal.” While these staff are at different levels of CPS authority, all are administrators with similar graduate educations and years of experience.

Louise was the first and certainly not the last treatment client to convey this narrative,

Before I got pregnant, I was on pain medication for a wreck I was in. When I got pregnant they put me on, the baby doctor himself, I wasn’t going to like no clinics or nothing, the baby doctor himself put me on [buprenorphine]. When I had [my daughter], they automatically removed her from my custody and nothing was in her but what was prescribed by the [obstetrician] himself. They took her from me and I placed her with my uncle. They told me to do [Horizons], and as long as I stayed straight, completed it, I’d get her back.
Louise completed Horizons and regained child custody. Hazel, Isabel, and Marge all lost custody of their newborns at birth because they were on prescribed buprenorphine without naloxone. The three women live in Adams or Douglas counties, which are served by the same CPS office. CPS charged all with misdemeanor neglect. Alisha said that five of the women she is currently working with in Teller County lost child custody because they were pregnant and tested positive for prescribed buprenorphine. Brittany lives in Adams County and works as peer support at River County Horizons. She said that the Adams and Douglas CPS office justifies their actions by saying that women should be weaned off of buprenorphine by the time they give birth. This justification contradicts both Kentucky CPS documents on buprenorphine and the policies the regional CPS administrator detailed for me in our interview. Brittany said this is also against what women say their physicians are telling them. She is confused how CPS can go against physicians’ care or why physicians would be offering care that contradicts CPS.

CPS caseworkers in Adams County told two Horizons participants that even if they are on prescribed buprenorphine when they are pregnant, if the newborn has any withdrawal symptoms, the newborn will be removed. The caseworkers reportedly said that if there is no withdrawal, the newborn will not be removed, no matter what the mother tests positive for, whether it is buprenorphine or heroin. Beth lost child custody when she told her labor and delivery nurses that she illicitly took buprenorphine when she was pregnant. Her aim was to wean herself off of clinician prescribed oxycodone and ibuprofen because she thought those were worse for pregnant women as compared to buprenorphine. Neither she nor her newborn ever tested positive for anything and her daughter did not withdraw, but her CPS caseworker said this is irrelevant, “And I was
told by my caseworker, ‘Well it wouldn’t have mattered if you would’ve had a prescription or if you wouldn’t have had a prescription. We still would’ve took her. We would’ve been in your business.’”

Sissy and Katie had cases open with two different CPS offices, the office in Adams and Douglas counties and the office in Eagle County. Both are convinced that women prescribed buprenorphine are only losing their children in Adams and Douglas and not Eagle County because the Adams and Douglas office is biased against buprenorphine. Sissy was prescribed buprenorphine while she was pregnant, breastfed, and her daughter did not display any withdrawal symptoms, which is why she thinks she did not have a CPS case opened on her. Throughout our conversation on the subject, Sissy kept shaking her head and exclaiming that it was wrong that women are being punished for seeking help. We talked about clinicians telling women not to breastfeed their newborn when mothers are on buprenorphine. Sissy said this is ridiculous because breastfeeding is exactly what mothers should do if they want to, “She can’t even try! She can’t even try to help [her baby]. It’s not [CPS] policy. So why is it happening? And it’s totally wrong against the baby, the mother, all of it. The baby doesn’t get that bond with the momma, you know, knowing there’s somebody there who will always drag them back from the edge.”

Hannah and Laura lived in River County at the time of their pregnancy and delivery and were prescribed buprenorphine without naloxone. A CPS caseworker visited them in the hospital and asked a few questions about their living situation, but the worker did not open a case or even contact them again.

These gaps between buprenorphine prescribers as well as various CPS offices and administrators create harm. Louise was upset with her obstetrician because he did not
know or did not tell her that CPS was removing children when pregnant women test positive for buprenorphine until two weeks before she gave birth. This was not enough time for her to taper off of buprenorphine. Debbie, a buprenorphine provider, said providers have to be patient advocates,

   Your treatment provider needs to have a high level of understanding of the legal and the regulatory things. There are times when someone “in charge” tries to discriminate illegally against your patient; you have to remind them of the law. I’ve had several issues where I’ve copied your rights from SAMHSA, can you be fired for taking it? I’ve sent that to judges. You can’t say that this person can’t have visitation rights to their child because they’re taking buprenorphine. You have no legal grounds for that.

Debbie argued that prescribers have to be advocates so patients remain unharmed when they face a state agency or employer who discriminates against those on buprenorphine. Additionally, she saw it as part of treatment providers’ jobs to educate state agencies, employers, and others on the benefits of buprenorphine so patients do not fall into these dangerous gaps. The situation is overall very confusing, for women, treatment program staff, prescribers, and CPS caseworkers. Yet women and their families pay the price for this confusion.

   Bias against buprenorphine or women who use drugs is not unique to CPS. Almost a quarter of participants had negative encounters with local medical providers who accept uninsured or publically insured patients. They do not seek care unless they are ill enough to be immobile. Others do not access services locally, and insist on driving at least two hours away to seek care in urban areas. Women feel stigma most acutely when they are pregnant. Katie said providers treated her “like a dog” when she went to the doctor late in her pregnancy because she was on heroin and had not received prenatal care. Unsurprisingly, one reason she cited for not seeking prenatal care was because she
thought she would face judgment. Several women I interviewed used the phrase “treated like a dog” to explain their experiences with health care providers at the River County hospital and with local obstetricians and gynecologists. They often described situations where they were regarded as nonpersons; as those who were having procedures done to them without having any say in their treatment. Some in the medical field treat women who use drugs as nonpersons because using women are supposedly unable to fulfill traditional feminine and mothering roles. This treatment has embodied consequences. Medical professionals take away women’s rights to make decisions regarding the health of themselves and their children (Friedman and Alicea 1995).

Despite some service providers’ avowal that removing children from the home is beneficial to women because it forces them to a “rock bottom,” ultimately most women do not agree with this. While they may enter treatment because of removal, they find the removal process to harm their progression through treatment more than it helps. The stress of having an open CPS case often exacerbates the weathering effects of prolonged marginalization. Several women described the social isolation they felt when their children were removed and outlined effects on their health, especially depression symptoms, anxiety, and suicide attempts. Women more often than not increased drug use because it is their main available form of self-care. Only three women said that loss of child custody was good motivation for them to actually do well in treatment. When these three women did not have child custody, all had their children placed with their parents and could see their children whenever they wanted, alleviating much of the pain of removal.
The vast majority of women I interviewed view CPS as another system that makes them feel intruded upon without helping them in any way. Theresa lost permanent custody of her daughter the day before she completed her CPS case plan, and CPS did not mention this in court. Star was upset that CPS removed her children. Now that her children are back in the home, what makes her truly angry is that CPS makes determinations about her children’s welfare based on a once monthly fifteen-minute home visit. She says this demonstrates her caseworker’s lack of knowledge and care of her family’s well-being. For Star, she cares; her caseworker does not, so why does the person who does not offer care have such power?

CPS limits the emotional support women receive from children partially or entirely. Child loss is generally devastating. Women talk about “losing their mind” when their children are removed, increasing drug use because there is no reason to be sober, and feeling the loss as a death. Several women with whom I spoke attempted suicide soon after their children’s removal. Women feel guilt when CPS removes children from their care. As Sarah stated, “My baby crying, ‘I’ll be better, please don’t leave.’ I’ve had to deal with some of the most heartbreaking stuff.” Women feel shame that their children blame themselves, that the burden of childcare is placed on their family, and that they miss their children’s developmental stages, or have to view these stages “from behind the glass” at jail visitations. When children are removed, participants miss connections they have with other humans, “Before I was a drug addict I was a mother. I’m not happy being a drug addict at all. There’s no happiness to it. I’ve learned that through experience. If this is my life… this isn’t my life. There’s got to be so much more to it” (Barb). Barb wanted to return to a life where she had consistent relationships with her children because
she said she was happier in that life. Yet she could not imagine how to make that return. This leads to one of the major hurdles in treatment; treatment not only removes drugs from a life, but generally many of those in care networks.

Child removal directly affects families, but it also has larger influences on how we understand marginalized women’s suffering. At the national and international level, child suffering has become the focus. When children are removed from situations, human rights surveillance often ends (Viterbo 2016). In Central Appalachia, when children are removed from a home, state resources, such as SNAP, and surveillance leave that home, turning the lens away from adult suffering. Removal often results in a loss of personal and political identity. Women lose their affected relationship with their children and their political identity as mothers who have the right to protect their children, which may be why other research shows that removal can harm recovery efforts (Chiplis 2010; Flavin 2009; Fuentes 2014). The women I spoke with felt stigmatized as drug users and “bad” mothers. Cultural narratives and program materials continue to ignore women’s marginalization and treat addiction as a moral failure while only picking and choosing particular aspects of addiction as a brain disease model. Women are automatically categorized as “bad” mothers when they are perceived as continuing risky behaviors, such as drug use or living in substandard housing.

*Navigating impossible identities*

Women’s reproductive capacity may be empowering or repressive based on local and global assemblages (Ginsburg and Rapp 1991). Attaching a motherhood identity to political activity is not new in Appalachia or globally and may represent one of the few
pathways women have to enter the political realm or make demands on the state in certain settings (Collins 2000; Karandinos et al. 2014; Mason 2005). Recent research on Appalachian activism shows how women identify as mothers or protectors, which secures moral authority to make environmental justice arguments, clearly showing the relationship between claims of good motherhood and the ability to make claims on the state. Yet women may have to identify as mothers to make claims for any kind of justice because they are expected to put the welfare of their children and communities before their own welfare. Thus women do not have the power or authority in these situations to advocate for themselves (Bell 2013).

State intrusion is experienced variously according to geographic and funding contexts, and it is also navigated differentially. Despite the stigma women feel when they identify or are identified as a mother who uses drugs, they strategically accept this identification to access services through Horizons and to make it through their CPS case plan. Hannah described the impact of having the label of “addicted mother” codified into her record, “I’ve never said ‘Yes, I’m a drug addict.’ When I came in [to Horizons] I was like, ‘Oh Lord, it’s on record that I’m a drug addict.’ It was awful.” Being categorized as a mother who uses drugs in many ways prevents women from attaining resources, such as employment. Yet in other ways, it is the primary avenue they have to access particular resources. One of the only ways women can enter substance abuse treatment in the five county region is to be a mother who has an open case with CPS.

While women are negatively affected by these labels as well as the policies that emanate from them, they actively work against negative characterizations. Participants almost always agree that they cannot be quality child caretakers when using. Several
women navigate this dichotomy of “good” versus “bad” mothers by finding ways to preserve their feeling of being a somewhat “good” mother while continuing drug use. This usually involves caring for their children, such as cooking dinner and providing for their needs as well as wants, not using in front of their children, and only using when their children are asleep or being taken care of by someone else. Star demonstrated this, as well as her anger that she received neglect and dependency charges from CPS,

I just told [the judge] straight out, neglect to me sounds like someone who beats their kids, don’t feed their children, leaves them unattended. I neglected myself, not my children. I mean my mind wasn’t there, but I never harmed my kids. My kids were always still fed. They had a roof over their head. All that and I tried to hide [my drug use] from them too.

Women eschew the idea that attending Horizons indicates that they are or were “bad” mothers. Sarah noted this when discussing her reluctance to go to Horizons, “I didn’t think I was a bad parent. I still don’t think I’m a bad parent.” Ellie, on the other hand, talked about guilt, but also forgiveness,

When you’re in addiction, you think about how great of a mother you are but you’re not. I can think of all of the times that I locked myself in the bathroom and they’re beating on the door crying, wanting me to come out. You’re not the best mother. It hurts me so bad because I carry that guilt and shame. I’ve done so much wrong to my kids and it hurts me so bad. Your kids are just like a ball, [the Horizons counselor] tells us, they jump up and go on. So why should we keep punishing ourselves?

I think these different narratives in some ways reflect varying levels of drug use. Both Star and Sarah claimed that their drug use had tapered down significantly by the time they had children, while Ellie’s drug use was at its peak. Further, women had conflicting feelings. Star was frustrated with CPS and did not think she deserved to be sanctioned through a court system, but she also spoke of guilt. She saw her graduation from drug court, her continued work on sobriety, and her devotion to her family and to God as atonement for her drug use.
Participants feel judged and use this judgment as motivation through treatment, “A lot of motivation for me is proving a lot of people wrong, who had the wrong idea about me. That pushes me, a lot. People are going to form their own opinions and everyone’s entitled to their own. Just knowing that I’ve done the right thing and told the truth, that’s good enough for me” (Lucy). Women in recovery see strength in their past. Their past drug use can make their children and themselves stronger because all better know how to contend with adversity. Star thinks her past helps protect her kids from experimenting with tobacco, alcohol, or other drugs, “[My kids] knew mommy had to go away [to jail], you know, and that’s made my kids stronger. They’re afraid. They don’t want no part of danger, you know.”

The stigma against drug users can become a uniting force for users and service providers. The negative characterizations service providers see in the community is an entry point for empathy, and becomes something providers and women can come together to fight. While this sentiment was most common among Horizons staff, it also appeared among buprenorphine prescribers, as demonstrated in the quote from Debbie above, and drug court staff. A former drug court judge, Rob, gave a common speech to drug court graduates, “All of us, I don’t care who you are, if you had to be accountable for every moment of your life, I know I’d hop in the car and drive as fast I could. I just would. So you all shouldn’t care what anybody says or thinks, just try to beat this and go on.”

Once in recovery, the women I spoke with began building cases that they are “good” mothers. Although these cases are certainly used with CPS, they are also displayed to treatment providers and others who enter their lives, including
E. Summerson Carr (2011) documents the construction and importance of case files in substance abuse treatment as they affect what services women receive and how women are sanctioned. Clients, especially those with previous institutional experience, are keenly aware that case files affect what resources are available to them (Carr 2011). When I was in women’s homes, it was not uncommon for them to immediately start showing me pictures of their children, their kids’ rooms, and boxes of toys and children’s clothes. They explained that I could see as well as anyone that they provide for their children and the kids lack for nothing. I think this demonstrates that they viewed me as inhabiting a position of power with the authority to report negatively or positively to their treatment program or CPS.

When I entered Ashley’s house for our first interview, she took me to her daughter’s and then son’s room to show me that they not only had enough toys, clothes, and nice beds, but were “spoiled.” In the kitchen, she showed me that although she did not have enough food for herself, she always tries to have food that the kids will eat, in case they come for a visit. Ashley spent substantial time showing me the folder she planned to take with her to her next court date for child custody. This folder represented a case file she had built for herself, instead of a case file built for her by a clinician or caseworker. She has pages with the number of drug tests she has passed through treatment and dozens of documents from community members stating that she is a “good” mom. She told me how her children’s occupational therapist testified on her behalf during a previous court date. Ashley kept explaining that she volunteers in the community and at the local school, demonstrating that she is not only a “good” mother, but a citizen who contributes to the community.
Women develop strategies for dealing with CPS, which is constrained if families lack funding for legal fees (Hedwig 2013). Even if they are able to access the monies to hire quality legal representation, they may have to deplete their savings or home equity, further pushing them into dire economic circumstances. Alisha, a former drug court graduate, has connections to county judges and the CPS office through her parents, so she was able to unofficially work with CPS, without any record of her involvement. Anna, who said she does not have a formal education, but knows how to work through the system, left Kentucky to resolve a CPS case. She then returned once the case was closed. If women can find family members who are willing to take their children, they are more likely to be able to see their children freely, instead of only during the official CPS visiting times.

Others dismiss the advice of caseworkers. Hannah, who is prescribed buprenorphine, breastfed her son against CPS and clinician advice,

But the stupidest thing I’ve ever heard is that at the hospital they didn’t want me to breastfeed my last son because they didn’t want me to pass along the drug to him. They tried to tell me you can’t breastfeed if you’re an addict, but bullcrap, because if you are in the hospital and they give you pain medicine, don’t you pass that pain medicine? And if you’ve never been on drugs, they give you pain medicine. I don’t understand.

Yet Maggie argued that the actions of CPS are hard to navigate because caseworkers are deceitful,

Maggie: [The caseworker] did see like week old [track] marks on my arms. I said, “I haven’t used in a week,” and when I said that, that sealed my fate. [Caseworkers] tell you to sign all these papers, that everything will be ok, and they lie to you. And once you sign those papers, they chuck the kids up, and they’re gone. Thankfully my mom was here and thankfully she was able to sign and take [my sons], but, gosh, I couldn’t imagine if I didn’t have mom there to took them. It’s really bad how they do people. I know they’re here to help, but the initial them being here and telling you it’s all going to be okay, we won’t do this unless we have to, then you sign it. The minute you sign it they say, “Get the kid.”
That’s terrible. And I’m sure all the other girls you’ve talked to could tell you the same thing.

Lesly-Marie: Yeah, so you felt like it wasn’t explained to you?

Maggie: Oh no, it’s not explained and you’re so tore up, you can’t read ten pages of writing. And I tried to read over it and I’m pretty educated, and I couldn’t understand it. And I know some people couldn’t understand it, so no, it’s not explained. And it’s explained in a deceitful way if anything.

Even Becky, the Horizons case manager, was frustrated with CPS because she said they tell Horizons staff one thing, and clients something else entirely, which confuses everyone. For example, a caseworker had spoken with a client in front of Becky, telling the client she would regain child custody if she completed Horizons. When the client walked away, the caseworker turned to Becky and said that the client would probably not regain child custody whether she completed Horizons or not.

Sometimes women’s constrained navigations go horribly wrong. CPS opened a case on Barb. Barb’s aunt offered to sign a legally binding private agreement with Barb that the aunt would take custody of Barb’s infant in order to get the CPS case closed. The aunt said she would give Barb her son after the closure. Once Barb signed the papers, the aunt stopped allowing Barb to even see her son. When Barb entered the aunt’s driveway in her car, the aunt sent her husband to chase Barb and her boyfriend off with a shotgun. Some forms of navigation are closed off to women. Some may not be able to place their children with family members because the family members have felony records. When Crystal was incarcerated and left her child with who she thinks is a reliable family member, CPS charged Crystal with neglect because the person had a decades-old felony record for theft.
Others are hampered by the pure stress of dealing with CPS and their children’s removal. Ashley’s case for regaining full child custody was ultimately halted because of two positive drug tests. She started using right before her court date because of the stress of court,

Ashley: It’s like just what my social worker said, “You self-sabotage. You do great up until it’s time for court.” Then as soon as it hits court, I backslide. Every single time. And I think it’s just the stress of it all. Of knowing that I’m going to go to court and then they can say, “Yes, you’re getting your babies back or no, you’re not.”

Lesly-Marie: So wasn’t your last court date in October?

Ashley: It was this month on the 19th and I missed it. I completely forgot about it. Who does that? But I feel myself starting to fall until I get this deep depression and I don’t know what’s causing it. I went four days without taking a bath the other day. I just sat on the couch and all I do is sleep. So I feel it coming on and I’m just trying to prepare myself to be forceful to myself about taking a bath, getting up, and doing stuff because if I don’t, I lay on this couch and I won’t ever get up.

Ashley was prescribed a selective-serotonin reuptake inhibitor (SSRI) and an antidepressant. She questioned the effectiveness of these drugs and lamented her limited access to non-pharmaceutical services, such as counseling, to treat her depression and anxiety.

At times, a strategy for avoiding CPS is not having children for them to take. A few women see being a “good” mother as someone who gives up permanent custody or chooses not to have any more children. While Ashley is fighting to regain custody of her two oldest children, she permanently placed her third child with a friend,

I have a third child, a son, and I was taking Subutex when he was born. I ended up giving him to my friend when he was born because my mom passed away two months before he was born and I knew I couldn’t handle the attention. I loved that baby so much that I knew I couldn’t give him what he needed and my best friend could. I see him every week and we decided that we were going to tell him that he
is so fortunate because some people don’t have a mom at all and he has two moms
that love him.

For Hattie, though she judges other women for having what she thinks is too
many children, she justifies herself as a “good” mother. She always took care of her son
when she had custody and made sure she would not have any additional children,

But at least I don’t throw my young’un down for drugs. I mean I’m not going to
do that and I have my tubes tied and burnt. I’m not bringing another child into this
world knowing I can’t take care of it. Protect yourself because the man’s not
going to do it. I’ve learned that and so I went and had my tubes tied and burnt,
that way you know, I’m protected for good. If that doesn’t show a good mother,
than what does? I think. I tell you the truth of it, I love my baby more than
anything. I mean I might have done drugs, but it did not interfere with my
relationship with my young’un. But it did, but it didn’t, do you know what I’m
saying? My abilities maybe to do things, but moneywise taking from him, no.
Huh-huh. My loving for him? No, not that. I mean I’d do anything for my
young’un to make sure he had food and stuff. I mean any mother would. I mean
that’s just it, your young’un goes first. That’s just like my boyfriend I got here, I
said I got a young’un, my young’un comes first or we don’t do it.

Hattie utilizes a conservative moral argument for limiting the reproduction of women
who use drugs to justify her own morality. Yet she makes clear that this strategy is
constrained by her drug use as well as economic marginalization.

While they contest negative labels based on their parenting and attempt to find
ways to make it through CPS, some women are frustrated by the constant spotlight on
mothering. They want to focus on their own lives, their grief, and their healing before
they can once again shoulder caretaking responsibilities. Due to drug use, caretaking
responsibilities, and concerns over basic resources, they may have not had the time or
energy to work through these traumas. They see substance abuse treatment as an
opportunity to take on this work. When contemplating regaining child custody, Marge
said, “I think the first thing I need to do is find myself again before I can parent.” Even
service providers talk about the need for women to engage in self-care. Yet this is often
couched in trying to determine what is best for children’s welfare. An EKSAC representative said that women need to take time for themselves away from their children to get clean so that they can be “good” mothers.

Women fight negative labels. They attempt to redefine what it means to be a mother and build cases to support their redefinition. Women find ways that are constrained and at times unsuccessful to avoid CPS, to ignore caseworker recommendations, and to regain child custody. Some treatment clients contest programmatic aspects that solely focus on a motherhood identity. Inadequately resourced treatment programs and state agencies structure women’s strategies. These strategies become potentially more harmful when there are gaps between these entities, as in the case of buprenorphine. Community members and program staff are often informed in ways that negatively portray Appalachian women and women who use drugs, creating spaces where negative characterizations of the women with whom I spoke are normalized.
Chapter Seven

A Curation of Stories

Focusing on six women’s stories was not my original plan. After the first draft, though, I realized that I specifically drew narratives from a smaller group of women. This is not because their experiences are unique. I tended to spend more time with them, which means I had more robust and nuanced stories. Some people are more articulate than others, and the women I outline below more often have this gift. This chapter is a political gesture against medicalization, criminalization, and stereotypes. My hope is that this section complicates stories and the institutions within which they take place. I use the term institutions to refer to state or quasi-state institutions within which women are embedded, primarily substance abuse treatment and CPS, as well as familial institutions. By examining family, I do not want to reify the positions women at times hold in the family, but instead question these positions and what they come to mean in lives.

As Appalachians may be eschewed as cultural producers, people who use drugs are treated in similar ways. I use some extensive quotes here in part to highlight the value of women’s experiences, beliefs, and theorizing. These women in particular provided me space to work through ideas and ask questions in ways that would be impossible or uncomfortable in others spaces. I ran theories past Sissy, Alisha, and Katie, and they constructively critiqued what I was saying. I would not have felt entirely comfortable doing this, had they not provided the open dialogue they did.

As I was completing research, I realized how much children physically and narratively came in and out of interviews and other encounters. Sissy’s toddler heading
for the outside door would halt things, while Star’s son asking me his own questions would turn the conversation. Additionally, it was not until I began thinking and writing about these interviews that I realized how much dogs, and occasionally cats and chickens, were part of the story. I think I may have I spent more time helping women care for dogs or strategize how to deal with problematic dogs than children. I am attempting to analyze the intricacies of care and drug use, and dogs present just one of these expansions of the concept of care beyond caring for other humans.

The first four narratives I present are from women who have experiences with Horizons and the last two women graduated drug court. Five of the six were enrolled in buprenorphine programs when I spoke with them. All six spoke extensively about their survival strategies, which involved employment as well as financial support from family members and the government. When we talked about treatment, four of the six focused almost exclusively on the care they received or bestowed in treatment, mostly from other clients, but from staff as well. Yet Ashley and Maggie juxtaposed discussions of care in treatment against the violence they experienced prior to and during their drug use. Katie and Star had long conversations with me about relapse, which revealed the crises women often navigated. Sometimes these crises contextualized relapses. I wanted to utilize Ashley’s narrative in particular because she showed me some of the intricacies of having addiction issues in conjunction with mental health concerns.

_Sissy_

The woman I refer to as Sissy exemplifies the name. Sissy is a mostly Southern US colloquialism for sister. While Sissy may be used in many families, especially when
children are young, I have found that the name generally survives to adulthood for women who show a cheerful warmth to those beyond her household. The name for me connotes affection that is easily won and emotional strength. Unfortunately the name turns derogative when applied to men and female strength becomes male weakness where care and care work is undervalued.

Sissy had encounters with Horizons and buprenorphine programs. I write of Sissy here and the care networks in which she is embedded for several reasons. How care travels through Sissy’s life muddles gendered understandings of care work. While she certainly serves as an emotional resource for a number of women in recovery throughout her home county, her strength is buttressed by the support she receives from male caregivers, namely, her husband and brothers. Further, I highlight the importance of care networks in providing environments in which structural inequalities as well as bodily addictions can more successfully be navigated. At the same time, those with whom women have relationships can be the place where women start using drugs. Even though she faces economic hardship in a county with few jobs, Sissy is optimistic, and she owes this optimism to the people around her. Sissy does not think she could have succeeded in recovery if not for the people in her care networks who help provide emotional support, housing, food, household goods, and childcare.

A Horizons case manager, Becky, gave Sissy my number, who reached out within a few days. Sissy and her family live in a singlewide trailer. There was a winter storm that made it seem like night the first day I arrived to her house, and as I scrambled inside the trailer with a puppy at my heels, I was thankful for the comfort and warmth I found inside. Once I spent time with Sissy and was able to see her home through the seasons, I
realized her home was an enormous resource for her family, including nearly 100 acres of inherited land with a large garden, a few barns, waterfalls, and walking trails. I do not state this to glorify some bucolic other, but to emphasize Sissy’s land resources.

Each time I spoke with her, we were accompanied by her infant and then toddler daughter, a puppy turned dog (the puppy and daughter were born the same day), and a few cats. While these could be seen as distractions, they proved quite the opposite. If not for her daughter, we would not have spent as much time discussing caretaking strategies and providing for children on one low-income job. If not for the dog, I would have missed the conversation on how Sissy’s neighborhood relationships and gardening techniques are centered around dogs more than anything else.

Sissy describes her typical day as taking care of herself and her family, which she defines as the two of her three daughters who are in her household as well as her husband. Her oldest daughter is over 18 and lives in Central Kentucky. Sissy is connected to several other women in recovery. I eventually spoke to two of Sissy’s close friends, both of whom said that she helped them enter and remain in recovery, offering emotional support whenever she could. One, Stacey, reciprocated by taking care of Sissy’s youngest daughter when Sissy attended her bi-monthly counseling session at the buprenorphine clinic. Sissy’s care work even extended to me. About six and half months into my pregnancy, I was rushed to the hospital. I had to cancel appointments with a few people, including Sissy. I was not done being terrified when I called Sissy to cancel, and I think she could tell. She talked to me for an hour about her two high-risk pregnancies, told me about her good experience with the hospital I was in, and then distracted me by talking about names.
Sissy differentiates between her life in recovery and in opioid use by saying that while using, she never took care of herself. Now she makes sure she eats, drinks water, and sleeps. She links this lack of self-care to childhood, “I was sexually abused as a child, so that makes it easier for me to abuse myself.” Yet when she talks about her day, she describes how she makes sure to carve out time away from her youngest daughter where her middle daughter or husband get her full attention for a few moments so she can care for them. She never gets moments alone. This is not to say she is only a caretaker, and never receives care nor is able to provide self-care. Sissy attributes her success with buprenorphine to the support of her husband, who she says has never used drugs as well as to her non-judgmental physician and nurses,

And [my husband’s] supportive, rather than tearing me down with it, he’s hold me up. Whenever I first got on the Suboxone program, it’s been a few years, I wasn’t real good at taking my medication correctly, and so I’d talk about it with my doctor, I told him, I let my husband keep it. He gives me what I’m supposed to have every day in the morning and before he leaves for work. I just didn’t trust myself when I first got on them. I was still kind of shaky and it had been rough and I wanted to do it right. For probably the first year that I was on it, he kept them for me and doled them out to me, which he never made it a thing, he just always put them in this little drawer in the kitchen and he never was acting like he was God or something.

Strong family support, especially from her brothers, has helped Sissy navigate motherhood and experiences with gendered violence,

Anytime I’ve needed any kind of support, it doesn’t matter what kind with my girls, just myself, whatever, they’ve been there. I mean back 11, 12 years ago when I had a bad relationship and had to move out overnight, my brother was there to move me out. I hadn’t seen him in two or three months maybe almost a year, but I called him and he was there.

While it was difficult for her to cut ties with some people who use drugs when she was entering recovery because she thinks they are good people, Sissy was able to insert
herself directly back into her family because they accepted her. This decreased any isolation she felt as she stopped spending time with people who use drugs.

These care networks in which Sissy is embedded tie her to Eagle County, whether she is receiving care or providing care to her immediate family or grandparents. She is tied to this place, not by some irrational fear of leaving or bucolic independent spirit, but by a network of support that is mapped on and through the landscape. Her living relatives are all around her. She is nestled on the land bequeathed by those who have passed, teaches her children to eat purple clover just as her grandparents taught her, and has named her daughters after the strong women in her family, hoping to pass on that might. Sissy is using the resources she has, and those resources are land and people.

At the same time, Sissy started using through a relationship with a previous husband who she met and lived with in Central Kentucky,

But he was the one, he would be doing whatever and say, “Hey do some of this, it will make you feel better” when I was having a dragggy day. He did whatever he could get his hands on, whether it was a OxyContin, speed, cocaine, crank. Three or four years we were together, because there’s a lot of ups and downs when you’re doing that kind of stuff, we would split up and get back together. I won’t say that he didn’t love me, and I loved him, but nobody’s going to survive doing that kind of stuff, but that is what got me, and I’m not blaming it on him, I take full responsibility for it, but that is what lead me into being an everyday user.

She ended that relationship, and found support and stability with a new husband.

Sissy and her family rely on her current husband’s income. She said they are lucky to have this resource considering the lack of jobs in the county, but they still fall below the poverty line for a family of four. Sissy’s family passes down most of the children’s items they need, since Sissy has the youngest child in the family. Sissy contributes to the family income as well. At the time of our interviews, Sissy was staying home full time with her youngest daughter, and planned to do so until the child reached
school age. Before she got pregnant, Sissy was getting paid to take care of older people in the county who still lived at home, but could no longer drive or do certain things around their home, like clean or laundry. She hopes to start doing this again once her youngest goes to school. In the summer, Sissy grows a sizable garden to produce most of the fresh vegetables she and her household need. She saves seeds from year to year and starts her plants as seedlings, meaning the yearly start-up costs are small. In 2016, her reliance on this was threatened by a neighbor’s dog, who continued to eat her plants. The dog was beginning to cause tensions with neighbors, because it had already taken out her entire green bean crop.

They supplement their economic strategies with assistance from state programs. Sissy and her daughters are covered by Medicaid and she qualifies for Women, Infants, Children (WIC), which she calls a “lifesaver.” In terms of health insurance, Medicaid is inadequate. By the last time I saw Sissy, she had had all of her teeth removed after they began to break off painfully. She was embarrassed to leave her house. While Medicaid paid for the extraction, it would not cover dentures. She did find a place that provided dentures at a lower cost, but the drive is 12 hours round trip.

Sissy went through Horizons when she lost custody of her 10-year-old for using prescription opioids. She had gone to another outpatient program in Eagle County, but she felt like the director was too easy on her because he had rented property from Sissy’s mother. When I asked Sissy about the best parts of Horizons, relationships again took center stage,

Definitely, the [other clients]. They helped, at the same time, it was like going through a land mine field. You never knew when one of them would freak out on you because they had had a bad day in court. They were a blessing and a curse at the same time, like most things. Get a bunch of girls together and emotion is
going to come out eventually, I mean that’s the way it is. Especially when we were going through the things we were going through. Me too, there’s days I went in there crying too, not just them.

In Horizons, clients are asked to help and to care for each other. This can be the best part of treatment, as well as the most difficult. This care work feels good, supportive, and, at the same time, draining, explosive, and even dangerous, as when someone breaks confidentiality.

Sissy had other experiences with treatment programs and is on buprenorphine. She claimed the drug not only helped her physically get off illicit opioids, but helped her cut ties with other people who use drugs. Breaking these relationships was necessary for her to get out of the “game” of addiction, going from person to person trying to find the drug she wanted, “It was different getting used to not running. I mean I can’t stress enough, how hard it is to get used to not being around. There’s some friends that you got to give them up because they’re still living the life. And they will not even meaning to, drag you into it.” For her, buprenorphine cannot be successful without a care network,

I don’t think it will work for anybody who doesn’t have a stable home. I mean every home is kind of up there, stuff happens, there’s ups and downs, but by stable I mean somewhere to call home. You can’t do it if you’re just a vagabond, going here, there. It’s not going to work like that and you just have to have some kind of stability, something to build on.

For Sissy, sobriety is only aided, not determined, by any type of substance abuse treatment. It is that life outside of treatment that enables her to remain in recovery.

Without her immediate family, extended family, other women in recovery who she met through Horizons, and support provided through government agencies, she did not see sobriety as a realistic outcome of her efforts.
Ashley’s narrative reveals some of the complexities women must face when they are attempting to navigate a multitude of issues, including addiction, mental health concerns, and domestic violence. Ashley felt socially isolated in Adams County. Although Ashley was on buprenorphine, she focused our conversations around Horizons. When she spoke of buprenorphine, she spoke of it as just another pharmaceutical she was prescribed. Horizons had a larger impact on her life. She found the counseling and social interaction at Horizons especially helpful. Yet she eventually became frustrated with the program. Ashley’s survival strategies further reveal how these strategies, as well as state resources, are embedded in relationships.

I met Ashley at Horizons and went to her house a few days later for our first interview. Dogs dominated the first moments of our interaction, as I had to first avoid running over a pack, and then had to sprint from them to make it in her house without being bitten. Ashley barely leaves her house anymore for fear of the neighbor’s half dozen dogs. She used to walk to neighbors’ houses and a church, until she was bitten twice. She blames the dogs for losing connection to the neighborhood because she no longer feels safe walking to visit other people or attend events.

I had a hard time keeping up with Ashley, both physically and mentally. In the half dozen times I was at her house, she ran from room to room and subject to subject. She was sometimes trying to give me objects, like books or clothes. She was sometimes showing me that she had enough resources for her children. At other times she was revealing bare cabinets to convince me that we needed to go to the food banks, and quickly. When I first met her, our relationship became a bit exhausting, with late night
phone calls and last minute requests. Then she started a new romantic relationship, and I did not hear much from her.

Ashley grew up in a single-parent home with a mother who was diagnosed with bipolar disorder. Ashley, her sister, and mother remained locked in their house for days. Ashley’s mother was unable to get out of bed and unwilling to let her daughters out of the house without her oversight. Ashley has similar struggles with mental health issues. She said she has PTSD, bipolar disorder, attention deficit hyperactivity disorder (ADHD), and physical pain. Ashley spent considerable time documenting much of what she told me. She showed me notebooks of materials from Horizons, the court system, and medical providers. She was the first, but not the only, person I spoke with who took considerable time going through her prescription bottles and boxes, including buprenorphine, the SSRI Lexapro, Abilify for her bipolar disorder, the antidepressant Remeron, and Neurontin, which she uses to treat pain.

I think this documentation was in part to convince me and others of her story, but it was also to help her. Ashley keeps videos and pictures saved on her phone with time stamps to help her remember. She remembers events well, but has difficulty thinking about them on a timeline. I had a hard time keeping up with some of her stories because it was not clear what happened when or after what, just that these things happened. Ashley claimed she has had dozens of different jobs primarily in restaurants and retail, but her mental health issues often lead to her either being fired or quitting. During the year or so in which I saw her somewhat regularly, Ashley never had an income. She has been attempting to enroll in disability for five years for her mental health concerns, but has been unsuccessful in correctly completing and filing the paperwork.
Ashley directly connected some of her mental health concerns, particularly PTSD, with her previous relationships with men. Her father was an abusive alcoholic when she was a child. Her first husband was verbally abusive. Ashley spent six years with her children’s abusive dad. After a particularly violent episode where he punched her in the head repeatedly, Ashley’s friend called the police and he was incarcerated for six months. After that incarceration, he ceased the physical abuse. Since he has custody of their children and gives some money to Ashley, she said he is still able to exert influence over her life, despite the fact that he is engaged to another woman and lives hours away. When I asked her if the individual counseling at Horizons was helpful, she said it helped her work through some of this trauma,

Because my mental health and because the abuse I went through with my baby’s father where he hit on me. I wanted to tell somebody. I know what it feels like to want to say something and not be able to say it because you know you’re going to get beat down. He really wasn’t a bad guy; he just couldn’t control his temper. His dad beat up on his mom and grandpa beat up on his grandma and he came from a family that beat up on. That’s the type of people he was raised up with, so he kind of was taught it. Then when we had kids, everything changed. I told him I said, “I’ll leave you.”

She sees the violence she experienced as complicated, bleeding through familial generations but not in and of itself defining her children’s father as a “bad guy.” Ashley nonetheless wanted someone to talk to about the emotional and physical pain resulting from that trauma. Horizons provided a safe space for this talk.

Ashley lived most of her life outside of the five county area, where she used heroin and to a lesser degree crack cocaine. She attempted to cease use for years. She moved to Adams County to get away from heroin and be closer to her dad’s family. Ashley found a new appreciation for meth when she came to Adams County. In our first interview, she spent time characterizing meth as the worst drug someone could do. By the
time I talked to her the last time, she was using meth weekly. Unlike Sissy, who often
treated giving up drugs like just another thing she made it through, consequential but not
defining, Ashley considers herself addicted. Either addiction or attempts at recovery
dominate her life, along with a general lack of resources.

Ashley has two preschool aged children who she raised by herself for most of
their lives because their father was in jail. Her children and their father initially moved to
Adams County with Ashley. He moved to another state without Ashley and their children
because he could not find employment. Adams County CPS removed Ashley’s children
from her home because of an anonymous report from a neighbor who said they heard
“slapping sounds” coming from Ashley’s house. Ashley says her children’s occupational
therapist told Ashley to slap her hands together to get her children’s attention, and that
was where the sounds were coming from. Her children were sent to live with their father
in another state. With her children and their father moved away and few established
relationships in the area, Ashley had a limited network of supportive people. Ashley had
one close friend, but she died of an overdose. Ashley’s mom had died a few years earlier
and another close friend she lived with died of an overdose as well, “I think that’s another
reason I don’t really hang out with anybody is because everyone I’ve ever loved usually
overdoses, you know what I mean? Or they’re still using and I can’t be around them.”

She blamed her sporadic relapses on the continued loss of her children, “Just all
the pressure. The pressure of not knowing. Everybody else is in control whether I get my
kids back or not, so it makes it kind of hard.” Not being around her kids is devastating.
She has reminders of them everywhere, including two fully set up bedrooms and a play
area. Ashley is trying to use the court system to regain full child custody. She showed me
her children’s father’s criminal record as well as a newspaper article about his thefts of large quantities of metals from factories. These materials were part of a folder Ashley was building to argue against his having full custody of their children. When I last spoke with her, he technically had joint custody, but effectively full custody because he would not drive the children to Kentucky to see Ashley, and Ashley had no transportation to another state.

Ashley has made some friendships through Horizons, which she values. Yet like Sissy, Ashley cited other Horizons participants as being the biggest hurdle to her sobriety,

It makes it hard. Like there was a girl, we were in the middle of class and we look over, and she’s passed out. She came to class high as hell. So seeing that stuff sucks. I can’t get high, so why the hell can you? [laughs] And some of those girls I really care about, and I’m seeing them hurt themselves and living that life and it sucks.

It is not only seeing others use that is difficult, but Horizons asks Ashley to continue to care for those who may overdose and leave her once again.

Although she described Horizons positively in our first interview, by the time we got to our second interview almost four months later, Ashley was frustrated. She felt disconnected from the staff because she thought they had told CPS about issues that arose in individual counseling sessions that they should not have. For instance, she knew Horizons had to report her positive drug screens to CPS, but she did not know Horizons staff would report that Ashley was injecting her physician prescribed buprenorphine.

When I asked her the most helpful thing about Horizons the second time, she said the free lunch everyday.

State resources are embedded within relationships. The removal of Ashley’s children not only has relational but also material impacts. When she had custody of her
kids, who both have developmental disabilities, she received over $1400 a month. The funds paid for their housing, transportation, and some food. When she lost custody, her children’s father began receiving the disability and she was also disenrolled from K-TAP. Her car was repossessed as she could no longer make payments. She maintained housing as well as Medicaid benefits. With her children, Ashley qualified for $511 in SNAP benefits, but now qualifies for $194, which does not quite cover her food for the month. She tries to use food banks to provide for the rest.

Ashley receives rent assistance through HUD, and thus only has to pay $55 a month for her three-bedroom house and utilities. She applied for the HUD assistance for six years before she actually received it, during which time she utilized a variety of strategies to remain housed. Before her children were born, she slept on friend’s couches and at times could afford an apartment with her boyfriend. She spent years in and out of shelters once her children were born.

Ashley’s new relationship further demonstrates how benefits travel through family and friends. One disability check often supports more than one person. The father of Ashley’s new boyfriend qualifies for the USDA’s Commodity Supplemental Food Program that is meant to supplement the diets of low-income persons above age 60. His qualification for that program benefitted himself as well as his son and Ashley, with whom he shared his commodities. Further, the new boyfriend lived with Ashley, gaining housing through her HUD assistance.

The last time I spoke to her, Ashley was regularly using meth and cannabis. She attributed her relapse in some ways to boredom. She was only going to Horizons two days a week, she could not find a job despite having applications in across the county, she
never saw her children because they live in another state, and she no longer has transportation to visit anyone.

*Katie*

Katie says she loves heroin. She used heroin for a long time in Central Kentucky. Katie also loves her daughter intensely. These loves come in conflict. My interactions with Katie are important because she most frankly discussed treatment and relapse with me. We completed an interview a week before a major relapse. I unknowingly attended a Christmas giveaway with her while she was using. I then spoke with her several times after the relapse, once at a court hearing for a DUI she received while using. Katie was sent to Horizons through family court because she became involved with CPS when she delivered her daughter, who tested positive for heroin. She gave birth in Central Kentucky, but decided to move her case and herself back to her parent’s home in Adams County. She was hoping to receive support there, but was entwined in conflicted familial relationships. Katie was about to graduate Horizons when I first met her. She lives close to the county seat in Adams, and I saw her the most out of anyone I interviewed.

Katie’s drug use began with a prescription to alprazolam when she was 15, and she continued onto OxyContin, instant release oxycodone, and then heroin when she moved out of the area. The rising price of instant release oxycodone and widespread availability of heroin made the switch to heroin logical. Katie used heroin in Central Kentucky for five years and Houston, Texas for four years, “Pills never took me to the places that heroin did.”
Katie had a good experience with CPS, which she attributes to her doing what was asked of her by CPS and Horizons. Yet she says others in town are treated more harshly, even though they are following the rules. Horizons was Katie’s second experience with court-ordered treatment. She went to an inpatient program in Western Kentucky as part of a DUI diversion program, but “I only made it there seven days so. Rehab was not for me. Don’t come wake me up at six in the morning and tell me it’s time to get up and cook for 30 head of people. It may work for some people; I’m not sure that it does but it wasn’t my cup of tea.” She left and entered an inpatient psychiatric facility in Eastern Kentucky that has some drug counseling services. The psychiatric facility was helpful because it addressed what she thought was her primary problem, drug use. She thought the program in Western Kentucky was trying to address too many behaviors beyond drug use, such as sleeping habits.

Katie has been through a medical stabilization program. She went into a methadone detox the day after she found out she was pregnant,

They put me on methadone and then I was completely weaned off before I went home. It was just enough to get me off of the heroin. Not enough to get me addicted to methadone. I hadn’t been out of there 45 minutes and I had used again. I wasn’t ready. But they wanted me to switch to a clinic for pregnant women who are on drugs. And they would’ve done my Subutex and my OB care. But now I’m glad that I didn’t do that either because Subutex is ten times more dangerous for a child in the womb than heroin ever thought about being. And plus, if I would’ve been put on Subutex, my child would’ve been took anyway. I do not understand that.

This narrative displays the native knowledge and misunderstandings of Subutex, which is buprenorphine without naloxone. While thinking Subutex is far more harmful than heroin may be a misunderstanding, the knowledge that CPS may enter a family’s life whether a woman is prescribed Subutex or illicitly taking heroin is vital.
Katie went to Horizons in Adams and Eagle Counties. She wanted to start in Eagle because she is from Adams and was afraid it would be harder to go through Horizons in the county where she is from. Katie attributes her relative success in Horizons mostly to herself, while also acknowledging some family help she received,

I hold myself to a higher standard and not everybody holds theirselves to that. I did not miss one day. I never had a bad drug screen, nothing. You know I knew that I had to do it to get my child back. Which I was blessed because I had my parents who had my child. I’ve never been away from her one day since she was born. So, and I know that not a lot of people have that privilege.

Many of her critiques were thus individualized and focused on clients choosing to not work the program. Horizons itself is individualized with treatment personal plans. At times this focus on the individual was the most helpful part of the program for Katie, especially when involving self-care and self-respect, “Because I mean you have to take care of yourself before you can take care of a child. And if you’re not taking care of yourself, then you don’t need your kids back because there is no way possible that I could be living the life that I lived this time last year and take care of my nine-month-old daughter. It’s impossible.”

Yet individualization is problematic. Katie connected the individual plans, as well as the constantly changing clinicians, to an overall feeling of chaos. The individualization may leave one of the greatest resources in treatment untapped, which is the collective strategizing and empathy built within group. Katie named group as the best and at times hardest part of Horizons. When I asked her about the most helpful aspect of Horizons, she replied,

I mean just group; whether it’s structured or not, I mean just being able to go into group and just talk things out. And you know no matter what, you always feel like, oh man, I’m having the worst day ever, but you go in there and somebody is always having it just a little bit rougher than you. You know it may be a
completely different situation but somebody else is going through something that’s way more difficult.

Katie finds helping others to be the most beneficial part of Horizons, but this work does not receive remuneration, “I think one thing that’s helped me now is that they’re actually giving me responsibility to help other people. That’s what works the best for me, putting my knowledge in use to help someone else. I don’t want to just sit here, I want to help.”

Katie offers unique insight into Horizons because she has gone through two different versions of the program. She likes Eagle Horizons far more than Adams Horizons because it is highly structured, has a consistent clinician who runs the program, and has a smaller number of clients, meaning each client receives more one-on-one counseling time. This is exemplified in her comparison of peer support, which was implemented NA in Eagle County. She describes here the peer support sessions in Adams County, “It’s coloring. You know we’re all mostly 25 and older. There is no structure to coloring and that all falls back on the staff in my eyes. Being lazy. This is therapy. It’s not kindergarten. But a lot of those girls need structure. I needed that structure and I got it but I got it because I went to [Eagle] County.” Still Katie takes issue with Eagle Horizons, especially in regards to their lack of acknowledgement of the effects of CPS in their clients’ lives,

In [Eagle] County, the clinician and the peer support specialist; neither one of them have children. That bothers me. Because you never get no private visitation in phase one; you always have to have supervised visitation at least until you’re in phase two. In [Eagle] County, the clinician over there, if she hears from an outsider that you’ve been around somebody that she’s heard you talk about in group, like an ex-boyfriend, she will not phase you into phase two; she will hold you in phase one. She says that she feels like that you need more time, but they also don’t understand how crucial it is for these children to be with their parents either. I mean if they’re passing their drug screens and they’re coming to group, you know maybe it’s not affecting them if they’re talking to somebody from their past or whatever.
While this presents a problematic explanation of who can and cannot have empathy for others or understand care networks, it nonetheless shows that women are often critical of programs if they do not think their care for their children is being taken into consideration by program staff. Katie once again critiques the programs’ focus on behaviors that are not specifically drug use.

Horizons programs have gaps in services, but other programs can be used to fill these. Katie did not receive individual counseling in Eagle Horizons. She is on buprenorphine, though, and received individual counseling through that program, which she said helped her more than all of Horizons. The drug itself also helps her make it through. Katie is prescribed two buprenorphine strips a day, but only takes half of one. The others are stored away, in her anticipation of her clinic closing or buprenorphine being criminalized. She takes them on an as-needed basis, “Well there is some days that I do have to take two whole ones a day. You know if I feel overwhelmed. I mean I have to feel really bad before I will allow myself to take more than a half.”

During our initial interview, Katie told me that relapsing “never crossed my mind.” A week later, she began using, depleted her household’s savings on pharmaceuticals, and was charged with a DUI in Adams County a month into the binge. After she had recovered from the relapse, she told me she had been planning it for months and was pushed over the edge when a friend fatally overdosed. Katie relapsed that night. The less she had to attend Horizons programming due to progression through treatment, the more she planned out her relapse.
For Katie as well as others, using and quitting is not just about drugs. It is about people and losing those people. Katie discussed starting an NA group in Adams County so people in recovery could have a support system,

I would like to go to an NA meeting. I think that it would be helpful. Just because it gives you something to do for one. Two, it gives you an opportunity to be around people that maybe are having the same type of issues that you’re having. Like if you have relapsed, you’re not going to go and talk to you know your family members about having a relapse. I would have to be very black and white with it because either you’re going to come to NA and you’re going to participate and you’re going to be sober when you come. Or you can’t come because I don’t need people like that in my life anymore.

Having people around is about having the right people around, those who understand, but are also not using. This is a difficult thing to achieve with the ups and downs in the mazes of addiction, inequalities, interventions, and complicated family relationships.

Katie’s father was alcoholic and abusive during her early childhood, creating instability in the household. Her father has been sober for decades, but now her mother is abusive, starting fights with family members and hitting Katie on occasion. The week before our first interview, her mother had broken Katie’s nose, but Katie did not report it because this would bring unwanted attention from CPS or law enforcement. Despite this turmoil, she has strong family support in her grandparents and aunts, who watch her daughter on occasion.

Katie is widely connected through town, which makes navigating everything from landlords to physicians’ offices easier in terms of finding people who will help her, and at a reasonable price. Katie’s household survives with her boyfriend’s income, who commutes an hour and a half to work. Government benefits and family help subsidize his low wages. Most of Katie’s household food comes from SNAP as well as her grandmother’s Commodity Supplemental Food Program benefits and summer garden.
When Katie relapsed, she was in the middle of conflict with her family, was about to lose the structure of Horizons, and had just lost a friend to overdose. She said she felt isolated. I have texted and emailed with Katie a few times since I left the field. Her strategy for maintaining sobriety involves bringing people together through efforts to start a community driven self-help group for those in recovery and joining supportive community groups, such as religious congregations. She has also attempted to reconnect with extended family members who she views as stable and sober.

Maggie

Maggie has roots in a family that is well-resourced in Adams County. These roots have sheltered her to some degree as she is one of the few women I spoke with who owns her own home and the only who owns a business. She nonetheless continues to live paycheck to paycheck, relying on various income generating strategies to make it through. Since her entire drug using tenure has been spent in Adams County, she has a deep knowledge of the drug scene. Maggie informed me that I lived across the street from a set of apartments where you could buy most drugs that were available in Adams County. I never saw anything, until my last interview, which took me inside those apartments. She has survived single incidents of violence as well as long-term gendered violence. Although these experiences are not unique for the women I spoke with, Maggie went more in-depth exploring this issue in our first interview than anyone else. Maggie entered Horizons after CPS searched her home and temporarily placed her youngest son with Maggie’s parents, who live a quarter mile down the road from her. Although she was primarily using meth at the time, she decided to enter a buprenorphine clinic, and she
attributes her maintained recovery to that clinic. To be clear, she attributes her recovery to the *clinic*, not just buprenorphine.

Maggie contacted me through Katie. Yet another interview started with dogs, this time with me talking to Maggie in her yard as we prevented the dogs from going after the mail truck. Although I never met him, the sounds of her teenage son playing video games provided the backdrop to the only interview I completed at Maggie’s house. Maggie was excited about participant observation. I did not have to explain to her what it was; she had been assigned to sit at Wal-Mart for a few hours for her introduction to anthropology course in college. A week after the interview, I traveled with Maggie from Adams to River County to attain her weekly buprenorphine prescription, which proved to be a harrowing journey.

I unintentionally spooked Maggie after that. A local newspaper editor is enthusiastic about entrepreneurship. He asked if any of the women I spoke with were entrepreneurs. When I told him that some were interested in starting small businesses, he said he would be happy to offer them free advertising. I of course did not give him any names or allude to anyone in particular, but I did pass on the message to Maggie. She never returned my call or another call a few months later. Katie later said that some of the women at Horizons were nervous that I would expose their personal lives. I wonder if Maggie is included in these *some*. Maybe not, maybe she just got busy. I told Katie I made every effort to keep all communications confidential, but reiterated the duty to report. Unintentional consequences and uncertainty pervade these stories and this research.
I had talked to Maggie for about 30 minutes before I asked her about her drug use. When I began the question, she paused, and asked if she could smoke. She chain-smoked for the rest of our interview. For her, the story of her drug use cannot be untangled from her stories of gendered violence. Maggie got pregnant when she was 16, and married the father of her oldest son. They were happy for a few years, during which time she completed three years of college. Then her father-in-law became terminally ill. Her husband began drinking and abusing his father’s pain medication. When Maggie’s father-in-law died, the inheritance to his son ended up being multiple bottles of OxyContin 80 milligram tablets. As her husband’s grief and addiction worsened, he started beating Maggie. The most abusive night she remembers involved her sitting restrained with her then young son screaming and her husband pointing an assault rifle at her head for hours. She endured the violence for years after this incident. She later caught her then-25-year-old husband having sex with a 14 year-old, and she divorced him.

Once she was divorced, her cousin set her up on a blind date. The date took Maggie to a bar with his friends. Her memories only come in snapshots after that, after she was drugged, of her being carried to a car, of a house with guns and knives, of being raped. She woke the next morning before the men did, and Maggie thinks that saved her life. She ran down a gravel road, seemingly forever, until she found an exit, from that situation at least,

I finally got to the road and this little old man picked me up and took me to my car and after that, I just didn’t care. I figured if I went to the hospital, they would want to know who it was and why I didn’t know who it was and what do you tell somebody? I should have known who it was, but, well you don’t expect people to be that bad. But I just came back home and I just went all to pieces and I didn’t even think about that for a long time. I just did any drug I came across and I was like that for years.
After these narratives, we talked about the relationship between violence against women and women who use drugs. Maggie said that she would not have started using if not for the kidnapping and gang rape perpetrated after her divorce, but she went further. She did not think her husband would have become violent if not for his drug use.

About ten years into using pharmaceuticals regularly, she was looking for methadone one night, which had turned into her drug of choice. She could find neither methadone nor any prescription opioids that night. She started withdrawing from pharmaceuticals, smoked some meth with a group of people, and proceeded to go home and clean her house all night. She woke up the next morning and realized how cheap meth was. Five dollars’ worth kept her going for a week at the beginning. She stopped sleeping and eating and began distributing meth to four or five dealers. Maggie sent her sons to live with her parents and the only reason she was able to keep her house was because her parents paid her utility bills and fed her dogs. Even though she was distributing meth, not selling, a distinction Maggie made clear, she was running out of money. She sold everything in her house.

Her parents forced her to go to the hospital, and hospital staff said they would not give someone coming off meth any medication. Maggie’s dad marched into a buprenorphine provider’s office in River County, demanding they take his daughter into the program. They agreed. Maggie entered the program, and plans to be off buprenorphine within a year of entering the program. I questioned Maggie a bit on taking buprenorphine to get off meth because the providers I spoke with claimed that buprenorphine can in no way help with meth and it is not FDA approved for this purpose, but Maggie consistently insisted that buprenorphine saved her life. She also thought the
buprenorphine clinic assisted her in other ways, such as providing counseling and case management. The case manager was helping Maggie reenroll in college so she could finish her bachelor’s degree.

At about the same time as she entered the buprenorphine clinic, CPS searched her home, legally placed her sons with her parents, and mandated her to attend Horizons. Maggie overall appreciated the service Horizons provided, although she did think she received better quality counseling and case management at the buprenorphine clinic. Close to her Horizons graduation, Maggie began having issues with peer support. One of the peer support told Maggie if she did not share some of her buprenorphine, then the peer support person would claim that Maggie had a positive drug screen. Maggie went directly to the peer support’s supervisor. The supervisor investigated Maggie’s claims, found evidence to support Maggie’s story, and relocated the peer support staff to another program unrelated to substance use. Even though she did not get into trouble at Horizons, Maggie rarely went to the program after that episode.

Maggie was of course not the only woman I interviewed who has had success in recovery; many had. But her recovery seemed accelerated and felt to her, and to me and to those who were close to Maggie, to be extraordinarily solid. She attributes this to personal will. I have no intention to diminish Maggie’s work, but she also had the most solid family support system any woman described. Other women in Horizons know Maggie’s family, and often commented on this strength as well. This family solidarity is shown in her dealings with CPS.

Not unlike most, Maggie feels CPS used deception to remove her children from her home, but the closeness of her family made the struggle through her CPS case more
bearable. Since her parents live so close, as soon as they removed her children and placed them with her parents, she spent every day with her kids, going against CPS orders. This physical and emotional closeness prevented her from being cutoff.

Maggie has never had issues with housing due to family support. Her mamaw promised to match funding if Maggie saved money for a house. When she was in her mid-20s, Maggie put down half the money to build a house and her mamaw put down the other half. Maggie did not start using until her late 20s, and had a house that was paid for throughout her use and recovery. Maggie barely makes ends meet with her business because it is unstable, but she had financial support from her family in starting the business.

When she was using, Maggie would do odd jobs for her family, like clean someone’s house, or just beg family members for money. She still utilizes various strategies to make ends meet. A month before I spoke with her, Maggie had sold some junked cars that were in her yard to pay for Christmas dinner and presents for her boys. Maggie argued that gendered violence brought her into drug use. Yet support provided from her parents and grandparents, as well as high quality services through a buprenorphine clinic, helped her transition into recovery.

\textit{Alisha}

Alisha is one of the few I spoke with who has a family history intimately tied to illicit drugs. This history altered both her entrance into use and made her navigations of use as well as state interventions more embedded in family connections than some other women’s. Alisha has been in or had family involved with a state system for her entire life,
whether CPS, jail, or prison. She is thus one of the most adept at navigating these unending mazes as well as illicit economies. This is not to say that others do not experience interventions through or with family, Alisha’s embeddedness is just the most intense. Alisha spoke about how drug use strains care networks. At times, her use caused stress to her parents and grandparents. At other times, she was responsible for care taking because of her parent’s drug use. Overall, Alisha found treatment helpful if it was easily available and assisted in providing for her basic needs.

The local drug court administrator gave Alisha my information. She was excited to meet and talk about her opinions of drug court and drug policies. I would not want to be on an opposing side of a debate with Alisha. She is concise and successfully melds data and personal narratives to make her point. She volunteers to teach classes on parenting and substance abuse at a local outpatient treatment program. This program is similar to Horizons, but located in a county not served by Horizons. Her work is analogous to that of a peer mentor, but she is unpaid and part time. When she is teaching a class at the outpatient program, she brings empathy and camaraderie, while also calling people out if she thinks they are telling partial truths. This is a common characteristic to peer mentors and other similar positions I have encountered. Yet Alisha is somewhat unique in how she understands people’s histories and connections in the county. She uses this local knowledge to strengthen and personalize comments. Alisha says that the care work she provides, to both family and community members, causes her stress, but also in some ways supports her recovery, “It drives me crazy but I guess it’s what I need, that busy-ness. When I’m running, I don’t have time to think about, if you took something you’d feel better. I don’t have time to dwell on it.”
A complicated family context pervades Alisha’s life, where familial and intimate relationships may support continued use or recovery. Alisha’s parents divorced when she was a teenager, and the burden of care work for her younger siblings fell on her. Her father fought for and won custody, but was not prepared to care for the children. When Alisha was 16, one of her father’s friends began giving her cocaine, which helped her make it through long days of school and care work. He later raped Alisha. In that same year, her father was incarcerated for two months, and she remained in charge of her younger siblings, while also working to pay their bills. After the rape, Alisha visited a psychiatrist and was prescribed alprazolam. She took this medication for years. At 18, Alisha became pregnant with her daughter while living with her dad and stepmother. Her father began drinking and turned mean. He forced her out of the house, making her homeless for the first half of her pregnancy. Her stepmother eventually negotiated to have Alisha move back into their home. Alisha has an abusive ex-husband, who continues to terrorize her at some points, pulling her hair and pushing her when he sees her in public. When she divorced, she began using oxycodone. As she became immersed in oxycodone, her father, who was in recovery, began taking care of her children. At about this time, Alisha was offered drug court when she was arrested for drug trafficking.

Alisha had almost no family support entering drug court. This is in many ways due to the strain Alisha had already placed on her care network. Her mother was upset because she thought Alisha’s stint in drug court would result in her having to take care of Alisha’s kids for longer. Alisha’s granny told her it was easier to support her if she was in jail. Her granny had already spent much of her retirement sending Alisha to treatment centers throughout Kentucky and Tennessee. Although she had very little family support
through drug court, having family who had extensive personal experience with drug use offered different avenues through the mazes of recovery and treatment. For example, when Alisha went to one of the county jails, she always had a family member with her, which softened the blow of incarceration. She was often arrested and thus incarcerated with a family member. Within her family, if one person was arrested, then someone who had an outstanding warrant would turn themselves in so they could serve their time together.

While her mother did not support drug court, as a social worker, she helped Alisha get through the CPS system without ever losing custody of her children and went so far as to quit her job as a social worker so there would be no conflicts with Alisha’s case. Her mother’s help felt coerced. Alisha was able to stay out of CPS, but her mother forced her to sign a notarized contract stating that Alisha could only have custody of her son if she completed drug court. Her daughter, who is two years older than her son, would only live with Alisha if she chose to. At the time of my fieldwork, Alisha’s son lived with her, but her daughter did not.

Alisha was successful in drug court, but childcare was a problem because if she was drug tested at six in the morning, then her toddler had to be up with her. Alisha was a client in the program she currently volunteers for during her time in drug court. In her descriptions of this program, it seemed as though this program helped meet her material needs more than Horizons did in other counties. The program has a garden where clients are paid eight dollars an hour to work, which gave her enough income to pay her court fees.
The survival strategies Alisha uses are rooted in ones she learned from her father, who dealt cocaine in Teller County for years. Alisha learned how to earn an income through hustling and drug trafficking at an early age. Then she was arrested and is attempting to remain outside of the illicit economy. Like Star, Alisha lives in the Teller county seat, arguably the area with the most resources. Alisha has access to sober family housing and, when I first met her, a job at a restaurant that was a half-hour drive away. She disliked the job, but was thankful she could find what she thought was stable employment considering the felonies on her record. Although she was employed full time during our first meeting, Alisha continued to rely on her granny for some financial support.

Alisha’s job disappeared four months after I first spoke to her when corporate headquarters closed dozens of restaurants across Kentucky. Losing her job would have been hard regardless, but this blow was double because her son’s father also worked at the restaurant. It was one of the few places in the area that willingly hired felons. Management told them to apply for unemployment, but Alisha only received $47 a week. The last time I spoke with her, she had been looking for another job for months, without any success.

Alisha spends her days volunteering at a local outpatient treatment program. In some ways, this is a contextually coerced volunteering because working for free is Alisha’s only option and she struggles to provide for herself and her family. She could earn some income teaching the classes she does, but that would mean she has to charge people money for taking the classes. She does not want to take money from those who
are having difficulties with the state and whom she thinks are less financially stable than herself.

Before she started using heavily after her divorce, Alisha earned her associate’s in early childhood education and taught preschool for a year, enjoyed it, and greatly decreased her use of anything during that time. Now with felonies on her criminal record, she can no longer be hired in the early education field. Considering she only has felonies and not CPS charges, she is attempting to get the certificates she needs to become peer support. Yet this takes time and money. Health care costs are currently depleting any resources she has to pay for peer support courses. Even though she is on Medicaid, Alisha has large unpaid medical bills. She has had a series of strokes, which puts her in the hospital quite often. During her last stroke, her dad was sent to jail. She signed herself out of the hospital against medical advice to help her family contend with her father’s reincarceration. Because she signed out against medical advice, she had to pay some $2000 in fees that she would have otherwise not accrued.

Alisha learned how to survive in illicit economies from her father. Her attempts at working legally have been stalled. She can no longer use her associate’s degree due to her felony record, and has faced barriers in attaining any other employment. She found drug court and the outpatient treatment program in Teller County to be beneficial. Her primary complaints and complements revolved around non-counseling services, such as provision of childcare and work. Alisha is embedded in a complex care network that has been strained by multiple members’ drug use. Alisha sites harms produced within this network, but also claims her family has helped her navigate state institutions and that the care she provides in some ways assists her recovery.
Star

Star is not new to recovery. She graduated from drug court over five years ago, and is now on buprenorphine. Star talked to me extensively about the ups and down of drug court, buprenorphine, and sobriety. Star has a large family support system, not unlike Sissy, but Star tends to be the center of giving support, whereas Sissy has more shoulders to lean on. Star’s husband is also in recovery, and she takes care of her three children, sister, and mother. This entangled care network offers support, but at times propels Star into crises. Her negative comments about drug court involve discrepancies between how she views relationships and how drug court staff attempt to structure relationships. Star’s story is another example of how women develop survival strategies according to their geographic location, ability to rely on state services, and care networks.

I met Star in Teller County when I was visiting Alisha. Unfortunately, she was having extraordinarily bad days both times I met her. During our first encounter, she was coming to see Alisha, while Alisha was volunteering, to try to figure out a way to lessen the consequences of a DUI charge she recently received for physician prescribed benzodiazepine. The second time I was driving to meet her in Teller, Star texted me to meet her at the local health clinic. When I arrived, she jumped in my car and began telling me of her sister’s sexual assault the night before. Her sister did not have a history of drug use, but came into the house late after a date, unable to function and then began convulsing. Neither Star nor her sister wanted to go the local hospital because they feared the staff would call in law enforcement to arrest her sister for being intoxicated. They instead went to a local clinic where Star has a close relationship with the providers. Star was with her sister at the clinic helping her get a physical exam. I sat with Star for a little
while, and she insisted she still wanted to do an interview. We went to her house after, and I talked to Star, her son, and her husband for a few hours.

Star valued most aspects of drug court. She especially appreciated Rob, the drug court judge,

[Rob], he’s awesome. I hated him at the beginning. I felt like he took my life away, but actually, it was me that done that, and I was grateful for him. He actually realized [my husband and I] had a problem. When I was in drug court, I was like in heaven. Now, I would love to be back in drug court to be honest. Even if I had to sacrifice the rules or whatever, I didn’t never get one sanction. I was determined to get my kids back. I was allowed to say that I had an addiction problem and [Rob] was willing to work with me to help me find my way out. He kept telling me, there’s a light at the end of this tunnel. Also having the people around you, your friends, you know. Cause once you get into drug court, become good friends, you’re like a family. You don’t want to let the other person down, so that was another reason that kept me clean. I wanted to show all the rest of them that I was in it to win it and I wanted to get them to do the same. But when we first started drug court, we all had to drive to [Adams] County for drug testing. We kept on fighting it until they’re like yeah, we’re going to start letting you test in [Teller] County.

The main reason Star thrived in drug court was the connections she made there with drug court staff and the other participants. By having a close relationship with other participants, they were able to collectively call for drug tests in their home county so they did not have to take a two-hour round-trip drive to test every morning. In combination with the importance Star places on collective action, she also attributes her success to her care for her children, saying she was never sanctioned because she cares for her children. This brings us to a question I continue to ask, if Star thrived because she cared, what does this insinuate about those who do not succeed?

Due to the importance placed on these connections, Star struggled with the ban on seeing other participants outside of drug court. Her primarily problems with drug court centered around how drug court and drug staff attempt to structure people’s relationships,
And they tell you to change your people, places, and things. [Drug court] is your family now, but we’re not allowed to see our family [outside of drug court]. That’s not right at all. Which we done it anyway, to be honest. I mean that’s all we had, was each other. But [drug court staff] would like set up cook outs and stuff where we all could meet and hang out and stuff. We went bowling. When we were in drug court we were blessed because we had big people sponsoring us. They had to be, because we went out to eat every time. I hear drug court now, they hardly don’t have no funds. They’re not doing anything.

In terms of those she has to depend on outside of her household, Star has a friend she talks to who lives in Florida and another sister, but, “I don’t have no clean friends. When you get clean, you don’t have nobody, you know.” Here, Star shows that the quality of drug court may fluctuate with who or what entities are financially supporting them.

Star was upset that she was barred from seeing some participants through drug court, but then felt like she was coerced into a relationship with a sponsor,

We’re not all alike and I just feel like when newcomers come in, they need to be more addressed as letting them find out theirself, like not making them have to put in all their faith or trust in someone they don’t even know. Like you have to have a mentor and you have to have a sponsor, well trust was always a big thing for me anyway. I trust my husband completely, one person on my finger that I can count, 100 percent guaranteed trust and a lot of people can’t just get into trust and they expect that out of you, like that’s a rule. The sponsor thing, I guess it should be on your terms.

Additionally, Star did not feel like drug court did a good enough job supporting her role as a mother. She wished drug court would have offered some sort of childcare or childcare assistance.

Star is also on buprenorphine, which she struggles with,

Like they put you on [buprenorphine], saying, oh, this is going to help you get clean, but what helps you get clean from that? They say, taper yourself down. I taper myself down. I’ve tried to go without it. I don’t get sick like I did with OxyContin, I don’t throw up and have itchy feeling, diarrhea. I feel like somebody’s beating me with a baseball bat. My body, my bones are aching. I think my biggest fear is those bad days that you do have. As an addict, you don’t have calendar and you don’t know like Monday I’m going to have a trigger or Friday I’m going to have a bad day. I don’t have a fear of thinking I’m going to
need it every day, my biggest fear is when I am going to need it? I can’t call the
doctor up and say, hey, you’re going to give me a script for this week? And like I
said, I don’t want you to think it’s like having to have it every day, it’s just not
having it when I do need it. Now if there was like a way they could just give you
that milligram for that day. There’s got to be a way out of all this. I’m just trying
to figure out how.

The main problem she has with buprenorphine is that she is expected to take it daily, but
she wants to take it on an as-needed basis to control cravings, which is exactly what she
does. She claimed she saves the buprenorphine she does not take so that she will have it if
she ever needs it.

Star went on at length describing her recent relapse, when she received the DUI.

She situated this “lapse” in the context of her father’s death,

I’ve relapsed once in the five years. My dad died of a drug overdose. I was angry.
I literally went out, got nerve medication [benzodiazepines], not what I normally
use, but a nerve medicine just to kind of like calm me down. I didn’t have a
relapse. Me and my counselor came to it, I had a lapse, because I didn’t like go
back and destroy my life up. I went back to the doctor, willingly went to the
doctor and got nerve medication knowing it was going to make me feel different.
I wanted that. I was never hooked on that before. And I done it three days and
went to jail for six days [for the DUI], come home, and I’ve not done it since.

Teller is a different environment than Adams, Douglas, and Eagle counties. There
are more factory jobs and some pay living wages. Star had a job when she graduated drug
court making $21 an hour. Jobs still remain an issue for Star and her family. Star lost her
factory job when the factory downsized. Her husband earns some income selling ginseng
and agate rock, but that is seasonal work and they have no income beyond that. The last
time I spoke with Star, she did not have her license back yet from her DUI, and she was
waiting on getting her license to search for jobs. There is no available transportation
unless she can drive herself.
Star’s SNAP benefits provide enough food for her family for about three weeks out of each month. For the fourth week, she generally relies on food banks, food they buy out of pocket, or they try not to eat much at home that week, with her children receiving free breakfasts and lunches at school. They have stable housing at this time. Star said housing was difficult to find because of her reputation as a drug user in the county. She finally found a landlord willing to rent to her because the landlord lost two children to drug overdose, and is empathetic to Star’s position.

Star’s narrative continues the theme of state agencies offering wanted services, but these services still not meeting the needs of families. Her interactions with drug court and buprenorphine show how Star valued aspects of each program, but contested certain programmatic understandings of relationships with other people and with prescribed pharmaceuticals.

Care networks and survival strategies developed to navigate material deprivation came to the fore of many of these interviews. Crises seem to define entrance into recovery, as well as relapse. People whom women care for can be fundamental to their recovery, or can assist in creating situations in which sobriety seems impossible. Through their drug use, women often place strain on people who care for them. Women’s understandings of care and relationships may bring them to be at odds with treatment programs.
Chapter Eight
Conclusions

“These hills are just waves, washing through eternity. My brethren, they hain’t a valley so low but what hit’ll rise agin. They hain’t a hill standing so proud but hit’ll sink to the low ground o’ sorrow.” – James Still, River of Earth

This quote embodies part of the exercise of this dissertation. Despite the pain I have documented among study participants, there is hope. There is an energy in people and places that is humbling. But there are innumerable battles to fight and violence permeates almost every aspect of some people’s lives. So many of my days resembled this: driving through the flattened mountains in Eastern Kentucky mourning what humans have done to this place, and then speaking to an awe-inspiring woman who has spent decades working on social justice, succeeding in ways that seemed impossible. My intention through this has been to show the violence, the marginalization, as well as the work against these forces in ways that do not glorify, but reveal the complicated strategies that individuals, families, and communities must create as they make their way through this life. These navigations do not happen alone, but with others, living and dead.

I conclude by summarizing how this dissertation speaks to understandings of representation, marginalization, and encounters with the state. These encounters can be confusing, as is the case with buprenorphine and how buprenorphine is treated by various state actors. Navigations of the state and inequalities are situated within care networks. I make recommendations based on these findings, including ideas for future research.
Methods and representation

In terms of methods, using stories is a precarious strategy. People often listen to stories better than numbers, but individual stories may be easily dismissed as aberrations or something sad that happened somewhere else. The intent of this dissertation is to place narratives within larger contexts to create something that can be heard, but not as easily dismissed because these stories expand on themes. By situating women’s stories within analyses of large-scale political, economic, and social forces, this manuscript is intended to humanize women who use drugs as well as move understandings of their experiences beyond explanations that focus on individual or cultural differences (Farmer 1992).

Though discussing his fictional book that takes place in Central Appalachia, Robert Gipe (2018) captures some of the intricacies of representation in writing, “I try to write stories that help people identify with and love people with too-complicated lives. I don’t want anybody feeling sorry for them. I want people to see what it’s like, and realize maybe hard-luck people are actually pretty smart and creative and have a lot of grit.” In this study, I do not want to portray women processing through treatment as perpetual victims, unable to take action on their own behalf. They take actions every day. Sometimes these actions are undoubtedly harmful to themselves and those close to them. At other times, their actions are deemed harmful from the outside, but are more complicated. People’s lives are constrained by the cultural, political, and economic environments in which they live. Some people face more inflexible constraints that feel like they are forever bound in handcuffs; others only occasionally face a slight tug that may be shrugged off. Most of the women I spoke with narrated lives of being restrained, but nonetheless charging forward, even if into a wall. Some were abused and some have
abused. Most cited feelings of being treated at some point as though they are useless through harmful representations of women who use drugs. This shunning is dangerous for women, their families, and their communities.

Populations that are marginalized discursively as well as materially experience increased state surveillance as compared to privileged populations. Yet state surveillance among and between marginalized populations differ. The women in this study qualify for and at times are coerced to use particular state services because of their gender, race, class, and motherhood status. Through the current analysis, I add to literature showing that intersecting inequalities based on social parameters underlie health problems, encounters with state agencies, and treatment provision, even as people produce knowledge, respond to, and resist these constraints (Becker 2007; Braveman 2012; Briggs and Mantini-Briggs 2003; Farmer 1999; Mullings and Schulz 2006; Smith-Nonini 2009; Susser 2009). For instance, state intervention can be based on what women’s bodies look like, whether they are white, appear pregnant, or have scars. A deep blue or black puncture mark on the arm indicating injection drug use can result in child removal or incarceration.

The participants in this research live on the margins in an area that has poor economic indicators and is stereotyped as part of Appalachia. The negative assumptions that often accompanied the mid-20th century War on Poverty remain in Appalachia. Namely, culture of poverty models exist as gatekeepers and community members discuss “generational poverty” or “cycles of poverty.” At times, culture is used as a weapon to blame those in subordinate positions. Exploitation is hidden through processes of depoliticization and removal of economic considerations. Being in and of Appalachia is
more important for some as compared to others. Sissy and Maggie in particular come to mind when thinking of a strong connection to place. Some people carry their homes with them, and it cannot be taken away. How people feel about themselves and their home place may become inseparable. When people despair over themselves, their home may become a place to escape from. When people are told their home is despicable, they may see parts of themselves in that view. Ultimately, community members, kin, service providers, and treatment staff stigmatize these women for being poor mothers who use drugs in rural Appalachia.

Stigma affects women’s maintenance of child custody, emotional state, and talk about themselves and others in similar positions. Stigma is embodied as another aspect of weathering. For the women I spoke with, their physical pain and emotional stress that is caused by structural violence presents as depression, anxiety, and drug use. In order to cope with stress and pain, the only available forms of self-care may be detrimental and inadvertently lead to further marginalization. Such forces as health and pharmaceutical industry policies shape the availability of self-care options, where pain and poverty are addressed through medication.

Importantly, stigma limits material resources. Characterizations of poor mothers who use drugs justify decreases in government spending. Just as spending is reduced, portrayals of Appalachia as being overly dependent on government dollars and addicted to drugs propagate new arguments for entrepreneurial innovations to save the area rather than private or public investments. Criminalization of these women constrains their access to entitlement programs when incarcerated and once they have felony records. Community members and families at times deny employment and housing to women
based on their class, surname, and past drug use. Businesses and individuals prey on those in the margins by charging exorbitant prices for basic services, such as showers, and single serving food items or trading SNAP benefits for cents on the dollar.

Researchers pay women for their stories because of their categorizations in particular risk groups. In the midst of these inequalities, women are swept into government programs that may be more about surveillance than services.

People also rely on the privileges they have. Whiteness largely goes unmarked across the US, and often unexamined. The participants in this study may be heavily surveilled for many reasons, but for 37 of the 40 women, it is not because of the color of their skin. While their families and communities may be economically distressed, they have not faced the systematic racism experienced by communities of color. These women may thus have access to care networks that have socially and economically benefitted from white supremacist policies privileging whites in terms of housing, education, and employment.

Some gatekeepers and community members frame the women in this study as the “worthy” poor because of their roles as mothers as well as their victimhood within an Appalachian culture that is construed as especially violent. At state anti-drug coalition and economic development meetings especially, Appalachian and rural women are incorrectly pictured as all white, which may be seen as lending further support for their categorization as worthy recipients of social entitlements. Yet I argue that women are considered worthy because of their white children, not necessarily because of their own whiteness. Some, such as the CPS administrator Karen, view women who use drugs and come into contact with state programs as “unworthy” poor. These gatekeepers classify
treatment clients as irresponsible women who choose to be mothers, choose to use drugs, choose to be poor, and choose not to leave their home area to obtain a better life. Women are only characterized as valuable within this view if they are able to participate in legal economies and perform unpaid caretaking roles. Women are critiqued for not taking personal responsibility for their lives. To be fair, two service providers in particular, Hessie and Bill, refuted these categorizations. They argued that all social safety net services should be expanded and they understand their work as being part of a larger social justice movement.

Women’s access to entitlement programs and involvement in coercive regimes of state care are predicated on their social locations. At times women’s gender, class, or drug use status place them in programs that they otherwise would not have access to. This study focuses on their placement in forms of drug treatment that are not universally available in the five counties. Yet these same social positions open them to CPS intervention and incarceration. Their involvement with one state entity may undermine their ability to utilize another service. Women’s placement in drug court prevents them from enrolling in buprenorphine programs and in some counties at certain times, from entering Horizons. This reveals the multiple and at times contradictory discursive elements that flow through the state.

I focus on how women must navigate discursive representations of women who use drugs in rural Appalachia. Women, all of whom are construed as mothers, have a series of impossible identities they may be forced to accept when interacting with government programs. Some women go into programs having lived for years with the stigmatized identity of a mother who uses drugs within the community; others must
suddenly switch from considering themselves “normal” to identifying as a mother who uses drugs, at least when presenting themselves to program staff. Local understandings of drug use include individualistic ideas of addiction as a chronic neurological disorder that is, at the same time, attributed to moral failings. Some staff and community members adhere to a culture of addiction model where women are framed as bad mothers and citizens who perpetrate violence against children and perpetuate drug use through reproduction of damaged children.

Major findings

Women differentially find particular aspects of state punitive, rehabilitative, and therapeutic programs helpful and harmful. Structural violence constrains these programs materially and discursively. I outline how systems of governance, which are implemented by both state and non-state actors, intrude in women’s lives. Cuts in funding for social services do not mean the state is any further out of these women’s lives. Underfunded programs may be more chaotic, as exemplified with CPS caseworkers who do not have cell phones and the consistent turnover of Horizons staff. This makes the state difficult to navigate because rules are unclear, but women can also find gaps to exploit within and between programs.

The relationships between therapeutic as well as rehabilitative services and punitive agencies make program environments tense and perhaps adverse to successful therapeutic practice. Through its mission, Horizons is inextricably linked to CPS. Drug court is embedded in the criminal processing system. The public, media, and law enforcement have largely viewed buprenorphine treatment as illegitimate and harmful.
Buprenorphine providers become punitive towards clients in attempts to legitimize their businesses and protect themselves legally. Women face the consequences of these conflicts over buprenorphine and may lose child custody as a result.

The vast majority of women agree that these treatment programs are needed, but do not adequately address substance abuse or gendered inequalities. Women find therapeutic and rehabilitative services helpful, but also value material support through case management services. In terms of economic resources, most women rely on SNAP and those few who have access to housing subsidies see these as preventing homelessness. Medicaid Expansion and to a lesser extent additional ACA provisions have given some women or their family members unprecedented access to health care, including ORT. Yet women want access to more individual counseling sessions as well as to high-quality health care across the spectrum of mental health, obstetrics, et cetera. These services may not be available because there are no local providers. Poor quality care, whether health care or familial care, can in some cases be worse than no care at all.

Through this dissertation, I want to continue the ethnographic work that expands notions of drug use beyond the individual. What are the structural forces that frame entry into and maintenance of illicit economies and drug use? What are those networks of people, places, and things that bind women to others, in ways that hurt and strengthen? Yet I also want to complicate understandings of inner worlds. Pain and love, desires to leave and to stay, isolation and connection are all bound up in the self. Both drugs and relationships are taken within, entangled in the sense of self, and are only let go with great physical pain. Women’s care networks represent the localized place where drug use
and treatment occur. Relationships defy easy categorizations. Care networks and even the same relationship can support ongoing drug use or recovery.

These women’s stories aid in expanding understandings of care and care networks. A definition of care that focuses on positive outcomes not only leaves out particular relationships, but also the intricacies and unevenness of relationships. Just as state programs represent mazes, relations are equally labyrinthine. Even when care is intended to be supportive, it may not be. Program staff are limited in what they can offer. Families are taken to the brink of letting people go, and sometimes they must for their own survival. Women at times feel unable to take care of themselves, let alone anyone else. Kinship is how people make it through, and family members or intimate partners are the most likely to harm or kill women. For the purposes of this ethnography, the concept of social networks does not seem adequate and comes with some of the same challenges as traditional understandings of care. There is an underlying economic rationality in social network modeling that seems simplistic, and unable to contend with violent care.

Program staff ask women to treat their drug-using lives as unproductive and pernicious. In this vein, staff ask clients to change their “people, places, and things.” For those removed from drug using networks and who do not think their drug use ever harmed their social roles, this alteration may not feel remarkable. For those who are suddenly asked to remove themselves from all friends and family members and even neighborhoods and communities, this break is materially and emotionally jarring.

The complexities of violence and care presented here are embedded within experiences of structural violence. Interpersonal relationships may turn violent not because the people involved are inherently violent or bad, but because they are in a
system that fosters violence. Thus in order to curtail direct or interpersonal violence, structural violence must be addressed simultaneously (Galtung 1969). Health education or anti-violence campaigns that focus on personal responsibility, cultural difference, and lack of individual knowledge ignore structural violence and thereby support continued violence (Farmer 1999). Further, structural violence is systemic, and thus cannot be abolished by removing an individual who holds power. The violent system itself must be dismantled (Galtung 1969).

Some women do get through these mazes of programs, policies, and kin. Though this dissertation is focused on the forces that marginalize poor women in Central Appalachia, I want to highlight here how changes are occurring. Although it is the least common among participants, primarily because they are consumed with daily survival, the most explicit action that women are taking is attempting to regain their rights. They are fighting for their rights to be parents by struggling for child custody. One participant is active with a statewide group in attempting to restore voting rights for former felons.

Every single woman with whom I spoke is attempting to cease deleterious drug use. Again, some women were caught in the state system for testing positive for cannabis once, and they are currently sober. They reported that sobriety is not a struggle for them. For the women who said they had a serious addiction, I spoke with women who had been in recovery for years and those who relayed stories of recent relapse, but all are fighting to get or stay in recovery. Women in recovery have taken it upon themselves to care for each other and to try to help others through addiction. Sometimes this means volunteering or working for an existing organization, like Horizons. At times, this means seeing a need in the community and filling it. Adams County does not have AA, NA, or any other style
of self-help group. Many of the women and service providers I spoke with see this as a real problem, especially when people had completed treatment and are trying to maintain sobriety without the treatment support system. Katie, Maggie, and Beth are trying to start their own support group.

Staff and administrators within treatment programs are also attempting to make changes. They are offering services that are unavailable elsewhere. Some regional and state administrators, particularly those affiliated with Horizons, are supportive of keeping MedicaidExpansion and provisions of the ACA as well as destigmatizing the use of buprenorphine. They make this support clear at state and regional meetings and publicly through Facebook and editorials in local newspapers. While women who use drugs are stigmatized and work to fight against this stigma, so do some service providers. They are acutely aware of this stigma and see it as part of their mission to lessen the harm to women. Although it may be important for people to understand their structural limitations so they may map a navigable path, it is equally important to construe structures changeable. Even those structures that seem immutable were created and can be undone with a series of decisions, even if those with power must make these decisions (Wacquant 2009).

Recommendations

I make clear that some program staff have a deep knowledge of the structural inequalities with which women contend and do what they can to help women cope with these circumstances by offering various kinds of support. Yet some staff continue negative stereotypes of Appalachian women and women who use drugs which results in
harsher interactions with program participants. Staff demonize women’s relationships, causing difficult to overcome rifts in women’s considerations of themselves and those they hold dear. Women feel this stigma, and effort should be made to make treatment programs especially, in addition to broader community places, safe spaces. Clients will not return to programs where they feel like they are treated like “dogs.” Thus women are not getting services they want, and communities are left with residents who are frustrated with lack of support from the entities to which they turn. Tying services to vulnerabilities objectifies and highlights these vulnerabilities for all to see. Focusing on women’s overall health (Stewart 2016) and context within the political economic framework may be more effective and less marginalizing than pinpointing substance use as the problem.

Yet the daily endurance of stigma seems more like micro-aggressions. Yes, it is frustrating, but women usually make it through. Although stigma hurts, fixing negative attitudes towards poor people, women who use drugs, or Appalachians is not the only answer. If every biased service provider altered their attitude, they would still be working in underfunded programs with problematic policies serving populations marginalized by exploitive economic and political processes. This is where stigma devastates, when it leads to further material marginalization or child removal. Lack of resources and losing children is felt as a Promethean pain. Central Appalachian communities need public investment. There is public investment in substance abuse treatment as well as education based prevention, but the dollars are not there for harm reduction or wrap around services to make recovery more attainable. While prevention focuses on education, the money for building economically sustainable and equitable communities is minimal, is facing further cuts, or is simply nonexistent. With the 2017 Tax Cuts and Jobs Act, we will see
further inequalities as the ultra-wealthy reap the most benefits from tax reform. Federal and Kentucky state politicians have promised even deeper cuts to government programs in years to come.

Further state support is important, but not everything. Many in this ethnography rely heavily on SNAP, and may go hungry when that resource is taken. Only one woman I talked to, Ashley, was focused on enrolling in SSI. Most others just want anything to do that will help them live what they describe as normal lives. Employment is not in the area. For change to occur, efforts must be made across governments and communities to create livable options. Perhaps the call centers that are opening in rural Eastern Kentucky are one avenue, but communities need more options that offer stable employment with desirable wages and benefits. There are many diverse economic ventures across the region, from organic mushroom farmers to documentary filmmakers to permaculture experts. But despite the grand hopes and true importance of entrepreneurism, the belief that entrepreneurship will save the region seems naïve. I do not think already distressed communities and families will be successful for everyone in communities if the burden of a full economic shift is placed upon them.

Just as women take actions, so can communities and families. Materially and emotionally supporting those struggling with addiction is fundamental. Many kin and community members are already doing this. I see communities working extensively on prevention, but most are largely missing when it comes to recovery and harm reduction efforts. Normalizing these efforts may be a next step. No matter what efforts are made, listening to what those who are on the fringes say they need is fundamental. Paternalistic policies and programs that attempt to shape communities and individuals according to
idealized notions of what women, the rural, or care should be will falter or fail because they often operate outside of what actually is and what individuals and communities want.

Beyond substance abuse treatment program, state agency, and economic policies, health and drug policies should be shifted. If drug use patterns are to be changed, the policies around pharmaceuticals and other health technologies must be reexamined and enforced. When the cost of lying is minimal, especially in comparison to exorbitant profits, the lying will not stop. Policies involving illicit drug use continue the mass incarceration of poor people and people of color. This harms individuals, families, and communities. When people are incarcerated, they are removed from care networks and may be permanently disenfranchised from the economic as well as political system. Communities are left decimated when people are removed and tax dollars are spent on incarceration.

Limitations

All researchers are in particular positions, often based on power, in relation to the people or things studied. These positions influence how and what data are collected as well as generalizability. For part of my fieldwork, I was visibly pregnant. Since I was interviewing some women who were also pregnant and all are mothers, they often immediately asked me about my pregnancy and family, which served as an easy entry point to build some rapport before we began interviews or participant observation. Yet my physical body may have engendered a concentration of conversations regarding childbirth and childcare that would not have taken place if I were in a different position. At the same time, all of the clients I spoke with except two had intimate and usually
current experience with CPS, so perhaps their children and assigned caregiving roles were at the forefront of their thoughts regardless of my protrusion.

Participants were not powerless in interviews or participant observation. Participants shape their narration, and narration is key because it can be used to navigate communities, state institutions, and additional interpersonal relationships (Dewey 2014), including those with inquisitive researchers. All women’s behaviors are self-reported. I did spend time with women outside of interview settings, but this was limited and participants actively shape these observations just as they did interviews. Perhaps houses were cleaned before I came and more innocuous activities highlighted, just as drug use is at times over and other times underestimated in interviews.

Two greater limitations regard my exclusion from parts of women’s lives that I think are somewhat unique to the subject matter of this study. Widespread “duty to report” laws require that all persons, social workers, treatment program staff, anthropologists, et cetera, report any suspected cases of child abuse and neglect. Clients are fully aware of this duty to report. I became, for a short time, another form of surveillance. This tension was multidimensional, as one of my greatest concerns in commencing this work was being put in a position where I felt like I was bound by law to communicate a potentially harmful situation to CPS. During fieldwork, this limited women’s willingness to have me in their homes and my comfort with entering their homes. In the end, I did spend time with women outside of the programs, but I was diligent in explaining the duty to report before doing so. Thus, children were never present when I was speaking to women in active use. I only spent time with women and their children when they were in recovery and had child custody. Several women told me actions they had taken that may not have
been approved by CPS, such as visiting their children outside of official visitation times. I
never felt that anything we discussed revealed current harms to children.

Substance abuse treatment programs greatly limited my access to witnessing the
programs in action. Drug court was the most open. I still could not participate in a daily
capacity and was not allowed to document individual interactions between drug court
staff and participants, including participants’ time with the judge in the courtroom. At
Horizons and buprenorphine clinics, I was primarily constrained to the waiting areas. I
had much greater access to client spaces and to staff member interviews at Horizons as
compared to the buprenorphine clinics.

Further research

Part of the current study, as undoubtedly with most research, was discovering
issues halfway through fieldwork or even in the data analysis stage post-fieldwork. After
I had completed a quarter of my interviews, I realized that women through the area are
losing child custody for testing positive for physician prescribed medication, most often
buprenorphine. Even though I was completely unaware of this practice, I was able to
reformulate my questions for future interviews and go back and speak to the clients and
gatekeepers I had already interviewed, either with follow-up informal conversations or
interviews. Yet there were two issues that I was unable to explore because I did not fully
understand their depth until later in the process. I think both deserve further analyses.

First, I asked women broadly about their health concerns and followed up with
questions where appropriate. I failed to ask specifically about suicide attempts. I think
this represents a miscalculation on my part of how prevalent and enduring these attempts
are in women’s lives. Even though I did not ask about suicide, six women chose to tell me their stories of attempts at suicide. These narratives make clear that the line between overdose and suicide is blurred and removal of children may be an impetus to a suicide attempt. Recent anthropological works provide a framework for beginning analyses of suicide and care that document and place suicide in specific cultural and politico-economic contexts (see Stevenson 2014). As the attention to suicide among white US residents and those in Appalachia increases among quantitative researchers as well as the media (see Meit et al. 2017), frameworks and studies that can complicate these at times simplistic narratives will be vital in understanding the phenomena.

Second, future research could explore the interactions between how medications are prescribed and used, claims of disability, and how administrators at substance abuse treatment and health care facilities work with enrolling clients in government funded programs. I outline how treatment programs enact regulations that encourage clients to not only become sober, but to become employed citizens. If women are unable to work, some programs, including Horizons and buprenorphine clinics, encourage clients to try to enroll in SSI or SSDI. A few women talked about the difficulty of the enrollment process and how they thought having SSI or SSDI affected encounters with service providers. Lizzy in particular had concerns with physicians trying to prescribe psychotropic medications that she said she had negative reactions to, and thus did not take. Her physician then labeled her non-compliant and questioned her claims of disability, arguing that if she “really” has mental health concerns, then she would be compliant. I did not fully articulate these links between prescribed medications, disability claims, and issues of enrollment because I do not have enough data to do so, but I think these are worth
exploring, especially in a region that is stereotyped as having a high incidence of individuals who supposedly exploit SSI and SSDI.

This research has made me want to take a step back, which I have. I say that not to indicate taking a step back from thinking about substance use issues. Instead, I am working on sustainable and equitable community change. I think it is important that governments assist in supporting economies that may present an alternative to illicit markets that remain dangerous in some ways because of substances that are harmful and in other ways because of state responses to those substances. I hope to assist in building ways of living and making it through that work around modes of production that often rely on exploitation of communities, families, and individuals. I am certainly not opposed to “sinking this capitalist system to the darkest bits of hell,” in the lyrics of Sarah Ogan Gunning (1937), writing in support of striking coal miners. But as we work in the current everyday, I think it is imperative to find practical ways of utilizing this system to fight for the justices we seek, whether that is through harm reduction models, international social justice movements, or worker owned cooperatives as well as additional diverse economies, as advocated by many of those working in Appalachia (Colias 2002; Fickey 2014). As we travel forward, I would like to not only see more effort at harm reduction, but also utilization of harm reduction programs to serve as sources of social support and community action. As we repeatedly learn, whether in terms of substance abuse treatment or actions done in the name of human rights, the road to hell, or at least a realm of it, is paved with good intentions. Yet I think careful attention to the details of people’s lives who programs intend to serve may limit these negative consequences. We cannot expect
programs or clients within them to consistently succeed if we continue to socially and economically marginalize both.
Appendix A: Glossary of Relevant Programs and Policies (in alphabetical order)

**AA (Alcoholics Anonymous):** A nonprofessional, self-supporting organization of individuals with the desire to stop drinking and become sober, “normal,” and “constructive.” There are no dues or fees and the organization attempts to be non-denominational and apolitical. AA considers alcoholism to be “a physical compulsion, coupled with a mental obsession.” Thus, alcoholics do not have control over their drinking and are classified as having an illness that can never be cured. Yet AA reiterates that there is no shame in having an illness. AA maintains that the program should work for everyone who has the desire to stop drinking despite differences in background, drinking patterns, or socioeconomic conditions. Although AA is non-denominational, the group promotes a reliance on a greater Power in order to gain and maintain sobriety, especially in their Twelve Steps (AA 1984).

**ACA (The Patient Protection and Affordable Care Act):** ACA is meant to expand health coverage to those who previously did not have private health insurance, did not qualify for public health coverage under Medicaid, or were underinsured. Increasing health coverage is performed in various ways depending on the state, including expanding access to Medicaid and providing a marketplace to buy health plans run by private insurers (Dao and Mulligan 2016). Individuals with incomes from 100 to 400 percent of the Federal Poverty Level are eligible for subsidies to purchase health insurance in state marketplaces (KCHFS 2013). President Obama signed the ACA (HR 3590) in 2010.

**ACADA (Adams County Against Drug Abuse):** Pseudonym. A community-based organization in Adams County designed to reduce substance abuse by targeting middle and high school aged youth with prevention efforts. ACADA coordinates substance use prevention workshops in the local schools and funds a number of after-school activities meant to distract youth from substance use. During my fieldwork, ACADA was facing financial crises and had to close their storefront on the main street of the county seat. The storefront served as a place for after-school and additional community activities and had a computer lab open to community members. A number of different representatives of local organizations, including the schools, health department, family court, drug court, CHEK, and churches, attend the monthly meetings to discuss substance use in the county. ACADA is funded by a limited amount of money from Adams County and the town that is the county seat. ACADA is the county-level partner of EKSAC and receives limited funding through that organization as well.

**Adams Housing:** Pseudonym. A non-profit organization that receives and distributes funding through Community Development Block Grants and is a member of the Federation of Appalachian Housing Enterprises (FAHE). Both Adams Housing and FAHE offer US Department of Agriculture mortgage loans. The main focus of Adams Housing is to assist families in home ownership, in completing homeowner repairs, and providing temporary housing to families or single mothers with children in Adams and Douglas counties. Adams Housing also distributes monthly food boxes and has a clothing bank.
**ARC (Appalachian Regional Commission):** Created through the Appalachian Redevelopment Act in 1965 as part of Lyndon B. Johnson’s War on Poverty. The ARC is a partnership between state and federal governments for economic development in the region. The Commission is comprised of the 13 governors of the ARC defined Appalachian region and a presidentially appointed federal co-chair. The ARC invests in five strategic areas, including entrepreneurial and business development, workforce development, infrastructure, especially broadband at this time, natural and cultural assets, and leadership development. Resources are targeted to counties that the ARC defines as economically distressed (ARC 2017a).

**ASAP (Kentucky Agency for Substance Abuse Policy):** Created in 2000 to coordinate state and local agency efforts to reduce alcohol, tobacco, and substance use, particularly through policy change. ASAP funds local boards to support a three-pronged approach to substance use, including prevention, treatment, and law enforcement. In 2016, ASAP distributed funds through grants to local boards to help support the establishment of local needle exchanges, the distribution of naloxone, an opioid antagonist used to reverse an overdose, and the establishment of programs to reduce the effects of neonatal abstinence syndrome (ASAP 2017).

**ASFA (Adoption and Safe Families Act of 1997):** The act was passed to encourage swift adoption of children in temporary familial placements and foster care as well as a shift away from a focus on family reunification after child removal. Parental rights are terminated once a child is in foster care for 15 of 22 consecutive months. One consequence of the ASFA has been lower reunification rates once a child is removed from the home because of both a shift in focus and temporal barriers. This is especially true in homes where parents are using substances due to lengthy treatment programs and at times, the inability of parents to enter recovery quickly.

**CHEK (Community Health Eastern Kentucky):** Pseudonym. The nonprofit CMHC that serves Adams, Douglas, Eagle, and River counties. CHEK employees over 500 service providers and has over 50 locations. CHEK houses the Horizons program. All programming is focused on mental health, developmental disabilities, substance use, and/or trauma services. Provided services include individual and group therapy, residential treatment, aftercare, case management, assessment, and referral. CHEK does bill to Medicaid, Medicare, and private insurance, but services are offered for free or on a sliding scale for uninsured clients.

**CMHC (Community Mental Health Centers):** Kentucky is divided into 14 multicounty regions, all of which are served by one community mental health centers system. Thus, there are 14 CMHC in Kentucky, all of which are private, nonprofit organizations. All are regulated and contracted by the state to provide a comprehensive range of mental health services, including inpatient, outpatient, therapeutic rehabilitation, and emergency services. Yet specific funding streams, programming, and management varies between CMHC (KY DMS 2017).
**CPS (Child Protective Services):** Although Kentucky’s division of child protective services is officially labeled as the Department for Community Based Services (DCBS) and referred to as DCBS by many respondents, I use CPS because women most commonly use this acronym and it is the more common usage across the US. In Kentucky, CPS provides child and adult protection, family support, determinations for Medicaid and food benefit eligibility, and administers a number of programs, including an energy cost-assistance program, the foster care system, K-TAP, and SNAP. A primary goal for CPS is finding permanency for children. In their mission statement, CPS is tasked with reducing poverty, decreasing child and adult maltreatment, and helping individuals and families find self-sufficiency and recovery (KY DCBS 2017).

**Commodity Supplemental Food Program:** A US Department of Agriculture program that supplements the diets of low-income persons over age 60 with a variety of canned and dry foods as well as cheeses. While there are age and income requirements, this program may benefit others in the household who do not meet the eligibility standards.

**DADA (Douglas Against Drug Abuse):** Pseudonym. A community development organization in Douglas County created to promote self-empowerment and community leadership. The services DADA offers vary through time with grant cycles. During my fieldwork, the DADA storefront in the county seat of Douglas County served as a place for after-school and additional community activities and has a computer lab open to community members. DADA offers some assistance with housing. A number of different representatives of local organizations, including the schools, fiscal court, and law enforcement, attend the monthly meetings to discuss substance use and other issues in the county. DADA is the county-level partner of EKSAC and ASAP.

**Eagle Health:** A health clinic in Eagle County that primarily serves residents in Eagle, Adams, and River counties. Although the clinic provides a variety of services from cradle to grave, they also have a buprenorphine program with case management and individual and family counseling.

**EKSAC (Eastern Kentucky Substance Abuse Coalition):** A non-profit organization located in Kentucky’s 5th congressional district that abides by Kentucky’s law enforcement, treatment, and prevention/education three-pronged approach to substance use. EKSAC is widely known for their undercover narcotics investigations and their education programs in middle and high schools. EKSAC is a police agency with its own law enforcement personnel. EKSAC also coordinates the provision and funding of substance abuse treatment through a voucher program for individuals living in the 5th congressional district. Individuals are only eligible for one voucher in their lifetime. Most EKSAC funding is from federal and state funds.

**KASPER (Kentucky All Schedule Prescription Electronic Reporting):** The KASPER prescription monitoring program was established in Kentucky in 1999 to collect data on the dispensing of all schedule II through V prescription drugs through pharmacies and other prescription drug dispensers within Kentucky. Out-of-state entities that ship prescription drugs are also required to submit data to KASPER (Relay-Health 2011).
**K-TAP (Kentucky Transitional Assistance Program):** A cash benefit program that is funded by a block grant from Temporary Assistance for Needy Families (TANF) and administered through the Family Self-Sufficiency Branch of the Department for Community Based Services. Individuals apply for K-TAP at county-level Community Based Services offices. Maximum monthly payment amounts ranged from $186 for a family of one to $482 for a family of seven in 2016. A family is only eligible for K-TAP for 60 months in a lifetime. K-TAP provides short-term cash benefits to families with children younger than eight or children younger than 19 who are full-time students. The vast majority of adults who receive K-TAP are required to work for the monthly benefit (KY DCBS 2017b).

**NA (Narcotics Anonymous):** An offshoot of AA that is focused on all addictions, not just alcohol. As with AA, there are no dues or fees and the organization attempts to be non-denominational and apolitical. NA, like AA, is focused on a twelve-step program, a higher power, group meetings, and a peer support network of “addicts helping addicts” (NA 2016). In terms of drug replacement, NA leaves decisions on group membership of those on drug replacement up to local groups. The overall organization encourages the inclusion of those on drug replacement, but not in leadership positions and those on drug replacement are not considered “clean.” Definitions of who is and is not clean or a full member become more unclear and more based on local group decisions with medications besides drug replacement (NA 2007).

**Pastoral Association:** Pseudonym. A group of approximately one dozen pastors in Adams County who meet regularly to discuss county, state, and national issues, including homelessness, hunger, and substance use. The association attempts to coordinate holiday church services, food banks, and clothing banks. The Pastoral Association is supporting the opening of a new homeless shelter in Adams County, which would make it the first county in the area to have a homeless shelter. The association is considering offering faith-based self-help meetings for substance users and their families.

**River Buprenorphine:** This clinic only provides buprenorphine. The clinic employs numerous prescribers and counselors who offer buprenorphine prescriptions, individual counseling, and case management services. The clinic primarily services populations in River, Adams, and Douglas counties.

**SNAP (Supplemental Nutrition Assistance Program):** Referred to most commonly as “food stamps,” SNAP is the largest hunger safety net program in the US. SNAP eligible households cannot have a gross monthly income above 130 percent of the poverty level. Maximum monthly allotments range from $194 for a family of one to $1,022 for a family of seven, but these allotments vary according to a households’ monthly income. Individuals who are eligible to work have work requirements to receive SNAP. Two-thirds of SNAP recipients are ineligible to work because they are children, seniors, or have a disability (USDA 2017).
SSDI (Social Security and Disability Insurance): A program funded through Social Security, so recipients, their parents, or a spouse must have paid into Social Security. Recipients must meet disability requirements of having a medically-determinable physical or mental impairment that is expected to cause death or has lasted or will last for at least 12 months. Recipients qualify for Medicare. If one earns over $1,130 a month for 2016, they are considered as having substantial gainful activity and do not or no longer qualify for SSDI (US SSA 2016).

SSI (Supplemental Security Insurance): A program funded through general tax revenues. Recipients must have limited income and resources. The same disability definition applies for adults as with SSDI, but there are different eligibility requirements for children. Recipients qualify for Medicaid. If one earns over $1,130 a month for 2016, they are considered as having substantial gainful activity and do not qualify for SSI (US SSA 2016).

TANF (Temporary Assistance for Needy Families): Created as part of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) to replace Aid to Families with Dependent Children (AFDC), Job Opportunities and Basic Skills Training (JOBS), and Emergency Assistance (EA). TANF eliminated open-ended federal entitlement programs for poor families and replaced these programs with block grants for states to provide time-limited assistance to poor families who now have to meet work requirements. States are allowed to use TANF dollars to meet the four goals of TANF: to provide assistance to poor families so children may remain in the home; to reduce dependency on government entitlement programs by promoting “job preparation, work, and marriage”; to prevent out-of-wedlock pregnancies; and, to encourage two-parent families (US DHHS 1996).

WIC (Women’s, Infants, and Children): A US Department of Agriculture program for low-income women and their children up to age five. Food supplements and basic health and nutrition education is the program focus. Households with an income at or less than 185 percent of poverty level are eligible.
# Appendix B: List of Women Interviewed (n=40)

<table>
<thead>
<tr>
<th>Name (pseudonym)</th>
<th>Treatment Experience</th>
<th>Regular Income Source</th>
<th>Housing Status</th>
<th>Highest Grade/Degree Reached</th>
<th>Ethnicity</th>
<th>Age</th>
<th>County of Residence</th>
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<tbody>
<tr>
<td>Abby</td>
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<td>None</td>
<td>Technical homeless</td>
<td>Some college</td>
<td>White</td>
<td>34</td>
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<td>Renter</td>
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<td>Some college</td>
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<td>Biracial</td>
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<td>River</td>
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<td>Location</td>
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<td>Theresa</td>
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### Appendix C: List of Gatekeepers Interviewed

Gatekeeper Interviews Completed in 2013 (n=13)

<table>
<thead>
<tr>
<th>Name (pseudonym)</th>
<th>Role</th>
<th>Organization</th>
<th>Ethnicity</th>
<th>County/Area of Origin</th>
<th>County/Area of Residence</th>
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<tbody>
<tr>
<td>Andy</td>
<td>Judge</td>
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<td>Asa</td>
<td>Substance abuse treatment program administrator</td>
<td>Kentucky Department of Corrections</td>
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<td>Indiana</td>
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<td>John</td>
<td>Research project director</td>
<td>Kentucky college/university</td>
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<td>Name</td>
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<td>Region</td>
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<td>Nina</td>
<td>Counselor</td>
<td>In-patient treatment program</td>
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<td>Phil</td>
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Gatekeeper Interviews Completed in 2015 and 2016 (n=19)

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<th>Name</th>
<th>Role</th>
<th>Organization</th>
<th>Time at Position</th>
<th>Ethnicity</th>
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<th>County/Area of Residence</th>
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<tr>
<td>Abe</td>
<td>Counselor, pastor</td>
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<td>7 years</td>
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<td>Amy</td>
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<td>County health department</td>
<td>17 years</td>
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<td>Adams</td>
<td>Douglas</td>
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<td>Becky</td>
<td>Case manager</td>
<td>Horizons</td>
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<td>Ben</td>
<td>Counselor, pastor</td>
<td>Drug court</td>
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<td>White</td>
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<td>Adams</td>
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<td>Bill</td>
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<td>Cas</td>
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<td>Debbie</td>
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<tr>
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Vita

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**Gender and Women’s Studies Graduate Certificate**, University of Kentucky 2013, Lexington, KY

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Billings-Eller Appalachian Center Mini-Grant, University of Kentucky, 2015

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Merit Scholarship, College of Charleston, 2001-2005

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Peer Reviewed Journal Articles

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2014  Buer, Lesly-Marie, Jennifer R. Havens, and Carl G. Leukefeld

2013  Buer, Lesly-Marie
      “Substance Abuse Treatment: Maintaining the Status Quo?” Anthropologies 17.

2012  Clevenger, Lesly-Marie, Susan Dreisbach, Jean N. Scandlyn, and John Brett

**Conference Proceedings**


**Film Reviews**