IN THE UNITED STATES DISTRICT COURT

OF THE WESTERN DISTRICT OF TEXAS

EL PASO DIVISION

LEONEL NAVARRO RODRIGUEZ,

Petitioner,

v.

MERRICK B. GARLAND, U.S. ATTORNEY GENERAL;

KRISTI NOEM, SECRETARY, U.S. DEPARTMENT OF HOMELAND SECURITY;

and CHRISTOPHER W. DEMPSEY, ACTING FIELD OFFICE DIRECTOR; ICE ERO EL PASO FIELD OFFICE,

Respondents.

Case No. 3:25-CV-00420-LS

PETITIONER'S REPLY IN OPPOSITION TO RESPONDENTS' MOTION TO DISMISS

I. Introduction and Procedural Background

Petitioner Leonel Navarro Rodriguez, proceeding pro se, respectfully submits this Reply in Opposition to Respondents' Motion to Dismiss (ECF No. 10). Respondents contend that this Court lacks jurisdiction under 8 U.S.C. § 1252 and that Petitioner is no longer "in custody" for

habeas purposes. These assertions misconstrue both the nature of this action and the continuing restraints imposed by an unlawful removal order.

Petitioner does not seek appellate review of a discretionary immigration decision. He seeks collateral relief from a void judgment entered without jurisdiction and in violation of due process. Federal courts retain authority under Fed. R. Civ. P. 60(b)(4) and 28 U.S.C. § 2241 to vacate judgments that are void ab initio or constitutionally defective.

On October 6, 2025, this Court entered an Order to Show Cause (ECF No. 8) directing Respondents to respond by October 27, 2025. Petitioner files this Reply in accordance with that Order and to address the government's arguments.

II. Jurisdiction to Vacate a Void Judgment

Respondents' reliance on the REAL ID Act and § 1252(a)(5) is misplaced. Those provisions limit direct review of final removal orders through petitions for review in the courts of appeals but do not divest district courts of jurisdiction to remedy judgments that are void for lack of jurisdiction or fundamental due-process violations.

The Supreme Court has long recognized that a judgment entered without jurisdiction or in violation of due process is void and may be set aside at any time. *United Student Aid Funds, Inc. v. Espinosa*, 559 U.S. 260, 271 (2010); *Klapprott v. United States*, 335 U.S. 601, 613 (1949). Habeas jurisdiction likewise remains available for fundamental constitutional claims that could not have been meaningfully addressed through the immigration appellate process. *INS v. St. Cyr*, 533 U.S. 289, 314 (2001).

Here, the Notice to Appear lacked the statutorily required date and time, depriving the immigration court of jurisdiction under *Pereira v. Sessions*, 138 S. Ct. 2105 (2018), and *Niz-*

Chavez v. Garland, 141 S. Ct. 1474 (2021). Accordingly, this Court retains authority to vacate the resulting order as void under *Espinosa* and *Klapprott*.

III. Petitioner Remains "In Custody"

The government's claim that Petitioner is no longer "in custody" fails. The Supreme Court has held that collateral consequences such as legal disabilities or restrictions on movement satisfy the custody requirement. *Carafas v. LaVallee*, 391 U.S. 234, 237-38 (1968); *Chaker v. Crogan*, 428 F.3d 1215, 1219 (9th Cir. 2005). Petitioner remains subject to a final order of removal that bars lawful re-entry and permanently separates him from his U.S. citizen children—continuing restraints sufficient to establish habeas custody. District courts routinely recognize such constructive custody in immigration contexts. *Rosales-Garcia v. Holland*, 322 F.3d 386, 395 (6th Cir. 2003) (en banc).

IV. The Government's Silence on Substantive Defects

Respondents fail to address the core constitutional violations:

- The jurisdictionally defective Notice to Appear (NTA);
- The Immigration Judge's admission that he lacked the underlying criminal record;
- The improper reliance on uncertified PACER records and a Presentence Investigation Report (PSR), inadmissible under *Shepard v. United States*, 544 U.S. 13 (2005);
- The absence of a competency evaluation despite involuntary medication; and
- The missing hearing record dated April 5, 2023.

This silence underscores the validity of Petitioner's claims and the necessity of judicial correction to preserve the integrity of the proceedings.

V. Extraordinary Circumstances Justify Relief

Even under Rule 60(b)(6), relief remains warranted. The combination of jurisdictional error, deprivation of counsel, involuntary medication, and separation from U.S. citizen children constitutes the type of extraordinary circumstance recognized in *Liljeberg v. Health Services Acquisition Corp.*, 486 U.S. 847, 864 (1988), and *Klapprott*, 335 U.S. at 613.

While detained by ICE, Petitioner was involuntarily medicated. The Immigration Judge never held a competency hearing as required by *Matter of M-A-M-*, 25 I&N Dec. 474 (BIA 2011). Petitioner's medicated state prevented him from understanding the proceedings or exercising appellate rights, rendering any waiver of appeal unknowing and involuntary.

Issuing a final order under these conditions violated due process and rendered the judgment constitutionally void. *Pate v. Robinson*, 383 U.S. 375, 384-86 (1966); *Calderon-Rodriguez v. Sessions*, 878 F.3d 1179 (9th Cir. 2018).

Further, Petitioner's FOIA requests confirm missing and withheld records, demonstrating that the removal order rests on an incomplete and unreliable record.

VI. The "Aggravated Felony" Designation Was Legally Erroneous

The removal order rests on a finding that Petitioner's 2021 conviction constituted an "aggravated felony" under INA § 101(a)(43)(B). That finding is legally invalid because the Immigration Judge failed to apply the categorical or modified categorical approach required by *Moncrieffe v. Holder*, 569 U.S. 184, (2013); and *Shepard v. United States*, 544 U.S. 13 (2005).

Under those precedents, adjudicators may rely only on a narrow set of *Shepard*-approved documents – including the indictment, plea agreement, plea colloquy transcript, and judgment of conviction – to identify elements of the offense. The record shows DHS submitted only an

unsworn ICE declaration attaching a PACER printout, not a certified judgment or plea agreement. The Immigration Judge further relied on statements from a Presentence Investigation Report (PSR) describing Petitioner as an "*organizer*" or "*leader*" to classify the conviction as a "*particularly serious crime*." A PSR is not a Shepard-approved document and cannot be used to establish the elements or nature of a conviction. *United States v. Allen*, 950 F.3d 1184, 1188 (9th Cir. 2020).

Reliance on these inadmissible materials violated due process and controlling Supreme Court precedent. Because the government failed to produce competent evidence establishing that the offense met the elements of an aggravated felony under INA § 101(a)(43)(B), the classification was ultra vires and void. The resulting order of removal must therefore be vacated under Rule 60(b)(4) as void *ab initio*, or alternatively, under Rule 60(b)(6) to prevent manifest injustice and to ensure termination of all proceedings predicated on the defective aggravated felony finding.

VII. Relief Requested

Petitioner respectfully requests that this Court:

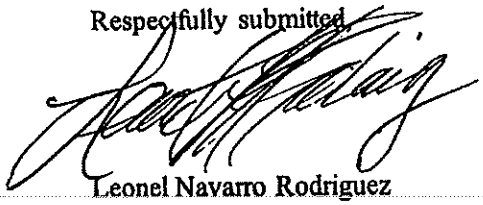
1. Deny Respondents Motion to Dismiss;
2. Declare that the immigration court lacked jurisdiction because the Notice to Appear was statutorily defective under 8 U.S.C. § 1229(a)(1);
3. Declare the aggravated felony classification and particularly serious crime determination void as a matter of law, for failure to apply the categorical approach and reliance on non-*Shepard* materials;
4. Vacate the Final Order of Removal as void *ab initio*;

5. Order termination, with prejudice, of the underlying and future removal proceedings arising from the same conviction;

6. Direct the Department of Homeland Security or other appropriate agency to reinstate Petitioner's Lawful Permanent Resident (LPR) status consistent with this vacatur; and

7. Grant such other and further relief as the Court deems just and proper.

Respectfully submitted,



Leonel Navarro Rodriguez

Petitioner, Pro Se

13922 Bee Flower Ln

Cypress, Texas 77429

I declare under penalty of perjury that the foregoing is true and correct.

Executed on 29th day of October, 2025.

CERTIFICATE OF SERVICE

I, Leonel Navarro Rodriguez, hereby certify that on this 29 day of October, 2025, I mailed a true and correct copy of the foregoing Petitioner's Opposition to Respondents' Response and Motion to Dismiss via certified mail, postage prepaid, to the following:

1. Office of the United States Attorney

Western District of Texas – El Paso Division

700 E. San Antonio Avenue, Suite 200

El Paso, Texas 79901

2. U.S. Immigration and Customs Enforcement (ICE)

El Paso Field Office, Enforcement and Removal Operations (ERO)

8915 Montana Avenue

El Paso, Texas 79925

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 29 day of October, 2025.

Leonel Navarro Rodriguez
Pro Se Petitioner
13922 Bee Flower Ln
Cypress. Texas 77429

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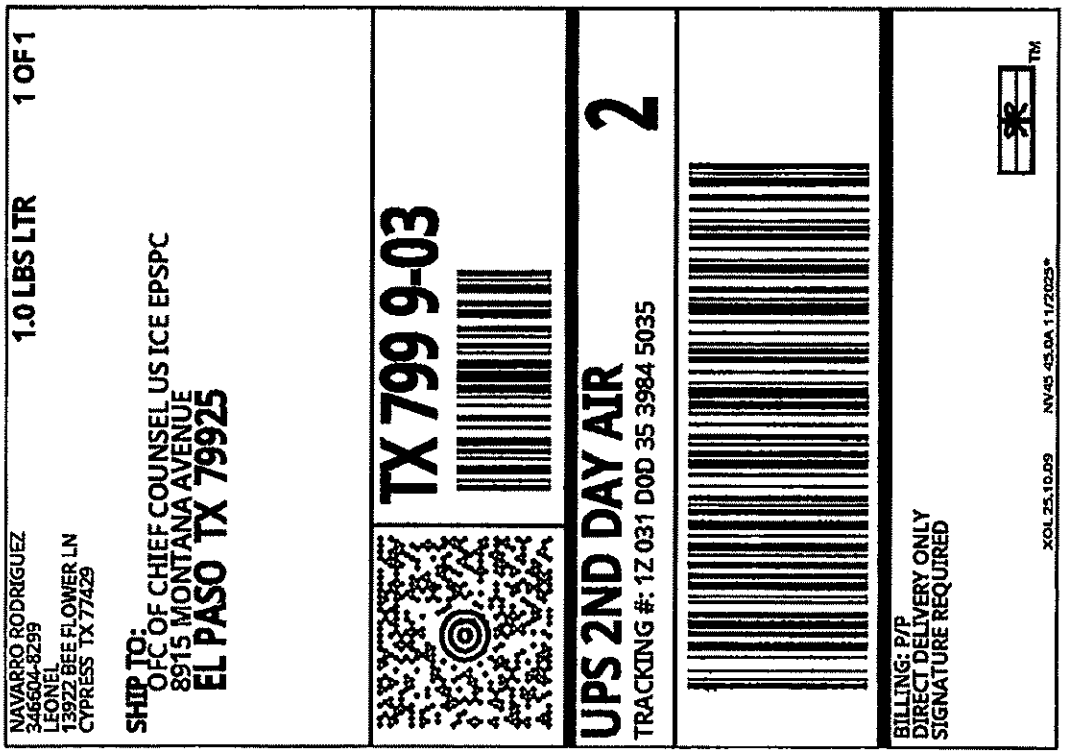

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NAVARRO RODRIGUEZ
346-604-8299
LEONEL
13922 BEE FLOWER LN
CYPRESS TX 77429

LTR 1 OF 1

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EXHIBIT N — MEDICAL RECORDS SUMMARY

Facility: TXBB – Bluebonnet Detention Center (GEO Group)

Dates Covered: August–September 2024

Medical Staff: Christine Moore, MRC; Brandi Loya, NP; Darrell Youngblood, Psychiatrist

Overview:

These records document Petitioner's involuntary and ongoing psychiatric and medical treatment while detained at the Bluebonnet Detention Center during the weeks preceding his September 17, 2024 removal hearing. The medical history includes chronic physical conditions (Type II diabetes, hypertension) and multiple psychiatric diagnoses:

- Anxiety disorder, unspecified (ICD-10: F41.9)
- Depression, unspecified (ICD-10: F32.A)
- Inflammatory disease of prostate (N41.9)

Psychiatric Medications Prescribed:

- **Buspirone (Buspar):** anti-anxiety agent that may cause dizziness, confusion, and difficulty concentrating.
- **Citalopram (Celexa):** SSRI antidepressant that can cause fatigue, mental fog, and delayed reaction time.
- **Nortriptyline (Pamelor):** tricyclic antidepressant known for drowsiness, disorientation, and impaired cognitive processing.

Relevant Clinical Notes:

- Multiple "Refusal of Meds" and "Refusal of Treatment" entries from Feb–Sept 2024, including repeated notation by facility staff (Moore, Pitts, Vasquez, Loya).
- "Psychiatric FU 1 month" and "Schedule follow-up mental health" entries indicate continued management of psychiatric medications.
- Notation of SHU confinement conditions aligns with known side effects of isolation: increased anxiety, confusion, and cognitive decline (*Ruiz v. Johnson*, 37 F. Supp. 2d 855 (S.D. Tex. 1999)).

Legal Significance:

These medical entries corroborate Petitioner's claim that he was involuntarily medicated and mentally impaired at the time of his removal hearing. Combined with SHU confinement, these records establish that Petitioner lacked the mental competence required to knowingly and voluntarily waive relief under *Matter of M-A-M-* (25 I&N Dec. 474 (BIA 2011)) and *Pate v. Robinson* (383 U.S. 375 (1966)).

Attachments:

1. EHR Clinical Report (pp. 4, 13 of 13, TXBB Medical Summary)
2. Refusal of Treatment Logs (Jan–Sept 2024)
3. Psychiatric and Medical Appointment List (Aug–Sept 2024)
4. Medication Side-Effect Reference (NIH and Mayo Clinic printouts)

YOUNGBLOOD, DARRELL

TAKE 1 CAPSULE(S) ORALLY AT BEDTIME

Problem List

Problem Description	Start Date	Diagnosed By	Resolved By	Stop Date
ICD-10- (N41.9) - (ACUTE) - Inflammatory disease of prostate, unspecified	8/30/2024	U- LOYA, BRANDI		
ICD-10- (F41.9) - (CHRONIC) - Anxiety disorder, unspecified	8/13/2024	DOC- YOUNGBLOOD, DARRELL		
ICD-10- (F32.A) - (CHRONIC) - Depression, unspecified	8/13/2024	DOC- YOUNGBLOOD, DARRELL		
ICD-10- (B35.4) - (ACUTE) - Tinea corporis	8/13/2024	U- LOYA, BRANDI		
ICD-10- (E11.9) - (CHRONIC) - Type 2 diabetes mellitus without complications	8/6/2024	U- LOYA, BRANDI		
ICD-10- (E78.5) - (CHRONIC) - Hyperlipidemia, unspecified	8/6/2024	U- LOYA, BRANDI		
ICD-10- (I10) - (CHRONIC) - Essential (primary) hypertension	8/6/2024	U- LOYA, BRANDI		
ICD-10- (R25.2) - (ACUTE) - Cramp and spasm	8/6/2024	U- LOYA, BRANDI		

Lab Result Summary

Service	Provider	Collected Date	Result Date
PSA Total (Reflex To Free)	LOYA, B	09/03/2024 4:07A	09/04/2024 13:11P
Urinalysis	NORRIS, MARY	08/29/2024 11:30A	08/29/2024 11:24A
Albumin/Creatinine Ratio,Urine	LOYA, B	08/06/2024 16:06P	08/10/2024 20:08P
Request Problem	LOYA, B	08/06/2024 16:06P	08/09/2024 11:14A
Hemoglobin A1c	LOYA, B	08/06/2024 16:06P	08/09/2024 11:14A
Lipid Panel With LDL/HDL Ratio	LOYA, B	08/06/2024 16:06P	08/09/2024 11:14A
Comp. Metabolic Panel (14)	LOYA, B	08/06/2024 16:06P	08/09/2024 11:14A
CBC With Differential/Platelet	LOYA, B	08/06/2024 16:06P	08/09/2024 11:14A
Request Problem	LOYA, B	08/06/2024 16:06P	08/08/2024 21:08P
Magnesium	LOYA, B	08/06/2024 16:03P	08/08/2024 9:14A
Hemoglobin A1c	LOYA, B	08/06/2024 16:06P	08/08/2024 9:14A
Lipid Panel With LDL/HDL Ratio	LOYA, B	08/06/2024 16:06P	08/08/2024 9:14A
Comp. Metabolic Panel (14)	LOYA, B	08/06/2024 16:06P	08/08/2024 8:21A
CBC With Differential/Platelet	LOYA, B	08/06/2024 16:06P	08/08/2024 8:21A

Vitals Summary

Male

Anniversary Date:	8/5/2024	TB Date & Result:	Negative - Test Date(02/22/2024, 12:00:00
Race	U	Language	English
Lactation Flag	False	Alt Num	
Smoking Status		Suicide Status	N/A
Height/Wt	5'10" 233 lbs	Pregnancy	No

Allergies

Allergy	Onset Date	Severity	Onset Type
ACE INHIBITORS		N/A	N/A

Immunizations

No Immunizations indicated

Medications

Medication	DC Date	Start Date	Stop Date	Last Admin
Active				
NovoLIN R 100unit/ml Vl (INSULIN REGULAR HUMAN)		8/29/2024	9/28/2024	9/19/2024
LOYA, BRANDI R				
*S/S:120-149=4, 150-200=8; 201-250=12; 251-300=16; 301-350=20; 351-400=24; > 400 CALL DR [***DOSE IN UNITS***]*				
busPIRone 15mg Tablet (BUSPAR) - CRUSH		8/13/2024	11/10/2024	9/18/2024
YOUNGBLOOD, DARRELL				
*TAKE 1 TABLET(S) ORALLY TWICE DAILY [***+++CRUSH&FLOAT+++***]*				
Citalopram 20mg Tablet (CELEXA) - CRUSH		8/13/2024	11/10/2024	9/17/2024
YOUNGBLOOD, DARRELL				
*TAKE 2 TABLET(S) ORALLY AT BEDTIME [***+++CRUSH&FLOAT+++***]*				
Nortriptyline 75mg Cap (PAMELOR)		8/13/2024	11/10/2024	9/18/2024
YOUNGBLOOD, DARRELL				
*TAKE 1 CAPSULE(S) ORALLY AT BEDTIME [***TOP OF MEDCART***]*				
Aspirin low 81mg EC Tab (BAYER LOW STRENGTH) - KOP		8/6/2024	12/3/2024	9/4/2024
LOYA, BRANDI R				
TAKE 1 TABLET(S) ORALLY AT BEDTIME				
Atorvastatin 40mg Tablet (LIPITOR) - KOP		8/6/2024	12/3/2024	9/6/2024
LOYA, BRANDI R				
TAKE 1 TABLET(S) ORALLY AT BEDTIME				
Insulin Glargine Vial (SEMGLEE (YFGN))		8/6/2024	10/4/2024	9/18/2024
LOYA, BRANDI R				

INJECT 26 UNIT(S) SUBCUTANEOUSLY DINNER INSULIN

Losartan 50mg Tablet (COZAAR) - KOP		8/6/2024	12/3/2024	9/4/2024
LOYA, BRANDI R				
TAKE 1 TABLET(S) ORALLY ONCE DAILY				
metFORMIN 1,000mg Tab (GLUCOPHAGE) - KOP		8/6/2024	12/3/2024	9/6/2024
LOYA, BRANDI R				
TAKE 1 TABLET(S) ORALLY TWICE DAILY				
Metoprolol 25mg Tablet (LOPRESSOR) - KOP		8/8/2024	12/5/2024	9/6/2024
LOYA, BRANDI R				
TAKE 1 TABLET(S) ORALLY AT BEDTIME				
Inactive				
metFORMIN 1,000mg Tab (GLUCOPHAGE) DISCONTINUED - 8/10/2024 12:01:31 AM	**8/10/2024 12:01:31 AM**	8/5/2024	8/10/2024	8/9/2024
NORRIS, MARY				
*TAKE 1 TABLET(S) ORALLY TWICE DAILY [***TOP OF MEDCART***]*				
NovoLIN R 100unit/ml Vl (INSULIN REGULAR HUMAN) DISCONTINUED - 8/6/2024 4:43:33 PM	**8/6/2024 4:43:33 PM**	8/6/2024	8/21/2024	
LOYA, BRANDI R				
201-250=2, 251-300=4, 301-350=6, 351-400=8, 401-450=10, OVER 450 CALL MD				
Atorvastatin 40mg Tablet (LIPITOR) DISCONTINUED - 8/6/2024 4:39:07 PM	**8/6/2024 4:39:07 PM**	8/6/2024	8/21/2024	
LOYA, BRANDI R				
*TAKE 1 TABLET(S) ORALLY AT BEDTIME [***TOP OF MEDCART***]*				
Insulin Glargine Vial (SEMGLEE (YFGN)) DISCONTINUED - 8/6/2024 4:40:13 PM	**8/6/2024 4:40:13 PM**	8/6/2024	8/21/2024	
LOYA, BRANDI R				
INJECT 26 UNIT(S) SUBCUTANEOUSLY DINNER INSULIN				
Losartan 50mg Tablet (COZAAR) DISCONTINUED - 8/6/2024 4:40:57 PM	**8/6/2024 4:40:57 PM**	8/6/2024	8/21/2024	
LOYA, BRANDI R				
*TAKE 1 TABLET(S) ORALLY ONCE DAILY [***TOP OF MEDCART***]*				
metFORMIN 1,000mg Tab (GLUCOPHAGE) DISCONTINUED - 8/6/2024 4:42:31 PM	**8/6/2024 4:42:31 PM**	8/7/2024	8/22/2024	
LOYA, BRANDI R				
*TAKE 1 TABLET(S) ORALLY TWICE DAILY [***TOP OF MEDCART***]*				
Aspirin low 81mg EC Tab (BAYER LOW STRENGTH) DISCONTINUED - 8/6/2024 4:38:29 PM	**8/6/2024 4:38:29 PM**	8/6/2024	8/21/2024	
LOYA, BRANDI R				
*TAKE 1 TABLET(S) ORALLY AT BEDTIME [***TOP OF MEDCART***]*				
NovoLIN R 100unit/ml Vl (INSULIN REGULAR HUMAN) DISCONTINUED - 8/29/2024 1:18:17 PM	**8/29/2024 1:18:17 PM**	8/6/2024	10/4/2024	8/28/2024
LOYA, BRANDI R				

201-250=2, 251-300=4, 301-350=6, 351-400=8, 401-450=10, OVER 450 CALL MD

Aspirin low 81mg EC Tab (BAYER LOW STRENGTH)	8/5/2024	8/10/2024	8/9/2024
NORRIS, MARY			
*TAKE 1 TABLET(S) ORALLY AT BEDTIME [***TOP OF MEDCART***]*			
Atorvastatin 40mg Tablet (LIPITOR)	8/5/2024	8/10/2024	8/9/2024
NORRIS, MARY			
*TAKE 1 TABLET(S) ORALLY AT BEDTIME [***TOP OF MEDCART***]*			
busPIRone 15mg Tablet (BUSPAR) - CRUSH	8/5/2024	8/10/2024	8/10/2024
NORRIS, MARY			
*TAKE 1 TABLET(S) ORALLY TWICE DAILY +++CRUSH&FLOAT+++ [***TOP OF MEDCART***]*			
Citalopram 20mg Tablet (CELEXA)	8/5/2024	8/10/2024	8/9/2024
NORRIS, MARY			
*TAKE 2 TABLET(S) ORALLY AT BEDTIME [***TOP OF MEDCART***]*			
NovoLIN R 100unit/ml Vi (INSULIN REGULAR HUMAN)	8/5/2024	8/10/2024	8/6/2024
NORRIS, MARY			
201-250=2, 251-300=4, 301-350=6, 351-400=8, 401-450=10, OVER 450 CALL MD			
Insulin Glargine Vial (SEMGLEE (YFGN))	8/5/2024	8/10/2024	8/10/2024
NORRIS, MARY			
INJECT 26 UNIT(S) SUBCUTANEOUSLY DINNER INSULIN			
Losartan 50mg Tablet (COZAAR)	8/5/2024	8/10/2024	8/10/2024
NORRIS, MARY			
*TAKE 1 TABLET(S) ORALLY ONCE DAILY [***TOP OF MEDCART***]*			
Metoprolol 25mg Tablet (LOPRESSOR)	8/5/2024	8/10/2024	8/9/2024
NORRIS, MARY			
*TAKE 1 TABLET(S) ORALLY AT BEDTIME [***TOP OF MEDCART***]*			
Nortriptyline 25mg Cap (PAMELOR) - CRUSH	8/5/2024	8/10/2024	8/9/2024
NORRIS, MARY			
*TAKE 3 CAPSULE(S) ORALLY AT BEDTIME ***CRUSH/EMPTY*** [***TOP OF MEDCART***]*			
Prevident Rinse Sol	8/12/2024	9/10/2024	9/9/2024
KIM, ANDREW S			
SWISH & SPIT 10 MILLILITER(S) ORAL RINSE AT BEDTIME AS NEEDED			
Clotrimazole 1% Cream (LOTRIMIN) - KOP	8/13/2024	8/27/2024	
LOYA, BRANDI R			
APPLY CREAM TOPICALLY ONCE DAILY			
Nortriptyline 75mg Cap (PAMELOR)	8/14/2024	8/19/2024	

NAVARRO RODRIGUEZ, LEONEL [redacted] **Location: A1 - - - 6L** [redacted]

Task/Appt Name	First Occ	Last Occ	User List	Role List	Priority	Completed On	Completed By	Last Status
KOP -have detainee bring all blister packs to clinic - take up old blister pack when new one given - ONLY TAKE UP BLISTER PACK OF THE MEDICATION YOU ARE GIVING THE NEW BLISTER PACK FOR	9/4/2024	9/4/2024		LVN; NURSE	Routine	9/4/2024	ESPINOZA, MICHELLE	Completed: Completed
KOP -have detainee bring all blister packs to clinic - take up old blister pack when new one given - ONLY TAKE UP BLISTER PACK OF THE MEDICATION YOU ARE GIVING THE NEW BLISTER PACK FOR	9/6/2024	9/6/2024		LVN; NURSE	Routine	9/6/2024	PERKINS, JENNA	Completed: Completed
KOP -have detainee bring all blister packs to clinic - take up old blister pack when new one given - ONLY TAKE UP BLISTER PACK OF THE MEDICATION YOU ARE GIVING THE NEW BLISTER PACK FOR	9/7/2024	9/7/2024		LVN; NURSE	Routine	9/6/2024	DUGAN, VICKY	Completed: Completed
Telepsych F/U 1 month English	9/10/2024	9/10/2024	YOUNGBLOOD, DARRELL (DYOUNGBLOOD)	MH PROFESSIONAL; PSYCHIATRIST	Routine	9/4/2024	MCENTYRE, HEATHER	Moved: Rescheduled to 9/11/2024; Quick Rescheduled By h.mcentyre on 9/4/2024 4:06:1 PM
review PSA	9/11/2024	9/11/2024	LOYA, BRANDI (BLOYA)	MIDLEVEL - NP/PA	Routine	9/11/2024	LOYA, BRANDI	Completed: Completed
Telepsych F/U 1 month English (RESCHEDULED)	9/11/2024	9/11/2024	HAYES, RUSSELL (RHAYES1)	MH PROFESSIONAL; PSYCHIATRIST	Routine	9/11/2024	VAUGHN, RICKY	Completed: Completed
Schedule follow-up Mental Health appoinment for the following timeframe: - 30 days - Psychiatric Progress Note	9/11/2024	9/11/2024		MH PROFESSIONAL	Routine	9/11/2024	MCENTYRE, HEATHER	Completed: Completed
I would like to have my medical records all the blood work and meds I was taking while I was here, thank you very much!!	9/17/2024	9/17/2024		MEDICAL RECORDS CLERK; MEDICAL RECORDS TECH	Routine	9/19/2024	MOORE, CHRISTINE	Completed: Printed and delivered 9/19/2024.

ocument Date	Document Name	Group	Category	Created By
6/2024 4:35:26 PM	TRANSFER SUMMARY	Medical	Medical	PITTS, CARLOTA
6/2024 5:40:52 PM	Consent form	Medical	Consent	PITTS, CARLOTA
6/2024 5:57:13 PM	CORONAVIRUS SCREENING	Medical	Medical	PITTS, CARLOTA
29/2024 2:35:04 PM	refusals of treatment	Medical	Refusal of Treatments	PITTS, CARLOTA
8/2024 5:21:50 PM	refusals of meds.	Medical	Refusal of Meds	PITTS, CARLOTA
8/2024 5:34:44 PM	refusals of treatment	Medical	Refusal of Treatments	PITTS, CARLOTA
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8/2024 1:36:51 PM	ekg	Medical	Radiology	PITTS, CARLOTA
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9/2024 12:01:27 PM	refusals of meds.	Medical	Refusal of Meds	MOORE, CHRISTINE, MRC
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30/2024 6:32:43 PM	refusals of meds.	Medical	Refusal of Meds	PITTS, CARLOTA
9/2024 10:28:23 AM	refusals of treatment	Medical	Refusal of Treatments	VASQUEZ, J, MRC
9/2024 11:34:02 AM	refusals of treatment	Medical	Refusal of Treatments	VASQUEZ, J, MRC
29/2024 10:13:38 AM	refusals of meds.	Medical	Refusal of Meds	MOORE, CHRISTINE, MRC
4/2024 12:10:40 PM	refusals of meds.	Medical	Refusal of Meds	MOORE, CHRISTINE, MRC
5/2024 9:55:54 AM	KOP consent	Medical	Medication	MOORE, CHRISTINE, MRC
6/2024 3:24:13 PM	refusals of meds.	Medical	Refusal of Meds	PITTS, CARLOTA

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The Impacts of Solitary Confinement

April 2021 | Evidence brief

Kayla James & Elena Vanko

Introduction

Achieving transformative change in U.S. prisons and jails starts with focusing correctional practices on the human dignity of incarcerated people and staff. The use of solitary confinement—also known as segregation or restrictive housing—presents a major barrier to this change. Across the United States, advocacy and human rights groups, policymakers, health care professionals, faith-based organizations, and leaders in the field of corrections have condemned the widespread use of solitary confinement in U.S. prisons, jails, and immigration detention centers. Originally intended to address dangerous, violent behavior in such facilities, solitary confinement has become a common tool for responding to all levels of misconduct—ranging from serious assaults to minor, nonviolent rule violations—and for housing vulnerable people.

The argument to end solitary confinement is rooted in a vast body of research that shows the serious detrimental effects on mental and physical health of spending 22 to 24 hours per day alone and idle in a cell the size of a parking space. Numerous studies have also found that solitary has a disproportionate impact on Black and brown people, youth, and people with mental illnesses.[1] And in recent years, researchers have begun to examine the potential harmful effects of the practice on corrections staff in solitary confinement units.[2] Moreover, research suggests that the widespread use of solitary does not achieve its intended purpose—it does *not* make prisons, jails, or the community safer, and may actually make them less safe.

When viewed comprehensively, research on solitary confinement reveals that it can have a host of adverse impacts on people inside and outside corrections and detention facilities. This evidence provides compelling reasons for corrections agencies to swiftly and safely reduce—and ultimately end—its use.

Impacts of Solitary Confinement on Incarcerated People

Psychological

More than 150 years of research in psychiatry, psychology, criminology, anthropology, and epidemiology has documented the detrimental effects of solitary confinement on mental health and well-being.

- **Solitary confinement can lead to serious and lasting psychological damage.** Physical and social isolation, coupled with sensory deprivation and forced idleness, create a toxic combination associated with a variety of harmful effects, including[3]

- anxiety
- anger
- depression
- insomnia
- impulse control issues
- paranoia
- hypersensitivity
- obsessive thoughts
- cognitive disturbances
- post-traumatic stress disorder (PTSD)
- loss of identity
- psychosis

- **Solitary is particularly harmful for people with preexisting mental illness.** The isolation, forced idleness, and lack of intensive therapeutic mental health services can exacerbate mental illness and cause people's mental health to significantly deteriorate.[4]
- **Psychological harms may worsen the longer someone stays in solitary.**[5]
- **Negative mental health repercussions can persist long-term.** They may last well after a person leaves solitary confinement and even after their release from jail, prison, or immigration detention.[6]
- **Solitary is associated with an increased risk of self-harm and suicide.**[7]
  - In New York State, the rate of suicide was more than **five times higher** for people in solitary confinement than in the general prison population between 2015 and 2019.[8]
  - Similarly, a 2014 study of the New York City jail system found that people who had been confined in solitary were **3.2 times more likely** to self-harm than incarcerated people who were never placed in solitary.[9]
  - A study of more than 200,000 people released from prison found that those who had spent any time in solitary were **78 percent more likely** to die from suicide within the first year after their return to the community than people who had been incarcerated but not placed in solitary.[10]

Neurological

In recent years, there has been increasing research into the neurological impacts of solitary confinement. Studies are demonstrating that isolation can lead to physical changes in the brain and how it functions. There is widespread agreement within the field of psychology that people have a fundamental need for social connection.[11] Neuroscientific research in this area provides powerful evidence that **social deprivation can cause people to experience "social pain,"** which the brain processes in the same way as physical pain.[12] Research also suggests that the social deprivation experienced in solitary confinement can "fundamentally alter the structure of the human brain in profound and permanent ways."[13]

- **For example, even one week in solitary can lead to significant changes in electrical activity in the brain.**[14] This is not a new concept—as far back as 50 years ago, researchers linked social isolation and sensory deprivation to slowed brain activity and poorer performance on intellectual and perceptual-motor tests.[15]

A large body of research provides evidence of similar neurological impacts in mice and rats, which have neuroanatomy similar to humans'.[16] Studies show that the brains of rodents subjected to isolation exhibit

dramatic changes, including **fewer neurons (nerve cells), smaller neurons, decreased connections between neurons, and fewer blood vessels in the brain.**[17]

- One particularly impacted area is the hippocampus, the part of the brain that affects learning, memory, and spatial awareness. It also regulates the body's response to stress, and its shrinking can result in loss of emotional and stress control.[18]
- At the same time, the forced isolation can cause a surge of activity in the amygdala—the region of the brain responsible for mediating fear and anxiety; notably, people held in solitary confinement often report high levels of both.[19]

Physiological

Solitary confinement is a public health issue. Increasingly, research is showing that people placed in solitary can develop serious, long-lasting health problems, which may increase their risk for further health complications in the future and even premature death.

- **Hypertension, heart attacks, and strokes.** In a 2019 study of California prisons, the incidence of hypertension among people in solitary confinement was almost three times higher than for those held in maximum-security general population units (47.5 percent vs. 16.5 percent).[20]
- **Other negative health effects.** People in solitary can experience heart palpitations, insomnia, shaking, weakness, deterioration of eyesight, sensory hypersensitivity, and aggravation of pre-existing medical problems.[21]
- **Premature death.** One study found that people who had spent any time in solitary confinement were 24 percent more likely to die in the first year after their release from prison than those who had been incarcerated but not been placed in solitary confinement, particularly from suicide (78 percent more likely) and homicide (54 percent more likely). They were also 127 percent more likely to die of an opioid overdose in the first two weeks after release.[22]
- **Lasting effects even after short stays.** For example, formerly incarcerated people in Denmark who had spent less than seven days in solitary were found, five years after release, to have higher overall death rates from unnatural causes such as accidents, suicide, and violence than people who had not spent time in solitary.[23]

Impacts on Staff

The stressful conditions within many solitary units—including frequent loud shouting and banging, flooded or feces-covered cells, and instances of interpersonal and self-inflicted violence—can make for an extremely difficult work environment.[24] Yet there has been little research to date focused specifically on how working in solitary units affects corrections staff.

Studies of corrections officers and firsthand accounts from staff suggest that working in carceral environments can take a significant toll on health and well-being.[25]

- **Corrections work can be stressful, physically and emotionally demanding, and dangerous.** It also often comes with low pay, insufficient training, and high levels of overtime work in understaffed facilities.[26]
- **Corrections staff often become hypervigilant**—extremely attentive and continually on the lookout for danger—since they must be on constant alert for interpersonal and self-inflicted violence. They can also experience serious trauma when such incidents occur.
- Given the intense challenges they face over prolonged periods of time, it's not surprising that corrections officers have been found to suffer severe physiological, psychological, and behavioral effects from job stress.[27] These can be so pronounced that a specific diagnostic category, "**corrections fatigue**," has been proposed to account for them.[28]
- In fact, studies have shown that corrections officers suffer from **heart disease, hypertension, PTSD, and suicide** at especially high rates, even compared with people with similarly stressful jobs, such as military veterans or police officers.[29]

Further research is needed to understand how working conditions specific to solitary confinement units impact corrections staff. However, **Vera's experience in the field suggests that working in solitary is especially taxing:**

- There are frequent reports of staff being reluctant to work in solitary confinement, sometimes even quitting on the spot after being assigned to those units.
- Corrections staff often report experiencing significantly lower stress 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.

Impacts on the Community and Public Safety

Families

Placement in solitary dramatically decreases a person's contact with the outside world.

- **Phone calls** and other communications are frequently limited or prohibited outright.
- **Access to visits** is often similarly curtailed. People held in solitary may be restricted to "no-contact visits," where they must talk to loved ones through a glass partition. Or they may have fewer or shorter visiting periods or no visits at all.[30]

Limitations on communication and visits negatively impact not only incarcerated people, but also their loved ones on the outside.

- A large body of research shows that maintaining family engagement—particularly through frequent and meaningful in-person visits—is vital for the well-being of incarcerated people and their loved ones; it can also increase their chances of a successful transition back into the community after incarceration.[31]
- **Visits can be especially important for the many children of incarcerated parents.**[32] Studies have found that half to three-quarters of incarcerated people have children under age 18, and it is estimated that more than 5 million children (7 percent of all children in the United States) have had a parent behind bars at some point in their lives.[33] Research has shown that the

negative effects of having an incarcerated parent can be mitigated if children with strong parental bonds are permitted to maintain and develop their family relationships.[34]

Institutional Safety, Public Safety, and Reentry

The use of solitary confinement is generally intended to promote the safety of staff and incarcerated people within prisons and jails. Corrections practitioners often contend that it is a necessary tool to maintain order by preventing or deterring people from engaging in misconduct and violence and punishing such conduct severely when it occurs. However, there is little evidence to suggest that the use of solitary confinement improves safety in U.S. prisons and jails or in the community, and some evidence that it may actually have the opposite effect.

- **Solitary confinement does not make prisons or jails safer.** Most studies examining the effects of solitary find that its use *does not* decrease instances of misconduct or violence—including assaults on corrections staff or other incarcerated people—and therefore does not improve prison and jail safety.[35]
- **Solitary confinement does not improve public safety and may even increase re-offending.** Studies indicate that the use of solitary confinement does *not* decrease rates of recidivism, which refers to the percentage of people who are rearrested and/or reincarcerated after being released from prison or jail. In fact, research suggests that time spent in solitary may actually *increase* people's likelihood of post-release offending, especially violent re-offending.[36] And people released *directly* from solitary into the community have significantly greater recidivism rates.[37]
- **Solitary confinement can prevent or delay people's release from prison.** In many jurisdictions, parole boards consider a person's housing or security classification and disciplinary history when deciding whether to approve early release.[38] Someone with time in solitary on their record may be less likely to be granted parole. Parole boards may also misunderstand the different types of solitary—and the reasons why people are sent there—which may affect their perceptions of a person's risk to public safety. In this way, solitary may actually increase the amount of time some people spend in prison.

In short, solitary confinement does not improve safety and may actually lead to an increase in violence and recidivism. This is not surprising, given that people in solitary are typically denied the opportunity to participate in education, mental health or drug treatment, and other rehabilitative programs or to otherwise prepare for reentering the community.[39] The negative repercussions of this, along with the psychological damage caused by isolation, can persist long after a person's release from solitary and make their transition back to a jail or prison's general population or to the community considerably more difficult.

Economic Impact

In addition to the human cost, solitary confinement carries a high fiscal price tag.[40]

Solitary units are particularly expensive to run. The restrictions on movement and out-of-cell time for people in solitary make operations far more staff-intensive than in most housing units. Staff must deliver meals, mail, toilet paper, and other necessities to each person, and generally one or two staff members are required to physically restrain and escort each incarcerated person any time they leave their cell for showers, recreation, or other activities.

- The Federal Bureau of Prisons estimated in 2013 that it cost **$216 per person, per day,** to hold people in solitary in the Administrative Maximum Facility at the Federal Correctional Complex in Florence, Colorado. In comparison, the estimated cost of housing people in the complex's general population was **$86 per person, per day.**[41]
- An Illinois supermax prison was estimated to be spending more than **$60,000 a year** for each person in solitary confinement in 2012—almost three times as much as the average annual cost **(around $22,000)** of holding someone in the state's other prisons.[42]

The many negative impacts of solitary may lead to increased future costs.

- Serious and lasting damage done to people's mental and physical health in solitary is likely to significantly increase the costs of providing them with health care during their incarceration and beyond.[43]
- If the use of solitary confinement leads to increased recidivism, state and local governments are likely to incur additional expenses related to the new offenses, including the costs of law enforcement, prosecution, courts, community supervision, and reincarceration.[44]

Disproportionate Impacts on Certain Populations

Incarcerated people do not experience solitary confinement equally. The use of solitary confinement is rife with disparities. Mirroring inequalities often seen throughout the criminal legal system, some people are more likely than others to end up in solitary confinement based on their race, gender identity, sexual orientation, age, physical and mental disabilities, or other characteristics. These disparities may be compounded when an incarcerated person falls into more than one disadvantaged demographic group. Additionally, some groups of people, such as those with preexisting mental illnesses, may be even more vulnerable to solitary's harmful effects.

Race and Ethnicity

In many jurisdictions, people of color make up a larger proportion of the population in solitary than of the overall incarcerated population.

- According to a 2019 national survey of state prison systems, Black, Latinx, and Native American/Alaskan Native men were overrepresented in solitary confinement.[45]
  - For example, **40.5 percent** of the total male prison population of the surveyed jurisdictions was Black, while Black men accounted for **43.4 percent** of men in solitary.[46]
  - Black women were even more dramatically overrepresented. They made up just **21.5 percent** of the total female prison population but **42.1 percent** of women in solitary.[47]

- Analysis of six state and local corrections agencies by the Vera Institute of Justice found that people of color are sent to solitary confinement at higher rates and/or for longer average periods of time than white people.[48] For example, in New York City, Black people were admitted to solitary at 5.7 times the rate of white people, and in Oregon prisons, people of color made up 26 percent of the total population but 34 percent of those in solitary confinement.[49]
- There is little research on the causes of racial disparities in solitary units. However, theories about what may be causing these disparities include
  - **Policies that implicitly or explicitly target certain racial groups.**
    - For example, policies that prohibit specific hairstyles or head coverings associated with certain racial or cultural groups and make noncompliance a disciplinary infraction punishable by solitary confinement.
  - Classification systems, policies, or informal practices that rely primarily on solitary confinement to discipline or manage members or suspected members of **security threat groups (STGs) or gangs** (many of which are based on racial identity).[50]
  - **Risk assessments** based on criminal history, number of incarcerations, or other characteristics that often correlate with race because of systemic racism and overpolicing of communities of color.
  - **Implicit bias on the part of corrections staff**, particularly in areas where they exercise wide discretion (such as disciplinary write-ups and sanctions).
    - Members of different racial groups may be equally likely to commit infractions within corrections settings, but members of certain groups may be more frequently written up and/or sent to solitary for these infractions.[51]

Women

It is important to examine the use of solitary confinement for women in corrections institutions and consider how incarcerated women might experience solitary differently from men.

- **When discussing the experience of women, researchers often focus on cisgender women.**[52] Increasingly, however, research on incarcerated women includes all people housed in women's facilities or units. More research is needed to highlight the specific experiences of transgender women, nonbinary people assigned female at birth, and other gender-nonconforming people in prisons and in solitary.[53]
  - In some jurisdictions, corrections agencies still proactively place transgender women in solitary confinement units at men's facilities, purportedly for their own protection and often without their consent.[54]
- **Many jurisdictions only have one women's facility—and often one women's solitary confinement unit—that houses all types of solitary**, such as administrative segregation, disciplinary segregation, protective segregation, and death row. It may not be feasible under these conditions for corrections agencies to create tailored programs for each type of solitary, which often means all women in solitary are subjected to the most restrictive, "lowest-common-denominator" conditions.[55]

- **When corrections agencies use security classification systems created with men in mind,** women may end up assigned to a higher security level and placed in more restrictive environments than are necessary or appropriate.[56]
- **Women are often sent to solitary confinement for low-level, nonviolent behavior and are more likely to receive harsher punishments for minor violations than men.** As a result, women may spend shorter, but more frequent, periods in solitary.[57]
- **There is a higher prevalence of serious mental illness among incarcerated women than men.**[58] Nearly 70 percent of women in prison or jail have a history of mental health issues.[59] Likewise, women with mental illness are generally overrepresented in solitary confinement.[60]
- **Incarcerated women have high rates of past trauma and abuse.**[61] The isolation of solitary can be retraumatizing, as can strip searches, cell shakedowns, use of restraints, and other practices that are common in solitary units.[62]
- **Solitary can be particularly harmful for pregnant people.**
  - It can prevent them from getting proper prenatal care, and the use of restraints (common in solitary) can be particularly dangerous for this population.[63]
  - National and international organizations have widely condemned the use of solitary confinement for pregnant and postpartum people. Several state legislatures have passed legislation to prohibit this practice.[64]
- **Incarcerated women are more likely than men to have been the primary caregivers of minor children before their incarceration.**[65] Visitation and phone restrictions in solitary confinement mean that many women are unable to have face-to-face visitation or regular contact with their children, which can negatively impact them and their children.[66]

Sexual Orientation

- **Lesbian, gay, and bisexual people are more likely to be housed in solitary than heterosexual people.**[67] In many jurisdictions, policies require or permit housing these populations in protective custody—a type of housing that separates someone for fear they will be victimized.[68] Frequently, the conditions in these units are indistinguishable from traditional solitary confinement used for disciplinary reasons.
- In a 2014 survey by Black & Pink of nearly 1,200 LGBTQ+ incarcerated people, **85 percent of respondents reported having been placed in solitary confinement** at some point during their incarceration.[69]
  - **Racial disparities are also present within this population.** Black, Latinx/Hispanic, mixed-race, and Native American/American Indian respondents were twice as likely to have been in solitary than white LGBTQ+ respondents.[70]

People with Mental Illness

- **As noted above, conditions in solitary can exacerbate preexisting mental illness.** People with serious mental illness are particularly vulnerable to the psychological harms of solitary confinement.[71]
  - People with serious mental illness are disproportionately represented in solitary confinement, and most corrections facilities are ill-equipped to provide the level of care they need.[72]
  - Symptoms or behaviors associated with mental illness are often perceived as "behavioral issues" to be met with disciplinary action, resulting in those in need of the most care being placed in solitary, which may contribute to their decompensation.[73]

People with Disabilities

- **Many people in prison have physical disabilities.** For example, in a study of 10 state prison systems, the ACLU found that
  - one out of 10 incarcerated people in California had a hearing, visual, or mobility-related disability;
  - nearly one in 20 people in Pennsylvania's prisons were classified as blind, low-vision, Deaf, or hard of hearing; and
  - in Florida, the state corrections department had assigned nearly 21 percent of incarcerated people an assistive device or other special accommodation indicating a disability, such as access to lower bunks or an attendant.[74]
- **However, there is no publicly available data on people with disabilities in solitary confinement.**
  - Moreover, the ability to even track such data varies by corrections departments, and some jurisdictions do not track this information at all.[75]
- People with physical disabilities are sometimes housed in solitary confinement because there are **no other available cells to accommodate them.**[76]
- Solitary units usually severely limit recreation and other out-of-cell activities, which can be detrimental to incarcerated people with **medical conditions that require regular exercise and movement.**
- Incarcerated people with sensory disabilities, such as those who are Deaf or blind, experience **even greater isolation and sensory deprivation** in solitary.[77]
  - Lack of access to sign language interpreters, text-to-audio devices, and other assistance may also limit this population's ability to participate in rehabilitative programs or even exclude them altogether from programming and services offered to people in solitary confinement.[78]
- **The United Nations Standard Minimum Rules for the Treatment of Prisoners—known as the Mandela Rules—condemn the use of solitary for people with mental and physical disabilities.**[79] Legislators and advocates across the country are pushing for new

laws and policy reforms to end the use of solitary for people with disabilities, including developmental disabilities and traumatic brain injuries.[80]

Youth

- Solitary confinement is sometimes used for youth (under age 18) incarcerated in adult corrections facilities, and many juvenile facilities also use solitary-like practices, sometimes called "room confinement," "isolation," "separation," or "seclusion."[81]
- In Vera's analysis of five jurisdictions, **youth (under 18) and young adults (between ages 18 and 25) were often overrepresented in solitary.**[82]
- **Solitary confinement has detrimental effects on youth development.**
  - Youth and young adults are particularly vulnerable to the harms of solitary, given that they are in the formative stages of their physical and mental development. In fact, research shows that people's brains continue to develop well into their 20s.[83] Because of this, young people generally possess less mental and emotional resilience than adults and are even less able to cope with the isolating conditions of solitary.[84]
  - In Vera's experience in the field, the forced idleness associated with solitary can also lead to behavioral problems and disciplinary infractions, which often result in more time in solitary.

Immigration Detention

- **Despite the "civil" nature of immigration detention, the use of solitary confinement as both a punitive and nonpunitive management tool in detention facilities is strikingly similar to how solitary is used in U.S. corrections facilities.**[85] As such, detained people are susceptible to the same psychological and physical harms as those in solitary in prisons and jails.
  - U.S. Immigration and Customs Enforcement (ICE) policy deems placement in solitary a "serious step that requires careful consideration of alternatives," which should be used only when necessary and comport with strict standards.[86] However, ICE data analyzed by federal oversight agencies and outside watchdog organizations, along with testimony from detained people, suggests the practice is grossly overused.[87]
  - **Regardless of ICE policy, research has found that detained people may be sent to solitary for arbitrary reasons, in lieu of mental health care, or for their own protection.**[88]
- A 2019 report that examined 6,559 records of solitary confinement in ICE detention centers found that about **40 percent of placements in solitary were of people with a mental illness.**[89]
- A 2020 report on ICE detainees from 2013-2017 found that people with mental illnesses and immigrants from Africa and the Caribbean were overrepresented in solitary confinement.[90]

Conclusion

A large body of research reveals the extensive scope of solitary confinement's harmful impacts on incarcerated people, corrections staff, families, and the community. It can cause or exacerbate severe mental illness, negatively impact families, and be physically and mentally taxing on incarcerated people and corrections staff. Moreover, the practice does not significantly reduce misconduct, violence, or recidivism—and it may actually decrease institutional and public safety.

These findings underscore the urgent need for corrections and government leaders to end the use of solitary confinement in prisons, jails, and immigration detention centers across the country. Agencies must move away from the use of this harmful practice and instead employ humane and effective strategies to achieve safe facilities for incarcerated people and staff.

For more information

The Vera Institute of Justice is powered by hundreds of advocates, researchers, and community organizers working to transform the criminal legal and immigration systems until they're fair for all. Founded in 1961 to advocate for alternatives to money bail in New York City, Vera is now a national organization that partners with impacted communities and government leaders for change. We develop just, antiracist solutions so that money doesn't determine freedom; fewer people are in jails, prisons, and immigration detention; and everyone is treated with dignity. Vera's headquarters is in Brooklyn, New York, with offices in Washington, DC, New Orleans, and Los Angeles.

For more information, contact Margaret diZerega at mdizerega@vera.org.

Endnotes

[1] Léon Digard, Elena Vanko, and Sara Sullivan, *Rethinking Restrictive Housing: Lessons from Five U.S. Jail and Prison Systems* (New York: Vera Institute of Justice, 2018), 20-26, https://perma.cc/XHZ3-P4KM.

[2] Colette Peters, "Investing in People: Improving Corrections Staff Health and Wellness," National Institute of Justice, August 28, 2018, https://perma.cc/96KQ-F8AB.

[3] See for example Keramet Reiter, Joseph Ventura, David Lovell et al., "Psychological Distress in Solitary Confinement: Symptoms, Severity, and Prevalence in the United States, 2017–2018," *American Journal of Public Health* 110, no. S1 (2020), S56-S62, https://perma.cc/452X-C676; Craig Haney, "The Psychological Effects of Solitary Confinement: A Systematic Critique," *Crime and Justice* 47, no. 1 (2018), 365-416, https://www.researchgate.net/publication/323674531/; Craig Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," *Crime and Delinquency* 49, no. 1 (2003), 124-156, https://www.researchgate.net/publication/249718605; Peter Scharff Smith, "The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature," *Crime and Justice* 34, no. 1 (2006), 441–528, https://www.researchgate.net/publication/284428156_The_Effects_of_Solitary_Confinement_on_Prison_Inmates_A_Brief_History_and_Review_of_the_Literature; Southern Poverty Law Center (SPLC), "Solitary Confinement Can Cause Mental Illness," SPLC, October 16, 2017, https://perma.cc/N9UA-U5HR; *Braggs v. Dunn*, No. 2:14-cv-00601-MHT-TFM (M.D. Ala. 2017), 193, https://perma.cc/LW65-GFUT; Stuart Grassian, "Psychiatric Effects of Solitary Confinement," *Washington University Journal of*

Alcohol is not recommended in patients who are taking medicine.

Medicine may cause some people to become drowsy, have trouble thinking, or to have problems with movement. **Make sure you know how you react to this medicine before you drive, use machines, or do anything else that could be dangerous if you are not alert or well-coordinated.**

Your doctor may want to monitor your child's weight and height, because this medicine may cause decreased appetite and weight loss in children.

Check with your doctor right away if you have decreased interest in sexual intercourse, delayed or inability to have an orgasm, inability to have or keep an erection, or loss in sexual ability, desire, drive, or performance. These could be symptoms of sexual dysfunction.

Do not take other medicines unless they have been discussed with your doctor. This includes prescription or nonprescription (over-the-counter [OTC]) medicines and herbal (eg, St. John's wort) or vitamin supplements.

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Side Effects

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects may occur, if they do occur they may need medical attention.

Check with your doctor immediately if any of the following side effects occur:

More common

- Change or problem with discharge of semen

Less common

- Agitation
- Blurred vision
- Confusion
- Decreased interest in sexual intercourse
- Fever
- Inability to have or keep an erection
- Increase in the frequency of urination or amount of urine produced
- Lack of emotion
- Loss in sexual ability, desire, drive, or performance
- Loss of memory
- Menstrual changes
- Skin rash or itching
- Trouble breathing

Rare

- Behavior change similar to drunkenness
- Bleeding gums
- Breast tenderness or enlargement or unusual secretion of milk (in females)
- Chills
- Delayed or inability to have an orgasm
- Diarrhea
- Difficulty with concentrating

- Dizziness or fainting
- Drowsiness
- Increased hunger
- Increased thirst
- Irregular heartbeat
- Lack of energy
- Lethargy
- Nosebleed
- Overactive reflexes
- Painful urination
- Poor coordination
- Purple or red spots on the skin
- Rapid weight gain
- Red or irritated eyes
- Redness, tenderness, itching, burning, or peeling of the skin
- Seizures
- Shivering
- Slow or irregular heartbeat (less than 50 beats per minute)
- Sore throat
- Stupor
- Sweating
- Swelling of the face, ankles, or hands
- Talking or acting with excitement you cannot control
- Trembling, shaking, or twitching
- Trouble with holding or releasing urine
- Unusual or sudden body or facial movements or postures
- Unusual tiredness or weakness

Incidence not known

- Back or leg pains

- Black, tarry stools
- Blistering, peeling, or loosening of the skin
- Bloating
- Bloody stools
- Chest pain or tightness
- Confusion as to time, place, or person
- Constipation
- Cough
- Darkened urine
- Difficult or fast breathing
- Difficulty with swallowing
- Drooling
- Fast, slow, or irregular heartbeat
- General body swelling
- Hive-like swelling on the face, eyelids, lips, tongue, or throat
- Hives, itching
- Holding false beliefs that cannot be changed by fact
- Impaired consciousness, ranging from confusion to coma
- Indigestion
- Joint or muscle pain
- Large, hive-like swelling on the face, eyelids, lips, tongue, throat, hands, legs, feet, or sex organs
- Loss of appetite
- Loss of bladder control
- Loss of consciousness
- Muscle cramps, spasms, tightness, twitching, or jerking
- Painful or prolonged erection of the penis
- Pale skin
- Penile erections, frequent or continuing

- Puffiness or swelling of the eyelids or around the eyes, face, lips, or tongue
- Recurrent fainting
- Red skin lesions, often with a purple center
- Rhythmic movement of the muscles
- Seeing, hearing, or feeling things that are not there
- Sores, ulcers, or white spots in the mouth or on the lips
- Stomach pain
- Swelling of the breasts or unusual milk production
- Tenderness, pain, swelling, warmth, skin discoloration, and prominent superficial veins over the affected area
- Total body jerking
- Twitching, twisting, uncontrolled repetitive movements of the tongue, lips, face, arms, or legs
- Uncontrolled jerking or twisting movements
- Unusual excitement
- Vomiting of blood or material that looks like coffee grounds
- Yellowing of the eyes or skin

Some side effects may occur that usually do not need medical attention. These side effects may go away during treatment as your body adjusts to the medicine. Also, your health care professional may be able to tell you about ways to prevent or reduce some of these side effects. Check with your health care professional if any of the following side effects continue or are bothersome or if you have any questions about them:

More common

- Decrease in sexual desire or ability
- Sleepiness or unusual drowsiness

Less common

- Body aches or pain
- Change in sense of taste
- Continuing ringing or buzzing or other unexplained noise in the ears
- Gas
- Headache (severe and throbbing)
- Hearing loss
- Heartburn
- Increased sweating
- Increased yawning
- Loss of voice
- Loss or thinning of the hair
- Sneezing
- Stuffy or runny nose
- Tingling, burning, or prickly feelings on the skin
- Tooth grinding
- Unusual increase or decrease in weight
- Watering of the mouth

Rare

- Increased hair growth on the forehead, back, arms, and legs
- Tanning or blue-gray discoloration of the skin

Incidence not known

- Bruising
- Decrease in smell
- Inability to sit still
- Large, flat, blue or purplish patches in the skin
- Loss of sense of smell
- Need to keep moving

Review Am J Med. 1986 Mar 31;80(3B):17-21. doi: 10.1016/0002-9343(86)90327-x.

Review of the side-effect profile of buspirone

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PMID: 2870641 DOI: 10.1016/0002-9343(86)90327-x

Abstract

In 984 patients with generalized anxiety disorder who received buspirone in double-blind studies, the incidence of drowsiness (9 percent) did not differ significantly from that (10 percent) reported in 334 patients who received placebo. A probability value of p less than or equal to 0.10 was the criterion for significance. The incidence of drowsiness in buspirone-treated patients was significantly less than that in each of the groups receiving diazepam (32 percent), clorazepate (26 percent), lorazepam (58 percent), or alprazolam (43 percent). The side effects that did occur significantly more frequently in the buspirone group than in the placebo group were dizziness (9 percent versus 2 percent), headache (7 percent versus 2 percent), nervousness (4 percent versus 1 percent), light-headedness (4 percent versus less than 1 percent), diarrhea (3 percent versus less than 1 percent), paresthesia (2 percent versus less than 1 percent), excitation (2 percent versus less than 1 percent), and sweating/clamminess (1 percent versus 0 percent). The severities of these effects were predominantly rated as only mild or moderate. Fatigue occurred less frequently in buspirone-treated patients than in those receiving any of the benzodiazepines, and weakness occurred more frequently in diazepam-treated patients. Depression occurred less frequently in buspirone-treated patients than in those receiving clorazepate, diazepam, or lorazepam. Impotence occurred only in clorazepate- and lorazepam-treated patients. Decreased libido occurred more frequently in diazepam-treated patients, whereas increased libido was more frequent in clorazepate-treated patients. Nausea was reported more frequently in buspirone-treated patients than in those receiving clorazepate, diazepam, or alprazolam; diarrhea occurred more frequently in the buspirone group than in the diazepam group. The mean daily doses of the various treatments were buspirone, 20 mg; diazepam, 20 mg; clorazepate, 24 mg; lorazepam, 3 mg; and alprazolam, 1.5 mg. In an open-field study in West Germany involving 5,414 patients, gastrointestinal-related complaints were the most frequently reported side effects.

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