IN THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 22-1716

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 STEVEN 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 United States District Court for the District of Rhode Island
Case No. 1:19-cv-00497 (McConnell, C.J.)

MOTION FOR DR. ANDREW KOLODNY TO PARTICIPATE AS *AMICUS CURIAE* IN SUPPORT OF APPELLEE AND AFFIRMANCE

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Dated: May 11, 2023

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Pursuant to Federal Rules of Appellate Procedure 27 and 29, Dr. Andrew Kolodny respectfully moves for leave to file a brief as *amicus curiae* in the above-captioned case in support of Plaintiff-Appellee Jerry Cintron. Mr. Cintron consents to the filing of Dr. Koldony's brief. Defendants-Appellants do not oppose the filing of the brief.

1. Dr. Kolodny is the Medical Director for the Opioid Policy Research Collaborative at the Heller School for Social Policy and Management at Brandeis University. He is a national recognized authority on the epidemic of opioid-use disorder (OUD) that has afflicted millions of Americans like Mr. Cintron. Dr. Kolodny has provided testimony on OUD to committees of the U.S. Senate and House of Representatives, and has acted as an expert consultant for the U.S. Department of Justice and numerous state Attorneys General in connection with their investigations into the epidemic. His publications on OUD have appeared in a number of peer-reviewed journals, including the New England Journal of Medicine, the Journal of the American Medical Association, and the Annual Review of Public Health.[1]

[1] *E.g.*, Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 Ann. Rev. Pub. Health 559 (2015); Andrew Kolodny and Thomas R. Frieden, *Ten Steps the Federal Government Should Take Now to Reverse the Opioid Addiction Epidemic*, 318(16) JAMA 1537 (2017); G. Caleb Alexander and Andrew Kolodny, *Initial Opioid Prescriptions Among U.S. Patients, 2012-2017*, 380(26) N. Eng. J. Med. 2587 (2019).

Dr. Kolodny has a significant interest in providing the Court with important context situating Mr. Cintron's case in the broader history of the OUD epidemic, and in setting forth the well-established standard of care for prisoners suffering from OUD.

2. Dr. Kolodny's brief establishes why, in light of national experience and a robust consensus among doctors and policymakers, it should have been obvious to the Defendants in this case that Mr. Cintron suffers from OUD, and that his condition requires medical treatment, not the irrationally destructive punishment of long-term solitary confinement.

As Dr. Kolodny's brief explains, OUD is widely understood to be a severe but treatable medical condition, not a culpable sign of moral failure deserving punishment. Almost every American family has been affected by OUD, and the condition is especially ubiquitous among the prisoners Defendants interact with every day. Defendants therefore should have immediately recognized Mr. Cintron's OUD.

The brief further describes why Defendants should also have known how to treat Mr. Cintron's condition. All the relevant stakeholders have concluded that using medication for opioid-use disorder, or MOUD, is the single most effective way to abate OUD, both in and out of prison. It is especially implausible that these Defendants were unaware of this consensus, because using MOUD for pris-

oners suffering from OUD is the official policy of the state of Rhode Island—a policy that at least one of Defendants has praised in the press. Finally, authorities around the world agree that imposing long-term solitary confinement on a patient with a severe mental illness like OUD, as Defendants did here, is contrary to fundamental ethics and rational prison administration.

Dr. Kolodny's brief will therefore aid the Court in understanding why the district court correctly concluded that, among things, Mr. Cintron has stated a plausible Eighth Amendment claim, and Defendants are not shielded from the claim through qualified immunity. Accordingly, Dr. Kolodny respectfully requests that the Court grant him leave to file the accompanying *amicus* brief.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this motion complies with the type-volume limitations of Federal Rule of Appellate Procedure 27(d)(2)(A) because it contains 574 words, excluding the parts of the document exempted by Federal Rule of Appellate Procedure 32(f).

This motion complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman font.

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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing motion with the Clerk of the United States Court of Appeals for the First Circuit via the CM/ECF system on this 11th day of May 2023. I certify that service will be accomplished through the CM/ECF system upon the registered participants listed below, and that service by U.S. Mail was executed on non-registered participants.

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INTEREST OF *AMICUS CURIAE*[1]

Amicus curiae Dr. Andrew Kolodny is the Medical Director for the Opioid Policy Research Collaborative at the Heller School for Social Policy and Management at Brandeis University. He is a nationally recognized authority on the epidemic of opioid-use disorder (OUD) that has afflicted millions of Americans like Plaintiff-Appellee Jerry Cintron. Dr. Kolodny has provided testimony on OUD to committees of the U.S. Senate and House of Representatives, and has acted as an expert consultant for the U.S. Department of Justice and numerous state Attorneys General in connection with their investigations into the epidemic. His publications on OUD have appeared in a number of peer-reviewed journals, including the New England Journal of Medicine, the Journal of the American Medical Association, and the Annual Review of Public Health.[2]

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[1] As stated in Dr. Kolodny's concurrently filed motion for leave to participate as *amicus curiae*, Plaintiff-Appellee consents to the filing of this brief, and Defendants-Appellants do not oppose the filing of this brief. No counsel for any party authored this brief in whole or in part, and no party, counsel, or person other than *amicus* and his counsel contributed money to fund the preparation or submission of this brief.

[2] *E.g.*, Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 Ann. Rev. Pub. Health 559 (2015); Andrew Kolodny and Thomas R. Frieden, *Ten Steps the Federal Government Should Take Now to Reverse the Opioid Addiction Epidemic*, 318(16) JAMA 1537 (2017); G. Caleb Alexander and Andrew Kolodny, *Initial Opioid Prescriptions Among U.S. Patients, 2012-2017*, 380(26) N. Eng. J. Med. 2587 (2019).

Dr. Kolodny has previously served as Chief Medical Officer for Phoenix House, a national nonprofit addiction-treatment agency, and as Chief of Psychiatry at Maimonides Medical Center in New York City. He began his career in the New York City Department of Health and Mental Hygiene, where he led one of the Nation's first public-health efforts to address the OUD epidemic.

Dr. Kolodny submits this brief to provide the Court with context situating Mr. Cintron's case in the broader history of the OUD epidemic, and to describe the well-established consensus that prisoners like Mr. Cintron suffering from OUD need to be treated with medication, not subjected to the irrationally draconian punishment of long-term solitary confinement.

INTRODUCTION

Jerry Cintron is a prisoner in the Rhode Island penitentiary system who suffers from opioid-use disorder, or OUD. Mr. Cintron repeatedly requested treatment for this condition. Defendants refused it. They instead punished Mr. Cintron, sending him to solitary confinement because of conduct arising from his illness. In near-total isolation, Mr. Cintron's OUD has only gotten worse. Defendants have responded with yet more punishment, adding to Mr. Cintron's term in solitary whenever he relapses. The result is a self-perpetuating cycle of deterioration and punishment: Mr. Cintron has now spent over two-and-a-half years in solitary, where he remains today.

On these facts, the district court held that Mr. Cintron had pleaded a viable Eighth Amendment claim, among other claims, and that Defendants were not shielded by qualified immunity. That decision was correct. It should have been obvious to Defendants that Mr. Cintron's OUD requires medical treatment, not the irrationally harmful penalty of long-term solitary confinement.

That conclusion follows from national experience and a robust consensus among doctors and policymakers. OUD is widely understood to be a severe but treatable medical condition, not a culpable sign of moral failure. Virtually every American family has been affected by the decades-long crisis in opioid addiction. In the course of claiming more than a million lives in this country, the crisis has

followed a trajectory that closely matches Mr. Cintron's own experience: beginning with victims becoming dependent on opioids prescribed during ordinary medical treatment, then metastasizing when those victims turn to increasingly lethal synthetic opioids to satisfy the their addiction. And while OUD is prevalent across American society, the condition is especially ubiquitous among the prisoners Defendants interact with every day. The upshot is that Mr. Cintron's struggles with OUD should have been immediately recognizable to Defendants in light of this ongoing public-health disaster: an epidemic of *addiction* requiring urgent medical *treatment*, not a problem of morally culpable *misconduct* to be deterred through *punishment*.

The proper course of treatment should also have been well-known to Defendants. All relevant stakeholders—doctors, government policymakers, and prison administrators—have concluded that using medication for opioid-use disorder, or MOUD, is the single most effective way to abate OUD, both in and out of prison. And it is especially implausible that these Defendants were unaware of this consensus, because using MOUD for prisoners suffering from OUD is the official policy of the state of Rhode Island—a policy that at least one of Defendants has praised in the press. Finally, authorities around the world agree that imposing long-term solitary confinement on a patient with a severe mental illness like OUD, as Defendants did here, is contrary to fundamental ethics and rational prison administration.

For these reasons and those given in Mr. Cintron's brief, this Court should affirm the district court's decision.

ARGUMENT

I. Mr. Cintron Suffers From Opioid-Use Disorder, A Medical Condition At The Heart Of America's Opioid Epidemic.

Mr. Cintron has OUD. Appendix ("App.") 26 (¶72). *Amicus* understands from Mr. Cintron that he developed this addiction in the course of medical treatment for injuries he suffered as the victim of a violent felony. In 2015, he was robbed at gunpoint and shot five times. He was hospitalized for four-and-a-half months and had to undergo multiple surgeries. During his stay in hospital, he was, in his words, "pumped full of opioids." By the time he was discharged, he had become dependent on opioids—he says he "needed to get that fix" however he could.

Mr. Cintron's addiction led him to prison. He was arrested for possession of illicit drugs, among other charges, *see* Dkt. No. 50-1 at 95, and was ultimately convicted and incarcerated in a Rhode Island prison. Once in jail, he tried to satisfy his addiction with a half-pill of counterfeit Percocet, a brand-name for the opioid oxycodone. App.18 (¶18). The pill contained fentanyl, an extremely potent and dangerous synthetic opioid, *see* p. 10, *infra*, which caused Mr. Cintron to suffer an overdose. App.18 (¶19). But rather than treat Mr. Cintron for his addiction—something Mr. Cintron had repeatedly requested, even before overdosing, App.26 (¶73)—Defendants interrogated him, telling him he would be sent to solitary

confinement if he did not reveal who gave him the counterfeit Percocet. App.21 (¶41). When Mr. Cintron refused to do so, Defendants made good on their promise to "bury [him] alive." App.21 (¶41). Because of the drastic suffering he has endured in solitary, the symptoms of Mr. Cintron's OUD have worsened, and he has relapsed multiple times—with the result that more and more days have been added to his time in solitary. A.26 (¶41); Cintron Br. 6-7, 53. All told, he has spent more than two-and-a-half years in solitary and remains there today. App.37, 302; Cintron Br. 53.

Though tragic, the fundamentals of Mr. Cintron's story are not unusual, and his condition could not have been unfamiliar to Defendants. That is because OUD is widely recognized to be a severe but treatable medical condition—one that has afflicted America at epidemic levels and is especially endemic in prison.

A. Opioid-Use Disorder Is a Treatable Medical Condition, Not a Culpable Moral Failing.

OUD is an especially dangerous substance addiction, "a continued use of a drug despite negative consequences." Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 Ann. Rev. Pub. Health 559, 560 (2015), https://tinyurl.com/m6m2tnrr (*Opioid Crisis*). "Opioids are highly addictive because they induce euphoria," meaning they create "positive reinforcement," and also because "cessation of chronic use [of opioids] produces dysphoria," a kind of "negative reinforcement." *Id.* "Chronic exposure to opioids results in structural and functional changes in regions of the

brain that mediate affect, impulse, reward, and motivation." *Id*. As a severe substance-use disorder, OUD is part of a larger category of mental illness recognized by the American Psychiatric Association.[3]

In plain terms, then, OUD is "a medical disorder." National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction* 2 (Apr. 2007, revised June 2020), https://tinyurl.com/27jsb2zd (*Science of Addiction*). As such, OUD is "a lot like other diseases, such as heart disease." *Id.* at 4. Like heart disease, OUD "disrupt[s] the normal, healthy functioning of an organ in the body" and can "have serious harmful effects." *Id*. And like heart disease, OUD "is a treatable disorder." *Id.* at 22; *see also* Part II.A, *infra*.

This understanding of OUD as a treatable medical disease has replaced an older view of addiction as a culpable moral failing. A century ago, "scientists studying drugs and drug use labored in the shadows" of "misconceptions about the people with an addiction." *Science of Addiction*, *supra*, at 24. They thought "people with an addiction" were "morally flawed and lacking in willpower," and they "treat[ed addiction] as a moral failing rather than a health problem, which led to an emphasis on punishment rather than prevention and treatment." *Id*. As scientific

[3] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 483 (5th ed. 2013) (defining substance-use disorders as "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems").

knowledge about the medical foundations of addiction advanced, this mistaken view was discredited. *Id*.

The medical nature of OUD is essential to grasping both Mr. Cintron's experience and the larger opioid crisis his experience reflects. The crisis is not one of volitional misconduct deserving punishment. Instead, it is an epidemic of addiction requiring medical treatment. *See Opioid Crisis*, *supra*, at 563.[4]

B. Mr. Cintron's Struggle with Opioid-Use Disorder Echoes the Experiences of Millions of Americans from Every Walk of Life.

The OUD epidemic has lasted for over a quarter century and affected millions of Americans. Mr. Cintron's narrative sadly parallels the trajectory of the crisis, which began when large numbers of Americans became addicted to opioids prescribed by their doctors and dentists, and then became "a public health catastrophe" as these victims turned to a series of ever more deadly synthetic opioids to satisfy their addiction. Keith Humphreys et al., *Responding to the Opioid Crisis*

[4] *See also, e.g.*, *Combating the Opioid Crisis: Helping Communities Balance Enforcement and Patient Safety, Hearing Before the Subcomm. on Health of the Comm. On Energy and Commerce*, 115th Cong. 141 (2018) (Statement of Andrew Kolodny, M.D.) (explaining that "the correct way to frame the opioid crisis is as an epidemic of opioid addiction," and that "[w]e really have to accomplish two things": "prevent more people from becoming opioid addicted, and … see that the people who are addicted are accessing effective treatment"); *Unintended Consequences: Medicaid and the Opioid Epidemic: Hearing Before the Comm. on Homeland Security and Government Affairs,* 115th Cong. 74-77 (2018) (Statement of Andrew Kolodny, M.D.) (similar).

in North America and Beyond: Recommendations of the Stanford-Lancet Commission, 399 The Lancet 555, 555 (2022), https://tinyurl.com/2a43aecz (*Lancet Commission*); *see also Opioid Crisis*, *supra*, at 560-61, 562-65.

1. The North American OUD epidemic has resulted in record high levels of opioid-related overdose deaths that have involved prescription opioids, heroin, and illicitly synthesized fentanyl. *Lancet Commission*, *supra*, at 555; *see also* Centers for Disease Control and Prevention, *Understanding the Opioid Overdose Epidemic* (June 21, 2022), https://tinyurl.com/jjjzkytc (*Understanding the Epidemic*). Deaths involving prescription opioids began rising in the second half of the 1990s, when the availability of and prescription rates for pharmaceutical opioids like Percocet "exploded." *Lancet Commission*, *supra*, at 558; *Understanding the Epidemic*, *supra*. The result was that "millions" of Americans quickly became "addicted to prescription opioids" prescribed in the course of routine medical care for "a broad range of non-cancer pain conditions, from lower back pain to headaches to sprained ankles," *Lancet Commission*, *supra*, at 555, 558—the same way that Mr. Cintron became addicted during his hospital treatment for a gunshot wound, *see* p. 5, *supra*.

Around 2011, opioid-related deaths involving heroin began increasing as the many Americans who had developed OUD from taking prescription medications started looking for alternative sources to satisfy their addiction. *Lancet Commission*,

supra, at 559. Soon, "drug traffickers realiz[ed] that individuals addicted to prescription opioids were a fertile potential market for" other illegal drugs, particularly heroin. *Id*. As a result, "traffickers expanded heroin markets, including in small cities and towns where they had never operated before," and "many people addicted to prescription opioids were drawn in by the comparatively low price of heroin." *Id*.

In 2014, as illicitly synthesized fentanyl became increasingly available on the black market, opioid-related deaths soared. *Lancet Commission, supra*, at 559. Now, "illicit drug producers began adding extraordinarily powerful synthetic opioids, such as fentanyl, to counterfeit pills, heroin, and stimulants." *Id.* at 559, 564. The emergence of fentanyl as the dominant opioid on the black market resulted in "unprecedented lethality." *Id.* at 559; *see also Understanding the Epidemic*, *supra*. Many Americans who developed OUD from prescription medications are therefore drawn to the use of other dangerous illicit drugs—just like Mr. Cintron, who ended up in jail on a drug-possession charge for cocaine, and whose time in solitary was precipitated by overdosing on a fentanyl-laced Percocet, *see* p. 5, *supra*.

The damage from the OUD epidemic has been catastrophic. In America alone, more than a million people have died from drug overdoses since 1999[5]—

[5] Brian Mann, *More than a Million Americans Have Died from Overdoses During the Opioid Epidemic*, National Public Radio (Dec. 30, 2021), https://tinyurl.com/45smny73; *see also* Centers for Disease Control and Prevention,

meaning the OUD epidemic "has cost" America "more lives than World War 1 and World War 2 combined," *Lancet Commission*, *supra*, at 557. The mortality rate from the OUD epidemic is worse than anything seen during the height of the AIDS epidemic. *Id.* at 555. The economic costs of the epidemic have been tremendous as well: "The Council of Economic Advisers estimated the social cost of the opioid epidemic to be $504 billion in 2015." National Academies of Sciences, Engineering, and Medicine, *Medications for Opioid Use Disorder Save Lives* 17 (2019), https://tinyurl.com/32ky7tw7 (*Medications for OUD*). And the epidemic has been especially devastating in Rhode Island, where Mr. Cintron is held—in 2013, the state had the highest rates of drug use in the country,[6] and opioid overdose is the most common cause of accidental death in the state.[7]

The OUD epidemic is worsening, not abating. At the same time the rise of fentanyl has been driving up overdoses, the COVID-19 pandemic has both exacerbated the epidemic and sapped attention and resources away from it. *Lancet*

Provisional Drug Overdose Death Counts (Apr. 12, 2023), https://tinyurl.com/39su5jrp.

[6] Rhode Island Governor's Overdose Prevention and Intervention Task Force, *Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic* 3 (Nov. 4, 2015), https://tinyurl.com/k52ekanh.

[7] Rhode Island Department of Health, *Opioid Use Disorder and Overdose* (2023), https://tinyurl.com/36hm393r.

Commission, *supra*, at 557. Virtually every segment of our society has been hit: Black, white, Indigenous, and Hispanic Americans; younger and older Americans; the middle class and the unemployed. *Id.* at 559-60, 563. The federal government has estimated that, as of 2021, some 5.6 million Americans are suffering from OUD.[8]

2. Unsurprisingly, then, Americans from every walk of life have stories similar to Mr. Cintron's. Some are wealthy business owners like David, who "founded a multimillion-dollar brokerage firm [and] managed 75 employees." Centers for Disease Control and Prevention, *David* (July 17, 2020), https://tinyurl.com/5d3ynm6x. Much like Mr. Cintron, David "was prescribed opioids to manage pain from several knee surgeries," and quickly became addicted. *Id*. Also like Mr. Cintron, "[w]hen David could no longer get a prescription for opioids, he turned to" an illegal drug, "heroin, and from there his life spiraled out of control." *Id*. "He bankrupted his brokerage firm, lost his wife to divorce," and was incarcerated. *Id*.

Other victims are veterans like Britton, who developed OUD from opioids prescribed in connection with injuries sustained during his military service. Centers for Disease Control and Prevention, *Britton* (July 23, 2020),

[8] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* 35 (Dec. 2022), https://tinyurl.com/3pc9k8p4.

https://tinyurl.com/49efaw45. As a result of his OUD, Britton "separated from his wife, who ultimately passed away due to complications from her [own] drug use." *Id*. After losing custody over his children, he was arrested and ordered into treatment by a veterans court. *Id*. OUD has also harmed vulnerable young women like Jeni, who started using drugs and alcohol "to mask the pain of the sexual assaults she survived as a young teen," then became addicted to prescription opioids after a car crash, started using heroin and methamphetamines, and ultimately was incarcerated. Centers for Disease Control and Prevention, *Jeni* (July 17, 2020), https://tinyurl.com/d3zm5rhh.

Mr. Cintron's struggle with OUD is therefore tragic, but also tragically common. It is part of an epidemic that has touched the lives of virtually every American—a crisis so profound that the federal government has, for nearly six years now, considered it an ongoing public-health emergency. Department of Health and Human Services, *Renewal of Determination that a Public Health Emergency Exists* (Apr. 4, 2022), https://tinyurl.com/2krxne62.

3. For these reasons, Mr. Cintron's struggles with OUD could not have presented a strange or novel situation for Defendants. Indeed, OUD is even *more* common in prisons than in the general population. Some "[s]ixty-five percent of all currently incarcerated individuals meet the criteria for a substance use disorder," and "[a] significant portion" of this population "have or have had" OUD. Michael L.

Barnett et al., *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic*) 35 (Nov. 2020, https://tinyurl.com/434x2r6t (*Evidence Based Strategies*). In fact, "[o]ver 30 percent of incarcerated individuals report suffering from serious withdrawal symptoms or an inability to control their opioid use." *Id*. If anyone is able to recognize OUD, it is a prison administrator who sees people suffering from these symptoms every day.

II. Medication For Opioid-Use Disorder Is The Proper Standard Of Care For Opioid-Use Disorder, And Punishing Opioid-Use Disorder With Solitary Confinement Is Irrationally Harmful.

Just as Defendants should have recognized Mr. Cintron's OUD, they should also have known how to respond to his illness. By July 2019, when Defendants first put Mr. Cintron in solitary, *see* App.24 (¶62), overwhelming evidence had already established that the proper standard of care for OUD is medication for opioid-use disorder, or MOUD.[9] The same evidence made clear that MOUD is safe, effective, and affordable in prison. This was not just a consensus among experts, but a matter of government policy: Rhode Island had already implemented a successful MOUD program throughout the same prison system holding Mr. Cintron, and one of Defendants had even touted the program's effectiveness to the public. Likewise, it

[9] The literature also refers to medication-assisted treatment, or MAT, for the same regime of treatment described by MOUD. The two phrases are therefore effectively interchangeable, but MOUD is the term currently preferred in the medical community.

was already well-understood that using long-term solitary confinement to punish inmates with mental illnesses like OUD does nothing but inflict disproportionate harm and compound challenges to prison administration.

A. Medication-Assisted Treatment Is the Proper Standard of Care for Opioid-Use Disorder in Prison.

1. The principles for proper treatment of OUD are firmly established. "Research shows" that medication for opioid-use disorder, or MOUD, "should be the first line of treatment, often combined with some form of behavioral therapy or counseling." *Science of Addiction*, *supra*, at 24; *see also generally Medications for OUD*, *supra*. Three medications have been identified as appropriate for MOUD: methadone and buprenorphine, which are opioid "agonists" (meaning they help block opioid cravings and withdrawal symptoms), and extended-release naltrexone, an opioid "antagonist" that completely blocks the receptors that allow opioids to produce their intoxicating effect. *Evidence Based Strategies*, *supra*, at 8. All three of these medications have been proven to work and are approved by the U.S. Food and Drug Administration (FDA) for the treatment of OUD. *Medications for OUD*, *supra*, at 2.

MOUD has also proven far more successful at treating OUD than any other treatment option. "Research shows that [MOUD] is at least twice as effective as abstinence-based treatment that does not include medications." Christine Vestal, *This State Has Figured Out How to Treat Drug-Addicted Inmates*, Stateline (Feb.

26, 2020), https://tinyurl.com/rnekkxmb (*How to Treat*).[10] The difference is stark: some abstinence-based methods, like cold-turkey "detox" techniques, "fail 90% of the time," *id.*, whereas OUD patients receiving MOUD are "up to 50 percent less likely to die," *Medications for OUD*, *supra*, at 6.

So it is no exaggeration to say that MOUD has been proven to "save [the] lives" of many struggling with OUD. *Id*. at 2. For these reasons, MOUD has been hailed as the fundamental standard for treating OUD by a range of authorities, including the U.S. Surgeon General, the American Association of Addiction Medicine, and the World Health Organization, the last of which "lists methadone as an essential medicine." *Evidence Based Strategies*, *supra*, at 9.

The medical consensus is therefore clear: MOUD is the standard of care for OUD. Indeed, MOUD is so clearly the preferred treatment for OUD that the National Academies of Sciences, Engineering, and Medicine warn that "[w]ithholding or failing to have available all classes of FDA-approved medication for the treatment of opioid use disorder in any care or criminal justice setting is"

[10] *See also, e.g.*, Anita Srivastava et al., *Primary Care Management of Opioid Use Disorder*s, 63 Canadian Family Physician 200, 200 (2017), https://tinyurl.com/mty73nvf (concluding that "[b]oth methadone and buprenorphine-naloxone are substantially more effective than abstinence-based treatment").

tantamount to "denying appropriate medical treatment." *Medications for OUD*, *supra*, at 3.

2. Policymakers and prison authorities have joined this consensus and have embraced the use of MOUD for OUD in prison.

a. Rhode Island, where Mr. Cintron is incarcerated, has been at the forefront of the trend. The state has acknowledged what science has made plain: that "addiction is a chronic disease," that "opioid addiction has become an epidemic," and that "people with substance use disorders and other mental illnesses are greatly over-represented in the criminal justice system." R.I. Exec. Order No. 17-07 (July 12, 2017), https://tinyurl.com/yuj7mt5a. In response, starting in 2016-17, the state rolled out a comprehensive MOUD program across the Rhode Island Department of Corrections. *How to Treat*, *supra*. The program offers all three FDA-approved medications (methadone, buprenorphine, and extended-release naltrexone, *see* p. 15, *supra*) to all prisoners who need it. *Id*.

Rhode Island's MOUD program has been a resounding success. Researchers at Brown University have "observed a large and clinically meaningful reduction in postincarceration deaths from overdose among inmates released from incarceration after implementation of a comprehensive [MOUD] program in [Rhode Island's] statewide correctional facility." Traci C. Green et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide*

Correctional System, 75(4) JAMA Psychiatry 405, 406 (2018), https://tinyurl.com/yc35kdw3. The researchers found it especially "remarkable that the reduction in mortality occurred in the face of a devastating, illicit, fentanyl-driven overdose epidemic." *Id*.

The program has also received praise from Rhode Island prison administrators. Notably, one of the administrators on the record as supporting the program is Patricia Coyne-Fague, a Defendant in this case, who served at the head of the state's Department of Corrections from January 2018 to January 2023. "At first," Ms. Coyne-Fague admitted, she "didn't understand" the program. *How to Treat*, *supra*. But "[w]hen [she] saw the numbers of people not dying after release, that's all [she] had to see." *Id*.

Part of the reason why Ms. Coyne-Fague and other Rhode Island prison officials have admitted to changing their minds on the issue is that the MOUD program is administrable and has improved prison safety. Observation and strip-searches during treatment have been effective in ensuring that medication is not improperly diverted away from those in the program. *Id*. And MOUD has cut down on the number of "[i]nmates with untreated addiction," which in turn helps reduce the "violence, extortion, stress, conflict and … strengthening of illegal drug networks and gangs" that accompany large numbers of untreated prisoners. *Id*.

b. Soon, "[c]orrections officials around the country" took Rhode Island's lesson to heart and began "realiz[ing] that [MOUD] is not only good for the health of inmates, but [is also] good for the health of [prison] institutions." *How to Treat*, *supra*. By early 2020, nine more states had begun using MOUD in their prisons, and "at least 300" more state prisons and jails now offer extended-release naltrexone before prisoners are released. *Id*. In 2018, Congress directed the Bureau of Prisons to make MOUD more widely available in federal penitentiaries. *See* First Step Act, Pub. L. 115–391, 132 Stat. 5193, 5244 (2018). The same year, FDA issued guidance aimed at encouraging innovation in MOUD treatments, an initiative driven by the government's recognition that, in the words of then-Secretary of Health and Human Services Alex Azar, "[t]he evidence is clear: [MOUD] works, and it is a key piece of defeating the crisis facing our country." Food and Drug Administration, *FDA Takes New Steps to Encourage the Development of Novel Medicines for the Treatment of Opioid Use Disorder* (Aug. 6, 2018), https://tinyurl.com/mr24a6p9.

The expansion of MOUD programs in federal and other state prisons has been accompanied by more "evidence that providing the medications in correctional facilities improves conditions inside and reduces crime and recidivism once inmates are released." *How to Treat*, *supra*. As in Rhode Island, prison administrators are learning from experience that MOUD works. "One top bureau administrator who has worked in more than 10 federal prisons," for example, was initially skeptical,

but was converted to MOUD after seeing how the prison's special-housing unit "count went down," "[t]here were less fights" and "less debts" in the population, and "[t]he drug dealers on the compound went out of business." Beth Schwartzapfel and Keri Blakinger, *Federal Prisons Were Told To Provide Addiction Medications. Instead, They Punish People Who Use Them*, The Marshall Project (Dec. 12, 2022), https://tinyurl.com/mpk9jhc (*Provide Addiction Medications*).

c. MOUD has also proven cost-effective in prison. Studies suggest that MOUD "save[s] $2-$6 in health care and re-incarceration costs for every dollar invested,"[11] and around every $500 invested in MOUD results in saving a prisoner's life.[12] One study concluded that MOUD could bring savings of as much as $25,000 to $105,000 per person over the course of a lifetime. Michael Fairley et al., *Cost-Effectiveness of Treatments for Opioid Use Disorder*, 78(7) JAMA 767, 767 (July 2021), https://tinyurl.com/49jjx3j8.

d. As a result of these positive developments, a number of organizations focused on prison administration have embraced MOUD. The National Commission on Correctional Health Care and the National Sheriffs' Association call MOUD "a

[11] Human Rights Watch, *Prison and Drugs: State Often Denies Help, Then Isolates In-Prison Users* (Apr. 17, 2009), https://tinyurl.com/4cv24s3e (*Prison and Drugs*).

[12] Natasa Gisev et al., *A Cost-Effectiveness Analysis of Opioid Substitution Therapy upon Prison Release in Reducing Mortality Among People with a History of Opioid Dependence*, 110(12) Addiction 1975 (2015).

cornerstone of best practice for recovery from substance abuse," and they "encourage sheriffs and [their] jail-based colleagues" to employ MOUD. National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment* 3 (Oct. 2018), https://tinyurl.com/3ty2fze2. Similarly, spurred on by the First Step Act, *see* p. 19, *supra*, and by the success of smaller-scale programs, the Bureau of Prisons has put out internal guidelines directing federal penitentiaries to offer MOUD for OUD "to all eligible inmates." *Provide Addiction Medications*, *supra*.

3. In light of all this, the right course of action should have been clear for Defendants. Rhode Island, the state that employs them, had already recognized OUD as a medical illness and mandated use of MOUD to treat OUD in prison—a policy that at least one of Defendants has lauded publicly. That policy is echoed by guidance from professional organizations setting the standards for medical care and prison administration across the country. By refusing Mr. Cintron proper treatment for his addiction, Defendants knowingly flouted a well-established standard of care. *See also* Cintron Br. 35 (collecting authorities recognizing that denial of MOUD to a prisoner in need of it may give rise to a viable Eighth Amendment claim).

B. Imposing Long-Term Solitary Confinement on Prisoners with Opioid-Use Disorder Is Inhumane.

Rhode Island's own official policies and the strong consensus around the use of MOUD would be enough to show that Defendants violated a clearly established

standard of care by refusing Mr. Cintron treatment. But there is more. Defendants did not merely withhold necessary medication from Mr. Cintron. They "bur[ied him] alive" and banished him to long-term solitary confinement, App.21 (¶41)—a measure designed to increase his suffering and guaranteed to exacerbate his addiction. On this point, too, medicine and policy are unequivocal: imposing solitary confinement on patients with OUD is destructive and wrong.

The conclusion follows from two propositions. The first has already been explained: OUD is a recognized mental illness, and treating OUD-related conduct as a moral failing reflects long-discredited misunderstandings of addiction. *See* pp. 6-8, *supra*. The second proposition is equally accepted: imposing solitary confinement for any significant length of time on a prisoner suffering from a significant mental illness like OUD is inhumane.

1. Voluminous data show that solitary confinement inflicts drastic harm on prisoners' mental health.

The pattern of deterioration is "strikingly consistent" and begins within days. Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J.L. & Pol'y 325, 335-36 (2006) (*Psychiatric Effects*); *see also* Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. Rev. L. & Soc. Change 477, 515-24 (1997). Placed in solitary confinement, prisoners "soon become incapable of maintaining an

adequate state of alertness and attention," and they start to show "characteristic[s] of stupor and delirium." *Psychiatric Effects*, *supra*, at 330-31. As time goes on, they suffer from "insomnia," "cognitive dysfunction," "hallucinations," "paranoia," "hopelessness," "a sense of impending emotional breakdown," "self-mutilation," "and suicidal ideation and behavior." Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 Crime & Delinq. 124, 131 (2003) (collecting studies). The conditions in solitary confinement "will bring" even those of healthy mind "to the edge of madness, perhaps to madness itself." *Davis v. Ayala*, 576 U.S. 257, 288 (2015) (Kennedy, J., concurring); *see also* Cintron Br. 20-21, 33.

In light of this stark reality, a national consensus has emerged that long-term solitary confinement for prisoners already at risk of psychological deterioration and self-harm, like those with a serious mental illness, is unjustifiable. For almost a decade now, the American Public Health Association has "call[ed] upon federal, state, and local correctional authorities" to "[e]xclude from solitary confinement prisoners with serious mental illnesses." American Public Health Association, *Solitary Confinement as a Public Health Issue* (Nov. 5, 2013), https://tinyurl.com/45ntawsr. The American Psychiatric Association and American Bar Association have taken similar positions.[13] Organizations focused on prison

[13] American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (Dec. 2012; retained Dec. 2017), https://tinyurl.com/5uftd88c ("Prolonged segregation of adult inmates with serious

administration agree. The National Commission on Correctional Healthcare, for example, advises that "mentally ill individuals … should be excluded from solitary confinement of any duration." National Commission on Correctional Health Care, *Solitary Confinement (Isolation)* (Apr. 10, 2016), https://tinyurl.com/2y978rrh.

International organizations condemn the use of solitary confinement for mentally ill patients as a human-rights violation. The World Health Organization classifies "[t]hose with pre-existing mental illness" as "particularly vulnerable to the effects of solitary confinement." World Health Organization, *Prisons and Health* 30-31 (Stefan Enggist et al., eds., 2014), https://tinyurl.com/7d36hdfz. And the Special Rapporteur of the United Nations Human Rights Council has found that imposition of solitary confinement for "any duration" on prisoners "with mental disabilities" amounts to torture in violation of international law.[14] *See also* Cintron Br. 22.

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mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates."); American Bar Association, *ABA standards for Criminal Justice Treatment of Prisoners* 35 (3d ed. 2011) ("Do not place prisoners with serious mental illness in [solitary confinement, which is] an anti-therapeutic environment. Maintain appropriate secure mental health housing for them, instead.").

[14] Juan E. Méndez, *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* 19, U.N. Doc. A/66/268 (Aug. 5, 2011).

Governments have taken action in light of this consensus. As Mr. Cintron observes, through a combination of court orders and legislative initiatives, a number of states now limit or ban long-term solitary confinement, particularly for mentally ill inmates. *See* Cintron Br. 19; Gerald Rich and Eli Hager, *Shifting Away from Solitary*, The Marshall Project (Dec. 23, 2014), https://tinyurl.com/5hed7z7z. Again, Rhode Island has been part of the trend; a special legislative commission asked to study the issue in the state has recommended significant curbs on long-term solitary confinement. Special Legislative Commission of the Rhode Island Legislature, *Report of the Special Legislative Commission to Study and Assess the Use of Solitary Confinement at the Rhode Island ACI* (June 29, 2017), https://tinyurl.com/yc5t6nzf.

Accordingly, at the time Defendants chose to inflict solitary confinement on Mr. Cintron rather than treat his OUD, authorities at every level—state, national, and international—had already made clear that doing so was profoundly wrong.

2. Mr. Cintron's experience confirms that condemning a prisoner with OUD to solitary confinement rather than offering treatment is contrary to any rational goal of prison administration.

Mr. Cintron's inordinately long period in solitary confinement is the product of a vicious circle. As already noted, *see* p. 6, *supra*, his OUD has worsened in the severe isolation of solitary confinement, causing him to seek out more drugs and

relapse. In response, Defendants have just punished him with more days in solitary confinement. The result is something out of Kafka: a cycle of punishment that perpetuates itself by provoking the very misconduct it is supposed to deter.

Unfortunately, while there have been widespread positive changes in prison policy on the issue, Mr. Cintron's experience is not unique. In the course of the opioid epidemic, other prisoners with OUD report they too have been "caught in a Catch-22: at high risk of relapse, but punished and denied access to treatment if they do." *Prison and Drugs*, *supra*.

Take the story of a former inmate in the New York penitentiary system, Kyle Ruggeri. Mr. Ruggeri recounts that he was given a 60-day term in solitary for failing a drug test. By day 29 he was "losing [his] grip on reality at an unbelievably fast pace and decided [he] could not take it anymore." Kyle Ruggeri, *Voices from Solitary: Solitary Confinement's Cycle of Addiction*, Solitary Watch (Aug. 27, 2019), https://tinyurl.com/yyzt3239 (*Voices from Solitary*). Suicidal, he bought drugs from a neighbor for an attempted overdose, but was caught and sentenced to an additional 90 days in solitary. *Id.*

In response, Mr. Ruggeri again attempted suicide and used even more drugs. *Id.* He was released after 123 days in solitary and transferred to another prison. *Id.* By this time, his addiction had become so severe that he could only stay sober for a little over a half hour in the new prison before he began using drugs again, which

eventually landed him once more in solitary, where his pattern of self-harm and drug use repeated. *Id*. Mr. Ruggeri was ultimately sent to solitary four more times, for a total of over 12 months. *Id*.

Reflecting on his experience, Mr. Ruggeri "th[ought] about the definition of insanity—doing the same thing over and over and expecting different results." *Voices from Solitary*, *supra*. The prison's treatment of his addiction seemed to meet that definition of madness: "they took a bunch of drug addicts who have mental health issues, gave them no treatment, flooded the jail with drugs, locked them in a room with no human interaction, and cut them off of their life-saving medication." *Id*. "[N]ot only did [th]at plan not work, the prison got more violent" when solitary was used more aggressively as punishment for drug use, because "[a]ll these guys who needed these meds to keep their sanity now went crazy and got violent." *Id*. After release, Kyle was even more dependent on drugs than before and had suffered irreparable psychological harm. *Id*.

Evidence suggests this vicious circle of irrational punishment causes systemic damage to prisons. A review of "[d]ocuments obtained from the Department of Correctional Services show[s] that between 2005 and 2007," before its solitary-confinement policies were overhauled, inmates in the New York prison system "were sentenced to a collective total of 2,561 years in [solitary confinement] for drug-related charges." *Prison and Drugs*, *supra*. Rather than reducing drug use,

this "simply raise[d] demand for drugs in the prisons." *Id*. That is because, for the reasons already explained, punishing rather than treating OUD produces prisoners who are further trapped by their addiction, more likely to be noncompliant in the general prison population, and less likely to successfully reintegrate into society after release—exactly the *opposite* of the outcome a rational prison administration is supposed to produce.

* * *

Summing up, all the relevant guiding principles were clearly established when Defendants put Mr. Cintron in solitary confinement in July 2019. In Rhode Island as elsewhere, doctors, policymakers, and prison officials had already concluded that OUD requires MOUD. The same authorities also agreed that putting someone with a mental illness like OUD in solitary confinement is, in the words of one federal court, "the mental equivalent of putting an asthmatic in a place with little air to breathe"—an obviously cruel and unusual punishment *Madrid v. Gomez*, 889 F.Supp. 1146, 1265-66 (N.D. Cal. 1995).

The decision below was therefore correct. Mr. Cintron's Eighth Amendment claim should proceed to a trial on the merits, and Defendants cannot avoid the claim through qualified immunity.

CONCLUSION

The district court's decision should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this document complies with the type-volume limitations of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) because it contains 6329 words, excluding the parts of the document exempted by Rule 32(f).

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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing brief with the Clerk of the United States Court of Appeals for the First Circuit via the CM/ECF system on this 11th day of May 2023. I certify that service will be accomplished through the CM/ECF system upon the registered participants listed below, and that service by U.S. Mail was executed on non-registered participants.

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