TASC Training & Advocacy Support Center

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Q&A

Legal Issues Arising From the Denial or Termination of Psychiatric Medication to Individuals Confined in Prisons, Jails or Juvenile Justice Facilities

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Q. I have been contacted by a pre-trial detainee in the local jail who has a serious psychiatric condition. Before his arrest he had been prescribed and was taking psychiatric medication for this condition for years. Following his arrest, the jail authorities stopped his medication. He has repeatedly complained to the guards, the sheriff and the medical staff in the jail that without the medication he hears voices and has difficulty controlling his behavior. He has been involved in fights with other detainees on several occasions, which he attributes to not getting his medication. What would I have to show in order to hold the jail liable for denying medication to this individual?

A. To bring a claim pursuant to 42 U.S.C. § 1983, you will need to prove that the sheriff and/or his/her staff were "deliberately indifferent" to your client's serious medical condition. You may also have an ordinary negligence claim under state law.[1] This Q&A will focus on the issues that often arise under the "deliberate indifference" standard.

The inadequacies of mental health treatment in jails, juvenile detention centers, and prisons are well documented.[2] Despite advances in screening,

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[1] Most states have state tort claims acts that govern the tort liability of government officials. Often they contain short notice of claim requirements and include other provisions that provide such officials with greater protection from liability than private actors.

[2] U.S. Hse. Comm. on Government Reform—Minority Staff, Special Investigations Div., *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States* at 9-10 (July 2004) (27% of juvenile detention facilities "report poor, very poor, or no mental health treatment for youth in detention") (available online at http://oversight.house.gov/documents/20040817121901-25170.pdf); Teplin, Abram, McClelland, Washburn, and Pikus, *Detecting Mental Disorder in Juvenile Detainees: Who Receives Services*, 95 Am. J. Pub. Health 1173, 1176 & Table 2 (Oct. 2005) (only 7.8% of juvenile detainees in need of mental health treatment received it in detention facilities) (available online at http://www.ajph.org/cgi/content/full/95/10/1773); U.S. Dep't of Justice,

assessment and treatment over the past decade, significant deficiencies continue to exist. Detention facilities and jails are generally operated by counties or other units of local government. As a result of this decentralized structure, the quality and quantity of mental health treatment in such facilities varies greatly.[3] While some offer excellent mental health services and have policies and protocols in place to ensure that detainees' mental health needs, including their medication needs, are met,[4] others offer little if any mental health services and routinely refuse to permit detainees access to their psychiatric medication. In many cases, psychiatric medications, which are generally quite costly, are discontinued for fiscal reasons.[5] As a result, it is not at all uncommon to encounter situations in which pre-trial detainees are denied access to needed psychiatric medication for which they have both a critical need and a valid prescription. The consequences of inappropriate termination or denial of needed psychiatric medication can be extremely serious, including suicide, physical abuse by other detainees or jail staff, and serious and long-lasting deterioration in the condition of the individual.[6]

THE LEGAL FRAMEWORK

The landmark case establishing the "deliberate indifference" standard is *Estelle v. Gamble*, 429 U.S. 97 (1976). In *Estelle*, a prison inmate filed a *pro se* complaint against the state commissioner of corrections, the warden of the prison where he was incarcerated, and the prison's medical director alleging that they had subjected him to cruel and unusual punishment in violation of the Eighth Amendment due to their failure to properly diagnose and treat a back injury he suffered while working at the prison. The Court first held that states are obligated to treat the medical needs of prisoners in their custody. *Id.* at 103-04. However, not every failure

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Bureau of Justice Statistics, *Mental Health Problems of Prison and Jail Inmates* at 9-10 & Tables 14-15 (rev. 12/14/06) (showing appreciable decrease in mental health treatment in jails as compared with prisons in all areas, including prescribing of medication) (available online at http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf).

[3] See, Scheyett, Vaughn, Taylor & Parish, *Are We There Yet? Screening Processes for Intellectual and Developmental Disabilities in Jail Settings,* 47 Intellectual and Developmental Disabilities 13, 17-21 (Feb. 2009) (available online at http://www.aaidd.org/media/PDFs/PeoplewithIDDDinjails.pdf) (documenting extensive variation from county to county in jails' identification of and response to individuals with intellectual and developmental disabilities).

[4] See, e.g., the San Francisco County Jail policy regarding medication continuation (copy appended to this Q&A). This is not offered as a model policy. However, it does demonstrate that the jail administrators have carefully considered the issue. By establishing and following a facially reasonable medication policy, a jail or detention center will make it substantially more difficult for an aggrieved detainee to establish that the jail was deliberately indifferent to his/her medical needs.

[5] See, Council of State Governments, *The Criminal Justice/Mental Health Consensus Project*, Ch. III, Policy Statement 13.e at 107-08 (2002) (available online at http://consensusproject.org/downloads/Chapter_III.pdf).

[6] *Mental Health Problems, supra* n.2 at 10 (jail inmates with mental health condition 3 times more likely to have been injured in a fight than those without a mental health condition).

to provide appropriate treatment rises to the level of a constitutional violation. Only "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' … proscribed by the Eighth Amendment." *Id.* at 104 (quoting *Gregg v. Georgia*, 428 U.S. 153, 182-83 (1976) (joint opinion of Stewart, Powell and Stevens, JJ.). Such "deliberate indifference" can occur due to the inadequate response of prison doctors to a prisoner's medical needs or the actions of prison guards in denying or delaying access to medical treatment. *Id.* at 104-05. However, the Court was careful to explain that "an inadvertent failure to provide adequate medical care" does not constitute "deliberate indifference." *Id.* at 105-06. To state a claim, "the prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs." *Id.* at 106. Because the prison doctors had seen Gamble on numerous occasions and prescribed medication for his back condition, the Court affirmed the dismissal of Gamble's complaint against the medical director, finding any deficiencies in treatment to be "[a]t most, malpractice." *Id.* at 107. However, the Court remanded the case for further consideration regarding whether the actions of the Commissioner and warden rose to the level of "deliberate indifference."[7] *Id.* at 108.

While *Estelle* articulated the "deliberate indifference" standard, it did not provide the lower courts with any meaningful guidance regarding the level of culpability required to meet it. Following *Estelle,* some courts applied an objective "reasonable person" standard, while others employed a subjective "actual intent" standard.[8] The Supreme Court undertook to clarify the standard in *Farmer v. Brennan*, 511 U.S. 825 (1994). Relying in significant measure on the Eighth Amendment's specific focus on "punishment", the Court rejected an objective test and, instead, held that a prison official can be held liable under the "deliberate indifference" standard only if

> he knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and *he must also draw the inference*.

Id. at 837 (emphasis added).[9] Recognizing the difficulties involved in proving actual intent, the Court did explain that actual knowledge of the risk of serious harm can be inferred from circumstantial evidence. "[A] factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." *Id.* at 842. However, "the inference cannot be conclusive, for we know that people are not

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[7] The decision contains no description of the claims alleged against the warden and Commissioner and remands for consideration of these claims because the Court of Appeals decision did not address them.

[8] *Compare*, *McGill v. Duckworth*, 944 F.2d 344,348 (7th Cir. 1991) (requiring a "subjective standard of recklessness"), *with Young v. Quinlan*, 960 F.2d 351, 360-61 (3d Cir. 1992) (applying an objective "knew or should have known" standard).

[9] The Court did announce that the standard for determining whether the harm was sufficiently serious to constitute an Eighth Amendment violation was an objective test. *Id.* at 834.

always conscious of what reasonable people would be conscious of." *Id.* (quoting LaFave & Scott, Substantive Criminal Law § 3.7, p. 335 (1986)). "That a trier of fact may infer knowledge from the obvious, in other words, does not mean that it must do so." *Id.* at 844. Where prospective declaratory or injunctive relief is sought, actual knowledge of harm can be established by information and evidence provided during the course of the litigation. *Id.* at 846 & n.9.

Estelle and *Farmer* were Eighth Amendment cases involving convicted prisoners. Because neither juveniles nor pre-trial detainees are being held as punishment for wrongdoing, their claims of inadequate medical or mental health treatment should be evaluated pursuant to the Fourteenth, rather than the Eighth, Amendment.[10] *Youngberg v.* Romeo, 457 U.S. 307, 324 (1982) (Fourteenth, rather than Eighth, Amendment provides basis for civilly committed individual's liberty interest in medical care, safety and freedom from unnecessary restraint); *Revere v. Massachusetts General Hospital,* 463 U.S. 239, 244-45 (1983) (Fourteenth Amendment Due Process Clause establishes right of pre-trial detainee to medical care). This raises the question of whether the subjective "deliberate indifference" test of *Estelle* and *Farmer* applies in these contexts. In *Youngberg* and *Revere*, the Court stated that the standard for liability under the Fourteenth Amendment should be less stringent than under the Eighth Amendment. *Youngberg*, 457 U.S. at 321-22 ("Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish"); *Revere*, 463 U.S. at 245 ("the due process rights of a [pre-trial detainee] are at least as great as the Eighth Amendment protections available to a convicted prisoner").

Three possible tests for denial of medical care claims in the juvenile or pre-trial detainee context come readily to mind. One possibility is the standard announced in *Youngberg*: "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person actually did not base the decision on such a judgment." *Youngberg*, 457 U.S. at 323. In *Patten v. Nichols*, 274 F.3d 829, 834-842 (4th Cir. 2001), the Fourth Circuit considered whether the "professional judgment" standard of *Youngberg* or the "deliberate indifference standard of *Estelle*

[10] The majority of Circuits which have considered the question agree that juvenile conditions of confinement cases should be evaluated under the substantive due process provision of the Fourteenth Amendment, *See*, *J.M.K. ex rel. A.M. v. Luzerne County Juvenile Det. Ctr*., 372 F.3d 572, 579 (3d Cir. 2004); *L.B. ex rel. A.J. v. Kierst,* 56 F.3d 849, 854 (8th Cir. 1995); *Gary H. v. Hegstrom ,* 831 F.2d 1430, 1431-32 (9th Cir. 1987); *Hewett ex rel. H.C. v. Jarrard,* 786 F.2d 1080, 1085 (11th Cir. 1986); *Santana v. Collazo,* 714 F.2d 1172, 1179 (1st Cir. 1983); *Collard ex rel. Milonas v. Williams,* 691 F.2d 931, 942 n.10 (10th Cir. 1982); *Bowers ex rel. Alexander S. v. Boyd*, 876 F. Supp. 773, 796 (D.S.C. 1995), *aff'd in part and rev'd in part on other grounds*, 113 F.3d 1373 (4th Cir. 1997). *But see Nelson ex rel. Nelson v. Heyne*, 491 F.2d 352, 355 (7th Cir. 1974) (applying cruel and unusual punishment test of Eighth Amendment to evaluation of corporal punishment at state correctional institution for boys). The Supreme Court has not yet decided the issue. *See*, *Ingraham v. Wright*, 430 U.S. 651, 669 n.37 (1977).

should apply in a claim of denial of medical care by the estate of an involuntarily committed mental patient. The court noted that denial-of-medical-care claims by civilly committed mental patients, like those of pre-trial detainees, were based on the Fourteenth Amendment. *Id.* at 834-35. The court then concluded that the *Youngberg* standard applied. However, without any reasoned explanation, it acknowledged with approval its prior decisions applying the deliberate indifference standard to pre-trial detainees. *Id.* at 834-35, 838-39.

A second possible standard would be an entirely objective "deliberate indifference" test. The Supreme Court in *Farmer* considered, but ultimately rejected such a test for convicts. *Farmer*, 511 U.S. at 836-38. However, the Second Circuit in *Weyant v. Okst*, 101 F.3d 845, 856-57 (2d Cir. 1996) considered the appropriate standard to be applied to a denial-of-medical-care claim on behalf of a pre-trial detainee. Noting that the claim arose under the Fourteenth Amendment, rather than the Eighth, and the *Revere* court's admonition that pre-trial detainees, who had not been convicted of any crime, were entitled to protection at least as great as that of a convicted prisoner, the Second Circuit then considered that appropriate legal standard to apply to such claims. While it retained the "deliberate indifference" language from *Estelle,* it concluded that "deliberate indifference" under the Fourteenth Amendment should be evaluated based upon an objective "knew or should have known" standard, rather than the subjective "actual knowledge" standard adopted in *Farmer*. *Id.*

The third potential standard derives from *Bell v. Wolfish*, 441 U.S. 520 (1979). *Bell* involved a challenge to the conditions of confinement under which pre-trial detainees were being held. The court first announced that the case had to be evaluated under the due process clause, not the Eighth Amendment, because "a detainee may not be punished prior to an adjudication of guilt…." *Id.* at 535. The court then declared that "if a restriction or condition [of confinement] is not reasonably related to a legitimate goal – if it is arbitrary or purposeless – a court permissibly may infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon detainees…." *Id.* at 839. Because this test was developed for conditions cases, rather than medical care situations, it does not transfer very well. Except in the most egregious cases, medical care, whether grossly inadequate or incompetent, is not likely to have been provided as a punishment.[11] Nevertheless, the Third Circuit has adopted this as the test to be applied to denial-of-medical-treatment cases on behalf of juveniles or pre-trial detainees. *Hubbard v. Taylor*, 399 F.3d 150, 165-67 (3d Cir. 2005).

Despite frequent references to the fact that *Estelle* and *Farmer* merely established the constitutional floor for juveniles and pre-trial detainees and that the Fourteenth Amendment standard might be more lenient, most of the Circuits, except for the Second and Third, apply the same "deliberate indifference" standard to juveniles and detainees that they apply to convicted prisoners. *Ruiz-Rosa v. Rulfan*,

[11] It could, of course, be withheld as punishment and, under *Wolfish*, would then violate the inmate's due process rights.

485 F.3d 150, 155 (1st[st] Cir. 2007); *Patten*, 274 F.3d at 834-35; *Hines v. Henson*, 293 Fed. Appx. 261, 263, 2008 WL 5155330 at *2 (5th Cir. 2008); *Ford v. County of Grand Traverse*, 535 F.3d 483, 494-95 (6th Cir. 2008); *Wilson v. Rodriguez,* 509 F.3d 392, 401 (7th Cir. 2007); *Crow v. Montgomery*, 403 F.3e 598, 601 (8th Cir. 2005); *Lolli v. County of Orange*, 351 F.3d 410, 418-19 (9th Cir. 2003) (applies "deliberate indifference" standard, but holds open the possibility of more lenient standard if properly presented); *Gaston v. Ploeger*, 297 Fed. Appx. 738, 741-42, 2008 WL 4672294 at *3 (10th Cir. 2008); *Lloyd v. VanTassell*, 2009 WL 179622 at *3 (11th Cir. 2009). [most circuits are listed – any citations to a DC Circuit case that you can add? If not, change language highlighted above from "all" to "most".]

Nevertheless, when representing juveniles or pre-trial detainees, it remains important to argue for a more deferential standard than "deliberate indifference." *Youngberg* and *Revere* provide strong support for such an argument. Most of the Circuits have fallen back on the "deliberate indifference" standard without any meaningful analysis, often because the plaintiff never argued in the trial court for any other standard. Even if the district court feels constrained to adopt the "deliberate indifference" test due to Circuit court precedent, the court may be inclined to apply the "deliberate indifference" test to your facts in a more deferential fashion in response to a cogent argument in support of a more lenient standard.

DENIAL OR TERMINATION OF PSYCHIATRIC MEDICATION CASES[12]

There are a growing number of cases raising "deliberate indifference" claims arising out of the denial or termination of psychiatric medication to prisoners, pre-trial detainees and juveniles. Some involve claims against the individuals directly involved in the inmate's mental health care, while others raise claims against individuals in a supervisory capacity. Below are some of the more significant cases involving the termination or denial of psychiatric medication:[13]

***Waldrop v. Evans*, 871 F.2d 1030, 1035 (11th Cir. 1989)** (termination of psychiatric medication by prison psychiatrist upon inmate's arrival at facility raises factual issue sufficient for deliberate indifference claim. Prison doctor's failure to refer inmate to psychiatrist after treating him for slashing his forearm sufficient to make out

[12] There are numerous cases raising deliberate indifference claims regarding the denial of medication for non-psychiatric conditions. For citations to such cases, see Vaughn, *Civil Liability Against Prison Officials for Prescribing and Dispensing Medication and Drugs to Prison Inmates*, J. Legal Medicine 315, 324-42 (Sept. 1997); Annot., *Relief under the Federal Civil Rights Act to State Prisoners Complaining of the Denial of Medical Care,* 28 A.L.R. Fed. 279 (2005).

[13] The cases tend to be highly fact specific and often involve multiple defendants. Most are decided on motions to dismiss or for summary judgment, and therefore do not definitively establish liability, but rather hold that the plaintiff has raised facts that could establish deliberate indifference. Constraints of space prevent detailed descriptions of the individual cases.

deliberate indifference claim).[14]

***Greason v. Kemp*, 891 F.2d 829 (11th Cir. 1990)** (termination of psychiatric medication by prison psychiatrist without checking inmate's chart that indicated continuing need for medication sufficient to establish deliberate indifference. Supervisory personnel also deliberately indifferent because they were aware of termination of medication and prisoner's medical records indicating need for medication and failed to intervene).[15]

***Steele v. Shah,* 87 F.3d 1266 (11th Cir. 1996)** (upon transfer to new facility, prison psychiatrist terminated inmate's psychotropic drugs based upon a cursory meeting that lasted less than one minute and refused to reinstate them even after medical staff from the prior facility called and wrote, explaining that he was a suicide risk and in need of psychotropic medication. Facts sufficient to withstand defendant's motion for summary judgment on deliberate indifference claim).

***Campbell v. Sikes*, 169 F.3d 1353 (11th Cir. 1999)** (upon transfer from jail to prison, inmate's psychotropic medication discontinued. Court finds prison psychiatrist's failure to diagnose patient as bi-polar and to continue her medication did not constitute deliberate indifference. Psychiatrist met with inmate on numerous occasions and discontinued medication based on his professional opinion that she was not bi-polar. Despite expert evidence that the psychiatrist misdiagnosed the inmate, the court held that this did not create a triable issue regarding his subjective knowledge that his diagnosis was wrong. Distinguishes *Steele* and *Greason* where the errors and inadequacies of evaluation and treatment were so obvious that the doctors had to know that their actions were well below professional standards).

***Coleman v. Wilson*, 912 F.Supp. 1282 (E.D.Cal. 1995)** (class action challenge to system-wide inadequate mental health treatment in California prisons, including inadequate procedures to ensure that prescriptions were filled and continuity in the provision of psychiatric medications. Defendants were high ranking officials with responsibility for the overall operation of the prison system and were sued solely in their official capacities for declaratory and injunctive relief. The court rejected the defendants' claims that they did not possess the requisite subjective knowledge that their actions or inactions were causing serious harm and were therefore not deliberately indifferent, noting not only that there was compelling evidence of the obviousness of harm to warrant an inference of actual knowledge, but, more importantly, that the litigation itself provided them with actual knowledge of the substantial risk of serious harm).

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[14] *Waldrop* was decided prior to *Farmer* and applied an objective "reasonable person" test regarding the psychiatrist's knowledge of risk. It is not entirely clear whether the facts would satisfy the requisite subjective knowledge of risk standard. *See*, *Steele v. Shah*, 87 F.3d 1266, 1269 n.2 (11th Cir. 1996).

[15] It is interesting to note that the same prison psychiatrist was the defendant in both *Waldrop* and *Greason*. Waldrop ended up gouging out both his eyes and castrating himself after his medication was stopped. Greason committed suicide.

***Adams v. Durai*, 2005 WL 2867785 (7th Cir. 2005)** (inmate with schizophrenia who upon arrival at prison had his medications changed to an unapproved drug that caused serious side effects and then, in response to the side effects, was taken off all psychiatric medication adequately pled a claim of deliberate indifference against the prison psychiatrist).

***Viero v. Bufano*, 925 F.Supp. 1374 (N.D.Ill. 1996)** (juvenile who committed suicide after his medication was discontinued upon admittance to juvenile facility, despite mother's attempts to deliver medication to the facility and her telephone calls alerting facility staff to his need for medication and his risk of suicide, stated claim for deliberate indifference against probation officer and facility staff who did not take action in response to this knowledge).[16]

***Wakefield v. Thompson*, 177 F.3d 1160 (9th Cir. 1999)** (inmate was prescribed two weeks of psychotropic medicine to be issued upon his discharge. Inmate stated claim that prison guard who refused to provide him with the medication or check with the prison medical unit about it was deliberately indifferent in violation of Eighth Amendment).

PRACTICE TIPS

If you are considering legal action regarding the denial or termination of psychiatric medications to a juvenile, pre-trial detainee, or prisoner, there are a number of factors to consider and steps to take to enhance the likelihood of success:

1. Carefully investigate the prior medical history of your client and obtain records of his/her psychiatric treatment. You will need to establish that your client had a *serious* mental health condition that required treatment with psychiatric drugs.
2. Review your client's records at the facility, including medical and disciplinary records. Based upon information from your client, other witnesses and the facility records, identify all individuals who played any role in the denial of medication.
3. Determine the nature and extent of injuries your client experienced due to the denial of psychiatric medication. Be aware that, pursuant to the Prison Litigation Reform Act (PLRA), no claim for damages "may be brought by a prisoner confined in a jail, prison or other correctional facility,[17] for mental or emotional injury suffered while in custody without a prior showing of physical

[16] The *Viero* court describes the constitutional basis of the plaintiff's claim as the Eighth Amendment. As a juvenile, plaintiff's claim is more properly based on the Fourteenth Amendment. *Id.* at 1381 n.15.
[17] This includes juvenile facilities.

injury." 42 U.S.C. § 1997e(e).[18]

4. Obtain copies of any policies, procedures or protocols at the facility regarding the screening, assessment and treatment of individuals with mental health conditions. Try to ascertain if your client's treatment was consistent with the general treatment of inmates or was specific to your client. Such information will be important to determine whether to raise claims against supervisory personnel and seek systemic declaratory or injunctive relief.

5. Obtain any assessments or evaluations of the medical services in general and mental services in particular in the facility or system. Often legislative committees, accreditation agencies, blue ribbon commissions or the department itself have undertaken studies which have identified deficiencies. Failing to correct deficiencies identified in such a study can establish the requisite subjective knowledge of harm needed to hold high level officials liable for their failure to institute remedial steps.

6. Send a demand letter to all potential defendants setting forth in detail the nature and extent of your client's mental illness, his/her history of psychiatric medication, his/her behavior without it, the risk of injury to which he/she is exposed, any injury already experienced, the actions or inactions of the defendant that have subjected your client to a substantial risk of serious harm, and the steps that must be taken to rectify the situation. Such a letter may serve three purposes. First, it may prompt the defendants to provide your client with the needed medication.[19] Second, it may lead to discussions with the responsible officials regarding changes in their policies and procedures to minimize the likelihood of similar situations in the future.[20] Third, in the event

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[18] This section actually reads that "no Federal civil action" may be brought. However, the courts have uniformly held that this section only applies to damage claims. Claims for prospective declaratory and injunctive relief can be maintained even without proof of physical injury. See, *e.g., Thompson v. Carter*, 284 F.3d 411, 418 (2d Cir. 2002). For a discussion of case law regarding what constitutes "physical injury" under this section of the PLRA, *see*, Boston, *The Prison Litigation Reform Act: Current Problems and Issues* at 160-181 (The Legal Aid Society, Jan 2008) (available online at http://www.napas.org/TASC/issues/cj/General_Topics/Litigation_%20PLRA/PLRA-Current_Problems_&_Issues.pdf)

[19] Where cost is the primary reason for not providing the client's psychiatric medication, it may be useful to suggest that the facility attempt to obtain the medication through the drug manufacturer's free or reduced price patient assistance program. For a list of such programs and information about how to access them, go to https://www.pparx.org/Intro.php. The Kentucky P&A was successful in getting a local jail to utilize such a program to obtain medication for a client. Of course, cost is not a valid justification for failing to provide needed medical care. Nevertheless, alerting the jail or detention center authorities of the means to obtain medications for free or at reduced cost may resolve some problems without the need for litigation.

[20] Even if your P&A is not in a position to undertake litigation, discussions with the jail or detention facility about its medication policy may result in significant improvements. See copy of the San Francisco Jail Medication Policy appended hereto which may be useful in identifying areas that such a policy should cover.

of litigation, it will be very useful in establishing the requisite subjective intent required under *Farmer*.

7. In the event of litigation, be very specific and detailed regarding the facts relating to each defendant that demonstrate that the defendant actually knew that their conduct was likely to subject your client to the risk of serious harm. The vast majority of these cases are tested by motions to dismiss where the allegations of the complaint and any reasonable inferences therefrom are taken as true. A detailed and well pled complaint should survive such a motion.[21] The likelihood of settlement after a defendant loses such a motion increases exponentially.
8. If the complaint includes a claim for damages and your client remains incarcerated, you must allege that you client suffered a physical injury in order to comply with the PLRA.[22]
9. If you are suing on behalf of juveniles or pre-trial detainees, be sure to argue for a more lenient standard than the Eighth Amendment deliberate indifference standard. While most courts simply pay lip service to the fact that the Fourteenth Amendment standard should be lower than the Eighth Amendment test and then analyze the case under the Eighth Amendment, it remains important to push courts to articulate a more deferential standard, perhaps a standard in which knowledge of the risk of harm is measured under an objective, rather than subjective, test.
10. In the event of potential litigation, identify experts early on who can testify to the grossly inappropriate and inadequate treatment your client received. If you are suing the prison doctor, expert psychiatric testimony will be needed. If suing prison guards or administrators, experts in prison administration should be consulted. The defendants will likely argue that the case presents nothing more than an honest dispute among professionals about the best course of treatment or the appropriate diagnosis. Failing that they will assert that the behavior was only negligent. Absent truly egregious facts where it is obvious that grossly unprofessional care was exercised, you will need expert testimony to counter such defenses.

CONCLUSION

The termination of needed psychiatric medication to individuals held in prisons, jails and juvenile facilities remains a serious problem. Whether due to hostility, indifference, carelessness, or the cost of the drugs, it is inexcusable and often leads to disastrous consequences. The courts have established the relatively stringent “deliberate indifference” standard against which to measure

[21] In *Erickson v. Pardus*, 551 U.S. 89 (2007) (*per curiam*), the Supreme Court applied the liberal pleading standards of Fed. R. Civ. Pro. 8 in reversing the dismissal of a *pro se* prisoner’s complaint alleging inadequate medical treatment. Nevertheless, absent detailed and focused pleading, the risk of dismissal at the pleading stage is substantially increased, particularly in cases governed by the PLRA.
[22] The PLRA only applies to suits by prisoners. If your client has been released, he or she should not be subject to the “physical injury” requirement.

inmate claims of injury. Nevertheless, where such problems have been identified, the credible threat of litigation may prompt officials to revise their policies and procedures. If not, with careful investigation, preparation and pleading, these cases can be successfully litigated and practices changed.

San Francisco Jail Medication Policy

ORDERING CRITICAL MEDICATION AT INTAKE

I. **POLICY**

Function: To facilitate and guide the RN in providing critical medications at Intake to patients who have been prescribed these medications prior to arrest.

II. **DEFINITIONS:**

A. Critical Medications: For the purposes of this policy critical medications refers to those medications that if missed can result in deterioration of a patient's health status. These include HIV medications, antibiotics, cardiac medications, seizure medications, anti-hypertensive medications, diabetic medications, asthma medications, anti-coagulants, psychiatric medications, medications for active tuberculosis, and methadone for emergency narcotic addiction treatment.

B. Verification: For the purposes of this policy verification can be obtained through confirmation by the prescribing physician, other health care provider, or other facility staff (registered nurse, licensed vocational nurse, licensed psychiatric technician), a current prescription container, or the dispensing pharmacy (pharmacist). Verification of medications will be documented as a note in the patient's electronic record and will include the following information: name, address and telephone number of the prescriber, name (address and telephone number if different from the prescriber's) of person transmitting the order, name of the drug, strength, directions for use, date order written and duration of the order.

C. Verbal Order: For the purposes of this standardized procedure medications which have been verified as above will be documented in the electronic medical record as a verbal order from the JHS Medical Director, or designee. This is done to facilitate the tracking of these orders on the JHS computerized medical record system. Such orders are not truly verbal orders and do not require verbal contact with the Medical Director or Acting Medical Director.

D. Regular Waking Hours: For the purposes of this standardized procedure regular waking hours are from 8 am until 12 am (midnight). It is the responsibility of the night shift charge nurse to alert the day shift charge nurse of the need to contact the physician.

III. **PROCEDURES:**

A. **If the patient is taking one of the following medications, attempt to verify medications ASAP:**

1. Anti-hypertensives;
2. Anti-retrovirals: If not taken in the last 48 hours, advise patient his/her medication will be reviewed by the clinician;
3. Anti-seizure medications;
4. Cardiac Medications;
5. Antibiotics;
6. Psychiatric Medications;

7. Medications for active tuberculosis;
8. Steroids;
9. Oral diabetes medications: see attached “Drugs for Diabetes”; Insulin requires referral to a clinician or on-call MD;
10. Anti-asthma medications:
    a. Oral agents: see attached - “Drugs for Asthma”
    b. Inhaled agents: see attached –“Drugs for Asthma”, “Inhaled Corticosteroids” and “Inhaled Beta Agonist (short acting)”;
11. Anti-coagulants;
12. Methadone for narcotic addiction treatment;
13. Any other life sustaining medications that fit the definition of a “critical medication” as defined above.

IV. If the patient has been prescribed a corticosteroid inhaler other than Beclomethasone HFA (QVAR) refer to the INHALED CORTICOSTEROIDS, Estimated Comparative Daily Doses (attached) for equivalent doses of beclomethasone. The RN may order the equivalent dose of beclomethasone inhaler as in XVIII below. If patient presents on a high dose of inhaled corticosteroid (see Estimated Comparative Daily Doses), refer the patient to next sick call for evaluation.

V. If the patient has been prescribed a short acting beta agonist other than albuterol (Ventolin, Proventil, various generic), refer to INHALED BETA AGONISTS (SHORT ACTING), Estimated Comparative Daily Doses (attached) for equivalent doses of albuterol. The RN may order the equivalent dose of albuterol inhaler as in XVIII below.

VI. If the patient has been prescribed psychiatric medications, they must be off all detox protocols or seen by a psychiatrist prior to receiving psychiatric medications.

VII. If the stated medications cannot be verified (see definition), check the JHS medical record. If the patient was receiving the medication at the stated dosage and his/her most recent release from custody was within three months, the medications may be ordered for seven days. If there is any discrepancy between the patient’s report and the chart, the MD should be called during regular waking hours.
Exception: the three month rule DOES NOT apply to methadone for narcotic addiction treatment. The on-call physician should be called during regular waking hours when verification cannot be obtained from the Narcotic Treatment Program.

VIII. If the patient has been prescribed a narcotic analgesic other than Tylenol with Codeine or Vicodin, contact the on-call physician during regular waking hours as defined above. If the patient has been prescribed Tylenol with Codeine or Vicodin, schedule for sick call or chart review as appropriate.

IX. If the patient is taking a non-formulary medication that is available from floor stock, the medication may be ordered for seven days. If the medication is not available, contact the on-call physician during regular waking hours

X. If the medications cannot be ordered according to the above procedures, but the patient is reliable, contact the on-call physician during regular waking hours as defined above. The chart should be referred for review by a clinician at the next clinic. The on-call MD should be called for insulin orders ½ hour before it is due to be given.

XI. Once medications and dosages are verified, the medications should be ordered for seven days (exception: methadone-72 hours limit for emergency narcotic addiction treatment, and prenatal for 30 days), unless the history or physical examination reveals a reason not to do so. Such orders should be entered as a verbal order (see definition) in the electronic medical record from the JHS Medical Director or Acting Medical Director. The chart should be referred for review by a clinician at the next clinic.

XII. If the stated medications have not been verified at CJ9, nursing staff at the jail where the inmate is currently housed will be responsible for verifying these medications at chart review or sick call.

XIII. If it has been verified that a patient is pregnant, order Prenatal vitamin 1 tab po qd x 7 days; refer patient to next ob-GYN clinic.

XIV. Advise patient of importance of taking medication as prescribed and provide teaching as needed.

XV. If medications are ordered and the patient is asymptomatic, the chart should be referred for review by a clinician at the next clinic. If the patient has symptoms, s/he should be referred to the next clinician. If the patient's condition is urgent, contact the on-call MD. (See attached: Ordering Critical Meds at Intake Decision Tree.)

XVI. **Requirement for Registered Nurse:**

A. Education and Training: graduate of an accredited school of nursing.
B. On-going evaluation: The Nurse Manager monitors for ongoing competency; annual performance review documents continued ability to use the standardized procedures.

XVII. **Related policies and standardized procedure:**

A. ASTHMA
B. SEIZURE STANDARDIZED PROCEDURE
C. MEDICATION ORDRERS FROM AFFILIATED FACILITIES (401L)

XVIII. **Review: Annually**

XIX. **Attachments:**

A. DRUGS FOR DIABETES
B. DRUGS FOR ASTHMA
C. ORDERING CRITICAL MEDICATION AT INTAKE DECISION TREE
D. INHALED CORTICOSTEROID DECISION MAKING TREE
E. INHALED CORTICOSTEROIDS
F. INHALED BETA AGONIST DECISION MAKING TREE
G. INHALED BETA AGONISTS (SHORT ACTING)

XX. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. This procedure was developed collaboratively and has been approved by the following:

XXI. **REGISTERED NURSES AUTHORIZED TO UTILIZE THIS STANDARDIZED PROCEDURE:**

The list of Registered Nurses authorized to utilize this procedure with dates of initial and follow-up evaluations is to be maintained at the nurses' primary job site and at the Jail Health Services Staff Development office.

_____ _____

Joe Goldenson, MD Date
Director/Medical Director

_____ _____

Jackie Clark, RN MS Date

Director of Nursing

_____ _____

Yuki Kubo-Hendricks, PharmD Date
Pharmacy Director