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"SOMEBODY IS GONNA BE HURT": INVOLUNTARY DRUG TREATMENT IN MEXICO

Claudia Rafful[a], **Maria Elena Medina-Mora**[b], **Patricia Gonzalez-Zuniga**[c], **Janis H. Jenkins**[d], **M. Gudelia Rangel**[e], **Steffanie A. Strathdee**[c], **Peter J. Davidson**[c]

[a]Faculty of Psychology, Universidad Nacional Autonoma de Mexico, Mexico City, Mexico

[b]Instituto Nacional de Psiquiatria Ramon de la Fuente Muniz, Mexico City, Mexico

[c]Division of Infectious Diseases and Global Public Health, Department of Medicine, University of California, San Diego, California, USA

[d]Department of Anthropology, Department of Psychiatry, University of California, San Diego, California, USA

[e]US-Mexico Border Health Commission, El Colegio de la Frontera Norte, Tijuana, Baja California, Mexico

Abstract

Involuntary drug treatment (IDT) is ineffective in decreasing drug use, yet it is a common practice. In Mexico, there are not enough professional residential drug treatment programs, and both voluntary and involuntary drug treatment is often provided by non-evidence based, non-professional programs. We studied the experiences of people who inject drugs (PWID) in Tijuana who were taken involuntarily to drug centers under the auspices of a federally-funded police operation. We provide insight into how the health, wellbeing, human rights, dignity, and security of PWID ought to be at the center of international drug policies included in universal health care systems.

Abstract

El tratamiento de drogas involuntario es una práctica común a pesar de no ser efectivo. En México no hay suficientes programas residenciales profesionales para el tratamiento por consumo de drogas y, ya sea tanto voluntario como involuntario, lo proveen centros no-profesionales que no están basados en la evidencia. Analizamos las experiencias de las personas que se inyectan drogas (PID) que fueron llevadas involuntariamente a centros de tratamiento bajo un operativo policiaco

Address correspondence to Claudia Rafful, Faculty of Psychology, UNAM, Mexico, Av. Universidad 3004, Coyoacán, Copilco Universidad, 04510. Mexico City, Mexico. craffull@ucsd.edu.
CLAUDIA RAFFUL is an Assistant Professor at Universidad Nacional Autónoma de Mexico, Mexico.
MARÍA ELENA MEDINA-MORA Researcher at Instituto Nacional de Psiquiatría Ramón de la Fuente, Mexico City, Mexico.
PATRICIA GONZÁLEZ-ZÚÑIGA is director of the parent study.
JANIS H. JENKINS is Professor at the Departments of Anthropology and Psychiatry at UCSD. GUDELIA RANGEL is the Executive Secretary of the US-Mexico Border Health Commission. STEFFANIE A. STRATHDEE is Associate Dean of Global Health Sciences at UCSD, and Principal Investigator of El Cuete IV.
PETER J. DAVIDSON is Associate Professor at UCSD.

Media teaser: Involuntary drug treatment financed by governments is a human rights abuse that has negative health consequences for people who inject drugs.

en Tijuana. La salud, el bienestar, los derechos humanos, la dignidad y la seguridad de las PID deben ser elementos centrales de las políticas de drogas internacionales y de los sistemas universales de salud.

Keywords

Mexico; disciplinary power; human rights; involuntary drug treatment; people who inject drugs

In Mexico, most of the people who use drugs (PWUD) and receive residential care, either on a voluntary or involuntary basis, are treated at centers that are not operated by the government (CONADIC 2014) due to lack of infrastructure and human resources (Marin et al. 2013). According to Mexico's national census on specialized treatment centers, in 2013, there were 2,043 residential drug centers,[1] of which 98% were privately run (CONADIC 2014; Zamudio et al. 2015). Of these programs, 87% are referred to as "mutual aid" and the adoption of the 12-step model of Alcoholics Anonymous (AA) (CONADIC 2014). Drug centers run by non-state actors generally operate outside of public oversight (Center for Human Rights & Humanitarian Law 2013); in 2017 there were only 224 certified centers by CONADIC (2017a). Some of the uncertified centers have been previously described as "hybrid institutions composed of a 12-step approach, mental asylum, prison and church" (García 2015: 1). These centers run at minimal or no cost to families in places where local governments do not provide enough treatment options (Center for Human Rights & Humanitarian Law 2013; Rosovsky 2009). Since 2009, the Mexican Government made an effort to regulate treatment centers by modifying the Legal Norm on Prevention, Treatment, and Control of Addictions (known as NOM-028) (Secretariat of Health 2009b). This legal norm stipulated basic characteristics for the certification of treatment centers recognizing three types of rehabilitation centers: professional (medically based), mixed-model (professional treatment with 12-steps model) and mutual aid (12-step based). While voluntary treatment can be sought in any of the treatment modes, IDT may only be provided at professional or mixed-model facilities where a physician is required to oversee the treatment plan. IDT can be requested by a family member or can be legally mandated. In both cases, a district attorney has to be notified within 24 hours after admission (Secretariat of Health 2009b). This law also stipulated that rehabilitation centers must be certified by the National Commission Against Addictions (CONADIC), which requires provision of adequate living conditions, food, treatment plans, adequate human resources, and infrastructure.

Tijuana, Baja California, Mexico is the fifth largest city in Mexico and the largest city in the US-Mexico border region (INEGI 2010). Tijuana experiences demographic pressure as a consequence of the migration to and from the US and Central America and internal migration from other parts of Mexico. Tijuana's casinos, bars, and commercial sex work have long attracted persons from the US (Bucardo et al. 2004; Zenteno 1995). Because of its geopolitical and social context, Tijuana is currently a city with one of the highest rates of

[1]We chose to call them drug centers rather than drug treatment centers because they do not provide evidence-based treatment.

drug use in Mexico and arguably, the city with the highest prevalence of injection drug use (IDU) nationwide.

In an effort to "clean up" Tijuana's image and increase security, between December 2014 and March 2015, a federally-funded policing program, Tijuana Mejora, was implemented in the canal of the Tijuana River, a zone widely known as a hot spot in which, at any one time point, there were up to 1000 people lived, most of whom were active people who inject drugs (PWID) (Velasco and Albicker 2013). This program was unprecedented in terms of coordination between federal and local law enforcement agencies. The explicit goals of Tijuana Mejora were to: "revitalize" the canal and relocate homeless people to their states of origin or admission into rehabilitation centers. Tijuana Mejora resulted in the displacement of approximately 800–1000 people who were involuntarily sent to treatment centers (Durán and Caballero 2015). Our aim was to examine the dynamics of IDT, including entering into the treatment centers, the daily-life conditions there, discharge from the center, and relapse in IDU from the perspectives of PWID in the context of the above described federally-funded initiative.

Theoretical Framework

We applied Foucault's concept of disciplinary power as our analytic lens. Disciplinary power is defined as "a mechanism of power that extracts time and labor from bodies, and it is exercised through constant surveillance" (Foucault 2003). The regulation of conduct is achieved through the ordinary relationships of force and discipline (Duff 2007). Disciplinary power operates through the normalization of deviant behavior in which providers see the deviant people as objects of intervention (Passos and Souza 2011). Such intervention occurs within prisons, asylums and drug centers. Disciplinary power is situated in the everyday practice of care, in the contact between carer and cared-for through discourses of professionalism and theory (Fox 1995). Other studies in Latin America have used disciplinary power to study the interaction between the state and people who use drugs. Such is the case of crack use in Brazil, where despite the situation of social exclusion of users, the legislation places greater focus on repression among crack users (Acioli Neto and Sousa 2015). Additionally, we also address the context of structural violence and human rights violations inflicted towards the PWID in this border city. The study of structural violence describes the social structures related to poverty and social inequality. It is the violence exerted systematically and embodied as death, injury, illness, subjugation, stigmatization, and even psychological terror (Farmer 2004).

METHODS

Participants were purposively selected from a prospective cohort study of PWID. Researchers from the parent study have collected bi-annual data from 735 PWID since 2011 until 2020 in relation to HIV risk behaviors, drug use and the environmental context (Robertson et al. 2014).

For this article, we interviewed participants who reported to the study staff that they had been taken involuntarily to drug treatment during the period when the police Operativo

Tijuana Mejora took place (i.e., from December 2014 to March 2015). Between December 2015 and April 2016, participants who agreed to share their experiences on IDT gave oral consent and were informed on the confidentiality and anonymity of the interview. Interviews were recorded and transcribed verbatim for analysis; all files were kept in an encrypted computer and de-identified from the rest of the parent study data. At the end of the interview, participants received $20 USD as compensation.

Based on international reports, the authors' ethnographic fieldwork (visiting main neighborhoods in which PWID lived, visiting parks, cemeteries, vecindades, and the canal for over 2 years) and findings from other previous research by our research team (Syvertsen et al. 2017), we developed an interview guide specific to dynamics related to entering into IDT, daily life conditions while detained in these drug rehabilitation centers, and the conditions of discharge and potential relapse to drug use. We used an inductive approach to thematic analysis (Patton 1990), since data were collected specifically for the research and themes identified were strongly linked to the data (Braun and Clarke 2006). The first author conducted and transcribed all interviews, which were then printed and read. After reading all the interviews she performed an initial coding, independently analyzed each interview and evaluated the dynamics of power. She then performed a second coding to identify codes across PWID responses and categorized according to commonalities in the themes. The analysis was performed in the language in which the interview had been conducted (either English or Spanish at the participant's preference). In addition, given the nature of the parent study, the first and third author were able to follow the trajectories of most of the participants. The third author had daily contact with the participants as a physician and the field director of the parent study. The first author conducted fieldwork approximately once a week for over two years before and after the interview period. The third author also leads a voluntary wound clinic where the first author volunteered for over a year. The first author collected ethnographic field notes and memos that enriched the analysis by informing about aspects of the participants' lives subsequent to the interview. The coauthors substantially contributed to the conception, analysis and data interpretation, critically reviewed the intellectual content, approved the final version, and agreed on all aspects of the work.

RESULTS

The first author interviewed people who reported to the field staff that they had been taken involuntarily to drug treatment by the police during Tijuana Mejora. During the Operativo and by the time of the interview, 25 interviews (15 women and 10 men) were performed, until saturation was reached. Among these, 20 participants were involuntarily taken once, four participants twice, and one participant three times. The median age was 41 years (36.7–46.5), the years since first injection were 18.5 (13.7–25.5), and about 31% (n=11) of the participants had been in a drug center at least once before the Operativo.

Five major themes, based on the interviews and fieldwork, were identified related to the power dynamics and human rights violations PWID suffered during these events and up to the time of the interview. All the coauthors have performed fieldwork (interviews to PWID and visits to shooting galleries, unstable housing arrangements, health centers in which PWID have been hospitalized, among others) in Tijuana related to substance use. For this

specific article, we focused on the experience of fieldwork and ethnographic analysis of participants of El Cuete project. These themes were: (1) uncertainty and fear about the degree of extrajudicial violence the police would resort to as the Operativo intensified, (2) discretionary selection of people taken to treatment, (3) discrimination and violence at drug centers, (4) lack of state oversight at the treatment centers, and (5) treatment ineffectiveness.

UNCERTAINTY AND FEAR ABOUT THE VIOLENCE IN THE OPERATIVO

The experience that PWID reported exposes the violent policing tactics that were used to regain control over the people living in the canal, including intimidation and threats, which have also been previously reported (Miller et al. 2008). Consequently, uncertainty was the predominant feeling they experienced from the moment the policing process began until they were taken into the drug centers. Because of this uncertainty and the violent context, there were accounts of people hurting themselves so they were not taken by the police. Reportedly, people bleeding or visibly hurt were left behind without provision of health services.

When the police presence intensified, 4 different assumptions emerged: (1) they were being taken to drug centers based on warnings given by insiders (some participants had contact with public officials that warned them about the eviction and drug centers), (2) they were being taken to a shelter to protect them from weather conditions, (3) they were going to "disappear", or (4) they were being taken to the police station and detained for a couple of days.

Belief that they were being taken to Drug Treatment Centers

Some participants had received warning about the Operativo. Two of them had contacts (based on sex trade and corruption) at the police station and were told to watch out for the Operativo because people were going to be evicted from the canal and taken into drug centers. Other participants were warned by the municipal social services staff for whom they were part of the usual clientele who received the sporadically available HIV prevention kits (i.e., condoms and occasionally syringes) in exchange for information on the drug user population. These interactions were frequently observed and registered during the fieldwork immediately prior and during the Operativo.

Belief that they were being taken to Shelters

The Operativo took place during the peak of the rainy season, and people living in the canal were preparing their tents so they could be able to stay warm. Based on prior experiences, when police came into the canal, participants thought that they would be taken into shelters to prevent accidents and deaths. Overall, participants reported there were so many police officers that no one could have escaped. The force of the state was made visible in terms of number of police officers present.

Belief that they were being 'disappeared'

People who were taken after the first weekend the Operativo began, especially those who were taken at night, thought that the police officers were going to make them "disappear".

People disappearing in the context in which PWID live translates into never going back to the place they were taken from and, possibly, being killed or permanently incarcerated. PWID in Tijuana, although they are visible –and perceived as a nuisance- for the rest of the community, do not officially exist. They are not counted by the census and consequently, invisible and even 'expendable population' (Scheper-Hughes 1992), giving them a sense of invisibility in which violence and disappearances can occur without having a backlash from the general society. Although there are historical accounts of disappearance in Latin America (e.g., dissidents and undocumented migrants), they tend to be politicized. They are part of the marginal mass that is a permanent structural feature of contemporary societies (Kilanski and Auyero 2015), and that suffers of social abandonment (Biehl 2001).

Belief that they were being arrested

Most of the people living in the canal had been frequently arrested and detained for up to 48 hours by the police. As such, some participants thought they were going to spend a couple of days at the police station as they usually did. Compared to previous experiences, this time almost no one was taken to the police station where usually a judge determines how long people will stay at the police station.

The regular protocol that PWID reported living prior to the Operativo was to be stopped and arrested, taken to the judge, and be sent to a cell for up to 72 hours. In this case, some participants reported to have been taken directly from the canal to the treatment centers by the centers' vans and public transportation; others that were taken from areas other than the canal were taken to the canal on police cars and then also put into the drug centers' vans and buses.

> I was aware there was something going on and that they [police] could take us to a center, but [only] when we are in a very poor condition because of the drug use, right? … It is not legal… Police do whatever they want, they've always done it. One [does not complain] because [we are] addicts and because we don't say anything, one doesn't know where to go to defend oneself. That is why police are picking on one. (Man, 52).

The experience of violence was enhanced by the time spent between detentions and getting to the centers. Since officers were waiting for backup and the centers' vans to arrive, people were detained for several hours. A man asked for some evidence of the Operativo's legality:

> You say the government is sending us [to treatment], well, where is the document that says so? 'We will take you to a center and so and so, so you quit drugs.' The way they [police] take people, how they beat us up… based on what do you [police] get here taking people and all that? What gives you the right? Who says so? Which document? (Man, 44).

Some of the policing actions described by respondents appeared to be about coercing an excluded population and normalizing their actions (an example of Rose's (Rose 2000) definition of the exercise of 'disciplinary power' as acting by the law but through the normalization and coercion of excluded population. However, what is particularly notable in

this case are the attempts to 'de-normalize' police actions by pointing out how they were in conflict with the law and with their human rights:

> I am an adult, this is kidnapping… you cannot take me. –It is not whether you want to go or not, here it is that you are going now [to a drug center] (Woman, 29).

Several participants, but especially women reported to have been yelled insults at them ("you are the trash of society!") and to have been told they had no rights ("you live on the streets, you have no rights!"). Physical violence included being beaten up mostly at the time of detention and when forced to get into the centers' vehicles.

After people started escaping from some of the drug centers, other PWID dispersed into more isolated areas in Tijuana. Some of them were able to avoid the Operativo, but others were arrested.

DISCRETIONARY SELECTION OF PEOPLE TAKEN TO DRUG CENTERS

Although most participants reported being detained straight from the canal, others reported to have been walking by the Red Light District or even standing outside of their rooms in the surrounding neighborhoods. Those who were not detained at the canal, reported that they had been living in rented rooms at tenement houses or at hotels. That is, some people were taken based on their appearance. The discretionary characteristic of the process is also combined with internalized stigma, as expressed by this woman:

> Police only take tecatos [heroin users] and not alcoholics or cristalones [meth users] because tecatos give a bad appearance to the city… And it is also our fault, right? Because we're also to blame. Sometimes we fix on the street, you know? In the sidewalk, we sit down and get a fix, or we sleep on the streets, or there are others that are dirty, filthy, that shat and wet themselves. And well, the community doesn't like that, they want something different, that is why they're doing it [taking PWID to drug centers], they want to clean up… it is called Proyecto Limpiar Tijuana [Cleaning Tijuana Project][2], and that is what they're doing (Woman, 41).

Discretionary selection of people taken was also evident in that regardless of where the detention occurred, several participants reported not being in possession of drugs or drug paraphernalia. This process exposes the discriminatory basis in which people were taken from the streets as a way to control their presence and behavior. Reportedly, non-users that looked like PWUD may have also been detained and taken as part of the Operativo.

DISCRIMINATION AND VIOLENCE AT DRUG CENTERS

Bureaucratization of drug treatment services translates into stigmatization of PWUD that seek care (Mora et al. 2016). When this care is not voluntarily sought, expressions of violence at drug centers emerge. This violence originates fear among users, which stop them from speaking up (Lozano et al. 2016). Experiences at unregulated drug centers have been widely reported by PWUD as violent and stigmatizing (Mora et al. 2016). We found

[2]The real name is Tijuana Mejora/ Improving Tijuana. This is the name that the community, including the police uses.

presence of verbal and physical abuses that others had previously described (Lozano et al. 2016; Mora et al. 2016). However, we will not elaborate on them because they are not in the scope of this analysis. Instead, we focus this section on the specific discrimination and abuses suffered as direct consequence of having been admitted as Government Request (Petición Gobierno). Government Request was the mode in which users were admitted in lieu of Relative Request (Petición Familiar) or Voluntary Admission (who were the least).

Repeatedly present in all interviews were narratives describing constant and pronounced discrimination based on their Government Request status. Although the drug centers are not part of the state, since they received public funding, they became agents of the State. In this sense, drug centers were the main 'apparatus of punishment' (Foucault 2003) through which power was executed and discrimination perpetrated. This discrimination translated into violence including, but not restricted to, verbal abuses ("you deserve nothing"), not getting medication that was available for other people at the center, access to food ("why do you complain if outside you have nothing to eat"), clothes or services ("no phone calls for Government Requests"), and having to do all the cleaning at the centers (having to hand wash all the blankets) among others. The next paragraphs will describe and analyze the most distinguishing violations of human rights: (1) coerced consented admission, (2) overcrowded conditions, and (3) absence of medical services.

Coerced consented admission at drug centers

Some, but not all participants were asked to sign a consent for admission. Of those, none of them read the document they were signing either because they were still intoxicated or because they did not pay attention. Most of those who voluntarily signed assumed they were agreeing to stay for 3 months, but were eventually told that they had signed for 6 months. Even more concerning are the cases of those who were forced to sign the consent under the threat of being indefinitely detained if they did not sign. Others were told that "their time would not start to count until they sign", and others were told that managers could sign on their behalf ("either you sign or I sign for you"). Confinement then, did not intend to reform but to control (Rose 2000). A woman referred to this experience as the worst out of the 5 times she had been at a drug center. However, since she was forced to sign, she could not denounce the abuses she suffered because she had no proof of the involuntary nature of the detainment.

Overcrowded conditions

All centers had a room called the "detox room", which is a cell where the recently admitted are locked until the most severe withdrawal symptoms have passed. The average length of stay is 4 days, but some participants reported having stayed there for over a month because the center was overcrowded. Some centers were so overcrowded that people spent the first night standing up –not having space to sit down-. After the first night, some were taken to another center, also overcrowded, where they had to share beds. To be in an overcrowded room with everyone having withdrawal symptoms at the same time is probably the least likely condition in which PWID will come to consider a drug-free life. Respondents reported that being faced to their own and others' withdrawal symptoms psychologically heightened their intense need of the drugs (Garcia 2010).

Absence of medical services

What occurred at the drug centers was not only a continuation of the structural violence lived on the streets. Violence was increased as a consequence of the detainment and restriction from the few resources people had access to while living on the streets (e.g., public hospital). Denied access to health services translated into suffering and pain that has been considered by some as torture (Nowak 2006).

The main complaint of most of the participants was that at the drug centers, they did not receive any medication to ameliorate the withdrawal symptoms. About a quarter of the participants reported that they received medication for withdrawal, but in all cases it consisted of sedatives, which is not the standard of care. There were also cases in which participants were concerned about other health issues such as urinary tract infection and epilepsy. The two women with epilepsy had seizures and were not seen by a health professional because the staff considered they were faking them to avoid helping in the cleaning activities or to be discharged. One of them expressed her concerns about the mistreatment: “If we are here for Government Request then we should have got the basics, right? But no, in that sense we really struggled” (Woman, 46).

The most striking case of violence and discrimination was exposed by a recently amputated man that lost his leg as a consequence of a bad injection (i.e., unsuccessful venipuncture). While at the drug center, he was mistreated and discriminated for being homeless and the managers did not have special considerations towards him due to the amputation. As a result, he suffered several falls that damaged the recently amputated leg. He was not taken to the hospital because the center would not spend money on gasoline and he was not allowed to call and ask his family to take him to the hospital either. He finally threatened servidores[3] with a razor blade, escaped and went to the hospital by himself: “I am not asking to be treated like a king, only to get the medication I needed… There is a lot of injustice. Think of all the centers there are, how many people there are… that are mistreated” (Man, 50).

Consistent with the characterization of the use of torture by local authorities to inflict disciplinary power (May and McWhorter 2016), missed medical interventions were not only negligence but a form of torture that sought the complete docility of the individuals. While infections certainly need to be taken care of, mental health is an even more neglected issue among homeless people. Two women reported signs of need of mental health services, including a participant that was discharged because she had psychotic symptoms and another woman who had a suicide attempt when she was taken to the drug center. Both participants, instead of being referred to care were punished –sent back to the detox room- for their symptoms and behavior.

Only one participant reported being seen by a doctor at the time of admission, as the law stipulates (Secretariat of Health 2009b). Others were seen at some point by a health provider but mostly to get a general check-up that included height, weight and blood pressure. Some participants hypothesized that this was done only to be able to provide information to the government of the people that were taken from the canal but not to provide further treatment.

[3]People who used drugs that enter the drug centers as interns but that are now recovered and volunteer their service to the center.

LACK OF STATE OVERSIGHT

Lack of supervision within the drug centers translated into an even more pronounced violence towards PWID. Government officials visited a few centers to make inspections or basic health fairs. Before these visits, servidores threatened to punish those who complain to the authorities. Also before the inspections, people that were locked in the detox rooms were temporarily allowed to be in the common areas as a way to disguise the overcrowding conditions.

A participant reported a prior experience at the same center she was taken during the Operativo. Interestingly, she also justified mistreatment and abuses as a consequence of misbehavior.

> I: So, you said you had just been at a center?
>
> P: Yes, at the same center. I had been out [of the center] less than 2 weeks. They [the servidores] did not behave well, they did a lot of things to me…
>
> I: But wait, the first time you were at that center, did you go voluntarily?
>
> P: Yes, I wanted to be there. It was very different. Very different.
>
> I: How was it different?
>
> P: Very different. No, very different. Look, [there was a] a lot of discrimination, every little thing that happened “oh, [it was] the ones from El Bordo”, something else happened and “oh, [it was] the ones from El Bordo”.
>
> …
>
> I: Were you hogtied?
>
> P: No, no I wasn’t hogtied. Because I behaved. But they [the servidoras] did hogtie.
>
> I: Did you see people hogtied?
>
> P: Yes, a girl that is called [name], she was hogtied. Because she hit them.” (Woman, 48).

Another participant was also ambivalent about how the Operativo worked. On one hand he considered it was an overall positive thing to have people evicted from the canal- including himself- because homelessness and drug use was becoming too visible. However, he criticized the lack of supervision from the government on the drug centers and from the owners of the drug centers on the servidores. This provides insight on the expectations of the government as protector of their rights, similarly to what Foucault described in the natural process of seeking a sovereign right power that controls the situation (Foucault 2003). In this case, people were expecting a more paternalistic government. A participant even referred to ‘big daddy State’ (papá gobierno) when the government officials provided sacks of rice and beans: “Finally! Big daddy government sent the remittances”.

“TREATMENT” INEFFECTIVENESS

Drug centers are institutions of power that play a key role in shaping the lives of ‘addicts’ (Garcia 2010). What was considered as treatment at the drug centers were ongoing 12 step meetings, abstinence-only withdrawal process. That is, there were no evidence-based approaches to substance use disorders. Among study participants there was no opioid substitution therapy and no psychosocial therapy, both of which have shown to be more effective for heroin use, whereas abstinence-only models have not. Additionally, there were no referrals with social services that could link PWID to services after discharge to cover their basic needs. This lead to an almost expected relapse, which was expressed by a woman who was concerned with the unintended consequences of IDT provided by non-professionals:

> Look, so I don’t know what the government is trying to do, I don’t know, they’re never gonna stop people doing drugs, you know, forcing people won’t work. It’s gonna make it worse. It’s ridiculous! Because they’re kidnapping us! You know. And somebody is gonna get hurt… A lot of people are not trained, and they don’t even know what to do with us, but there they are! (Woman, 42).

There was only one report of a center that offered training workshops (e.g., beautician training and cooking). However, even in this environment, Government Requested people were not allowed to attend the courses because they could not afford the cost of the materials. There were no opportunities to learn new skills with which they would increase the likelihood of finding a job and change their living conditions.

Since prisons are the main disciplinary institution, participants referred to their time at drug centers as if they were imprisoned in phrases such as “I was given 3 months”, “I served my time”, and “I did my time”. The standard time that most should have stayed were 3 months, but most of the participants escaped. There are reports from two participants that stayed for up to 6 months and then escaped. The ones that did not escape were persuaded to stay longer, to “do their time” with the assurance that they would be linked to a job. The few that agreed to stay did not get the promised job and eventually escaped. In the literature, there have been previous accounts of the use of “doing time” in relation to substance use treatment (Jenkins 2015). This indicates that the lived experience may be generalizable to other settings of IDT.

Servidores turned a blind eye when most of the people escaped. Consequently, a participant referred to it as a “fake escape” (fuga disfrazada). There were a few ways a fake escape could be arranged. First, it could be arranged with a servidor to be allowed to leave quietly in the middle of the night. Second, if a person was causing too much trouble at the center, either by asking for their rights to be respected or organizing a riot in which all could escape, the manager would open the door to that person and hence prevent a bigger problem. The third and most common way to escape was to send people to provide a service to the municipality or beg for money on the streets and then not ask them to go back to the center. As disciplinary institutions, drug centers sought to take advantage of the free labor of people detained; they are businesses that outsource cheap labor to the municipal government and

private businesses. As such, a fake escape is allowed once the “interns” performed the free labor for which the center will be reimbursed by the municipality.

Some of the participants felt that IDT was acceptable as when someone’s behavior “upsets” the government. Reportedly, what upsets the government is that chronic heroin users eventually turn into crime to sustain their use (“several people cross the line… they go… not only do they use drugs but then they… you know… they do a mess in the city and that is what upsets the government”). This has been previously analyzed by Bourgois and colleagues (1997) referring to how petty crime legitimates repressive responses towards PWUD.

Almost all the participants considered their experience to be ineffective in terms of drug use decrease. Some thought it was ineffective because it was involuntary (and referred to it as a fraud) or because although they were aware of their treatment need, they would have rather chosen the time and type of treatment. But also, others thought it was ineffective because of the characteristics of the centers, including the mistreatment inflicted by servidores, most of which had gone through withdrawal themselves and yet, underscoring lack off training. Others elaborated on the problems they faced when they went back to the streets: “One starts to think ‘well, I believe this is right [to stop injecting drugs]’, but when you go out [of the center], I mean, you say… once you’re out everything changes” (Man, 36).

In this case, a man considered permanently stopping using drugs but he relapsed as soon as he went back to the same drug using context in which he had lived. A woman expressed a similar experience by saying that her “greatest mistake is to always go back to the Red Light District” because whenever she is there she will use drugs. She also reflected on the importance of having a job and keeping herself busy. This relates to the individualistic model of substance use both as a moral failure and as independent of the contextual factors in which the 12 step model is based (Rosovsky 2009), in which although she is aware the environment influences her use, she does not consider her drug use to be structurally conditioned and that, combined with the chronic nature of addiction and not her moral failure that she has to go back to the same place where she used to live -and use drugs.

DISCUSSION

Disciplinary power was the prevalent mechanism of power at drug centers where PWID were detained through the federally funded security Operativo Tijuana Mejora. Participants in this study were all members of Tijuana’s most marginalized populations. Aware of their exclusion of the mainstream dynamics of power, the most prevalent complaint was that there was not an adequate supervision of the drug centers by the state. At a broader level, this may translate in the willingness of PWID to become citizens of the state, which implies both being controlled and protected by the state. Other authors have shown that homeless PWUD refuse to accept the state’s legitimacy to enforce any kind of measure towards them (Gowan 2010). In contrast, PWID in Tijuana would have complied if the drug centers had the adequate tools of discipline (e.g., medical services). This characteristic is similar to the ‘social abandonment’ exposed by Biehl (Biehl 2001). As the people living in Vita, the self-

regulated asylum in Porto Alegre, the PWID in Tijuana waited for the State to recognize and assume the responsibility to oversee the treatment centers.

In Mexico, as in most countries, there is a general tolerance of violent police actions in urban areas related to drug trafficking. Substance use is the dimension of urban poverty most susceptible to short-term policy intervention (Bourgois 1996). Although policing programs such as the one described in this article may superficially and temporally address homelessness in the Tijuana river canal, it certainly did address the problems evicted people faced, including substance use. In this article we exposed the ill effects this Operativo had on PWID in Tijuana.

Drug treatment, as a form of medical care, must comply with established standards of quality health care (International Harm Reduction Development Program (IHRD) 2009; Schleifer 2012). As such, access to medically appropriate drug treatment should be tailored to the person's individual needs, including the right to refuse treatment (Schleifer 2012). However, if the existing laws allow IDT, it is the responsibility of the state to provide evidence-based interventions (i.e., programs that have proved to be successful among a similar population several times). To date, access to public out-patient treatment is provided nationwide through 341 public centers (CONADIC 2017b). These type of treatment is needed but inadequate to cover the needs of the most problematic users with chronic addiction, especially for those, as our participants, that may lack official documents (e.g., birth certificate or other type of identification) and cannot enroll in public health care services. As such, most of this population is treated at centers not run by the government, due to lack of infrastructure and human resources to cover all the treatment need (Marin et al. 2013). Consequently, drug centers are covering the treatment gaps that the state cannot provide, not even for those mandated to treatment by the federal policies (Secretariat of Health 2009a; Secretariat of Health 2009b). According to NOM-028, drug centers need to be certified in order to receive public funds. As such, the Operativo has two interpretations: first, that drug centers that participated in the Operativo were certified and still committed human rights violations; and second, they were not certified but they still received public funding.

Non-evidence based interventions such as the ones provided by drug centers, often aim to get PWUD to a drug-free abstinent life. Treatment need results in a complex challenge; although non-scientific services are criticized by academia, human rights activists and, more unfrequently, by PWUD themselves, these unregulated services are the ones that most of the population have learned to recognize as treatment. To coerce people into abstinence disregards the chronic nature of substance use disorders as well as the scientific evidence of the ineffectiveness of punitive measures (Fairbairn et al. 2015).

PWID in Tijuana who used to live in the Tijuana river canal are in the most part chronic heroin and methamphetamine users, for which treatment programs should be tailored. This Operativo was in fact tailored to this specific population but not in the sense of targeting their problems, but as the problem per se. Those who had worked in social services for the community for a long time and have seen this population were well aware of how IDU is only one of the problems embedded in a context in which chronic poverty, marginalization,

lack of education and job opportunities are barriers for recovery. It was only expected that chronically homeless PWID would have more than one health condition other than substance use disorders, it should have been expected to have to provide care for infections, chronic diseases, and disabilities. As such, IDT not only did not translate into less drug use, but it inflicted violence and its deleterious consequences were still suffered even a year after the event.

While all the participants held themselves accountable of their relapse in drug injection, there was a lack of a deeper analysis in that accountability. Some of them assume their responsibility of injecting drugs and understand that they relapsed because they went back to places where drugs are easily obtained. Others assumed their responsibility of getting back together with that partner or friends that also inject drugs. While this is true, there is still uncertainty around determining whether they had any other option based on their context and living conditions. Through a social justice approach we see their patterns of drug use are in part consequence of the actions of the powerful (Farmer 2003). For instance, the Operativo that took them to the drug centers did not contemplate their future but only their displacement from their unstable housing. It is then not surprising that all but one participant engaged in drug injection after the IDT experience.

CONCLUSIONS

Our sample of PWID in Tijuana is characterized by chronic heroin and methamphetamine use in the context of poverty in one of the most unequal international borders. As such, our findings of the experience at drug centers and IDT may not be generalizable for all PWID in Mexico or internationally. Self-report may also be a limitation; however, we prioritized to give a voice to PWID in the quest of promoting social justice research in the public health realm. Finally, desirability bias may be present in the narration of their experience. However, the reports of this sample on physical and verbal abuse are comparable to what others had previously reported from studying annexes (Lozano et al. 2016; Mora et al. 2016).

The uncertainty lived at the time when participants were involuntarily taken to treatment centers set a violent context in which PWID were supposed to improve their health by drug detoxification. People taken to the treatment centers were not screened or selected based on an objective measure but by their physical appearance. Once at drug centers, Government Requested people were discriminated and stigmatized, stressing the structural violence lived in the streets. Regardless of this violence, the main complaint was the lack of State oversight of the drug centers, which exemplified how PWID are not part of the population that the State protects. Overall, we provide an insight of how health, wellbeing, human rights, dignity, and security of PWUD ought to be at the center of international drug policies included in universal health care systems (Buse et al. 2016). Public programs that force people into abstinence in a secluded context are a violation of human rights and have a negative health impact on PWID.

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