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The Constitutional Right to Medical and Mental Health Care in Correctional Facilities

Andrew Noel

Symposium Remarks

The Constitutional Right to Medical and Mental Health Care in Correctional Facilities

Andrew Noel*

Andrew Noel: I appreciate the opportunity to be here. As I was listening to Professor Dolovich, a lot of thoughts were going through my mind about things that she was talking about and a lot of important issues. My focus is a smaller slice of correctional institution litigation. I've been doing this type of work for about twenty years. Most of our work involves the county jail system in Minnesota and North Dakota. It's a smaller slice, and the things that Professor Dolovich talked about with the exhaustion of remedies, the PLRA—that's really the front lines of where this fight is happening, and the advocates who are doing that are doing great work, and it's important for everybody.

My world is more of a single-plaintiff lawsuit against either correctional officers or correctional medical providers. And federal court is where all these cases live and sometimes die as well. My first exposure to this world came as a law clerk about twenty years ago when I went along on a case that was tried in Milwaukee. It was a jail suicide. The mother of the decedent was the plaintiff, and the primary defendant was the prison psychologist. The case was dismissed on a 12(b)(6) motion, so we got thrown out of court right away. And by we, I mean the lawyers, since I wasn't a lawyer yet, so I didn't have anything to do with that loss or the victory at the Seventh Circuit that brought it back.

But this was a thirty-year-old male who was in prison for assaulting his mom, and mom was the plaintiff. And I found then that what these cases really boiled down to, in my view, is the mindset of either the correctional officer or the correctional health care provider. The psychologist in that case—just in the basic line of questioning—said this in response to a question about whether the inmate looked okay. And this was an individual who

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had lost forty pounds, and after about three months in prison, looked like a prisoner of war. And he had been in segregation for a while. And the psychologist's simple answer to that question was, "He looked like a segregation inmate."

So, that was the defining moment of that trial. And the case was won, thankfully. And the lawyers who I helped on that case told me, "Don't expect this to happen every time." And they were right about that—they're very hard cases. But what I'm really looking for—and trying to get to the core of in these cases—when I'm either taking depositions or looking into taking a case is this mindset, the attitudinal issues that exist in corrections. Because when you make the decision to get into a case, you can expect—as all the panelists and probably many in the audience can understand—it's going to be hard fought. These aren't cases where the defendants and [either their] county boards or state funds are just going to roll over and say, "Yeah, we did wrong here. We're going to try to make it right." That doesn't happen enough, in my view.

So, we look at, "can we win the case?" is obviously the most important thing going forward. And one of the tenets that we always embrace is the notion that inmates are essentially the only class of people in the United States that have a constitutional right to health care. So, when we talk about universal health care, a lot of people don't really think about it that way, but that's where it exists. And so that's what we have to try to get either the juries or the judges, expert witnesses, and correctional medical providers to understand. The cases, like we said, are challenging. We deal with qualified immunity—we'll talk about that a little bit here today. But there are some benefits to federal civil rights litigation in the jail and prison setting that don't exist in other types of cases.

One of those benefits is that there are no damage caps. State law—states all over the country have damage caps set up that don't apply to these claims. Attorney's fees are also recoverable, so you have that hammer when you're dealing with the defendants and their decision-makers about whether or not to deal with a claim early. And what's been happening more and more—and I'm sure some of you have read about it in the paper or in the news—is this privatization of health care in jails and prisons, particularly in the county jails. There was just an article a couple days ago or a story on KARE 11 dealing with MEnD, which is a company that we've been suing a lot, and it seems like they're going away.[1]

But they're a private, for-profit medical provider in a lot of county jails in Minnesota, and there's no qualified immunity for those folks. The Eighth Circuit just came out with a decision on that in 2021 so that those private

1. Brandon Stahl, *KARE 11 Investigates: Troubled Jail Medical Provider Files for Bankruptcy*, KARE 11 (Dec. 1, 2022, 10:05 AM), https://www.kare11.com/article/news/investigations/kare-11-investigates-jail-medical-provider-files-for-bankruptc/89-2ce1aeb0-6b6b-47c4-98e9-5ccf7789cbe5.

actors do not get qualified immunity[2], and they also have the same things in terms of punitive damages that are available and no damage caps that other, more traditional public defendants have to deal with. The private correctional world is in flux.

There's MEnD, which is the leading correctional care company in Minnesota and has recently had its medical director get his license indefinitely suspended.[3] His name was Dr. Todd Leonard. He was rung up pretty good by an administrative law judge with regard to the care of a prisoner in the Beltrami County Jail.

So, why does that happen? Well, it happens because MEnD is a for-profit company. So, by definition—and this is, of course, my opinion, which we're here to talk about—I don't think the provision of health care in jails and prisons should be a for-profit business. It should be a priority for counties and the state. Because—I'll give you just one example, a Wright County Jail case that's still going on. Wright County's in Buffalo, Minnesota. And Tony Valiant, who's our client, went to the Wright County Jail with his medications. One of the medications was Xanax. Xanax is a benzodiazepine, which anyone with medical training would understand you can't abruptly stop that medication, otherwise, you risk serious consequences.

What MEnD had in place was a correctional officer that would go through the medications when Valiant came in and flag the Xanax because it's a controlled medication. It's obviously a medication that would be in demand on the street. And then, they call a registered nurse who works for MEnD, and the registered nurse made the decision on her own to discontinue his prescribed Xanax. So, without consulting a medical doctor, a physician's assistant, or someone who has the ability to prescribe or unprescribe medication, and, obviously, without seeing Mr. Valiant, they discontinued his medication. Three days later, he had a seizure and suffered a serious head injury.

And the nurse told me in her deposition that this is how they were trained to do it. Dr. Leonard, in his deposition, said she must have been confused about what was supposed to be going on in the jail. So, I think, Dr. Leonard is one example of this mindset that really gets to the core of how things go bad in correctional institutions. And qualified immunity is something we have to deal with in every case. Fortunately, in that case they have not moved for summary judgment yet, which they seem to do in just about every jail or prison case that I've ever been associated with.

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2. *Davis v. Buchanan Cnty.*, 11 F.4th 604, 617 (8th Cir. 2021) ("But private individuals, as state actors, are not necessarily entitled to assert the defense of qualified immunity. . . .").

3. Brandon Stahl, *KARE 11 Investigates: Med Board Suspends Controversial Jail Doctor's License*, KARE 11 (Jan. 25, 2022, 4:47 PM), https://www.kare11.com/article/news/investigations/minnesota-jail-doctor-suspended/89-90701db0-a1d1-4e65-a839-f1d59960100f.

I'm dealing with cases primarily when we talk about deliberate indifference to a person's serious medical needs. Medical needs include mental health needs. So, we deal with delays in treatment, obviously, yanking prescriptions inappropriately, and essentially, the non-treatment of mental health conditions that can lead to suicide in correctional facilities. So, you have to prove, number one, on this first prong of deliberate indifference, was there a violation, a constitutional violation?

The first prong is, was there knowledge of a serious medical need? We can't say that you should have known; you had to know. The second prong is what did they do, and was the response reasonable in light of that knowledge? And that's really where most of these deliberate indifference cases fall. The second prong of qualified immunity is, was there a violation of clearly established law? Would the state actor have known that the law was clearly established such that their conduct was unlawful? And that's one that we hear about a lot in the context of the Fourth Amendment, police use of force.

I think it fits not as well in the deliberate indifference setting. And, actually, we found in 2021 that we have an unlikely ally on that theory, and we're actually pursuing it at the Eighth Circuit right now on an appeal [in] a case that we prevailed [on] at the district court. The Fourth Amendment deals with police officers sometimes making split-second decisions. With the Eighth Amendment, when we're talking about deliberate indifference, it just sounds different. There's time to deliberate.

And Justice Thomas, in a case called *Hoggard v. Rhodes* in 2021—an ally in Justice Clarence Thomas on this issue—he asked this question, and I'm going to read it so I get it exactly right. He said, "But why should university officers, who have time to make calculated choices about enacting or enforcing unconstitutional policies, receive the same protection as a police officer who makes a split-second decision to use force in a dangerous setting?"[4] So, this is something that, moving forward with our cases, we're going to try to focus on the notion that the second prong of qualified immunity has no place in a deliberate indifference case.

There are many case studies that I could give you; I'll give you just one before I end. We had a North Dakota case where we had a jail medical provider, and his wife was the nurse who worked at the jail. And fifteen minutes into this doctor's deposition, we knew that we had attitudinal issues with the doctor. One of the questions that we tend to ask at the beginning of these is, "Do you agree with me that this person is your patient?" And the doctor's response to that question was, "He's a prisoner, not a patient."

This gentleman came into the jail with a gaping wound in his neck from a suicide attempt with instructions to be on suicide watch and to be treated with antibiotics. They gave him the antibiotics, but they didn't do

4. 141 S. Ct. 2421, 2422 (2021).

that well on suicide watch or the mental health. And this jail doctor—the medical record talked about it as a complex laceration. I asked the jail doctor why he didn't see or treat this individual, and his response was, "I don't see little cuts." And so, this case—even with this type of testimony—they fought the case through summary judgment, all the way to the eve of trial, before they would deal with the real problem that this doctor presented.

And, in my view, he defines the mindset that we need to keep out of correctional health care—which is basically an infected, jaded mindset that these people are prisoners and not your patients. And I look forward to hearing everybody else on other issues, and thanks for your time today.