No. 22-1716

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

JERRY CINTRON,

Plaintiff-Appellee,

v.

PAUL BIBEAULT, in his official and individual capacity; RUI DINIZ, in his official and individual capacity; MATTHEW KETTLE, in his official and individual capacity; PATRICIA ANNE COYNE-FAGUE, in her individual capacity; WAYNE T. SALISBURY, JR., Interim Director, in his official capacity; SPECIAL INVESTIGATOR STEVE CABRAL, in his official and individual capacity; JEFFREY ACETO, in his individual and official capacity; LYNNE CORRY, in her individual and official capacity,

Defendants-Appellants,

LT. HAYES, in his official and individual capacity; LT. MOE, in his official and individual capacity; LT. BUSH, in his official and individual capacity; JENNIFER CHAPMAN, in her official and individual capacity "COUNSELOR" FRANCO, in her official and individual capacity,

Defendants.

MOTION UNDER FED. R. CIV. P. 29(a) to FILE BRIEF FOR *AMICUS CURIAE* Dr. JENNIFER G. CLARKE SUPPORTING PLAINTIFF-APPELLEE and AFFIRMANCE

Dr Jennifer G. Clarke respectfully hereby moves for leave to file an *amicus curiae* brief in this appeal pursuant to Fed. R. App. P. 29(a). *See* Attachment 1 (Brief for Amicus Curiae Dr. Jennifer G. Clarke Supporting Plaintiff-Appellee and Affirmance).

BACKGROUND

The Nature of This Case and Dr. Clarke's Proposed Brief

In this appeal, Defendants-Appellants interlocutorily challenge the district court's denial of their motion for judgment on the pleadings. They argue that Plaintiff-Appellee Jerry Cintron has failed to allege a violation of his Eighth Amendment rights because his housing in solitary confinement for more than a year didn't constitute cruel and unusual punishment and that, in any case, qualified immunity applies. *See* Defendants-Appellants Brf. at 34-48. Cintron responds that that his segregation caused him to seriously injure himself, suffer depression and anxiety to the point of requiring medication, relapse into opioid use disorder, lose 70 pounds, and experience various other harms – and that Appellants well knew such consequences would occur. *See* Cintron Brf., Point I.

As her proposed brief sets forth, Dr. Clarke practiced medicine in the Rhode Island Department of Corrections ("RIDOC") for 22 years, first as a Staff Physician and then, from 2015-2020, as the department's Medical Director responsible for all RIDOC medical and psychiatric staff and services. *See* Clarke Amicus Brf. at 1-2. In these capacities, Dr. Clarke often personally cared for and, as director, oversaw the treatment of men and women placed in solitary confinement – inmates exactly like Cintron.

Consequently, Dr. Clarke has unique knowledge about and a broad, experience-based perspective on the nature of solitary confinement as practiced in Rhode Island for two decades and experienced by Cintron. As someone who treated innumerable segregated inmates, she offers detailed, specific information about the serious and lasting damage solitary causes – not in general, as reported by other courts and various studies cited in the parties' and other *amici's* briefing, but *at RIDOC*, the very facility at issue in this case. Her brief also sets forth how high-level RIDOC administrators were fully aware of solitary confinement's consequences and penal ineffectiveness.

ARGUMENT

I. Standards for Briefs From *Amici Curiae*

The Court may grant motions for leave to file *amicus* briefs upon a statement of the movant's interest and the reason why the brief "is desirable and why the matters asserted are relevant to the disposition of the case." FED R. APP. P. 29(a)(3). In a 2002 opinion, then-Judge Alito noted that "a broad reading [of the rule] is prudent." *Neonatology Assoc., P.A. v. Comm'r of Internal Revenue*, 293 F.3d 128, 132 (3d Cir. 2002). "[I]t is preferable to err on the side of granting leave. If an *amicus* brief that turns out to be unhelpful is filed, the merits panel, after studying the case, will often be able to make that determination without much trouble and can then simply disregard the amicus brief. On the other hand, if a

good brief is rejected, the merits panel will be deprived of a resource that might have been of assistance." *Id.* at 133. Put differently, "courts should welcome amicus briefs for one simple reason: '[I]t is for the honour of a court of justice to avoid error in their judgments.'" *Lefebure v. D'Aquilla*, 15 F.4th 670, 675 (5th Cir. 2021) (quoting *The Protector v. Geering*, 145 Eng. Rep. 394 (K.B. 1686)). This is true even if the amicus has personal motivations. *Id.* at 674.

Given these lenient standards, "[e]ven when the other side refuses to consent to an amicus filing, most courts of appeals freely grant leave to file, provided the brief is timely and well-reasoned." *Neonatology Assoc.*, 293 F.3d at 133 (quoting MICHAEL E. TIGAR AND JANE B. TIGAR, FEDERAL APPEALS – JURISDICTION AND PRACTICE 181 (3d ed. 1999)).

When deciding a motion for leave, former Judge Posner recommended considering "whether the brief will assist the judges by presenting ideas, arguments, theories, insights, facts, or data that are not to be found in the parties' briefs." *Voices for Choices v. Illinois Bell Tel. Co.*, 339 F.3d 542, 545 (7th Cir. 2003) (Posner, J., in chambers). *Amici* will pass this test when they have "a unique perspective or specific information that can assist the court beyond what the parties can provide." *Id.* Then-Judge Alito recognized: "Some *amicus* briefs collect background or factual references that merit judicial notice. Some friends of the court are entities with particular expertise not possessed by any party to the

case." *Neonatology Assoc.*, 293 F.3d at 132 (*quoting* Luther T. Munford, *When Does the Curiae Need an Amicus?*, 1 J. APP. PRAC. & PROCESS 279 (1999)).

II. The Court Should Grant Leave for Dr. Clarke to File Her Brief

Dr. Clarke's brief easily meets the generous standards set forth above.

First, her brief offers the Court "insights, facts [and] data" and "a unique perspective or specific information that can assist the court." *Voices for Choices*, 339 F.3d at 545. Given her long, hands-on experience treating inmates in solitary confinement at RIDOC – and then her bird's-eye view as medical director of the whole department – she has unique, comprehensive, detailed, and specific information about how solitary confinement actually works at RIDOC and affects the inmates there. Her brief pinpoints how segregated housing regularly damages their mental health by leading them to engage in self-harm and occasionally commit suicide, aggravates preexisting mental health conditions, exacerbates substance abuse, compromises inmates' physical wellbeing, and causes other damaging and lasting effects.

This information bears directly on a key contested issue in this appeal: whether what happened to Cintron constitutes the type of more serious harm that offends the Eighth Amendment. *See* Cintron Brf., Point I(A). Indeed, information on this topic from scientific experts appears in Cintron's brief and is also the subject of an *amicus* brief filed by four mental health experts that Appellants

consented to. *See* Cintron Brf. at 33; Brief for *Amici Curiae* Terry Kupers, Craig Haney, Pablo Stewart and Stuart Grassian in Support of Plaintiff-Appellee and Affirmance. The crucial difference is that Dr. Clarke addresses the subject from the unique vantage point of what happens to inmates and medical providers *at RIDOC* – not study subjects or people at other, different facilities outside Rhode Island. This gives her brief special relevance above and beyond what is already before the Court, some of it by Appellants' consent.

Furthermore, Dr. Clarke also has "background or factual references that merit judicial notice," *Neonatology Assoc.*, 293 F.3d at 132, on the subject of RIDOC officials' knowledge of the grave harms of solitary confinement – another relevant issue given that Cintron must have properly alleged that Appellants knew of and disregarded an excessive risk to his health and safety. Cintron Brf., Point I(B). Cintron addresses this point in part by citing RIDOC reports and testimony from RIDOC officials. *See id.* at 40-41. Dr. Clarke's brief concerns this issue as well, with different and additional information.

Second, what Dr. Clarke offers is "not to be found in the parties' briefs" and goes "beyond what the parties can provide." *Voices for Choices*, 339 F.3d at 545. Cintron can certainly speak to his own time at RIDOC, and he has, but he necessarily lacks information and perspective at this initial stage about the experiences of other RIDOC inmates or medical providers. Appellants have access

to the kind of information Dr. Clarke covers but it is absent from their brief, which instead essentially ignores Cintron's most serious allegations and proceeds as if this case is about "depriv[ation] of a mirror, newspapers, radio, a desk, a television, and an MP3 player," or the absence of "programming." Defendants-Appellants' Brf. at 37-38. Consequently, Dr. Clarke's brief presents information the Court will not otherwise get from the parties. *See, e.g.*, *New Mexico Oncology and Hematology Consultants, Ltd. v. Presbyterian Healthcare Serv.*, 994 F.3d 1166, 1175-76 (10th Cir. 2021) (granting leave to file *amicus* brief because *amici* "provide more information about the Defendants' practices").

In denying consent to the filing of Dr. Clarke's brief, Appellants cited the fact that her name appears in Cintron's medical records and that she could therefore potentially be a fact witness at a later stage in the case, and that Dr. Clarke would discuss factual matters about RIDOC outside the existing appellate record. These objections are meritless. *Amicus* briefs often cover factual information outside the appellate record; as noted above, that is a reason to accept them, not bar them, as long as the information is relevant and helpful. Appellate courts including this one are perfectly able to take extra-record factual material in briefs submitted by *amici* "for what it's worth" without prophylactic exclusion.

The possibility of Dr. Clarke being a witness in some later stage of this case is entirely speculative. There is no way to know now if that will happen, and,

regardless, it is irrelevant to the Court's consideration of this appeal already presently before it. Indeed, Appellants' objection only highlights the relevance and importance of what Dr. Clarke knows and has to say; if she may be a fact witness, as Appellants posits, it is definitionally true that the "matters asserted [in her brief] are relevant to the disposition of the case." FED R. APP. P. 29(a)(3). In any event, no rule bars a potential fact witness from submitting an amicus brief, nor is there any obvious rationale for such a prohibition.

Other cases illustrate the point. In *Copeland v. CAIRR*, the court permitted graduates of a drug and alcohol treatment program to file an *amicus* brief in an appeal where other inmates challenged the program under federal labor laws. 2023 WL 3166345 at * 1, n. 8 (10th Cir. 2023). Yet the *amici* who supported the program could easily have appeared as witnesses in proceedings to determine how it functioned. In another example, a judge filed an *amicus* brief (cited by a dissenting judge in a different case) discussing the judicial campaign funding system in which he personally participated. *See Wersal v. Sexton*, 674 F.3d 1010, 1055 (8th Cir. 2012) (Beam, J., dissenting) (quoting amicus brief of former Minnesota Supreme Court Chief Justice Keith).

More generally, courts commonly receive *amicus* briefs from former government officials who, like Dr. Clarke, provide relevant additional information about their former departments. In *Johnson v. California*, *amici* filed a brief

similar to Dr. Clarke's here, and the Court found it useful enough to merit quotation. 543 U.S. 499, 508 (2005). The brief, from former correctional officials, supported an inmate in a case challenging California's then-practice of segregating prison housing by race, arguing that, based on their observation, "'racial integration of cells tends to diffuse racial tensions and thus diminish interracial violence.'" *Id.* Likewise in *Ramirez v. Collier*, a prisoner on death row challenged Texas's policy forbidding chaplains to touch inmates during executions, and former chaplains filed an *amicus* brief describing how the state had previously permitted this very same practice, with no ill effects, before changing policy. 142 S. Ct. 1264, 1274 (2022). Dr. Clarke's brief is closely analogous to these; she seeks to apprise the Court of her unique factual experience with the effects of a prison condition and housing policy at issue in this appeal.

Outside the correctional context, *Watson v. Phillip Morris Co*., 551 U.S. 142 (2007), is also instructive. That case involved whether the Federal Trade Commission delegated authority to test cigarettes to an industry-financed entity, and former FTC officials filed an *amicus* brief detailing, factually, how the commission had done just that. *Id*. at 156. Likewise, in *Hernandez v. Mesa*, former border patrol officials submitted an *amicus* brief supporting plaintiffs attempting to extend *Bivens* liability to border patrol agents involved in a cross-border shooting, arguing that, given the nature of the force and how it operates,

such civil liability is necessary to ensure official accountability. 140 S. Ct. 735, 760 (2020) (Ginsberg, J., dissenting) (citing brief). There are numerous other examples.[1]

CONCLUSION

Dr. Clarke's proposed brief is relevant and will assist this Court in deciding this appeal. The Court should give her leave to file it.

May 11, 2023

Respectfully Submitted,

/s/ *Andrew S. Wainwright*

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[1] *See, e.g.*, *Republic of Sudan v. Harrison*, 139 S. Ct. 1048, 1063 (2019) (Thomas, J., dissenting) (citing amicus brief of former counterterrorism officials); *Trump v. Hawaii*, 138 S. Ct. 2392, 2444 (2018) (Sotomayor, J., dissenting) (citing brief of former national security officials); *Wyoming v. Zinke*, 871 F.3d 1133 (10th Cir. 2017) (noting amicus brief filed by former Department of Interior officials challenging regulation of Bureau of Land Management, a Department of Interior subdivision); *Armstrong v. Exceptional Child Ctr.*, 575 U.S. 320 (2015) (Sotomayor, J., dissenting) (citing amicus brief of former HHS officials explaining circumstances under which agency initiates certain compliance actions); *South Florida Water Mgmt. Dist. v. Miccosukee Tribe of Indians*, 541 U.S. 95, 107 (citing former amicus brief by EPA officials explaining that agency previously took contrary position); *Connick v. Thompson*, 563 U.S. 51, 107 (2011) (Ginsberg, J., dissenting) (citing former prosecutors' brief in case concerning prosecutors' *Bivens* liability for *Brady* violations).

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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing Motion for Leave to File Brief of Amicus Curiae with the Clerk of the United States Court of Appeals for the First Circuit via the CM/ECF system this 11th day of May, 2023 to be served on the following counsel of record via ECF:

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g), the undersigned hereby certifies that this motion complies with the type-volume limitation of Fed. R. App. P. 27.

1. The motion contains 2,547 words.

2. The brief has been prepared in proportionally spaced typeface using Microsoft Word for Office 365 in 14 point Times New Roman font. As permitted by the Federal Rules of Appellate Procedure, the undersigned has relied upon the word count feature of this word processing system in preparing this certificate.

/s/ *Andrew S. Wainwright*
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May 11, 2023.

ATTACHMENT 1

No. 22-1716

UNITED STATES COURT OF APPEALS
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JERRY CINTRON,

Plaintiff-Appellee,

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PAUL BIBEAULT, in his official and individual capacity; RUI DINIZ, in his official and individual capacity; MATTHEW KETTLE, in his official and individual capacity; PATRICIA ANNE COYNE-FAGUE, in her individual capacity; WAYNE T. SALISBURY, JR., Interim Director, in his official capacity; SPECIAL INVESTIGATOR STEVE CABRAL, in his official and individual capacity; JEFFREY ACETO, in his individual and official capacity; LYNNE CORRY, in her individual and official capacity,

Defendants-Appellants,

LT. HAYES, in his official and individual capacity; LT. MOE, in his official and individual capacity; LT. BUSH, in his official and individual capacity; JENNIFER CHAPMAN, in her official and individual capacity "COUNSELOR" FRANCO, in her official and individual capacity,

Defendants.

On Appeal from the U.S. District Court for the District of Rhode Island
Case No. 1:19-cv-497; Chief Judge John J. McConnell

BRIEF FOR *AMICUS CURIAE* Dr. JENNIFER G. CLARKE SUPPORTING PLAINTIFF-APPELLEE and AFFIRMANCE

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STATEMENT OF IDENTITY AND INTEREST OF *AMICUS CURIAE* [1]

For 22 years, Jennifer Clarke, M.D., M.P.H., F.A.C.P., practiced medicine in the Rhode Island Department of Corrections ("RIDOC"). After graduating Cornell University Medical College and completing a residency and fellowship at Brown University/Rhode Island Hospital, she served as a RIDOC Staff Physician and consultant for 17 years. There, she provided primary medical care to men and women at all of the department's individual facilities, including its high security unit.

From 2015 to 2020, Dr. Clarke served as RIDOC's Medical Director "responsible for the overall direction of all professional medical, psychiatric, pharmacy, and geriatric staff and services, inclusive of physicians and psychiatrists, laboratory services, radiology services, physical and psychiatric medicine, dental medicine, medical education and medical staff committees."[2] As director, Dr. Clarke also led budgeting, planning, and implementation for RIDOC clinical services; oversaw approximately 80 medical, psychiatric, nursing, and administrative personnel; and helped develop the department's medical policies

[1] This brief was prepared entirely by *Amicus's* counsel on a *pro bono* basis; it was not authored in any part by counsel for a party; and no money was contributed by any party, counsel, or other person to prepare or submit this brief. *See* Fed. R. App. P. 29(c)(5).

[2] Rhode Island Department of Administration, Medical Director (DOC) Job Description, *available at* https://datadoa.ri.gov/hr/documents/jobs/MEDICAL%20DIRECTOR%20(DOC).PDF ("RIDOC Medical Director Job Description").

and objectives while assessing existing programs for effectiveness and potential improvement.

As a longtime physician at RIDOC and ultimately its medical director, Dr. Clarke often cared for and oversaw the treatment of men and women placed in solitary confinement – inmates exactly like Plaintiff-Appellee Jerry Cintron. Consequently, she has unique knowledge about the nature of solitary confinement as practiced in Rhode Island and experienced by Cintron, and the serious and lasting damage it causes. Her interest in this case is simple: to inform the Court about those injuries from the special vantage point of a clinician and correctional administrator at the exact facility at issue, to confirm that high-level RIDOC administrators were fully aware of solitary confinement's consequences, and to illuminate the unique professional quandary she and other medical personnel face when treating inmates in solitary: how to "provide the highest possible standards of medical care," as her job description put it, while also serving a system that systematically and quite knowingly inflicts grievous harm on her patients.[3]

ARGUMENT

I. Dr. Clarke Saw That Solitary Confinement Harmed Her Patients

As a Staff Physician, Dr. Clarke was repeatedly called on to treat inmates from solitary confinement. Sometimes she met them in their restricted housing

[3] RIDOC Medical Director Job Description.

cells to triage or treat medical conditions. As Medical Director, she oversaw the providers who did this, and was regularly briefed on inmates' conditions and care. Although Dr. Clarke was never part of the decision to place someone in segregated housing – a measure ordered exclusively by RIDOC security staff and administrators – she had no choice but to continually witness and try to address its predictable and recurring effects, which are described below.

A. Mental Illness, Self-Harm, and Suicide

Foremost among these were a wide variety of injuries inmates inflicted on themselves. Dr. Clarke saw men and women sent to her for treatment from solitary who'd punched the walls of their cells and fractured or otherwise injured their hands, who'd banged their heads against the walls, who'd cut themselves by inserting objects under their skin, and who'd scratched themselves all over their bodies. She treated men who'd saved plastic forks from meals and then used them to make painful and damaging rectal and urethral insertions. She had to care for pregnant women who'd punched themselves in the abdomen or tried to jump off the bed in their cell in order to land on their stomachs. Some inmates dealt with solitary by deliberately refusing to take necessary medication and thereby aggravating preexisting medical conditions. Some began hunger strikes. In general, inmates forced to contend with the extreme isolation of solitary did "anything you could imagine," Dr. Clarke reports. "Patients would tell me about

harming themselves while in segregation just to be able to 'feel something.'" Many of the self-inflicted injuries Dr. Clarke treated were serious, and some were grave enough that inmates had to be transferred out of the prison for more advanced care at a nearby hospital.

The ultimate self-injury is suicide, and Dr. Clarke soon learned of this recurring byproduct of solitary confinement, too. Several inmates committed suicide while in solitary confinement, likely at least one per year. Despite their inability to leave their cells for more than an hour and the restriction on interactions with others, determined inmates still managed to use what few items were at hand to take their own lives. For example, prisoners tied bedsheets around their necks and, using their bodyweight, strangled themselves to death.

Solitary confinement also exacerbated preexisting mental illnesses. "It is sensory deprivation," Dr. Clarke observed, "and I have seen the devastating effects that it has on people. It particularly seemed to contribute to a vicious cycle for people with traumatic brain injury (TBI). TBI often causes impulse control issues which may lead to isolation (*i.e.*, segregation) and isolation can cause problems with impulse control." Some prisoners also experienced a form of retraumatization as their enforced solitude acted to resurface injuries from the past. Dr. Clarke noticed that some with a history of abuse particularly suffered in segregation. It was not uncommon to hear about childhood experiences of being locked in a small

room or closet and assaulted physically or sexually. Being once again placed against their will in a tiny room with an officer looking in on them every 15 minutes would flood women with memories and fear. Men, too, though far less willing to disclose abuse, would occasionally suffer in this way. "Patients would tell me about the pain of being isolated and left with nothing but their own thoughts," Dr. Clarke states.

In some cases, the mental breakdown of inmates in solitary confinement was so severe that they were transferred out of the facility and into the state mental hospital. Other times, inmates worsened to the point where, paradoxically, they resisted leaving their cells. "Sometimes I would see patients in the segregation unit because someone had developed a fear of leaving their cell and social anxiety. The unit was full of men with blank stares. They often couldn't make eye contact, were jumpy and complained of having problems concentrating." Some of these inmates acknowledged to her that, if she entered their cell, they couldn't promise not to attack her. "Am I safe if I go in?" she would ask, and the inmate would admit she wasn't, saying "I can't control my behavior right now."

What Dr. Clarke witnessed at RIDOC for over two decades – the consistent, predictable, well-known mental stress produced by solitary confinement – is also alleged by Jerry Cintron. Cintron "cried often and had severe anxiety. He had intrusive thoughts, negative and disturbing ideas and images that he could not

control." Cintron Brf. 14. Eventually, Cintron "began engaging in self-injurious behavior. For example, he badly injured his hand from punching the walls of his cell and pulled out his hair. And he lost almost 70 pounds." *Id*. He needed antidepressants for the first time. *See id*. Perceptively recognizing his own, gradual deterioration, Cintron repeatedly sought help but appears to have been largely ignored and put off by RIDOC personnel. *See id*.

Cintron's experience simply mirrors what Dr. Clarke observed throughout her years at RIDOC – and what several other courts have noted. *See, e.g., Glossip v. Gross*, 576 U.S. 863, 926 (Breyer, J., dissenting 2015) (and citations therein); *Davis v. Ayala*, 576 U.S. 257, 289 (2015) (Kennedy J., concurring); *Sanders v. Melvin*, 873 F.3d 957, 960 (7th Cir. 2017) (Easterbrook, J.) (mentally ill inmate plausibly alleged that solitary confinement caused his self-mutilation, especially given past instances of self-harm). Voluminous medical and scientific literature also documents this effect. *See, e.g*., Brief for *Amici Curiae* Terry Kupers, Craig Haney, Pablo Stewart and Stuart Grassian in Support of Plaintiff-Appellee and Affirmance at 10-12.

B. Exacerbation of Substance Abuse

While serving as Medical Director, Dr. Clarke was particularly active in improving substance use disorder treatment. Using newly available state funding, she greatly expanded the system's Medication Assisted Treatment program

("MAT") by ending the practice of simply withdrawing newly arrived inmates' use of methadone and other medications for opiate addiction. Instead, inmates maintained treatment through continued use of medication for opiate disorders, and other inmates in need were placed on medication. There were also vital counseling services, group meetings, and other support from RIDOC staff and outside substance use treatment professionals. MAT reduced the ill effects of opiate addiction inside RIDOC and improved health outcomes for released inmates. Indeed, the department touts MAT's effectiveness in a series of videos available online.[4] As Lorraine Howard, then the Coordinator of Substance Use Disorder, Treatment and Recovery Services, said: "this program is saving lives."[5]

Despite that recognition, RIDOC allowed solitary confinement to disrupt the MAT regimen that served as a lifeline for so many prisoners. While Dr. Clarke successfully insisted that men and women in solitary be allowed to continue taking necessary medications like methadone, they were not released from solitary for the other essential components of the program, including counseling, group sessions such as AA meetings, and follow-up tracking and support. This palpably interfered with their ongoing treatment and recovery.

[4] *See* RIDOC MAT Program: Full Video (May 13, 2019), https://vimeo.com/335954242.

[5] *Id*. (at 00:48).

More than that, Dr. Clarke observed that segregated housing often *triggered* individuals to crave substances and left them primed to ramp up drug usage after release. Elementary social engagement, too, is well understood to form an important part of any addict's recovery, and solitary confinement also eliminated that crucial tool. Again, this dovetails with Cintron's experience. "His years of living in these conditions took a heavy toll – including by worsening the substance abuse disorder that landed him solitary in the first place. Due to the stress of extended solitary, Cintron abused his prescription pain medication, accumulating additional bookings that extended his isolation." Cintron Brf. at 13-14.

C. Worsening of Other Conditions

Finally, Dr. Clarke observed poor outcomes for inmates in solitary beyond mental illness and substance abuse. Not infrequently, segregation led to the neglect and worsening of a variety of other preexisting ailments.

Diabetes was one example. Dr. Clarke often saw RIDOC patients from solitary whose diabetes had worsened. While inmates in regular housing could control their diets by ordering meals from the commissary, segregated inmates couldn't. Extreme restriction of mobility and exercise privileges also decreased their physical activity and thereby aggravated the disease. Even the elimination of routine physical activities like climbing stairs and walking back and forth to the dining hall would affect inmates' blood sugar levels, she noticed. As a result,

inmates whose diabetes previously appeared stable began experiencing worsening blood sugar levels. "That is your real slow killer," Dr. Clarke confirms, "elevated blood sugar levels, which can cause a host of serious health problems down the road."

More generally, no one's physical health is served by the radical curtailment of mobility forced on segregated inmates. Take older prisoners suffering from arthritis. The reduction in sustained exercise as well as the absence of more basic physical movement from circulating normally in the facility can lead to decreases in joint mobility, muscle strength, and balance. Some prisoners also refused to take medication as solitary confinement proceeded, either as a self-defeating reaction to limits on their autonomy or as a more conscious way to inflict self-harm. Overall, the World Health Organization lists conditions including gastro-intestinal and genito-urinary problems, diaphoresis, insomnia, deterioration of eyesight, lethargy, weakness, profound fatigue, heart palpitations, migraine headaches, back and other joint pains, weight loss, diarrhea, and tremulousness as byproducts of solitary confinement.[6] Obviously, these ill effects are magnified in inmates condemned to solitary confinement for longer periods, as Cintron was.

[6] World Health Organization, *Prisons and Health* 28 (2014), *available at* https://apps.who.int/iris/bitstream/handle/10665/128603/9789289050593-eng.pdf?sequence=3&isAllowed=y.

* * * * *

One issue in this appeal is whether Appellants' conduct constitutes the type of more serious harm that offends the Eighth Amendment. *See* Cintron Brf., Point I(A). Dr. Clarke can attest that, as described herein, the deterioration in mental health, pronounced aggravation of substance use disorder, and other injuries suffered by RIDOC inmates in solitary for prolonged periods, like Cintron, were indeed grave, degrading their health in lasting and comprehensive ways.

II. Seeing Inmates Harmed by Solitary Confinement Was All the Harder for Dr. Clarke Because They Were Her Patients

Dr. Clarke wasn't only in a unique position to see how solitary confinement worked at RIDOC, she was especially demoralized by it because the practice harmed the very people she was employed there to help: her patients. In other words, her employer knowingly damaged her patients and then asked her to repair that damage.

As noted, RIDOC affirms that its Medical Director should "provide the highest possible standards of medical care."[7] Yet solitary confinement blatantly undermines this mission – *her* mission at the time – by causing the very conditions providers like Dr. Clarke then have to treat. "It was depressing. I'd see a patient who I understood had mental health and medical issues and know that they were

[7] RIDOC Medical Director Job Description.

put in a situation that was making both worse," she confirms. "I knew that there has to be a way to make the prison safe, but also that putting someone in isolation for 30 days is not going to positively impact that person's behavior. If anything, it's going to cause harm." "You're seeing people caged up like animals," she continued, "the way they would look out their little window to see who's walking by – the desperation in their eyes for some sort of interaction, that defeated look. If you really want to break someone, that's going to do it. It was heart-wrenching to see people tortured in this way."

Not surprisingly, then, Dr. Clarke was far from alone among the many primary care physicians, psychiatrists, nurses, social workers, and other medical personnel at RIDOC who believed solitary confinement was counterproductive as a correctional tool and also worked against their basic mission as healthcare providers in the department. Most medical providers there shared her view, she believes.

Nor does RIDOC seem to be unusual in this regard. In 2016, the National Commission on Correctional Health Care, the standard-setting and accreditation body for correctional medicine and the only national organization dedicated solely to improving penal healthcare, adopted a position statement on solitary

confinement.[8] The statement details the many harms of solitary confinement discussed herein and reaffirms both that "[c]orrectional health professionals' duty is to the clinical care, physical safety, and psychological wellness of their patients," and that providers "should not condone or participate in cruel, inhumane, or degrading treatment of inmates."[9]

Thus, correctional medical personnel are sometimes put in a difficult position by their own institutions and asked to walk a fine line: "By virtue of working in facilities where security and control, rather than the health and well-being of their patients, are the priorities, health professionals… are often faced with ethical dilemmas. The participation of health care staff in actions that may be injurious to an individual's health is in conflict with their role as caregivers."[10] More broadly, the Commission declared that "[p]rolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual's health," and recommends its complete

[8] *See* National Commission on Correctional Health Care, Position Statement: Solitary Confinement (isolation), April 10, 2016, available at https://www.ncchc.org/wp-content/uploads/Solitary-Confinement-Isolation.pdf.

[9] *Id*. at 1.

[10] *Id*. at 3.

"eliminat[ion] as a means of *punishment*," as occurred in Cintron's case, rather than simply as an exigent, short-term safety measure.[11]

The organization Social Workers Against Solitary Confinement has also noted the complicated ethical questions faced by correctional personnel in this context:

> The literature is clear that prolonged solitary confinement (confinement in excess of 15 consecutive days) is linked to severe psychological and health-related consequences that could be permanent – leading to poorer outcomes, higher recidivism rates, and even early death. Through this lens, helping professionals must conclude that prolonged solitary confinement is not in the best interests of their clients' well-being. This creates an ethical dilemma between a commitment to the client and a commitment to the practice setting/agency when employment in this particular practice area is accepted. This ethical dilemma is known as "dual loyalty", in which a conflict exists between opposing ethical codes that involve professional loyalties.[12]

Solitary confinement may even compromise staff-members' own wellbeing. A recent Vera Institute of Justice report cites the health challenges faced by correctional officers generally – elevated stress, PTSD, heart disease, greater rates of suicide – and posits that working around solitary confinement heightens these dangers. "Corrections staff often report experiencing significantly lower stress

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[11] *Id.* at 4 (emphasis added).

[12] Social Workers Against Solitary Confinement, Media Statement on Solitary Confinement 5 (2018), *available at* https://www.cswe.org/CSWE/media/Diversity-Center/10-SWASC-Toolkit-1-5.pdf.

levels and increased feelings of safety after leaving solitary to work in less restrictive units, or when working in solitary units that have implemented substantial reforms."[13]

In sum, managing the myriad physical and mental health problems facing thousands of inmates in a state prison system was hard enough for Dr. Clarke. But that was the job she agreed to as a RIDOC clinician and then its Medical Director, believing she was performing an important public service. What she shouldn't have had to face was her own employer sometimes thwarting the very mission she was there to fulfill: improving the health of her patients.

III. RIDOC Officials Well Knew that Solitary Confinement Was Harmful and Ineffective

Lastly, Dr. Clarke confirms that she shared the facts about solitary confinement with other senior officials at RIDOC, and that they fully understood that segregation failed as a method of maintaining discipline and compliance in the facility – and worse, that it severely damaged the men and women incarcerated there.

One of the duties of RIDOC's Medical Director is to "maintain and foster a working relationship with the wardens and administrators of the correctional facilities which will work toward providing the highest possible standards of

[13] Kayla James & Elena Vanko, *The Impacts of Solitary Confinement* 3 (April 2021), *available at* https://www.vera.org/downloads/publications/the-impacts-of-solitary-confinement.pdf.

medical care."[14] Dr. Clarke met this objective by regularly meeting with senior RIDOC officials, including its Director and Assistant Directors. These meetings sometimes included discussion of the practice of solitary confinement. Often the topic arose because of some particular development with an individual inmate, such as a need to be transferred, a suicide, or something similarly noteworthy.

Once they were on the subject of solitary confinement, Dr. Clarke frequently explained that, in her long experience at RIDOC, segregating inmates often made them worse, whether by eroding mental health, setting back substance abuse treatment, or something else. She is certain RIDOC officials understood the information she conveyed. Moreover, some agreed with her view. Nonetheless, Dr. Clarke was not a policymaker when it came to the continued use of solitary in the Rhode Island system and could only transmit the knowledge she possessed and the view she came to, informed by two decades of observation and experience. Those with actual policy-making authority over solitary have chosen to maintain it – even to the tune of housing inmates like Cintron there for extended periods of time, and even in the face of information provided by the medical personnel best positioned to know its effects, like Dr. Clarke. To the degree Citron must adequately allege that Appellants knew of and disregarded an excessive risk to his

[14] RIDOC Medical Director Job Description.

health and safety, *see* Citron Brf., Point I(B), Dr. Clarke confirms that RIDOC officials were far from ignorant about the effects of segregation.

CONCLUSION

Solitary confinement at RIDOC produced grievous mental and physical harms in inmates, as witnessed and treated by Dr. Clarke. The Court should affirm the decision below.

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Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing Brief of Amicus Curiae with the Clerk of the United States Court of Appeals for the First Circuit via the CM/ECF system this 11th day of May, 2023 to be served on the following counsel of record via ECF:

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g), the undersigned hereby certifies that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B)(i).

1. Exclusive of the exempted portions of the brief, as provided in Fed. R. App. P. 32(f), the brief contains 3,305 words.

2. The brief has been prepared in proportionally spaced typeface using Microsoft Word for Office 365 in 14 point Times New Roman font. As permitted by Fed. R. App. P. 32(g), the undersigned has relied upon the word count feature of this word processing system in preparing this certificate.

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