Salud Mental 2013;36:393-402
ISSN: 0185-3325
DOI: 10.17711/SM.0185-3325.2013.049

Study on the experience of men treated in residential substance abuse support centers

Rodrigo Marín-Navarrete,[1,2] Angélica Eliosa-Hernández,[2] Ignacio Lozano-Verduzco,[2] Carla Fernández-De la Fuente,[2] Bernardo Turnbull,[1] Antonio Tena-Suck[1]

Original article

SUMMARY

Addictive disorders and behaviors have increased in the last few years in Mexico. These behaviors and disorders are considered a public health issue because of the social and economic strains they generate. However, the state is unprepared to attend such high demands. Non-governmental organizations have arisen in order to fulfill this demand, but it is known that many of them do not regard federal health regulations and often they have infringed the basic human rights. The objective of this study is analyzing the experience of men who have been attended in residential substance abuse support centers. Fifteen focalized interviews were carried out with men of different characteristics, all of them having been attended in at least two centers. The results help to understand the consumption dynamics, usually linked to family abandonment and anger. It further analyzes the unhealthy and inhuman services offered in many of these centers such as poor feeding and hygiene services; many of the men are admitted violently and against their will. It is concluded that, even though these centers respond to the demand that addictive disorders have, it is necessary to guarantee the respect for human rights, thus ensuring the regulation of centers.

Key Words: Addictions, treatment, mutual support, men.

RESUMEN

Los trastornos y conductas adictivas se han incrementado en México en los últimos años. Estas conductas y trastornos son considerados un problema de salud pública debido a los estragos sociales y económicos que implican. Sin embargo, la demanda de atención ha rebasado las capacidades del Estado, por lo que han surgido organizaciones civiles que buscan responder a dicha problemática, aunque en muchas ocasiones esto suele hacerse sin atender a la reglamentación federal para la atención de la salud y las adicciones, por lo que existen casos en los que se han violentado los derechos humanos básicos. El presente estudio tuvo por objetivo analizar la experiencia de hombres atendidos en centros residenciales de ayuda mutua para la atención de las adicciones. Se llevaron a cabo 15 entrevistas focalizadas con hombres de diferentes características, que habían sido internados en al menos dos de estos centros. Los resultados ayudan a comprender la dinámica de consumo, que usualmente está ligada al abandono familiar y al enojo. Además, se analiza el uso de servicios de estos centros, como alimentación e higiene. Se encontró que muchos de estos hombres fueron ingresados de manera involuntaria y se vieron expuestos a diversas formas de abuso. Se concluye que a pesar de que estos centros responden a una necesidad de la sociedad para atender los problemas de salud que generan las adicciones, es imprescindible garantizar el respeto a los derechos humanos, asegurando la regulación y reglamentación de los centros.

Palabras clave: Adicciones, tratamiento, ayuda mutua, hombres.

INTRODUCTION

The consumption of psychoactive substances affects significantly people's quality of life and, due to its high social and economic cost, it is recognized as a public health problem. In Mexico, The National Addictions Survey (ENA, in Spanish) reports that the number of persons who used a drug in their lifetime increased from 3.5 million in 2002 to 4.5 million in 2008. Nevertheless, in 2011 there was no significant increase in drug use; in contrast to alcohol use, which had an increase. Youngsters and young adults are the most affected by the use of drugs, since it has been identified that current generations are most at risk, since it has been reported that risk of drug experimentation increases considerably when a friend or relative use it (2.69 and 3.78 times, respectively).[1-4]

The same study reports that close to 10% of substance users got treatment during the last year and the healthcare resources most used by this small part of the population

[1] Psychology Department of Universidad Iberoamericana, Mexico.
[2] Clinical Trials Unit, National Institute of Psychiatry Ramón de la Fuente Muñiz.

Correspondence: Rodrigo Marín-Navarrete. Unidad de Ensayos Clínicos, Sub-Dirección de Investigaciones Clínicas, Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz. Calz. México-Xochimilco 101, San Lorenzo Huipulco, Tlalpan, 14370, México DF. Teléfono: (55) 4160-5480 y 5481. E-mail: rmarin@inprf.gob.mx

Received: December 14, 2012. Accepted: May 27, 2013.

were: mutual support groups (53.8%), psychological care (45.1%) and psychiatric care (40.1%).[3] According to the 2008 report of the Ministry of Health, it is estimated that there are approximately 500,000 illicit drug consumers who need specialty care and approximately four million who need a brief intervention, not including needs of tobacco and alcohol treatment. Therefore, the increase of psychoactive substance use disorders has significantly impacted during the last few years thus increasing care needs.[1]

In Mexico, as in other countries, problems derived from alcohol and drug use often exceed the resources allocated by the State for attending them.[5] This circumstance has caused different organizational forms by civil society with the purpose of compensating the lack of public funding.[6-8]

One of the most usual forms followed by social organization in many countries to face the addiction problem is turning to support groups. Such groups are attended by individuals that share a particular problem, support themselves collectively and, eventually, solve their problem. Most of them use variants of the twelve-step program, originally developed by Alcoholics Anonymous on June 10, 1935 in the City of Akron, Ohio, U.S.[9-11]

In Mexico there are over 14,000 "Central Mexicana de Servicios Generales de Alcohólicos Anónimos A.C." groups registered,[12] and another 2,402 "Sección México de Alcohólicos Anónimos A.C." groups,[13] without considering other variations such as the groups: "AA 24 horas de Terapia Intensiva",[14] "Grupos 24 horas de Alcohólicos Anónimos",[15] "Grupo Jóvenes de Alcohólicos Anónimos"[16] and "Narcóticos Anónimos Región México".[17] the foregoing ranks Mexico as the third country with more AA groups after United States and Canada.[11]

Furthermore, several specialized medical societies have acknowledged the essential contribution of Mutual Support Groups (*Grupos de Ayuda Mutua*) for the rehabilitation of persons with any kind of dependence. These societies state that, when patient receives formal treatment and involves in the twelve-step program, better results are obtained than when only attending one of these care manouvres.[10] Notwithstanding, Mutual Support Groups are not considered a formal treatment since they are not managed by health care providers and their procedures scientific evidence and validation.[18,19] However, it is evident that they represent an important complement of professional treatment, more than a substitution of same.[20]

In addition, "Traditional Groups",* that is, outpatient groups which sessions last one hour and a half, do not seem to be effective when people suffer from a high addiction severity, as well as from comorbid mental disorders.[20] This inefficiency situation not only occurs with traditional mutual support but in general with outpatient treatments, since the seriousness of the problem in many cases requires residential control, which implies at least detoxification, stabilization of the acute psychiatric symptomatology and comprehensive psychological stabilization (cognition, emotion and behavior). On that basis and considering the reduced professional offers of the public sector and the expensive and inaccessible offers from the private sphere for residential addiction care, the civil society was confronted with the necessity to perform adaptations to the "Traditional Groups", creating groups offering residential care based on the mutual support model, which services have mainly been addressed to needy people. Such groups were called "Annexes" that gave rise to the Residential Substance Abuse Support Centers (CRAMAA, in Spanish) model,** which had adopted the twelve-step philosophy developed by Alcoholics Anonymous (AA). However, "Traditional Groups" are far from being equal, since the CRAMAA do not follow the AA's twelve steps, but it does follow the recovery philosophy.[11]

Regarding the foregoing, the 2011 National Addictions Survey states that attendance to the so-called CRAMAA diminished for male population (from 36.4% to 30.5%). It is also true that there has been an increase in the use of these services for women (from 42.9% to 53.7%); besides they continue to be an option for one third of the affected population (32.1%).[3]

Therefore, it is evident that the CRAMAA have become a first-choice strategy for patients and their relatives who suffer from disorders related to alcohol and other drugs use. The main characteristic of these centers is their heterogeneity, since the majority offers a variety of residential services with a variable duration that could range from four weeks to twelve months. Another relevant characteristic is its infrastructure; some have large facilities, while others —due to the limited space and the user demand— suffer from overcrowding. Moreover, it bears mention that the hierarchical structure of these centers is made up by individuals who have achieved staying drug free longer and who want to share their experience prompting others' recovery. Nonetheless, the great majority of such centers do not have support by specialists and/or health care providers.[9]

While it is true that the CRAMAAs offer a valuable alternative for many persons who need to overcome their substance use problems, it is also relevant to state that one of their main limitations is that most of them infringe the General Law on Health since they do not use appropriate equipment, staff and infrastructure pursuant to the guidelines stated by the Official Mexican Standard: NOM-028-SSA2-2009 for preventing, treating and controlling ad-

* "Traditional Groups" is the term that Alcoholics Anonymous' members have adopted to refer to original AA groups.

** "CRAMAA" is a Spanish acronym that is proposed for referring to the Residential Substance Abuse Support Centers.

dictions, besides the lack of an actual, current and official census of such organizations.[21,22]

On the other hand, it is common that the staff that works in those groups does not have specialized training for performing a systematic evaluation of procedures and results. As a result, people who join are not diagnosed. Thus, only the existence of a substance use problem is assumed, with a lack of awareness of the high correlation of comorbid mental disorders as reported by the scientific evidence.[23]

In turn, this has serious implications for the individual's quality of life, resulting in a higher rate of relapses, joining and re-joining to care units, as well as increase in risk behaviors and biopsychosocial deterioration.

In accordance to figures from the Ministry of Health, in Mexico there are close to 20,000 beads for providing residential treatment, from which it is estimated that only 4,000 comply with the application of NOM-028-SSA2-1999. On the other hand, approximately 1,730 care or rehabilitation centers for interned patients have been registered. From such centers 10 are Youth Integration Centers, 20 state centers, 400 private clinics and at least 15,000 groups that operate under the Alcoholics Anonymous' Mutual Support model; however, they lack of an established care protocol. Likewise, regarding the CRAMAAs, in Mexico City there are only 65 residential care units complying with the NOM-028-SSA2-2009 guidelines.[22]

Since several years a number of studies have highlighted the lack of clearness regarding therapeutic procedures, as well as the physical and emotional mistreatment that takes place within the CRAMAA.[9,24-26]

Besides the scientific studies, this situation has been widely documented in non-official sources such as news notes in written press, radio and television, where the conditions attacking human rights prevailing in several of these places known as "Annexes" are described. Foremost among them are: overcrowding, insalubrity, physical and verbal attacks, sexual abuse, torture, deprivation of liberty, exploitation and slavery.

Therefore, the purpose of this study was recovering user experience of CRAMAA services, as well as the consumption dynamics and internment trajectory, highlighting the way of operating and use of services within the centers.

METHOD

Participants

Semi-structured targeted interviews were conducted[27] to men who had the experience of having been in at least two CRAMAAs, who optionally had been receiving care at any of these centers at the time of the interview and who voluntarily consented to take part in the study. In average, interviewers were 40 years old, with a standard deviation of 12.18, at an age range between 23 and 58 years old. Two thirds were BA or MA degree holders and one third finished high school or secondary school. 60% was separated or divorced, one fifth was cohabitating and the rest were single.

Data Analysis

Interpretation of data followed the phenomenological-interpretative method through a content analysis of meanings, from public health point of view. A codebook was made based on the research objectives, which were enriched with the stories of each interview, achieving the "Theoretical Saturation" of the 15 participants. ATLAS.ti version 5.5 and NVIVO version 9.0 software were used, with the purpose of using sophisticated and powerful tools to analyze the contents of each interview.

RESULTS

From the data analysis the following thematic axes or groups were the most significant: a) Consumption Dynamics; b) Internment Trajectory; c) User Experience in the CRAMAAs; d) Use of Services.

A) Consumption Dynamics

In general, alcohol, tobacco and other drug use occurs during adolescence, since several changes are involved in the psychosocial functioning that could constitute risk or protection factors that facilitate or delay substance use.[28,29]

In Mexico, it has been observed that the tobacco and alcohol use begins at increasingly early ages, which increases the likelihood of using other drugs and progress to dependence.[1]

The foregoing theoretical premise was corroborated by the stories of the study participants, since they confessed to have started substance use at a very young age, ranging between 7 and 15 years old.

> *"The first time I used that was at… seven…seven or nine years old, I don't remember well…" (Efraín, 39 years old).*
> *"I started drinking alcohol at twelve; at that age I experienced my first drunkenness." (José Ramón, 35 years old).*
> *"I started drinking alcohol at fifteen… I was studying the third year of secondary school and I was drinking with some friends…" (Jerónimo, 39 years old).*

Several factors have been associated with the risk of starting drug use. Thus, it is of particular importance that both exposure and availability increase the likelihood of adolescent use. It is estimated that about half of youngsters who have been exposed to the chance of drug consumption have used them.[1]

Translation of the original version published in spanish in:
Salud Mental 2013, Vol. 36 Issue No. 5.

On the other hand, it is worth mentioning that the availability is not limited to physical access of substances, since social standards and the immediate environment have a strong impact on the beginning and maintenance of substance use.[2]

The analysis of the results suggests that initial substance use is influenced —to a great extent— by the family relationship, which sometimes increases the risk of users to pursuit new social relationships frequently related to the consumption.

> *"…on a Friday after school (my friends) invited me to drink tequila… That was the first time I drank. Then, I kept drinking with them in parties and get-togethers." (Jerónimo, 39 years old).*

> *"…I had the first contact with alcohol. It should have been brandy because that was what my dad drank. I took a bottle and with my brothers, friends and neighbors went up to the roof of a house. We drank on the roof until we got drunk…" (Efraín, 39 years old).*

> *"The gang guys arrived using a solvent, but they didn't offer me. How ever, I was curious about how they drugged with the 'mona' (tow). They're really laughing; they looked happy. That's why I found it quite interesting." (Pablo, 39 years old).*

Another finding was that participants reported a type of family distancing, as well as an approach to different risk groups, situations that impact consumption; that is the reason of the increase of both frequency and amount, aspects that eventually cause a development of a disorder due to dependence on substances.

> *"In the beginning I bought the equivalent to $5 pesos of 'mota' (marijuana); what today would be approximately $20 pesos. But after a while that amount no longer gave me real joy, it was so little." (Pablo, 39 years old).*

> *"I started drinking on Fridays; then Fridays and Saturdays; then Fridays, Saturdays, Sundays and Mondays; until drinking every day during a whole month… I also remember that being with people who drank a lot made me drink more; I drank up to 5 liters in a single day, plus another liter at night to control myself and avoid hangover…" (Jerónimo, 55 years old).*

Subsequently, the user starts consuming alone. Therefore, as the use increases, also the related problems increase, resulting in biopsychosocial deterioration with the need for care.

> *"Because of my consumption I got divorced and got homeless; I wanted to die. I didn't have the nerve to kill myself so I kept using drugs." (Ricardo, 53 years old).*

> *"I had my own business. I used to bring a bottle to work and drank all day while pretending to work. But I got to the point where I was not able to work. I lost everything and start depending on my family and friends…" (Alfonso, 45 years old).*

Due to the foregoing, persons who are significant to the user have several internment reasons justifying the patient's admission into a residential center, often even against their will (Figure 1).

> *"…after several days being homeless, finally I don't know how my mother found me and locked me in an 'annex'. I'd never been on a place like that one. Now, I understand that she didn't know how to help me, so she just brought me there and locked me in…" (Joel, 24 years old).*

> *"My mother became tired of paying internments since I relapsed constantly. She spent all her money in my recovery, until a neighbor who also goes to AA told her 'you don't have to keep paying, I know a place with free stay. You only have to bring some provisions every now and then and after three months you can get him out', so we did it…" (Gaby, 31 years old).*

> *"In the beginning and almost always my mother took me there. She used to tell me: 'why you can't control yourself? Try to control yourself!', and I always had a thousand of excuses. I really tried to control myself but I couldn't; that's why she had to 'annex' me." (Alfonso, 45 years old).*

B) Internment Trajectory

Evidence reports that the user seldom is the first in seeking professional help by himself or herself. This is due to the natural history of the disease, which implies a poor or non awareness of the patient's disease. Therefore, the first treatment admission is regarded as a family request or demand since, according to some interviews conducted, family members are the first in realizing that the situation of consumption has become dysfunctional. Physical deterioration, dropping out of school and/or of work, family distancing, reckless and antisocial conduct, among others.

However, studies conducted in Mexico suggest that in average the first care contact occurs, in the case of men, 8.8 years after the onset of alcohol or drug use, thus the seriousness in the individual's biopsychosocial deterioration is evident.[30]

Initially, users report that the family seeks quick solutions and then trust home care remedies, herbs, oaths and promises, among others. Subsequently, the relatives, after not obtaining effective and appropriate responses to solve

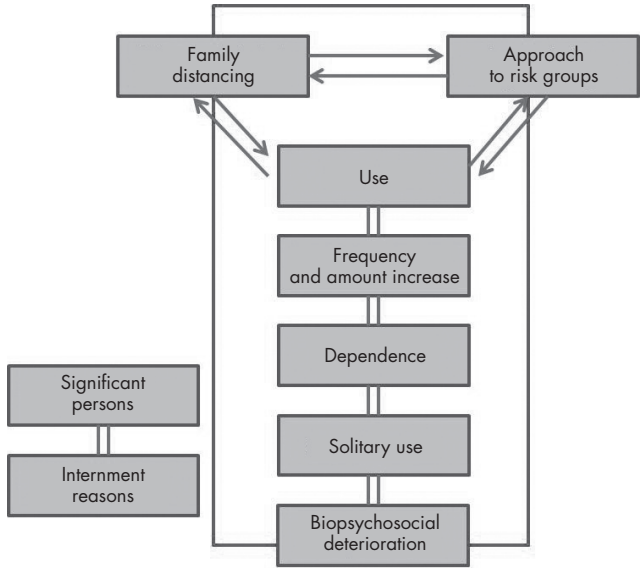

Figure 1. Consumption dynamics.

the problem, they seek support from institutions they are referred to by some other relative, acquaintance and/or professional not specialized in the area or even through telephone hotlines.

> *"Then when the doctor discharged me… he really stared at me and told me 'you're an alcoholic, and need to go to Alcoholics Anonymous', as he gave my mother cards of two groups: one where you're interned and the other where you attend talks in the afternoon or evening." (Alfonso, 28 years old).*

> *"… (my mother) called 'Locatel' and 'Vive sin Drogas'… they told her: 'there is a house as the one you're looking for… it's not expensive, and you can check the facilities out'. Finally, they gave her the telephone numbers and my mother called the center asking for information to intern me…" (Gaby, 31 years old).*

Users mentioned that during the first internments the using problem was not so evident for them, since they still kept certain functionality in some areas of their lives. Therefore, when the interning alternative is put forward they feel that it is not time yet, that they are not ready and even they feel they are too young to have a serious problem related to substance use, hence, the family often promote involuntary internship.

> *"I wasn't ready. Despite I used drugs, I had a good job and a good income, and I wasn't determined to give up that kind of life." (Ricardo, 53 years old).*

> *"Almost at the end, during the last few months, I realized that I was out of control: I started to steal things and to see my life surrounding the substance. However, I didn't want to be interned." (Joel, 24 years old).*

On the other hand, it is important to mention that such involuntariness in their admission to centers raises different emotions in the user, among others, anger and rage, which often cause the patient escapes from the internment process, a situation that is even associated with relapse to use.

> *"I attended internments with more resentment each time, angrier… every time with less energy to be recovered; I was interned because I was obligated, but not because I wanted to stay. Sometimes I wanted to intern my parents and siblings or my partner so that they could feel what I was feeling." (Ricardo, 53 years old).*

Moreover, interviewers reported that in spite of being aware of problems and of the lack of control on the use, the substance fulfilled its expected function, thus, besides avoiding or reducing the negative withdrawal symptoms, it allowed the user to obtain some secondary gains; among them, fun, pleasure, belonging to a social group and company.

> *"I didn't want to accept that… using drugs and alcohol was harming me, making me lose many things. Despite my groupmates warned me that each relapse would be worse and the consequences more severe, I didn't listen to them." (Gaby, 31 years old).*

Finally, it was found that there are multiple elements involved with the involuntary internship and that also, according to the interviewers, have a negative effect on their perception of rehabilitation. For example, being victims of constant abuse in the center is referred as one of the precipitators of consumption recidivism once they leave CRAMAA. On the other hand, there is a constant dissatisfaction since internship is experienced as the inclusion into a surveillance, control and subjection system (Figure 2).

C) Experience in the CRAMAAs

During field work the presence of two main types of CRAMAAs was evident. The first group was defined as *"light"* characterized by the voluntary stay in the center, a better use of services and avoiding violence as a means of control. The second group was called *"fuera de serie"* (unusual) where, according to the experiences mentioned by the users, there is a constant physical and psychological abuse; inside conditions are reported as precarious and it is common to have a lack of structure in everyday activities.

Mostly, interviewers reported to have experienced multiple internships, thus they had the chance to compare their experience in the *"light"* and in the "unusual" centers, making evident in the latter the use of violence as a means of control and subjection after the user's resistance.

> *"I was so mistreated… they broke my ribs, humiliated me, got beaten, squirted cold water on me… They did a lot of terrible things…" (José Ramón, 35 years old).*

> *"…I experienced many aggressions, I was raped, they stuck a broomstick in my anus... They did very terrible things… I remember they obligated a guy to have a shower with freezing cold water throughout the night. Then they woke him up at 7am with fans. At 2pm he was dying of pneumonia… He actually died and they didn't care at all." (Roberto, 53 years old).*

In contrast, the participants reported that the "light" centers are distinguished by the implementation of a distorted interpretation of the AA's twelve-step philosophy. Nevertheless, they would seem to promote respect for the integrity and dignity of the user although they use apparently regulated confrontational strategies to break psychological defenses,

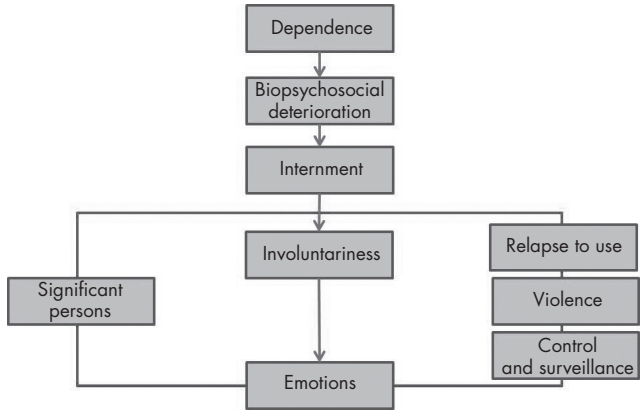

Figure 2. Internment trajectory.

ungovernability and pride of users, trying with this to introduce a 'humble, malleable and spiritual' thought.

> *"In this center nobody beats me. I don't have to be seated 12 or 16 hours listening to meetings and more meeting that don't teach anything… Here I've been told how to be aware of my disease. I've learned to know myself. I've found the essence of spirituality, which consists in serve others, making me feel useful… Also, food is good, the interaction is different, people think and act differently. Other mates that are going better set a good example showing that it's possible; since they've faced unfavorable life situations, as me, and have overcome them. Everyday I've got their example to keep going. That's the big difference between an annex ("unusual") an this place ("light")." (Ricardo, 53 years old).*

On the other hand, the reports reflect that the concept of "humility" is essential during the whole process, since it is used by "*servants and godfathers*" to treat and indoctrinate the sick person. "Humility", according to the interviewers' conception, consists in trusting a "higher power", which will allow them to improve their "spirituality" and find the strength to achieve abstinence and maintain it in the long term.

Interviews found that "*light*" centers mostly promote awareness of the reasons by which the user develops alcohol or other drugs dependence, through a confrontational and tough dialogue, which goal is to mold coherence between "judgments and attitudes", an strategy that seems to be based on the insertion of feelings of guilt. On the other hand, it is reported that the "unusual" centers use violence as the learning method for the "humility" development, a situation that seems to be grounded on causing fear rather than on developing true growing awareness. According to such position, it is thought that pride leads user to believe that he or she have control over substances and, thus, the hopelessness of the individual will allow him or her to develop humility and finally to achieve recovery.

> *"Ah!, since I arrived I was received with a lot of rude words, they beat me, I had to be in many meetings everyday… Some nights they forced me to remain standing up and without sleeping or eating. After the third day I was delirious… Finally, I was obliged to serve coffee dressed as a women and, according to them, I was being humble." (Ricardo, 23 years old).*

Another relevant aspect to assess the experience in "unusual" CRAMAAs are the strategies through which order and organization are maintained, as well as the consequences after the infringement of established guidelines. Punishments, also called "applications", which manifested themselves during the development of the interviews; according to the interviewers, the "applications" were made as a result of a behavior or attitude considered inappropriate, although in most of the centers the lack of rules as a reference to define and identify improper behavior became evident.

> *"after a while I was taken to the room where the so-called meetings are held. I was seated on a chair where I was not allowed to move from. I was forced to have my hands stretched, and if I slept they beat me and inflicted an 'application' such as doing push-ups with bricks on my back while they kicked me." (Cristian, 24 years old).*

> *"with blows, slaps and kicks, they sometimes forced me to kneel over crown corks, standing on my head or anything their imagination could advice." (Joel, 24 years old).*

> *"Approximately three times I was put in a cask with cold water. Once when they took me out they put me in the bathroom naked and told me: 'your hands on the wall!' and I did what they told me, so they "whipped" me with cold water… Then, one of them commanded me to dry and forced me to remain standing up the whole night and when daybreak was coming they gave me a pair of sweatpants with a lot of holes, a one-sleeve shirt and a sweater. Then, instinctively I started to get dressed, suddenly another guy arrived and slapped me, telling me: 'who asked you to get dressed?', so I replied: 'they gave me the clothes…' and he answered: 'they gave it to you, but who told you to get dressed?' then they punished me again…" (Pablo, 39 years old).*

In the case of "*light*" centers there are no "applications" but punishments were related to cleaning activities or giving a service in the centers facilities. It is evident that they do not use physical violence, but in case of failing to comply with a rule, the "*servants and godfathers*" used the confrontational and tough dialogue to promote responsibility for their actions.

The interviewers' assessment regarding their internment experience relies heavily on the type of center in which they were confined. However, there is a constant discomfort caused by internment, perceived like a deprivation of liberty, transgression of integrity and basic rights, which leave them in a situation of vulnerability and defenselessness.

> *"Actually, the 'unusual' centers experience is never pleasant and sometimes they seem horror stories, but they're real!… I was very hurt in the annexes; really harmed and I can't understand that these kind of places exist." (Ricardo, 53 years old).*

Finally, interviewers pointed out that one of the functions achieved by internment is controlling oneself, being forced to be away of persons, places and circumstances related to the use, and even, of substance availability. Also, being interned facilitates detoxification, which generates a better clarity of one's thinking and allows users to assess the problem of use and deterioration of the different areas of life. Nevertheless, they also mentioned that, generally, internment advantages are perceived much later (Table 1).

> *"The only benefit was controlling. For me not using drugs was impossible outside; hence, the benefit I had was maintaining my abstinence thirty days, and as a consequence I was detoxified and was able to make the decision to stay here." (José Ramón, 51 years old).*

D) Use of Services

An essential aspect of research was becoming aware of the operation of CRAMAAs and the available services, as well as their administration. Therefore, a part of the interview was devoted to knowing such aspects, highlighting the

Table 1. Experience in CRAMAAs

"Unusual"	"Light"
90-day obligatory internment	90-day voluntary internment
Use of violence as the learning method imposed by "godfathers" to promote "humility"	For the promotion of "humility" a confrontational and a tough dialogue is used
"Egoreduction" therapy through an imperative and offensive language, as well as psychological control	"Egoreduction" therapy through an imperative and offensive language, as well as psychological control
Physical, verbal and psychological violence conditions	Offensive language use, but not physical violence
"Servants and godfathers" use threats and promote fear as a way of control	Neither threats nor intimidation
Involuntary stay	Voluntary stay
Punishments or "applications", which are predominantly violent and sometimes put at risk the user integrity	Punishments through extra cleaning or service activities inside the center
Direct confrontation, punishments and physical, psychological and sexual abuse	Regulated confrontation of ideas and values that maintain the use behavior and are not compatible with the ideology promoted by the AA model
Subjection and control justified by the misinterpretation of the twelve-step philosophy	Interpretation of the twelve-step philosophy through confrontational dialogue, persuasion and reflection

main areas for a recovery, especially basic needs of feeding, rest and hygiene.

In general, it is reported that the CRAMAAs' infrastructure depends widely on their resources or supports, although most of them are overcrowded due to the strong demand of addiction care, the small number of institutions in the public sector and the high costs of treatment in the private sector.

In general, the facilities of "unusual" centers are described as a house putting 80 - 120 persons up, thus, sometimes users have to sleep on the floor or even standing up. In both types of centers there is a room for AA meetings. However, due to the small places, a space may be used for different purposes according to the necessity of the center. Therefore, the same space can become a dormitory, a dining room and even a bathroom.

> *"There is a dormitory with 28 bunk beds… but the meeting room may become a dorm and a dining room." (Gabriel, 39 year old).*

> *"The meetings were held in the dormitory. Somehow there was nothing else to do but meetings. You had breakfast, lunch and dinner in the same room. That room was used for all activities." (Efraín, 39 years old).*

> *"When it was time to sleep, they gave you sheets, which where mixed with other's sheets. All slept like sardines or standing up." (Juan, 23 years old).*

During the course of interviews it was common to find a reference to the poor quality of food. According to the interviewers, the main dish in the "unusual" centers is the so-called "caldo de oso" (bear broth), made with onion and garlic with some decaying vegetables. On the other hand, they mentioned that regularly the condition of food is deplorable, and that besides not having a special place for this, neither cooking utensils have basic hygiene.

> *"…the bears broth is boiled water with onion and garlic… and some few vegetables floating around. Bur rather it contains onion with a small piece of carrot and cabbage. It's not exactly a bowl. It's rather a recipient where you drink water and eat from and even pee…" (Tío, 45 years old).*

Compared to the "unusual" centers, it is said that in the "*light*" centers food is in good conditions and it is enough for all users and served three times a day.

> *"Here ("light" center) you have your three meals. Food is of first quality. All the interns are in charge of the house chores: some do the cleaning; others bring provisions; others the kitchen, maintenance… There's neither physical nor verbal abuse… It's a nice stay…" (Gaby, 31 years old).*

> *"It's a clean place… The food is of a good quality… There are three assorted and balanced meals every day. We sit at a table; as it should be…" (José Ramón, 51 years old).*

As for the bathroom, it was mentioned that there's an important difference between "*light*" and "unusual" centers, since the former, in general, have the necessary facilities, and they're in average hygiene conditions. However, in the case of the "unusual" centers, frequently, a lack of these services is reported. Therefore, they have buckets or even trays, where the users must meet their basic needs and, sometimes, even using them as bowls for food.

> *"¿The bathroom?... Awful! There can't be hygiene when you have a single bathroom for 270 persons and you have to pee or defecate in a 19-liter bucket!" (Roberto, 53 years old).*

> *"…Your bowl… is rather a recipient where you drink water and eat from and even pee…" (Tío, 45 years old).*

Hygiene is linked with the bathroom experience and space. According to the interviewers, personal cleaning in CRAMAAs was often limited due to the lack of resources, besides that sometimes there was no personal hygiene products, which affected negatively their health and qual-

Table 2. Use of services

"Unusual ("Fuera de serie)"	"*Light*"
Scarce and low-quality food also known as "caldo de oso" (bear broth) by users	Sufficient and balanced food served three times a day
Users do not have personal hygiene products (toothbrushes, towels, razors) and there are only cold showers	Users have personal hygiene products and hot showers
There are no proper bathrooms, and they are provided with a bucket to defecate, urinate and, sometimes, eat	Average-acceptable hygiene bathrooms
Usually, it is an overcrowded house (between 80 and 120 interns)	Wider spaces, although sometimes overcrowded
Users sleep standing up or seated. Also, there is sleep deprivation in order to attend AA meetings	Users have a designated bed and a resting schedule
There are no medical, psychological and/or psychiatric services	Some are visited by a primary care physician doctor who examines patients, and in some exceptions there have been specialized care services
There is only one space, which is used for AA meetings, eating and sleeping	They have different spaces for each activity and have an observation room
Lack of written rules	They have written rules
There is no clarity about the activities or schedules	They have a "role of activities" where users must be involved
There are no well-defined chores	Users perform different services during their stay (cleaning, cooking, gardening, among others)
No certifications	Only some are certified by the Ministry of Health

ity of life at the centers. Finally, during the stories the lack of personal hygiene products became evident, among them, toothbrushes, soaps, towels or razors, and sometimes such objects were shared with all users of the center (Table 2).

> *"The 18 days I spent in that 'annex' I neither brush my teeth nor take a shower because we could take showers every day but not with hot water. On the other hand, they gave me clothes after 10 days I was there…" (Gabriel, 39 years old).*

> *"We used the bathroom in groups of five persons and only two showers worked. We were in line, got wet and passed the soap and then we left the bathroom." (Efraín, 39 years old).*

> *"…hygiene in the "unusual" center was not good… Sometimes there was no soap in the shower and there were… how many razors? We were… close to 70 persons and only had three razors." (Pablo, 39 years old).*

CONCLUSIONS

Today there are approximately 500 outpatient centers making up the prevention and treatment network of the country (CIJ, CENADIC and others). Nonetheless, it bears mentioning that such centers are not ready to provide care for serious deceases of substance dependence, which need hospital care, according to the patients' physical and psychiatric conditions. Nevertheless, it is important to point out that there are public and private residential centers in Mexico. However, they are insufficient or, otherwise, very expensive for the bulk of the affected population.

Thus, considering this scenario, the CRAMAAs are still a first-hand option due to the lack of specialized residential centers for addiction care that can be adjusted to the needs of the population, despite the limitations of physical and human infrastructure that they can represent.

Given the picture given throughout this study, supervision and surveillance in the operation of these centers is essential, since there is no official register published of all these places.

Therefore, it is evident the need for regulating and training the staff managing such groups in order to ensure respect of human rights, as well as the compliance of the standards established by the Official Mexican Standard: NOM-028-SSA2-2009 for preventing, treating and controlling addictions and integration of treatment, in order to guarantee the improvement of the user and his or her family quality of life.

Finally, and as a researcher's proposal, we think that —according to both positive and negative contributions for substance abuse patient's rehabilitation— it is relevant to begin with the *de-stigmatization* of the so-called "annexes". Thus, our proposal is calling them Residential Substance Abuse Support Centers (CRAMAA, in Spanish); doing this there would be not only a complete reorganization but also a *resignification* of form, regarding the meaning that people give to these centers. Likewise, it is important to emphasize for everyone ignorant on this subject and for the general public, the difference between CRAMAAs and the effort of

Traditional Groups, since the former follow the twelve-step philosophy as a therapeutic method, being far from Alcoholics Anonymous (Traditional Groups).

Limitations

Results evidence the importance and contribution of same to assist public servants' decision making on health. Notwithstanding, the results are circumscribed within the analysis of male population. Therefore, it is relevant to spread them in order to know the same phenomenon in women, since gender is a significant factor affecting the seriousness of addictions and comorbid disorders, a situation which translates directly into a higher deterioration of women in contrast to men. Also, according to the available evidence, women report specific necessities for their care, such as providing care for children and diseases which affect only women.

Lastly, it is interesting and complementary to know more about this subject using families as spokespersons of this phenomenon experience, an aspect which would improve the constitution and closing of the CRAMAAs' users experience knowledge.

ACKNOWLEDGEMENTS

This project was approved and funded by the Research Department and the Psychology Department of Universidad Iberoamericana Ciudad de México.

Likewise, thanks are extended to professors and researchers involved for their support and knowledge for this project both from Universidad Iberoamericana Ciudad de México and Ramón de la Fuente Muñiz National Institute of Psychiatry, as well as to the participants interviewed who shared their life experiences.

REFERENCES

1. Encuesta Nacional de Adicciones 2008. México: Consejo Nacional contra las Adicciones, Instituto Nacional de Psiquiatría Ramón de la Fuente, Instituto Nacional de Salud Pública y Fundación Gonzalo Rio Arronte; 2010.
2. Medina-Mora ME, Natera G, Borges G, Cravioto P et al. Del siglo XX al tercer milenio. Las adicciones y la salud pública: drogas, alcohol y sociedad. Salud Mental 2001;24:3-19.
3. Encuesta Nacional de Adicciones 2011. México: Consejo Nacional contra las Adicciones, Instituto Nacional de Psiquiatría Ramón de la Fuente, Instituto Nacional de Salud Pública y Fundación Gonzalo Rio Arronte; 2012.
4. Danielsson AK, Romelsjö A, Tengström A. Heavy episodic drinking in early adolescence: Gender-specific risk and protective factors. Subst Use Misuse 2011;46:633-643.
5. Medina-Mora ME. Las adicciones: su situación actual. En: Berruecos L, Díaz-Leal L (eds.). Curso básico sobre adicciones. México: CENCA; 1994.
6. McGrady BS, Miller WR. Research on Alcoholics Anonymous: opportunities and alternatives. New Brunswick, NJ: Rutgers University Press; 1993.
7. Fiorentine R. Alter drug treatment: Are 12-step programs effective in maintaining abstinence? Am J Drug Alcohol Abuse 1999;25:93-116.
8. Humphreys K. Professional interventions that facilitate 12-step self-help group involvement. Alcohol Health Res World 1999;23:93-98.
9. Pulido MA, Meyers M, Martínez A. Algunos datos acerca del funcionamiento de una muestra de grupos de autoayuda en México. Revista Mexicana Investigación Psicología 2009;1:85-97.
10. Lile B. Twelve step programs: An update. Addictive Disorders Their Treatment 2003;2:19-24.
11. Rosovsky H. Alcohólicos Anónimos en México: fragmentación y fortalezas. Desacatos 2009;29:13-30.
12. Central Mexicana de Servicios Generales de Alcohólicos Anónimos, A.C. (2012). Available at: http://www.aamexico.org.mx/ (access date: November 13, 2012).
13. Alcohólicos Anónimos, Sección México (n.d.). Available at: http://www.aa.org.mx/ (access date: November 13, 2012).
14. Alcohólicos Anónimos 24 horas Terapia Intensiva (n.d.). Available at: http://www.aa24horas.com.mx (access date: November 13, 2012).
15. Grupos 24 horas Alcohólicos Anónimos (2012). Available at: http://wwww.aa24horas.com (access date: November 13, 2012).
16. Jóvenes Alcohólicos Anónimos (n.d.). Available at: http://www.jovenesaa.org (access date: November 13, 2012).
17. Narcóticos Anónimos Región México (n.d.) Available at: http://www.namexico.org.mx (access date: November 13, 2012).
18. Pérez GB. ¿Hacia dónde avanza el modelo asistencial al drogodependiente? Trastornos Adictivos 2001;3:205-213.
19. Kelly JF, Yeterian JD. Mutual-help groups for dually diagnosed individuals: Rationale, description, and review of the evidence. J Groups Addiction Recovery 2008;3:217-242.
20. Humphreys K, Wing S, McCarty D, Chappel J et al. Self-help organization for alcohol and drug problems: Toward evidence –based practice and policy. J Subst Abuse Treat 2004;26:151-158.
21. Norma Oficial Mexicana NOM-028-SSA2-1999 para la prevención, tratamiento y control de las adicciones. México: Diario Oficial de la Federación, 15 de septiembre de 2000.
22. Secretaría de Salud. Programa de Acción Específico 2007-2012. Prevención y tratamiento de las adicciones. México; 2008.
23. Marín-Navarrete R, Benjet C, Borges G, Nanni-Alvarado R et al. Comorbilidad de los trastornos por consumo de sustancias con otros trastornos mentales en Centros Residenciales de Ayuda-Mutua para la Atención de las Adicciones. Salud Mental 2013 (en prensa).
24. Ortiz A, Soriano A, Galván J, Rodríguez E et al. Características de los usuarios de cocaína, su percepción y actitud hacia los servicios de tratamiento. Suplemento de la Revista de Salud Mental (suplemento) 1997;20:8-14.
25. Romero M, Gómez C, Ramiro M, Díaz A. Necesidades de atención a la salud mental de la mujer adicta. Salud Mental 1997;20(2):38-47.
26. Hernández A, Galván J. Estudio sobre los antecedentes y redes sociales de un grupo de usuarios de drogas antes del ingreso a tratamiento. Cartel presentado en la XXI Reunión de Investigación del Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz; México; 2009.
27. Merton RK, Fiske M, Kendall PL. The focused interview. Glencoee III; Free Press; 1956.
28. Monahan K, Egan EA, Van Horn L, Arthur M et al. Community-level effects of individual and peer risk and protective factors on adolescent substance use. J Community Psychology 2011;39:478-498.

Translation of the original version published in spanish in: Salud Mental 2013, Vol. 36 Issue No. 5.

29. **Feinberg ME. Community epidemiology of risk and adolescent substance use: Practical questions for enhancing prevention. Am J Public Health 2012;102:457-468.**

30. **Consejo Nacional Contra las Adicciones. Observatorio mexicano en tabaco, alcohol y otras drogas 2003. México: Consejo Nacional Contra las Adicciones, SSA; 2003.**

Declaration of conflict interest: None

Translation of the original version published in spanish in:
Salud Mental 2013, Vol. 36 Issue No. 5.