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Comments of the American Civil Liberties Union (ACLU) and the ACLU of Southern California

Re: RIN 1120-AB20, Proposed Revision to Bureau of Prisons' (BOP's) Regulations on Providing Psychiatric Treatment and Medication to Inmates.

The American Civil Liberties Union and its Southern California affiliate welcome the opportunity to comment on the Bureau of Prisons' proposed revision to its regulations on providing psychiatric treatment and medication to inmates (73 Fed. Reg. 33957-33959). The ACLU is a nationwide, non-partisan organization of more than half a million members dedicated to protecting the principles of liberty, freedom and equality as set forth in the Bill of Rights to the United States Constitution. For more than 80 years, the ACLU has sought to preserve and strengthen individual freedoms and privacy in all aspects of American life.

The ACLU finds three defects in the proposed BOP regulations. First, the scope of the regulations is too narrow, insofar as it does not apply to federal detainees who are not held in BOP facilities. Second, the regulations should be amended to clarify that the exception authorizing more cursory procedures for emergencies requires that any treatment be "medically" appropriate, even in an emergency. Third, the regulations should be amended to clarify that the person deciding that a "psychiatric emergency" exists should be a psychiatrist, or at least a qualified physician.

I. Applicability

The proposed revisions to Bureau of Prisons (BOP) regulations, 28 CFR Part 549, note that the regulation applies to all "inmates" in Bureau custody, as defined by 28 CFR Part 500. According to 28 CFR Part 500, ICE detainees held in BOP custody appear to be included within the meaning of the term "inmate." The regulation provides in pertinent part,

“[i]nmate means all persons in the custody of the Federal Bureau of Prisons or Bureau contract facilities, including persons charged with or convicted of offenses against the United States; D.C. Code felony offenders; and persons held as witnesses, *detainees*, or otherwise. 28 CFR 500.1(c) (emphasis added).

However, the regulation does not appear to apply to ICE detainees who are not in BOP custody, but rather are imprisoned at either a Service Processing Center, county jail, or some other facility not run by the BOP. This is a serious defect in the regulation, as it arguably fails to create any procedures for the roughly 30,000 detainees in federal custody who are not imprisoned at BOP facilities. The regulation should be clarified to state that it also governs the treatment of federal inmates housed at other facilities, including those run by ICE and by county jails. Furthermore, to the extent that there is ambiguity as to BOP’s authority to bind facilities not under its direct control, BOP should take any and all additional action necessary to ensure that the mandate of these regulations extends to all such facilities, whether through contractual arrangements, intergovernmental working protocols, revised or additional regulations, or otherwise.

II. Psychiatric Emergency – “Appropriate Treatment”

Proposed regulation 549.46(b) creates a psychiatric emergency exception, whereby psychiatric medication may be administered when it constitutes an “appropriate treatment for the mental illness.” The proposed language lacks clarity on the question whether the “appropriate” treatment must be “medically” appropriate, as opposed to “appropriate” in some more general sense, perhaps concerning the security needs of the prison.

Recent Supreme Court and Ninth Circuit precedent confirms that the use of “appropriate” in the regulation must be understood as requiring that the treatment be “medically appropriate.” In Sell v. United States, the Supreme Court held that involuntary treatment must be “medically appropriate,” meaning that it must be “in the patient’s best medical interest in light of his medical condition.” Sell v. United States, 539 U.S. 166, 181 (2003). See also Washington v. Harper, 494 U.S. 210, 222-23 (1990) (noting that due process concerns require that inmate’s treating physician make decision of appropriateness of medication); U.S. v. Williams, 356 F.3d 1045, 1056 (9th Cir. 2004) (holding that court must give deference to medical determination of appropriate treatment in order to avoid abuse of discretion).

Given the court’s clear direction on involuntary administration of medical treatment, BOP regulations should state explicitly that “appropriate treatment” means “medically appropriate treatment”.

III. Psychiatric Emergency – Procedure

The proposed regulations also provide inadequate guidelines for determining whether a medical emergency exists. Most importantly, subsection 549.46(b)(1) fails to designate who has the responsibility and the authority for making the determination that such an emergency exists.

Under current law, only a qualified physician may make the determination. In Washington v. Harper the Supreme Court held that due process demands were met when the policy under review required that a qualified psychiatrist first determined that a mental disorder exists and then prescribed appropriate medication. Washington v. Harper, 494 U.S. 210, 222-23 (1990). In reaching that conclusion, the Court appeared to assume that a psychiatrist had to make the

decision. See id. at 215.¹ At the very least, it seems clear that the decision must be made by a qualified physician. As the Ninth Circuit noted in a case involving involuntary medication, “the unique nature of involuntary antipsychotic medication and the attendant liberty interest require that imposition of such a condition occur only on a medically-informed record.” U.S. v. Williams, 356 F.3d 1045, 1056 (9th Cir. 2004). Indeed, in Williams the court found that the district court had abused its discretion by failing to give due deference to medical findings made by qualified psychiatrists. See id. Where a psychiatric emergency requires the involuntary use of psychotropic medications, only a qualified physician – probably a psychiatrist – can make the determination that the emergency exists, that medication is necessary, and which type of medication is medically appropriate.

The regulation should be amended to clarify that a psychiatrist, or alternatively a qualified medical physician, must make the decision that a medical emergency exists.

If you have any questions, please call Joanne Lin, ACLU Legislative Counsel, at (202) 675-2317.

Sincerely,



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¹ Under the institutional policy at issue in Harper, if a psychiatrist determines that an inmate should be treated with antipsychotic drugs but the inmate does not consent, then the inmate may be subjected to involuntary treatment with the drugs only if he (1) suffers from a ‘mental disorder’ and (2) is ‘gravely disabled’ or poses a ‘likelihood of serious harm’ to himself, others, or their property. Only a psychiatrist may order or approve the medication. Washington v. Harper, 494 U.S. 210, 215 (1990). In addition, an inmate who refuses to take the medication is entitled to a hearing before a treatment decision team consisting of a psychiatrist, psychologist, and the Associate superintendent. See id.