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Involuntary Civil Commitment for Substance Use Disorders in Puerto Rico: Neglected Rights Violations and Implications for Legal Reform

CAROLINE M. PARKER, OSCAR E. MIRANDA-MILLER, AND CARMEN ALBIZU-GARCÍA

Abstract

Laws facilitating the involuntary civil commitment (ICC) of people with substance use disorders vary considerably internationally and across the United States. Puerto Rico, a colonial territory of the United States since 1898, currently harbors the most punitive ICC legislation in the country. It is the only place in the United States where self-sufficient adults who pose no grave danger to themselves or others can be involuntarily committed to restrictive residential facilities for over a year at a time without ever being assessed by a health care professional. The involuntary commitment of otherwise-able citizens—many of whom have never been diagnosed with a substance use disorder—continues to be ignored nationally and internationally. In this paper, we specify how Puerto Rican ICC law and procedures systematically violate rights and liberties that are supposed to be guaranteed by Puerto Rico's Mental Health Act, the US Federal Supreme Court, and the Universal Declaration of Human Rights. To ensure that Puerto Rico's ICC procedures conform to prevailing local, national, and international standards, we propose a series of legislative reforms. Finally, we highlight the importance of addressing the preponderance of poorly constructed ICC laws both within the United States and internationally.

Caroline M. Parker is a presidential fellow of medical anthropology at the Department of Social Anthropology at the University of Manchester, United Kingdom.

Oscar E. Miranda-Miller is a professor of law at the University of Puerto Rico School of Law, San Juan, Puerto Rico.

Carmen Albizu-García is a physician and a professor of health services research at the Graduate School of Public Health at the University of Puerto Rico, San Juan, Puerto Rico.

Please address correspondence to Caroline M. Parker. Email: caroline.parker@manchester.ac.uk.

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Involuntary civil commitment (ICC) for substance use disorder is a legal provision used in many countries to forcibly remand individuals who use alcohol or psychoactive substances into some form of treatment. Ostensibly, ICC laws are designed to protect those at risk of substance-related harm by facilitating their temporary commitment into care, with those who support the procedure usually considering it a lifesaving measure that empowers families to protect their loved ones before they overdose or otherwise harm themselves or others.[1] But in practice, many local and national health care systems lack sufficient services for effectively treating the substance use disorders of citizens who voluntarily seek care.[2] As a result, citizens subject to ICC are often channeled into prisons or jails instead, or into various paraprofessional services such as self-help groups run by nonprofit organizations that lack the necessary resources and expertise to employ effective, evidence-based treatments.[3] Unsurprisingly, reviews of ICC conclude that there is no evidence ICC reduces substance-related harm.[4] Quite the contrary, studies of ICC suggest that it damages family relationships, inflicts trauma on patients, and even places patients at greater risk of overdose death relative to voluntary treatment.[5] A systematic review of compulsory treatment evaluations did not detect significant positive effects on drug use or criminal recidivism, whereas negative impacts on criminal recidivism was reported in two studies.[6] Beyond these failures of clinical efficacy, studies of drug treatment in Latin America and the Caribbean have linked ICC to human trafficking, kidnapping, torture, and forced labor. [7]

Given all this, it is especially damning that four decades of professional handwringing and alarm-sounding on the part of professionals charged with implementing ICC have had so little impact on policy making.[8] In the United States, several states that currently lack ICC statutes for psychoactive substances and alcohol are now considering introducing them, with ICC actually gaining popularity nationally since the onset of the US opioid epidemic.[9] Currently, 37 US states, the District of Columbia, and Puerto Rico each have statutes in place that allow for the ICC of people diagnosed with substance or alcohol use disorder, alone or in combination with mental health disorders. The maximum duration of ICC varies significantly between US jurisdictions, from 48 hours in New York State to 180 days in North Carolina to open-ended commitment in Puerto Rico. In 17 states, the maximum time a candidate for ICC may be held in custody for evaluation is 72 hours.[10] As ICC gains broader attention, it is important to assess the unintended consequences of emerging variation in ICC laws, including laxity in procedural guarantees and existing gaps in the availability of evidence-based effective treatment modalities to provide appropriate patient-centered care.

In this paper, we stress the importance of documenting how ICC law and procedure is undermining human rights and civil liberties that are supposed to be guaranteed by prevailing local, national, and international laws. Much recent ICC research in the United States has focused on Massachusetts.[11] Our account, in contrast, is based in Puerto Rico, a colonial territory of the United States since 1898, and a place where ICC has never been studied academically. In fact, except for two brief mentions in reports by treatment activists and a short lay summary published online (and pro bono) by a Puerto Rican law school, no studies of ICC for substance use disorder in Puerto Rico have been published in either English or Spanish.[12]

There is no centralized surveillance system for counting ICC in Puerto Rico, which is adjudicated by 15 distinct municipal courts across the island. That said, some sporadic (if not necessarily reliable) figures can be obtained from individual municipal courts. According to hand-written logs we accessed, three municipal courts out of a total of fifteen that currently oversee ICC cases collectively processed 721 ICC cases via Law 67 between 2014 and 2017. The remaining 12 courts either did not keep records or declined to share their records with us on the day we visited. The only other source of government information on ICC prevalence in Puerto Rico comes from the Puerto Rican Administration of Mental Health and Addiction Services (ASSMCA). As part of its annual provider survey, distributed to all licensed drug treatment centers,

ASSMCA is supposed to receive a basic count from its drug treatment providers regarding the number of people admitted to each facility via ICC (via either Law 67 or the Mental Health Act). Unfortunately, due to widespread problems of underreporting, ASSMCA representatives consulted over the course of this research reported that these figures were unavailable. Consequently, basic questions regarding ICC's overall prevalence and its distribution across institutional settings and treatment modalities—including the number of people who are being held in restrictive residential facilities—is unknown.

As we show in this paper, Puerto Rico has some of the most draconian ICC legislation in the United States, legislation that is arguably unconstitutional. Under Puerto Rico's current legal framework for ICC, citizens who pose no imminent threat of harm to themselves or others, who are otherwise able to meet their basic needs, and who have never been diagnosed with a substance use disorder may be committed to restrictive residential facilities for over a year at a time without receiving legal representation and without ever seeing a health care professional. The data shared here will help practitioners, researchers, and policy makers in the United States and elsewhere evaluate existing ICC regulations and the extent to which they safeguard patients' rights and assess patients' treatment outcomes, thereby informing future policymaking.

Our findings derive from two long-term fieldwork projects examining rights-based issues in Puerto Rican drug treatment, and from the subsequent dialogue undertaken by the three of us—Caroline Parker (a British anthropologist), Oscar Miranda-Miller (a Puerto Rican legal scholar), and Carmen Albizu-García (a Puerto Rican physician and health services researcher).[13]

Parker's 18 months of ethnographic research (2016–2017) explored the nature and content of residential drug treatment and included 255 days of participant observation in 15 residential drug treatment centers; 20 days of participant observation conducted in ICC hearings across five municipal courts; and interviews with residents, their families, paraprofessional counselors, and policy makers. The full findings and methodology of Parker's study are published elsewhere.[14] The present analysis is restricted to the 31 interviews conducted with men living in six different residential drug treatment centers who reported a history of ICC, and to participant observation conducted at participants' ICC hearings. Albizu-García and Miranda-Miller's study examined the experiences of persons who had been relocated from Puerto Rico to the US mainland with the understanding that they would receive drug treatment for opioid use disorder. The aim of this larger study was to assess whether these relocation practices might meet the legal definition of human trafficking. The full findings and methodology are published elsewhere.[15] The present analysis draws primarily on the legal component of this research and on the experiences of male participants who reported being subject to ICC.

In the summer of 2019, the three of us began convening digitally to exchange findings and analyses, with the goal of collating and comparing the experiences of participants subject to ICC. Parker compiled and analyzed qualitative findings relating to ICC from both studies (interviews and fieldnotes). Here, we sum up what we have collectively learned about ICC in Puerto Rico through our sustained, iterative dialogue.

Puerto Rican ICC law for substance use disorders

Today, Law 67 of 1993 (amended in 1994, 2005, and 2008) is one of two pieces of civil legislation, along with the Mental Health Act (Law 408 of 2000, amended in 2008 and 2012), governing substance-related ICC in Puerto Rico. Though both laws are used to remand citizens deemed to have drug problems into some form of treatment, the two pieces of legislation have distinct histories and operate in different ways. Though commonly known as a "compulsory treatment" law, the Law of the Administration of Mental Health and Anti-Addiction Services (from here on, "Law 67") is what lawyers call "enabling" legislation: that is, it was introduced to establish a new government agency. Part of a series of health care forms introduced in the 1990s, Law 67 enabled the unification of the

former Department of Service against Addiction and the Department of Mental Health Services into a single new administration (the Administration of Mental Health and Addiction Services). Baked into this enabling legislation was a short clause in section 11 entitled "Procedimiento Judicial para Adictos" ("Judicial Procedure for Addicts").[16] Section 11 of Law 67, which is just one and a half pages long (1,040 words), lays out various juridical procedures for the involuntary treatment of people deemed to be "addicted to drugs and/or alcohol."

The insertion of an ICC clause into legislation primarily designed to merge two government departments was historically unusual. ICC provisions in the United States tend to be drawn up as part of the mental health laws, though this is not always the case. In an analysis of US ICC laws, researchers found that some of the ICC statutes identified were found in states' penal and welfare codes rather than in mental health laws.[17] Unlike ICC clauses that are drawn up as part of mental health law, which are typically overseen by professional medical societies and patient advocacy groups, the insertion of section 11 of Law 67 occurred without any external consultation. In fact, several government officials interviewed in Parker's research recalled that Law 67's ICC clause was the brainchild of a single government employee whose child suffered from a substance use disorder, though a lack of relevant archival documentation make this difficult to verify resolutely.

What should have been an opportunity to reform Puerto Rico's legal framework for ICC came in 2000, when its legislature introduced Law 408 of 2000 (from here on, "the Mental Health Act"), which became the second piece of legislation governing substance-related ICC in Puerto Rico. The Mental Health Act was a bill of rights that clarified the rights of patients, and, among other things, laid out new procedures for the ICC of people with substance use disorders, procedures that were compliant with standards set out by the US Supreme Court and the Universal Declaration of Human Rights. Oddly, when legislators introduced the Mental Health Act (and subsequently amended it in 2008 and 2012), they neglected to rescind Law 67's ICC clause. Similarly, although Law 67 was subsequently amended in 1994, 2005, and 2008, its civil commitment clause remained unchanged. As a result, Puerto Rico currently has two laws governing ICC for substance use disorders, one of which directly contradicts the other. Below, we draw on qualitative findings from both studies that illustrate some of the human consequences of this dysfunctional legal system, highlighting in particular the ways that Law 67 violates rights and liberties that are supposed to be guaranteed by local, national, and international law.

Mental health rights and civil liberties under Puerto Rican, US federal, and international law

The United Nations (UN) Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, adopted by the General Assembly in 1991, have served as a model and blueprint for ICC legislation across UN member states with respect to both mental health and substance use disorders. Under its provisions, psychiatric patients are accorded the same civil and political rights as all other people and cannot be compelled to undergo treatment without their consent, unless they are declared "legally incapacitated."[18]

Principles 11 and 16 of the UN resolution explain that "legal incapacity" can be declared under two circumstances: first, if a medical expert determines that the patient has a mental illness and poses a danger to themselves or others; or second, if a medical expert determines that the condition of a person with severe mental illness is such that not committing them will likely lead to a serious deterioration of their condition. These principles—professional diagnosis, danger, and threat of deterioration—have guided the drafting of civil commitment legislation for mental health across UN member states.

Civil commitment for substance use disorders in the United States operates according to broadly similar criteria. The constitutional guarantee of due process requires that the nature and duration

of commitment bear some reasonable relationship to the purpose for which the individual is committed.[19] According to rulings by the US Supreme Court in 1975, ICC laws are constitutional only when they contain stipulations for both proof of condition and dangerousness. ICC laws are constitutional only when they contain stipulations for both proof of condition and dangerousness.[20] In 1997, the US Supreme Court added that involuntary civil confinement is permissible only when limited to "those who suffer from a volitional impairment rendering them dangerous beyond their control."[21] According to the US Supreme Court then, simply having a proven substance use disorder is insufficient justification for ICC: the criterion of dangerousness must also be met. Worryingly, Law 67 fails to uphold this principle of dangerousness, instead permitting the ICC of anyone a court esteems addicted to narcotic drugs or alcohol.

This brings us to another of Law 67's deficiencies: its evidentiary standard for confinement is woefully low. Officially, Law 67 states that civil commitment is permissible when "the court determines that there is cause to believe that the person is addicted to narcotic drugs." Stated thus, this standard of evidence resembles the "probable cause" standard that is typical of preliminary hearings. But in *Addington v. Texas* of 1979, the US Supreme Court ruled that ICC required a higher standard of proof of condition: "the individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence."[22] In other words, Law 67's procedure for ICC contradicts the constitutionally mandated "clear and convincing evidence" requirement for involuntary civil commitment as prescribed by *Addington v. Texas*.

Law 67 also contradicts various local laws. Since 2000, Puerto Rico's Mental Health Act has stated that the treatment and care of the patient "should be based on promoting the best practices of self-determination and personal responsibility, consistent with their own needs and desires," and that "autonomy must be preserved, as far as possible."[23] It is not by chance that concepts such as self-determination and autonomy are found in Puerto Rican mental health law. These concepts are closely linked to the dignity of the human being, a fundamental value consecrated in the Puerto Rican Constitution.[24] In stark contrast, Law 67 does not safeguard the autonomy of the person. Instead, it allows for the long-term involuntary commitment of citizens *regardless* of whether they have been clinically diagnosed with a substance use disorder, *regardless* of whether they pose a danger to themselves or others, and *regardless* of their capacity to meet their own basic needs. Below, we unpack these grave deficiencies of due process and their human consequences.

An extremely poorly crafted ICC law divorced from clinical expertise

Contemporary legislation pertaining to mental and physical health ordinarily employs terminology that reflects current, accurate, science-based understandings of the health condition at hand, rather than relying on lay terms used by the broader public, which may have negative or offensive connotations. For example, current US legislation pertaining to geriatric care will not generally include lay or offensive terminology such as "demented people," instead using the medically correct term "people diagnosed with dementia." For several decades now, the medical community has similarly eschewed the term "drug addict" because it reduces a person's identity to their struggle with substance use and denies the individual dignity and humanity. Consistent with this medical consensus, most contemporary ICC legislation in the United States is written in accordance with classificatory systems endorsed by professional medical societies. Thus, Puerto Rico's Mental Health Act employs the classificatory framework of the American Psychiatric Association's *DSM-IV-TR* manual for diagnosis, explicitly using the terms "substance abuse" and "substance dependence." (This reflects the terminology of *DSM-IV*, replaced in 2013 with *DSM-V*, which replaced the two categories of substance abuse and substance dependence with one diagnos-

tic category: substance use disorders.)

Reflecting the lack of medical professional oversight when Law 67 was drafted, its ICC clause fails to use the classificatory systems of the medical profession, instead employing the lay (and, many would argue, offensive) term "un adicto a drogas" (a drug addict), with no further elaboration. This failure to employ professional medical terminology is problematic not simply because it perpetuates stigmatizing language.[25] More importantly, this vernacular formulation paves the way for Law 67's very low standard of evidence when it comes to "proving" that a citizen "needs" ICC. This became clear in Parker's court observations.

Whereas the Mental Health Act stipulates that a "clinical diagnosis" must be conducted "by a psychiatrist in consultation with a multidisciplinary team," thereby entrusting clinicians with the power to make recommendations to the court according to their professional discretion, Law 67 does not entrust this power to any specified profession.[26] Strictly speaking, it does not require a clinical diagnosis. Law 67 states only that an "evaluation" must be conducted by "any person/entity that the Administration of Mental Health and Anti-Addiction Services delegates to." Because Law 67 does not specify the professional credentials that the individual conducting the evaluation should possess, it permits a much wider variety of variably qualified (and unqualified) actors to present their "evaluations" to court, evaluations that are often devoid of clinical content.

In Parker's research, permissible evidence of "adicción a drogas" presented to courts included a positive urine test of recent cocaine use administered by a probation officer, a testimony from a sibling of reckless drunk-driving, and physical signs of injection-related scarring on the arms. On several occasions, there was no evidence at all. Instead, the subject of the proceedings simply "confessed" to "being an addict." What counted as an "evaluation" instantiating need for treatment varied significantly. Very few of the men we interviewed (in either study) were ever assessed by a clinician or by a multidisciplinary team. Instead, they were more commonly interviewed by probation officers (*socio-penales*), state police, or sometimes paraprofessional drug counselors. While police, probation officers, and paraprofessional drug counselors undoubtedly possess valuable forms of expertise, none of them is a qualified health care professional. Therefore, according to standards outlined in the Puerto Rican Mental Health Act—those that guarantee that patients be assessed by a clinical or multidisciplinary team—most of the professionals and paraprofessionals making recommendations to civil courts across the island are not legally permitted to do so.

Highly restrictive inpatient care void of clinical supervision

Contemporary ICC statues in the United States usually include guidelines for calibrating patients' clinical condition with their recommended level of care. Puerto Rico's Mental Health Act of 2000, for example, stipulates that the individual must be placed in the "least restrictive" level of care according to the "severity" of their substance use disorder. Any person ordered to enter "restrictive" (residential) care, according to the Mental Health Act, must be clinically evaluated regularly by a psychiatrist and relocated to "less restrictive" (outpatient) care once their condition improves.[27] Additionally, the Mental Health Act states that residential treatment must be reserved for people for whom a less restrictive treatment (outpatient or medication-assisted treatment) has not worked in the past.

Again, Law 67 proves markedly thin in this regard. Section 11 of Law 67 contains no guidelines for establishing the appropriate level of care, no requirements regarding ongoing monitoring of illness severity, and no recommendations for adjustments to level of care. Instead, and in direct contradiction of the Mental Health Act, Law 67 permits any citizen deemed to be a "drug addict," often on the basis of very poor evidence, to be institutionalized in highly restrictive residential settings without ever being monitored or reevaluated by a health care professional. In Parker's study, she routinely encountered residents remanded to residential drug treatment centers via ICC who had never been

reevaluated by a health care professional after their initial detention. Instead, once institutionalized, civil commitment was effectively a done deal. The level of care residents received was never adjusted or recalibrated, and their clinical condition was never monitored.

Adjudication of appropriate treatment was equally concerning. In Parker's research, she found that the question of "appropriateness" overwhelmingly came down to pragmatic concerns such as program availability or the personal preferences of the petitioner, rather than to patient-centered needs as determined by a qualified health care professional. So, for instance, petitioning parents might request that a judge send their relative to a particular residential drug treatment program because it was near the vicinity of their home or because it subscribed to their denomination or faith. Or, to take another example, a parent might request that a child be remanded to residential program rather than outpatient care because the parent needed respite from their child. While these are understandable familial preferences, again we encounter the incongruities of Puerto Rico's dysfunctional legal framework. The Mental Health Act *guarantees* that citizens undergoing ICC will receive appropriate care according to the severity of their health condition, as assessed by a clinical professional. In order to comply with the Mental Health Act, judges must remember that families are not qualified to recommend appropriate treatment for their relatives. Just as surgeons do not perform amputations or heart surgeries by request, judges should not legally oblige citizens to undergo kinds of treatment—in particular, questionable modes of restrictive residential institutionalization that fail to provide evidence-based care—if it has not been demonstrated by a health care professional that this is strictly necessary.

Excessively long commitment duration with highly ambiguous release criteria

Another striking idiosyncrasy of Law 67 is that both its maximum commitment duration and its release criteria are extremely poorly articulated. In most US states, ICC laws have clearly defined maximum durations, ranging from 48 hours in New York State to 30 days in Massachusetts and 180 days in North Carolina, with a minority of states permitting longer periods.[28] Notwithstanding this wide variation in ICC duration nationally, Law 67 stands out because its maximum duration is unclear. In one section, Law 67 states that the patient should remain in the institution until they have received "the maximum treatment that the institution can offer." (In a later section of the law, this is expressed as "all the treatment the institution can offer.") Thus, for one full year, release is granted only if it can be demonstrated to the court that the patient has received the maximum benefit from whatever "treatment" (mostly peer-based self-help) they are receiving. Only at the one-year-mark does the onus of explaining why a patient has *not* been discharged fall onto the host treatment center, when the law states (somewhat confusingly), "The Court, on its own initiative or at the request of the patient, and after the patient has been in treatment for one year, will summon the person in charge of the institution where patient is receiving treatment to explain why the patient has not been discharged." In other words, it is *after one full year* of involuntary institutionalization that Law 67 effectively assumes that the criterion of "maximum treatment" has been fulfilled.

In practice, commitment duration tends to be negotiated in court hearings that are held "periodically"—in Parker's research, usually bimonthly—though Law 67 does not specify a precise time frame. Parker found that when making decisions of release in practice, judges will usually equate "maximum benefit" with the recommendations given by the host drug treatment center. This is partly because in a later section of the law, Law 67 states that a "report" providing "recommendations" as to whether a person "should continue with involuntary treatment" must be presented at hearings throughout the resident's institutionalization. But again, basic stipulations regarding the credentials of the reporter and the principles that ought to guide any "recommendations" are left unspecified. Since no elaboration is provided as to the basis on which

"recommendations" ought to be made, and because the professional credentials of the person writing the report are also left unspecified, the task of providing recommendations to the court falls onto the paraprofessional drug counselors who operate residential drug treatment centers. In Puerto Rico, most residential drug treatment programs have a "recommended" program duration between one year and 18 months. Thus, paraprofessional drug counselors will usually advocate that an individual complete the "full duration" of their program, regardless of the individual's needs or condition. This one-size-fits-all approach is not adjusted or calibrated according to patients' needs.

Law 67's vague articulation of maximum treatment sheds light on why those subjected to it tend to remain committed for very long periods. In the 31 cases followed by Parker, 29 out of 31 individuals served at least one year in a residential facility, with 15 of those 29 serving 18 months. In nearly all cases observed, then, judges deemed residents to have met the criterion of "maximum benefit" only when they had completed the entirety of the host organization's "recommended" duration. In Parker's research, a direct recommendation for early release prior to the one-year mark was provided in just two of the cases she observed (both were granted). Notably, in neither instance did the release recommendation come from a paraprofessional drug counselor. In both cases, it was a psychologist—with whom the residents had preestablished relationships prior to the court order—who advocated for their removal in court using a mechanism called "juridical deference." In both cases, the psychologists emphasized that the client did not meet the clinical criteria for substance use disorder, and, in both cases, they were successful in persuading the judge to lift the court order. Aside from these two cases, Parker did not encounter any examples of professionals (psychiatrists, psychologists, caseworkers, social workers, or others) advocating for residents' release. Instead, civilly committed residents tended to attend their hearings accompanied only by the petitioner and a paraprofessional drug counselor from their host drug treatment center. This lack of qualified health care professionals in court hearings means that judges are forced to rely on the testimonies and reports of paraprofessional drug counselors, who, as discussed, lack the professional credentials to make clinical assessments.

Not only is Law 67's vague provision of duration unusual at the national level, but it also stands in stark contrast to prohibitions on extended confinement laid out in section 15.03 of the Puerto Rican Mental Health Act ("Institutionalization Prohibited"), which states that "any institution which is found to have institutionalized a person … who does not … present the severity that warrants his/her placement at the level of care where he/she has been kept … shall be guilty of a crime, under Article 168 of the Puerto Rico Penal Code."[29] Arguably then, every residential drug treatment center that is currently housing civilly committed residents (via either Law 67 or the Mental Health Act) without ensuring regular clinical monitoring and reassessment (in our experience, most of them) is currently committing a crime.

This raises an additional issue of fairness: a lack of legal counsel. Granted, there is no constitutional requirement for counsel to be provided to indigent persons in civil commitment proceedings, and constitutional due process protections are far less extensive for civil proceedings than for criminal proceedings, yet legal counsel remains a statutory right (if not a constitutional right) in civil commitment proceedings.[30] Despite the fact that this statutory right should, in theory, be enforced by courts, we did not come across a single Law 67 case in our research in which the individual subject to proceedings received legal counsel.

ICC is prone to misuse and exploitation

Among the most concerning developments observed in both studies were the handful of municipalities that have created their own protocols and dedicated agencies for managing Law 67 cases. Though still localized to a handful of municipalities, in these regions it tends to be a municipal government agency (rather than a family member) who acts as the petitioner. In Parker's research, residents who had been arrested in the municipality of Bayamón

specifically often believed that it was their homelessness, rather than their addiction, which had prompted the local government to seek the court order. In the municipally monitored cases Parker observed, it was quite common for all subsequent hearings to go ahead without the participation of either the resident or a representative from the treatment center. Instead, a municipal government agency in Bayamón called Nuevo Amanecer would simply request that the host drug treatment center fax them a copy of the resident's case report. The municipal agency, in turn, would then dispatch one of its employees to represent the resident in court, despite the fact that the municipal employee had little or no contact with the resident.

In Albizu-García and Miranda-Miller's study, some individuals were forced by municipal employees to accept relocation under the threat of Law 67. Those detained by Law 67 who do not accept the court order to enter "treatment" tend to be considered in contempt of court, a crime for which they are usually sentenced to prison.[31] One participant who reported being seized by the Municipal Police of Bayamón, operating in concert with municipal employees of the program Nuevo Amanecer, was relocated to the United States under threat of involuntary confinement under the provisions of Law 67. This participant specifically stated that he agreed to be transferred because he had previously been held in prison under what he identified as Law 67. Worryingly then, it seems very likely that Law 67 is being misused by municipal governments to remove homeless people and drug users from their municipalities.

Forced "treatments" that lack proven efficacy

Thus far, we have focused primarily on Law 67's deficiencies of due process and in particular on its departure from prevailing US ICC legislation. Yet an additional ethical failing here—one that actually has very little to do with Law 67 specifically and that constitutes a much more generalizable failure of ICC worldwide—is the sheer lack of effective treatments for substance use disorders. In Puerto Rico, as in many parts of the United States, ICC relies on drug services that fail to uphold the standards of evidence-based treatment as established by the World Health Organization and the US Substance Abuse and Mental Health Services Administration.[32] Across the island, by far the most widely available drug service is abstinence-based residential drug treatment, which made up 50% of the state-licensed drug treatment programs in 2021.[33] Puerto Rico's residential drug treatment programs—many of which are faith-based, Evangelical programs—are guided by the principle of "mutual aid," whereby people who share a common problem come together to assist one another. As a result, these "residential drug treatment programs" generally do not employ health or social care professionals but rather are run and managed by paraprofessional peers who have suffered with a drug problem in the past.

Most of Puerto Rico's residential drug treatment programs employ a modified iteration of the "therapeutic community" approach, grounded in long-term communalist living, abstinence, and group therapy, and frequently supplemented with prayer, bible study, and forms of spiritual and religious counseling.[34] Though no study to date has ever evaluated residential drug treatment in Puerto Rico, a systematic review of US-based therapeutic communities, which was dogged by poor-quality data sets and had to exclude most of its sample, indicated post-treatment relapse rates between 21% and 100%.[35] The fact that there is no evidence that Puerto Rico's residential treatment programs are effective in treating substance use disorders—and on the contrary, qualitative data indicate that these approaches can be harmful—should be an immediate cause for concern for judges who adjudicate ICC.[36] Let us recall that the Puerto Rican Mental Health Act is supposed to guarantee that mental health patients receive "effective services" (section 14.04). The use of Law 67 to remand individuals into institutions that are not known to be effective in treating substance use disorders thus constitutes yet another violation of Puerto Rico's Mental Health Act.

Conclusion

Thanks to Law 67 of 1993, Puerto Rico is the only place in the United States where undiagnosed individuals who pose no immediate danger to themselves or others, and who are otherwise self-sufficient, may be involuntarily committed to restrictive residential facilities—often for over a year—without ever seeing a lawyer, a doctor, or a health care professional. Our research shows that once individuals are committed, their condition will rarely be monitored, let alone reassessed, by a health care professional, as this is not legally required. Instead, citizens subject to Law 67 are routinely left to languish for months at a time, deserted by health care professionals and bereft of legal counsel, with no clear understanding of when or how they may qualify for release. By the letter of the law and in practice, Law 67 violates Puerto Rico's Mental Health Act and contravenes standards decreed by the US Supreme Court and the Universal Declaration of Human Rights. Considering these troubling findings, we recommend that legislators, government bodies, and judges adopt the following measures to prevent further abuses of civil liberties and patient rights.

The Legislative Assembly of Puerto Rico must annul section 11 of Law 67 as soon as possible, given that it allows self-sufficient adults who have never been diagnosed with a substance use disorder and who pose no threat to themselves or to others to be involuntarily committed into restrictive residential institutions for an unspecified period of time against their will. We also recommend that the Legislative Assembly release from residential drug treatment programs all persons who are currently institutionalized under Law 67 and lift all active Law 67 court orders.

Judges responsible for adjudicating ICC must stop using Law 67 in ICC proceedings, because doing so violates the Mental Health Act and the US Constitution. Where necessary, judges should use the Mental Health Act in all future ICC cases, which is compliant with the federal Supreme Court. Additionally, judges should accept only those court reports and recommendations regarding ICC patients that are written by qualified health care professionals, in order to comply with the Mental Health Act.

Puerto Rico's Mental Services Administration Health and Addiction, as the regulating entity charged with ensuring implementation of the Mental Health Act, must conduct a review into the monitoring processes for all ICC cases related to substance use disorder to ensure that all civilly committed patients receive the level of care that accords with the severity of their condition, as recommended by a qualified health care professional.

The US Substance Abuse and Mental Health Services Administration has published guidelines to assist policy makers in evaluating, reforming, and implementing ICC that consider competing interests as well as ethical concerns guided by respect for autonomy, non-maleficence, beneficence, and justice.[37] These guidelines are formulated to align policy and practice with nationally agreed requirements for inpatient and outpatient commitment statutes. These guidelines merit immediate attention from Puerto Rican legislators to prevent further rights abuses. Among these are clear specifications to assure due process protection, including prompt notice of rights, assignment of counsel, and an opportunity to challenge commitment or detainment in jail before a judge or other judicial authority without unreasonable delay.

Of course, constraints on access to appropriate treatment options will greatly influence involuntary commitment policy and practice. In Puerto Rico, as in many other jurisdictions, a continued policy emphasis on drug prohibition that diminishes the social value of individuals experiencing a substance use disorder will preclude much-needed access to treatment alternatives that are evidence based. Lack of appropriate treatment and of clear placement criteria increases the likelihood of severe illness and together make substance-related comorbidities and premature death—both of which are preventable—far more likely. The extent to which the structural factors described in this study prevail in other US jurisdictions requires immediate attention. Lessons from Puerto Rico should also inform considerations in enacting legislation for ICC where they are currently nonexistent.

Limitations

A number of study limitations should be noted. This sample was recruited exclusively from residential drug treatment facilities (from six different programs). Since our sample includes neither women nor individuals who have undergone ICC in other institutional settings (for example, in jail or in clinics for medication-assisted treatment), it is unclear whether the ICC processes and procedures observed here apply to women undergoing ICC or to individuals undergoing ICC in other institutional settings. Still, our 31 male participants reported notably consistent experiences, giving us confidence in their accounts of ICC in residential drug treatment settings. Additionally, Parker observed ICC hearings in five out of the nine municipal courts that oversee ICC for substance use disorders in Puerto Rico. It is possible yet unclear whether and how ICC proceedings may vary across the island's other municipal courts.

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