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“It Ruined My Life”: The effects of the War on Drugs on people who inject drugs (PWID) in rural Puerto Rico

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Abstract

Background—The War on Drugs has raised the incarceration rates of racial minorities for non-violent drug-related crimes, profoundly stigmatized drug users, and redirected resources from drug prevention and treatment to militarizing federal and local law enforcement. Yet, while some states consider shifting their punitive approach to drug use, to one based on drug treatment and rehabilitation, nothing suggests that these policy shifts are being replicated in Puerto Rico.

Methods—This paper utilizes data from 360 PWID residing in four rural towns in the mountainous area of central Puerto Rico. We initially recruited 315 PWID using respondent-driven sampling (RDS) and collected data about risk practices and conducted HIV and HCV testing. During a second phase, we conducted 34 micro-ethnographic assays, in which we randomly recruited 34 participants from the first phase and included their ego networks in this phase. Our ethnographic inquiry produced significant data regarding the effects of the war on drugs on the local drug trade, drug availability, and injectors’ social networks.

Results—Findings suggest that repressive policing has been ineffective in preventing drug distribution and use among those in our study. This type of law enforcement approach has resulted in the disproportionate incarceration of poor drug users in rural Puerto Rico, and mainly for nonviolent drug-related crimes. In addition, incarceration exposes PWID to a form of a cruel and unusual punishment: having to quit heroin “cold turkey” while the prison environment also represents a HIV/HCV risk. In turn, the war on drugs not only diverts resources from treatment but also shapes treatment ideologies, punishing non-compliant patients.

Conclusion—Shifting the emphasis from repression to treatment and rehabilitation is likely to have a positive impact on the health and overall quality of life of PWID and their communities.

Keywords

PWID; Puerto Rico; War on Drugs; Drug Policy; HIV/HCV Risk

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Introduction

Carlos¹, currently in his mid-30s, started injecting drugs in prison while serving a two-year sentence for marijuana possession. He said that he started smoking marijuana “late” (age 21), while attending college in Puerto Rico. It was during this time that he “caught a habit,” he said, and was charged with drug possession with intent to distribute after the police found a half-ounce of marijuana on him. His car was confiscated, and he received a two-year probation sentence. Carlos tried to quit his marijuana habit, but could not succeed. After failing his third drug test, a violation of the terms of his probation, he was sent to prison. Instead of going to the minimum-security prison he had hoped for, given his lack of a criminal record (aside from being caught with a relatively small amount of marijuana in his possession), he was sent to a medium-security prison for violating his probation terms. Carlos explained how he started injecting drugs while serving his sentence: “They call it the freezer because the air it is always on; it is freezing cold and closed.” Unable to find marijuana in the prison, he started selling drugs “to spend time and pocket some cash.” It was then that he started sniffing heroin. Soon after, heroin injectors started telling him that “it was better by the vein.” He bought one of the rare clean syringes available in jail and injected with somebody’s help. He then passed the syringe to others in his cell block, “over 20 inmates,” in his account. He explains that he tried to clean the syringe with bleach and water, but “could not avoid contacting HCV [hepatitis C virus]” because “everybody in jail has it.” He says that he knew he would become addicted to injecting drugs, but at that time he “just didn’t care.” Carlos explained, “I was full of resentment because the system was unfair to me. What they really did with that sentence was to fuck-up my life. After that, I stopped being one person and became another one.”

The War on Drugs, initiated by President Nixon more than four decades ago, provides a backdrop for understanding Carlos’s predicament. Focused on eliminating the production, distribution, and consumption of drugs, this policy has been criticized for being unable to attain these goals. Indeed, in the United States, the drug supply has not been disrupted and, in particular, heroin consumption is on the rise (Cicero, Ellis, Surratt, & Kurtz, 2014; Jones, 2013; Lankenau et al., 2012). The repressive approach of the War on Drugs has, however, dramatically raised the incarceration rates of racial minorities for non-violent drug-related crimes (Alexander, 2012; Williams, 1989, 1992; Moore & Elkavich, 2008; Drucker, 2013), profoundly stigmatized drug users (Greenwald, 2009; Weinberg 2000, 2005; Denning, 2000), and redirected resources from drug prevention and treatment to militarizing federal and local law enforcement (Kraska, 2007). Yet, while the War on Drugs is likely to endure with the new Trump administration, local and state challenges to this federal policy are becoming the norm, and are increasingly proving successful (Dickinson, 2015).

The War on Drugs was initially challenged by the introduction of medical marijuana (Hoffmann & Weber, 2010), followed by the legalization of recreational marijuana. Currently, 26 states and the District of Columbia have legalized marijuana in some form (Fuller, 2016). A study conducted by Cerda, Wall, Keyes, Galea, and Hasin (2012) suggests that while states that had legalized marijuana have a higher prevalence of users than those

¹Not his real name. All names have been changed to protect participants’ anonymity.

that do not, legalization does not seem to have increased overall drug use. Cohn, Johnson, Rose, Rath, and Villanti (2017) have more recently replicated previous studies and arrived at the same conclusion. In addition, in the past few years an epidemic of prescription drug use in the rural U.S. has led some states to consider shifting their punitive approach to drug use (incarceration) to one based on drug treatment and rehabilitation (Seelye, 2015). While some have drawn attention to the racial disparities behind this policy shift, asserting that it favors Caucasian drug users while racial minorities continue to face incarceration-first approaches (Chin, 2002), this policy shift still represents a clear challenge to the punishment approach.

Yet, nothing suggests that these policy shifts are being replicated in Puerto Rico. As of June 25, 2015, there were 12,381 people in Puerto Rican state prisons (Martinez-Guzman, 2015: 1). Of these, approximately 65% came from households with yearly incomes below \$20,000 (2015, p. 51), and 16% are behind bars for drug offenses (2015, p. 70). In addition, 69% report having had substance use problems prior to incarceration, and a striking 80% of these have never received drug treatment (2015, p. 123). In 2016, the average yearly cost of housing an individual in a correctional facility was \$28,259, and the yearly correctional budget currently nears \$376 million dollars (PR Gov, 2016a). In addition, the approved 2017 budget for local law enforcement surpasses \$754 million (PR Gov, 2016b). In contrast, only about \$123 million have been allocated for drug replacement therapies such as methadone (ASSMCA, 2009). Considering there are about 60,000 people in Puerto Rico with opiate misuse problems (Hotz & Rios, 2013), and a significant portion of people with substance use problems are behind bars, funding priorities are clearly aligned with punishment instead of treatment and rehabilitation. Unfortunately, the way data are aggregated makes impossible to know which portions of the budget for drug repression and drug treatment are funded by the federal government and which ones are supported by the island.

In this manuscript, we present findings based on two years of ethnographic fieldwork with people who inject drugs (PWID) in rural Puerto Rico. We examine the effects of the War on Drugs on a small group of PWID. Findings suggest that repressive policing has been ineffective in preventing drug distribution and use among those in our study. This type of law enforcement approach has, however, resulted in the disproportionate incarceration of poor drug users in rural Puerto Rico, and mainly for nonviolent drug-related crimes. In addition, aggressive policing has placed additional burdens on PWID, forcing them to travel (often by foot) to other locations to acquire the drugs they need and, through incarceration, exposing the vast majority of them to what is arguably a form of a cruel and unusual punishment: having to quit heroin “cold turkey.” Most correctional facilities do not offer drug replacement therapies. We argue that shifting the emphasis from repression to treatment and rehabilitation is likely to have a positive impact on the health and overall quality of life of PWID and their communities.

Methods

This research is part a larger longitudinal study, which received IRB approval through the University of Nebraska-Lincoln (IRB# 20131113844FB) and the University of Puerto Rico School of Medicine (IRB# A8480115). This paper utilizes data from 360 PWID residing in four rural towns in the mountainous area of central Puerto Rico, which are located about 30–

40 miles from the capital, San Juan. Sites were selected because they were representative of rural PWID on the island (López et al., 2015). In addition, these sites were chosen due to the presence of El Punto en la Montaña, the only syringe-exchange program operating in rural Puerto Rico, with which we established a close collaboration that facilitated data collection with this population (Welch-Lazoritz et al., 2017).

The study is divided into three phases. The first phase consisted of an analysis of the sexual and injection risk behaviors of PWID residing in these municipalities, as well as the degree of access to health-promoting services. We initially recruited 315 PWID using respondent-driven sampling (RDS) by starting two seeds in each of the four municipalities (for a total of eight seeds and 307 recruits). Data collection was completed between April 2015 and December 2016. RDS has proven effective in recruiting hard-to-reach populations (Abdul-Quander et al., 2006; Heckathorn, 2002, 2007; Johnston, Chen, Silva-Santisteban, & Raymond, 2013). Participants who completed the survey were paid \$25, and were also given the chance to become recruiters. After securing consent, they were provided with three referral coupons to recruit other PWID who had not previously participated in the study. Every eligible referral earned the recruiter an additional \$10.

To be eligible, participants had to be 18 years of age or older, alert at the time of the interview, and had to have injected drugs at least once within the 30 days prior to the interview. Verification of current injection use was done through visual inspection of injection track marks, as well as through a questionnaire that measured knowledge of injection practices. The questionnaire, administered by the interviewers, was based on the Centers for Disease Control and Prevention's National HIV Behavioral Surveillance study with injection drug users (Round 3). INSTI Rapid HIV antibody tests (Biolytical Laboratories) and OraQuick HCV Rapid antibody tests (OraSure Technologies) were used to assess HIV and HCV status. Every participant was compensated an additional \$5 for each rapid test performed. Participants who tested positive for HCV or HIV were offered a referral and transportation to a primary care doctor for confirmatory testing.

During the second phase (December 2015–December 2016), we conducted 34 micro-ethnographic assays, in which we randomly recruited 34 participants from the first phase to serve as key respondents, and we interviewed their full ego networks. Forty-four PWID that had not participated in Phase 1 were either acquiring or using intravenous drugs with at least one of the 34 key respondents recruited in this phase and were thus brought into the study. Demographic characteristics of participants in this phase mirror the characteristics of those already enrolled in Phase 1 and have been described extensively elsewhere (Abadie, Welch-Lazoritz, Gelpi-Acosta, Reyes, & Dombrowski, 2016). In addition to interviewing them and testing these participants again, we employed ethnographic methods to map their risk practices. We shadowed participants for up to two weeks, following them through their daily routines, from “hustling” to make income to drug acquisition and use. This methodology enabled us to document who was acquiring and using drugs and with whom, as well as their injection risk practices. While during this phase we did not directly inquire into the effects of the War on Drugs on the everyday lives of the 34 ethnography participants and their ego networks, our ethnographic approach produced significant data regarding its effects on the local drug trade, drug availability, and injectors' social networks. The data we present in this

manuscript was obtained during this second phase. In-depth interviews were transcribed and translated. All personal identifiers were removed. Qualitative software was used to manage coding. Codes were developed to convey the wide arrange of themes and variables buried in the narratives of PWID. As it is practice in qualitative analysis, these codes were iteratively revised and regrouped until they eventually represented a set of higher-level axial codes comprehensively describing participants' experiences regarding the effects of the war on drugs in their everyday life. Following Strauss' grounded theory approach (Strauss & Corbin, 1998), the interpretation of the data emerge inductively from the data, instead of imposing a pre-existing theoretical framework to fit the data.

The War on Drugs: the effects of this “cat and mouse” game on PWID and their communities

One of the most visible effects of the War on Drugs on the island is law enforcement's repression of drug users through the aggressive pursuit of drug dealers. These policing efforts are based on the belief that limiting drug supply is the best way to tackle the drug problem (Bertram, Blachman, Sharpe, & Andreas, 1996). These repressive policies have created a true “state of siege” in already poor and vulnerable communities. This is how Sandro, a participant who was a street-level drug dealer, remembers former Governor Pedro Rosselló's “*mano dura*” (strong hand) platform from 1994–2000:

Rosselló's *mano dura* on crime hit drug dealing in Puerto Rico hard. It stopped some *puntos* [drug-dealing spots] from opening, but also what it did is that it changed their location. For example, it stopped the *punto* at Berwin [a housing project in metropolitan San Juan] to the point that nothing could be sold there, but you could find drugs in the neighboring areas. But for that to happen, several months elapsed. It was not the case that Berwin stopped, and then the next week others were selling. They [police] also came here [my town], but not with the same intensity they did in the metropolitan area. He [Rosselló] used the National Guard to stop the drug trade and, of course, it worked for a while. In our town, you could see them roaming around and stopping by the *punto* and you wondered: God, what would I do now? The *punto* closes until they leave.

Massive operations aimed at entire neighborhoods continue to take place today, and with the same intensity. During the two years of fieldwork, we saw police cars parked day and night at the entrance of residential housing projects (*residenciales*) to prevent *puntos* from operating in these areas. We also witnessed weekly operations against certain drug spots, making the regular operation of this street-level drug trade difficult. In this way, the War on Drugs resembles a “cat and mouse” game, with one drug spot closing while others open to supply the market. As Sandro suggests, such efforts might effectively shut down the targeted venue, but instead of forcing rural PWID to quit their drug use altogether, these police operations only prompted PWID to find other sites to acquire drugs. Study participants complained about a reliable supply, and, to ensure they could acquire the daily dose needed to avoid withdrawal symptoms, they were forced to carpool, take the limited public transportation, or make other arrangements to access drugs in the metropolitan area. Others resorted to walking to different *puntos*.

Participants in our study provide further clues of how these police interventions are conducted. Just like in the continental U.S., the War on Drugs in Puerto Rico has militarized its police and introduced heavy weaponry and helicopters. In addition, law enforcement has made extensive use of cameras, some able to record activities from hundreds of yards away, others used by undercover agents who buy drugs directly at *puntos*. Chelo is a PWID who used to sell drugs at a *punto*. He explained, “Now they have a technology where they tape you, they have micro cameras they wear in their shirts, and anybody can incriminate you.” In addition, police recruit PWID to buy drugs from suspected *puntos* to record the transactions without calling attention to the police’s presence. And in an escalating drug war, the police have employed even more creative methods. For instance, our informants told us about an undercover policewoman pretending to be an “addicted nurse,” who was frequenting a local shooting gallery and asking unsuspecting users to buy doses for her. In doing so, she collected vital information about how the *punto* was run, and this led to many arrests. More recently, police scheduled an operation for Halloween day, allowing them to enter a *punto* while using masks and costumes. The images obtained through these means constitute part of the evidence that is used in court. Denny, one of our participants, was confronted with this type of evidence: “They told me, you were wearing this and this and once you paid for the drug, you put it in your trousers’ front pocket. I told myself: how the hell do they know that? I denied everything but then they showed me the images and I was right there!”

Despite the aggressive policing of *puntos*, injectors are usually left undisturbed when they are using drugs in open spaces like abandoned houses, bridge underpasses, or shooting galleries. According to our participants, while cops have been known to force participants to throw away their heroin (a practice they call “*la cura*,” meaning “the cure”) and injection equipment, this is very unusual. These spaces are often filthy, with used syringes and piled up garbage. Furthermore, injectors might have already used or had the drug mixed with their blood in their syringes, fear of HIV transmission would represent a powerful limit to police action. In addition, since these places are removed from the *puntos* where the drugs are acquired, this places a burden of proof on prosecutors in trying to bring criminal charges against drug dealers.

Most police raids result in the conviction of nonviolent street-level operatives. Some are PWID who entered the drug trade either as “look-outs,” alerting others to the presence of “suspicious” movements near a *punto*, such as cops or rival groups, or as “runners,” bringing purchased drugs to waiting customers. Often these raids end up also targeting the customers themselves, who are charged with “drug possession,” and in some cases, even “possession with intent to distribute” (a more serious charge that results in jail time.) Even the possession of a \$5 bag of either cocaine or heroin can lead to prosecution, especially if there has been a previous conviction or if the person is violating probation by being in possession of drugs. While we did not inquire into participants’ experiences with the criminal justice system, we can confidently say that most of the participants in our study had spent some time in jail, usually for nonviolent crimes. Paradoxically, police operations sometimes contribute to increasing the drug-related violence they aim to address. When one *punto* is shut down and their “*bichotes*” jailed, rival groups might use this moment of vulnerability to invade the area in order to remove the competition and to establish themselves. A battle will then ensue for

the control of territory to protect or expand the “market share.” Once established, the new “owner” might continue to resort to violence to further their control. As Sandro explains:

The owner of the *punto* left and it fell in the hands of other people. These new guys that came in used violence to impose themselves and earn respect. They did not hesitate in shooting you either in your leg or in the head. Yes, they were very abusive. One would shoot people for no reason whatsoever, and make comments suggesting that if you even considered selling drugs [as a competitor], no matter how little, that could get you shot. Even before you even sold a bag, just to prevent folks from doing it. And then folks saw that and thought: whoa!

We witnessed how in rural Puerto Rico aggressive policing renders nonviolent drug users and small-time drug dealers the most likely victims of the War on Drugs. In what follows, we present how the War on Drugs also translates into unbearable human suffering upon incarceration.

Cruel and inhuman punishment: quitting “cold turkey” in jail

When a PWID is incarcerated, in addition to the loss of personal freedom, they are cut off, even if temporarily, from the drugs they used outside. If they did not use drugs frequently, the heroin withdrawal effects might be mild and bearable. Once in the prison’s general population, they would either be able to acquire – albeit at a much higher price, typical of prisons – a low “maintenance” dose or quit altogether. But for those with heavier heroin habits, painful withdrawal symptoms are unavoidable. Vomiting, diarrhea, stomach and muscular pains, weakness, and ongoing nausea are some of the most frequent effects of heroin withdrawal. If a dose is not secured, these symptoms intensify over time. Since drug treatment provided in most Puerto Rican jails is very limited, users are forced to endure this period “cold turkey,” only with the help of a simple pain killer or a sleeping pill provided by the correctional officers. Of his experience, Pedro recalls:

I quit a 10-bag habit in that cold [air-conditioned unit]. I puked, shivered. I was calm, quiet, and suddenly I was jumping up and down! And then there are all the other symptoms that you get... a few days, it lasted like three days. In jail, you must quit cold turkey because they have you, 24 hours in, thrown on the floor sleeping on a thin mattress in the same cubicle where other users are also trying to quit. It’s not easy, I have seen folks, forgive me the expression, shitting on themselves. In jail, you are forced to quit. Their detox is to put you in that room and leave you there. “Are you ok?” they would ask. “Yeah ok, but I have a bit of diarrhea and can’t sleep,” I tried to explain to them. At night, sometimes the nurse makes a round and gives you a pill. You might get it for seven days. Sometimes the doctor sees you like that and says: “he’s discharged!” I have been there, I have been through it, and it is not easy. Man, it’s not easy.

As “cold turkey” was not grim enough, correctional facilities in Puerto Rico appear to purposely ignore the fact that people still inject drugs in prison. This mindset prevents the implementation of harm-reduction policies within prisons (such as clean syringes and other injection equipment for safer injecting). Inmates are forced to share contraband syringes or rely on “self-made” improvised “syringes” made by materials found or brought into jail. As

Carlos's testimony at the beginning of this manuscript illustrates, the same syringe might be shared by dozens of others. In this context, it is no surprise that a lack of clean syringes is fueling an HCV epidemic (Abadie et al., 2016; Abadie, Welch-Lazoritz, Khan, & Dombrowski, 2017; Peña-Orellana, Hernández-Viver, Caraballo-Correa, & Albizu-García, 2011).

While syringes and safe injection equipment are hard to find in prisons drugs enter easily. In these jails, one participant told us, "there is everything, like in the street." Drugs are sometimes smuggled in with the complicity of corrupt correctional officers. Pedro explained:

The very same prison guard [brings the drugs in]. [imitating a drug dealer outside prison] "Guard, I will give you \$500 for you to drop this into the cell. Just drop it, I'll take care of the rest." There are guards who do it because their pay is low, or because they have a family to take care of, or they need the money. But they do it.

A market economy with high demand and logistical supply problems brings prices up. As a result, the prices charged for drugs inside prisons are much higher than on the streets. Prison customers make payments through their relatives outside the prison, employing electronic payment methods like Western Union or MoneyGram to deposit into designated accounts. Once the deposit is confirmed, the drug is delivered. Because this process can be complicated for some drug users, especially those who lack financial support from their families, those who are heroin-dependent find themselves in a particularly challenging predicament.

“Three strikes and you’re out”: a punitive approach in opioid treatment programs

The War on Drugs creates a punitive environment that also shapes drug treatment programs. There are two main modalities of drug replacement therapy to address opioid dependence. Methadone maintenance treatment (MMT) has been around since the 1970s (Dole & Nyswander, 1965) and, more recently, Suboxone has been in use since the mid-2000s. Both substances are available in the area where we conducted our research and are covered by “La Reforma,” or the local version of Medicaid. The availability of these drugs, however, is very limited. There is only one methadone clinic in the four municipalities where we conducted our study, and it is running at full capacity with a long waiting list. Participants in our study indicate that it might take several months to receive an appointment to start treatment.

Methadone is administered daily and comes in a liquid form that participants swallow at a clinic under strict supervision. If participants show compliance, they can receive weekly or even monthly supplies, avoiding the daily visits. Suboxone treatment comes in the form of a daily tablet and, as in MMT, participants can receive up to a monthly supply – also depending on compliance – allowing them to avoid daily clinic visits. But unlike methadone, those taking Suboxone are not supervised by clinicians when taking their daily dose. Once participants receive their pills, they can decide whether to adhere to the treatment completely, or play around, taking some pills and selling others. Prices for Suboxone (better known as “Subu” on the streets) vary. In jail, where there is typically no drug treatment

available, a Subu pill can go for \$40 or \$50, or even more. On the streets, pricing depends on who is selling and who is buying. A friendly seller can may sell it for as little as \$5 while others can demand \$7 or \$8. In comparison, a small bag of heroin in the area is sold for as little as \$5.

Understaffed, underfunded, and unable to cope with the large demand for drug treatment, both methadone and Suboxone programs have established a series of procedures to control patient flow. In addition to waiting lists that delay entry into the program for months, these programs also adopt a “three strikes and you’re out” punitive strategy. To enroll, prospective participants must produce a positive heroin test, showing that they are active users. But once enrolled, they are expected to stop using illegal substances completely. A test showing “dirty urine” (urine with traces of an illicit substance other than opioids) prompts a warning, followed by a conversation with a social worker or other member of the staff about the participant’s commitment to the program. The participant is informed that after three positive drug test results, they will be “dropped” from the program. This is the case regardless of all the methadone literature that shows that secondary drug use among methadone program enrollees is common, and that such use is best addressed by enhanced support (Deck & Carlson 2005; Magura & Rosenblum, 2001; Magura, Rosenblum, Fong, Villano, & Richman, 2002; Magura et al., 2009; Magura & Haddox, 2007; Gelpí-Acosta 2014, 2015).

As Varas-Diaz, Santiago-Negron, Neilands, Cintron-Bou, and Malave-Rivera (2010) have suggested, the war on drugs have stigmatized PWID, in turn, affecting the way staff at these clinics perceive and deal with their clients. It might be that the limited resources of Puerto Rican drug treatment facilities pave the way for a false dichotomy between the “deserving” participant who follows the rules and stays “clean” and the “undeserving” participant who continues to test positive for drug use. In turn, participants adapt to the programs demands by displaying a series of routines that go from accommodation to resistance. According to Moore, similar scripts have been found among PWID in Australia (Moore 2009). Indeed, our ethnography shows how rural PWID manage this reality. Papito, a user in his early 30s, tried to do a “trick” to mask dirty urine. He had been attending the local Suboxone treatment for more than a month. Papito had two tests showing traces of heroin use; one more, and he would be suspended and unable to receive treatment. Papito told me he planned to pull off “a trick” and needed to use the bathroom at our office. He had obtained a “clean” urine sample from somebody else and had emptied a toothpaste tube that he planned to fill with the urine. He had also created a hole in his front pocket in order to sneak the tube into the clinic. He then would pretend to urinate but instead he would pour the clean urine into the container and hand it to the waiting nurse, who would be also present in the bathroom with him. (Nurses supervise the process to make sure that nobody cheats with their samples.) He emerged a few minutes later and headed to the Suboxone treatment center just a few blocks away. Four hours later, Papito was done with his appointment and came to our office again. He was ecstatic because his “trick” had worked. “The social” [social worker] did not suspect anything and he was marked down for a clean urine sample. As a result, he received 14 pills, two per day, enough for one week. He was a bit disappointed because he had hoped to get a one-month supply. He told us that he wanted to “have fun” and inject for three weeks, when he felt like it, then “discipline himself” during the last week to get a clean result and obtain

the next month's supply. Suboxone helps him afford his drug use while also keeping him a little bit in check, a win-win situation for him. The center told him that he might be able to get the monthly supply, but only after producing repeated clean urine samples. Unable to produce subsequent "clean" samples he ended up dropping from the program.

Discussion

After decades of implementing the "*mano dura*" War on Drugs in Puerto Rico, there is clear evidence that it has not succeeded in addressing the problematic use of illicit substances. Noting this failure, authors Santiago-Negron and Albizu-Garcia (2003) decry the unintended effects the misallocation of resources has had on public health policies in the Island. Drug use and drug markets continue to thrive with an estimation of 542 *puntos* island-wide. In Cidra alone, where the ethnography participant Papito resides, the underground drug market was recently valued at \$40.2 million (Torres, 2016).

Though enforcement seems to have had little effect on the availability of drugs, its impact on the health of drug users and their surrounding communities is likely to have been significant. Recent research has shown that self-organizing behaviors of PWID can create risk network structures with implications for the *non-spreading* of HIV and other injection related diseases (Dombrowski et al., 2016; Khan, Dombrowski, Saad, McLean, & Friedman, 2013). In these cases, stable "network firewalls" (Friedman et al., 2000) help prevent new, highly contagious infection outbreaks from reaching uninfected sections of the network, lowering the overall risk of infection despite non-zero HIV incidence and the ongoing practice of risk behaviors. The haphazard removal of people from the injection network results in large changes to the overall structure, putting at risk the "firewall effect" seen in more stable networks, and generally raising the risk of HIV infection across the community. In this case, while enforcement does little to change the availability of drugs, it can severely impact the way drugs are used and with this, the overall health risks associate with drug use (Dombrowski, Curtis, Friedman, & Khan, 2013; Duncan et al., forthcoming).

It is clear from this information that the emphasis on cutting the drug supply, instead of on addressing the treatment demand by treating drug misuse as a public health problem, has left drug treatment programs severely neglected. When combined with the extent of poverty present in Puerto Rico, this creates a serious problem. Per capita income is estimated at \$11,394, which is half of that in the poorest U.S. states like Mississippi or West Virginia (US Census Bureau, 2015). To complicate matters, the island had embraced extreme neoliberal policies that led to the privatization of its healthcare system, and it is now struggling with the effects of a protracted economic crisis that started in the mid-2000s (Lopez-Garriga, 2016). With declining revenue and increasing healthcare expenses, the government chose to cut from the already meager treatment programs. But while treatment options for drug misuse have dwindled, placing a strain on PWID and their families and communities, the demand for treatment, according to our observations, has not diminished.

To solve this problem, municipalities have resorted to a set of unusual measures. Treatment in Puerto Rico is heavily dependent on faith-based programs, such as *CREA*, although this organization does not provide any medication to help patients cope with the effects of heroin

withdrawal and has a very poor record of patients avoiding drug relapse (Upegui & Torruela, 2015). Another alternative has been to send PWID to the U.S. for treatment. Since Puerto Ricans are U.S. citizens, the idea is to help them access (abroad) the treatment they cannot receive at home (Deren, Shedlin, Decena, & Mino, 2005; Deren, Kang, Colón, & Robles, 2007a; Deren, Kang, Colón, & Robles, 2007b; Deren, Gelpí-Acosta, Albizu, González, & Des Jarlais, 2014a; Deren, Gelpí-Acosta, Albizu, González, & Des Jarlais, 2014b; Gelpí-Acosta, Hagan, Jenness, Wendel, & Neaigus, 2011, Gelpí-Acosta, Pouget, Reilly, Hagan, Neaigus, Wendel, Marshall, 2016). This, in turn, creates yet another strain for Puerto Rican PWID since this kind of migration is arguably structurally imposed and therefore not entirely voluntary. Furthermore, some of these programs have been criticized as a “modern form of human slavery,” for preying on vulnerable impoverished patients and their families while providing little or no therapeutic benefit (Lubrano, 2016).

Unfortunately, despite mounting evidence of its failure on the island, the War on Drugs does not show any sign of slowing down. On the contrary, the newly elected governor, Ricardo Rosello – son of the former governor Pedro Rosello – seems eager to produce his own version of the *mano dura*. He was elected on a “tough-on-crime” discourse and has introduced legislative changes to make it more difficult for convicted drug users to enter treatment in exchange for serving their sentences (Lopez-Caban, 2017).

It seems that the permanence of the War on Drugs, both in the continental U.S. and in Puerto Rico, can be explained less by its success in tackling the problem of drug addiction than by the material resources it can mobilize from the militarization of the police, the growing industrial prison complex, and the political support of a fearful electorate (Bourgeois & Schonberg, 2009; Benson, Rasmussen, & Sollars, 1995; Whitford & Yates, 2009; Johns, 1992). Research findings illustrate the unevenness of the war on drugs in the US. We suggest that a critique of the war on drugs should pay close attention not only to historical factors but also to the local contexts in which these policies are displayed. For example, findings on the effects on the war on drugs in rural Puerto Rico in particular, contrast with the introduction of a prevention based policy approach in rural US where the transition from prescription opioids to injection heroin has reached epidemic levels mainly among poor, white men. While generalizations are possible, they should be made with caution, making sure not to overlook how particular social contexts might have shaped the way the war on drugs is conceived and implemented.

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