Medical Care in ICE Detention

I. Introduction

The United States immigration detention system has grown significantly under the second Trump administration, increasing from roughly 40,000 people in January 2025 to over 70,000 in February 2026. That growth has coincided with a series of administrative changes that have affected the delivery of medical care to people in custody, including the termination of the Department of Veterans Affairs agreement that for more than two decades processed reimbursement claims for off-site medical services, the elimination of protective policies for pregnant and postpartum women, the revival of family detention, and the effective closure of the independent oversight office Congress established to receive detainee complaints.

Federal law requires U.S. Immigration and Customs Enforcement (ICE) to provide necessary medical care to everyone in its custody, and ICE's own detention standards set minimum requirements for intake screenings, sick calls, emergency care, and access to outside providers. This paper provides an overview of the current state of medical care in immigration detention. It begins with the background conditions driving population growth and the administrative changes that have affected care infrastructure. It then examines documented deficiencies in care delivery, the collapse of the off-site payment system, and the reduction of oversight capacity. It concludes with an assessment of health outcomes across four populations, including people with serious chronic conditions, pregnant and postpartum women, children, and people who have died in ICE custody, and identifies policy responses.

II. Background

The challenges surrounding medical care in immigration detention do not arise in isolation. They are shaped by the scale and pace of detention growth, by the legal framework governing who can be held and for how long, and by the administrative infrastructure available to deliver and pay for care. Understanding those conditions is necessary context for evaluating the specific challenges this paper documents.

A. System Under Strain

ICE's detained population reached record levels in 2025 and has continued to climb in 2026, driven by the Trump administration's enforcement policies, which have broadened the pool of people subject to mandatory detention and accelerated the pace of arrests. The expansion of mandatory detention is significant not only because it increases the number of people in custody at any given time, but because it extends how long individuals remain there: People who cannot be released on bond or supervision remain detained until their cases are resolved, which can take months or years. Research has found that the risk of adverse health events increases with time in custody, meaning a system defined by longer stays for more people carries compounding medical risk.

Facilities that were already operating near capacity before 2025 began holding significantly more people than they were designed to accommodate, while the pace of removals has not kept up with the pace of new detentions. A larger population held for longer periods means more chronic conditions to manage over time, more medication to dispense, more emergency referrals, and greater reliance on outside providers for specialized care. Those demands require staffing, administrative infrastructure, and funding that has not grown proportionally with the population.

Since the beginning of the second Trump administration, congressional investigations, independent research, and federal litigation have each documented failures to meet applicable care standards across multiple facilities, including gaps in intake screenings, routine care, and timely responses to medical complaints. Those standards require that detainees receive medical, dental, and mental health screenings upon arrival, along with daily opportunities to request health services, access to round-the-clock emergency care, and available preventive services. ICE's 2011 Performance-Based National Detention Standards, for example, require that detainees "have access to a continuum of health care services, including screening, prevention, health education, diagnosis and treatment," including a comprehensive intake screening within 12 hours of arrival.

B. Termination of the Department of Veterans Affairs Agreement

For more than two decades, the Department of Veterans Affairs (VA) Financial Services Center processed medical reimbursement claims for people in ICE custody who needed care outside of detention facilities. When a detainee required dialysis, chemotherapy, prenatal care, or prescription medication, the VA handled the administrative and financial infrastructure to pay for it. The agreement did not require any VA funds, VA clinical staff, or VA health care resources. ICE paid the VA separately for this service, meaning that no resources were diverted from veterans. The agreement between the VA's Financial Service Center and ICE spanned across multiple administrations, from the George W. Bush administration through the Biden administration but had drawn political scrutiny in the years before its termination.

As the detained population grew during the Biden administration, the volume of claims processed through the VA Financial Services Center increased significantly, from $63.6 million in fiscal year 2022 to $246.4 million in 2024, drawing attention and criticism. In 2024, the House passed amendments to two separate appropriations bills to prohibit the VA from processing ICE medical claims. However, the Senate did not pass those amendments, and the agreement continued to operate during the first eight months of the second Trump administration. Although the detained population had increased by more than 82% in 2025, only $157 million in claims were processed before the agreement ended on October 3, 2025.

The VA "abruptly and instantly terminated" its agreement with ICE, three days after the Center to Advance Security in America, a nonprofit organization critical of the VA's role, filed a lawsuit related to the agreement. According to internal ICE documents later posted to the federal contracting website SAM.gov, the termination left the agency with "no mechanism to provide prescribed medication" and unable to "pay for medically necessary off-site care," including

dialysis, prenatal care, oncology, and chemotherapy. Internal ICE documents described the situation as an "absolute emergency."

ICE moved to award two contracts to replacement vendors, signing agreements with private contractors on October 25, 2025, under expedited, “no-bid” arrangements. However, those systems were not immediately operational. By early 2026, ICE had instructed providers to hold all claim submissions until at least April 30, 2026, but that date passed without payments resuming. In the interim, some outside providers have refused to continue seeing detainees, and internal ICE documents warned that the breakdown could lead to "medical complications or loss of life." Internal administration data shows a nearly $300 million gap for 2025 between the medical care detainees needed and what was actually reimbursed, a shortfall that likely reflects both unpaid provider bills and care that was never delivered in the first place.

The loss of the VA agreement also raised questions about ICE's access to vaccines. Procurement documents released in January 2026 revealed that the VA had terminated ICE's access to the vaccines it had historically supplied to people in custody as part of the broader cessation of medical support services, prompting an emergency procurement. The Department of Homeland Security (DHS) stated that no gap in vaccine services occurred because a new vendor was secured, although ICE did not respond to questions about which vaccines were provided or the timeline for restoring access. Those questions took on added urgency in early 2026, when measles outbreaks were confirmed at facilities in Texas and Montana, with public health experts attributing the spread to crowded conditions and low vaccination rates among newly arrived detainees.

III. Issues with Medical Care in ICE Detention

The majority of people in ICE detention are held in facilities operated by private contractors. Healthcare at those facilities is governed by ICE's contractual detention standards, primarily the Performance-Based National Detention Standards (PBNDS), which set minimum requirements for medical screening, sick calls, emergency care, and access to outside providers. Compliance is evaluated through inspections conducted by ICE's own Office of Detention Oversight, a process researchers have found to be structurally limited: Inspections are often scheduled in advance, deficiencies rarely result in financial penalties, and contractors are largely responsible for monitoring their own compliance.

A. Documented Care Deficiencies

An October 2025 Senate investigation documented dozens of credible reports of medical neglect across ICE detention facilities nationwide, including individuals being denied essential medications and delays in emergency care resulting in serious complications. A peer-reviewed study published in late 2025 found that more than half of facilities examined lacked continuous physician coverage for at least one year, and that more than 10 percent of employed physicians providing care to these facilities were had state sanctions against them for violations such as prescribing with an expired license and practicing under the influence. Members of Congress who conducted unannounced facility tours in early 2026 described inadequate medical staffing, repeated violations of detention standards, and 911 call records documenting cardiac events, seizures, and suicide attempts going unaddressed.

Those broader patterns are reflected in individual cases. In late 2025, lawyers interviewed detainees at contractor-run facilities who described being denied insulin, wound care, cancer treatment, and cardiac medication. In one case, a detainee with a known cancer diagnosis was denied access to an oncologist for months. In another, a detainee experiencing seizures was unable to obtain heart medication. A February 2026 investigation into privately-operated facilities raised further questions about accountability, finding that patterns of delayed and denied care persisted across multiple sites and that the private entity's contractual obligations for healthcare delivery were largely self-monitored. The South Texas Family Residential Center in Dilley, another privately-operated facility that holds up to 2,400 people, faced concerns in court filings about systematic inadequate medical care between August 2025 and early 2026. Letters written by a family detained at the facility, which resumed holding families in 2025 after a halt to family detention during the Biden administration, described insufficient medical attention for their children, several of whom repeatedly complained of severe pain.

B. Collapse of Off-Site Payment and Its Effect on Care Access

Existing concerns with medical treatment in detention were significantly compounded by the termination of the VA contract in October 2025. Detention centers rely on outside doctors, hospitals, and pharmacies, especially for specialized or off-site care. The payment breakdown created a specific and documented access problem: Outside providers who had gone months without reimbursement began refusing to see detainees altogether, while some facilities, unable to obtain reimbursement from the federal government for the cost of care, began billing people in custody directly for care. Under ICE's own rules, detainees are not responsible for the cost of their medical care and are legally entitled to receive such care at no cost.

In practice, the billing appears to have been occurring in two ways: 1) facilities charging co-pays or fees not authorized under detention standards, and/or 2) private care providers, operating outside ICE's direct oversight, billing patients directly when ICE's payment mechanism failed to function. Internal data showed that despite an 83 percent increase in the detained population between 2024 and 2025, the dollar value of claims processed fell from $246.4 million to $157.2 million, suggesting a significant volume of care that was either not authorized, not delivered, or not reimbursed. It is therefore unclear "how or if ICE detainees are receiving medication or obtaining outside medical care" while the reimbursement system remains nonfunctional.

C. Reduced Oversight Capacity

As these compounding problems emerged, the primary federal mechanism for detainees to report them was shut down. The DHS Office of the Immigration Detention Ombudsman (OIDO), established by Congress under 6 U.S.C. § 205 to provide an independent, confidential complaints process, received reduction-in-force notices (RIFs) for nearly all of its staff on March 21, 2025.[1] After a federal lawsuit, DHS announced in May 2025 that OIDO would remain open, As the number of immigration detention facilities grew by more 90% by November 2025, the

[1] In addition, the Office of Civil Rights and Civil Liberties (CRCL) and the CIS Ombudsman also experienced mass RIFs in spring 2025.

office continued to operate with only five employees. Former employees warned that, without the OIDO, "ICE detention violations could go unreported and unresolved".

By June 2025, DHS had also removed posted information from detention facilities about how to file complaints, further limiting detainees' ability to seek redress. OIDO was formally closed on or around May 6, 2026, following a months-long partial government shutdown during which DHS announced that immigration oversight offices were not operational. When Congress passed and President Trump signed a DHS funding bill on April 30, 2026, that legislation allotted funding for several DHS components through the end of the fiscal year but did not include OIDO or specify that it should be closed. In public communications, DHS blamed Congress for the closure of the office, a fact disputed by legal experts, but yet to be challenged in court. As of May 2026, DHS has ended inspections and taken down the office's public-facing website, which had advised the families and attorneys of detainees on how to file complaints.

IV. Health Outcomes in ICE Detention

The expansion of immigration detention coinciding with the systemic issues described in the preceding sections — the collapse of off-site payment, understaffed facilities, and the elimination of independent oversight — has resulted in measurable harm to people in custody. This section examines that harm across four populations: detainees with serious chronic conditions, pregnant and postpartum women, children, and people who have died in ICE custody. Taken together, the evidence reflects a system in which detention growth has consistently and predictably outpaced the medical capacity needed to sustain it, with consequences ranging from denied medication and misdiagnosis to death.

A. Chronic Conditions

People with conditions that require consistent medication, specialist access, or ongoing monitoring are particularly vulnerable when care is delayed, inconsistent, or denied entirely. The consequences of disrupted chronic disease management are not abstract: interrupted insulin regimens can produce diabetic ketoacidosis within days; delayed oncology care allows cancer to progress; withheld cardiac medication increases the risk of acute events.

The documented pattern across facilities suggests these are not isolated failures but a predictable result of the structural conditions described earlier in this paper. In April 2026, at the North Lake Processing Center in Michigan, a detainee with a history of cardiovascular disease reported that staff responded to complaints of swollen legs, difficulty breathing, and hand tingling with only over-the-counter pain relievers, while a separate client's post-amputation wound went untreated and became infected. In 2026, families at Dilley reported that medical staff declined to treat children with gastrointestinal illness during the current administration unless they had vomited at least eight times, and that an 18-month-old developed a fever lasting nearly 19 days and lost two pounds before being hospitalized with COVID, pneumonia, and additional infections. An April 2026 investigation by the San Francisco Chronicle found that ICE facility medical staff repeatedly failed to diagnose critical illnesses and misdiagnosed patients across multiple facilities, including the case of Francisco Gaspar-Andrés, who visited the medical unit nine times in two months with symptoms of liver failure and was sent back each time with allergy and heartburn medication before dying. Illnesses spread swiftly

through crowded facilities, according to detainees and their attorneys, exacerbated by cramped sleeping arrangements and unclean communal areas, conditions that accelerate deterioration for people whose immune systems are already compromised by underlying conditions.

B. Pregnant and Postpartum Women

In 2025 and 2026, pregnant and postpartum women have increasingly been subject to immigration detention with limited access to necessary healthcare. The Trump administration has not uniformly adhered to ICE Directive 11032.4, issued July 1, 2021, which contains a presumption against detaining individuals known to be pregnant, postpartum, or nursing unless exigent circumstances or a legal reason requires it. While Trump administration officials have offered conflicting opinions in court on whether that policy remains in effect, a DHS said in a statement to the New York Times that it still stands. Yet, multiple women in detention since January 2025 have described being denied breast pumps, prenatal care, and follow-up treatment for conditions including preeclampsia and gestational diabetes. A March 2026 investigation found that DHS had breached established agency protocols for the treatment of pregnant women, detaining women as late as eight months into their pregnancies in conditions medical authorities warn could endanger both maternal and fetal health. The scale of the problem has been difficult to quantify because ICE does not publicly report this data, and previous congressional requirements that DHS report semi-annually on the number of pregnant, postpartum, and lactating women in detention lapsed in March 2025.

In response to a letter from Senators Patty Murray (D-Washington) and Richard Blumenthal (D-Connecticut) and29 Senate colleagues, requesting information about the number, treatment, and care of pregnant, postpartum, and lactating women in ICE custody, DHS released some responsive data in February 2026. DHS confirmed that 363 pregnant, postpartum, and nursing immigrants were deported between January 2025 and February 2026, and that 16 miscarriages were recorded in custody between January and September 2025. In total, 498 pregnant, postpartum and nursing people were "booked out" of ICE detention in that period, meaning that they were detained and then left ICE facilities.

C. Children

The number of children in ICE detention has increased dramatically since January 2025, driven primarily by the Trump administration's revival of family detention and its expansion of interior enforcement operations. The Biden administration had ended family detention in December 2021, releasing the last families with children from ICE custody and repurposing facilities like Karnes and Dilley for adult detention. In January 2025, the Trump administration reversed that policy entirely, reopening both Karnes and Dilley in March 2025 and formally rescinding the enforcement priorities and sensitive location policies that had previously limited interior arrests of families. The result was an immediate increase in the number of children in custody.

An analysis of detention data found that ICE held an average of 170 children per day under the second Trump administration, a more than sixfold increase from the roughly 25 children held daily during the last 18 months of the Biden administration. On April 12, 2025, the Department of Justice filed a motion to terminate the Flores Settlement Agreement entirely, arguing that updated facility standards justify prolonged confinement without the legal constraints Flores

imposes. That motion was denied in August 2025. By March 2026, the second Trump administration had confined more than 1,300 children in family detention centers for longer than 20 days, the limit established by Flores. The two primary family detention facilities, Karnes and Dilley, combined have capacity for more than 3,000 parents and children. However, as the detained population has grown, ICE has faced pressure to use additional facilities not specifically designed for families. The sizeable immigration enforcement and detention legislation that passed in 2025 allocated funding for indefinite family detention, which advocates argue directly conflicts with Flores requirements.

The healthcare challenges documented in adult ICE detention are replicated and, in some respects, compounded in the family detention context. RAICES, the Texas-based legal organization representing many families at Dilley, stated in a court declaration that its clients had raised concerns about insufficient medical care on at least 700 occasions since August 2025, with children consistently experiencing "delays, dismissals, or lack of follow-up" in response to medical complaints. Emergency call records obtained from Dilley revealed that staff placed repeated calls for emergency medical help for young children between October 2025 and February 2026, involving children as young as two months old, with most calls involving low oxygen levels and respiratory issues. One call described a boy in respiratory distress so severe that first responders sought to airlift him to a hospital but could not because of bad weather. A joint report released by Human Rights First and RAICES in March 2026 found that the recurring failures in medical care at Dilley reflect a systemic pattern in which the facility's operational priorities are inconsistent with the healthcare needs of children and families.

Mental health represents a distinct and particularly acute dimension of this problem. A peer-reviewed study published in 2025, examining medical records from 165 children at the Karnes ICE family detention facility between June 2018 and October 2020, found that the mental health screening process administered at intake overlooked significant mental health conditions present in large numbers of detained children. As a result, only one percent of children were identified as having any mental health concerns. That figure is far below what research on migrant children would predict: Among migrant children in the United States, studies consistently find that 15 to 20 percent report symptoms of depression, anxiety, or PTSD. Poor mental health screening at intake means children are not referred for follow-up, do not receive case management, and exit detention without documentation of needs that may require ongoing attention. Unfortunately, inadequate mental health screening and care in immigration detention is not a new problem. It has been documented across multiple administrations and predates the current enforcement expansion. What is new is the scale: The population of children experiencing these documented deficiencies has grown dramatically. The Trump administration has also rescinded or sought to terminate existing protections for migrant children held in detention, including the Flores settlement agreement, meaning that children are more likely to experience healthcare challenges that research has consistently shown are endemic to this setting.

Deaths in Custody

The most severe outcome of inadequate healthcare in immigration detention is death. ICE reported 33 deaths in custody in 2025, the highest annual number in over two decades and

a threefold increase from the 11 deaths recorded in 2024. The death rate per 10,000 detainees reached 15 in 2025, compared to 5.9 at the peak of the COVID-19 pandemic. As of March 2026, 18 more deaths had occurred in the first three months of the 2026 calendar year alone. A peer-reviewed study published in April 2026 found an annualized death rate of 88.9 per 100,000 detainees in immigration detention for the period between October 2025 and January 2026, a 22-year high.

To be clear, no single factor appears to be driving the increase in detainee deaths. Rather, the increase is likely linked to multiple factors, including the massive growth of the detained population overall. Not all deaths in custody are attributable to inadequate medical care; some involve cardiac events, chronic illness, and other factors that would exist even when adequate levels of care are made available. However, there are multiple indications that inadequate medical care has played a significant role in the rising number of detainee deaths. Notably, researchers found that 36 of the deaths recorded between January 2025 and March 2026 occurred among people who had been in ICE detention for three months or less, a pattern consistent with inadequate intake screening and failure to identify and manage serious conditions in the period immediately after arrival.

V. Policy Considerations

The healthcare challenges in ICE detention documented in this paper are not uniform in cause or origin. Some reflect longstanding structural deficiencies that have persisted across multiple administrations, including inadequate mental health screening, inconsistent chronic disease management, and limited oversight over contractors. Others are newly emergent, the direct result of decisions made since January 2025: the termination of the VA claims processing arrangement, the elimination of protective policies for pregnant and postpartum women, and the closure of the independent oversight office Congress created to receive detainee complaints. Addressing them requires both immediate operational fixes and longer-term structural changes.

Restoring the payment infrastructure for off-site care is the most urgent near-term need. The VA contract termination in October 2025 left ICE without any reliable mechanism to reimburse outside providers for dialysis, chemotherapy, prenatal care, and prescription medications for months. The replacement system had not been implemented as of April 30, 2026, creating a gap of more than seven months. Until outside providers are reliably reimbursed, detainees requiring off-site specialized care will continue to face barriers to accessing it, and some will go without needed care.

Existing detention standards must be enforced. ICE's published standards require intake screenings, daily sick calls, round-the-clock emergency care, and access to outside providers. In practice, those standards are often unenforced. Critically, none of the four sets of standards ICE uses across its facilities are legally codified, meaning there is limited recourse when facilities fail to meet them. Primary enforcement responsibility rests with ICE's Office of Detention Oversight (ODO), which conducts pre-announced inspections that researchers have found rarely result in financial penalties and are structured in ways that limit their effectiveness.

Congressional oversight remains crucial, too. While members of Congress have actively engaged in oversight — through unannounced facility visits, formal investigations, and letters to DHS —

the current administration has been slow to respond . Through legislation, Congress can play a role in mandating compliance and setting standards, including conditioning facility contracts on independent audit requirements and tying reimbursement rates to verified compliance rather than self-reported inspection scores. Stronger enforcement mechanisms are also available without new legislation. Federal courts have repeatedly demonstrated willingness to order compliance with detention standards through habeas proceedings and class action litigation. Presidential administrations can contract for higher standards and tighten compliance standards for contractors.

As described above, the crippling of OIDO and CRCL have made it significantly harder to identify and respond to medical care challenges in detention. Both OIDO and CRCL were created by acts of Congress in 2019 and 2002, respectively. The current administration has taken steps to incapacitate or close both offices, laying off the vast majority of agency staff and proposing large-scale budget cuts in its proposed FY2026 budget. Congress should explicitly fund both offices in the next DHS appropriations bill at adequate staffing levels.

For vulnerable populations, alternatives to detention are a proven and lower-cost option. As noted above, the risk of adverse health events increases with time in custody, and the period immediately after intake carries particular risk — a pattern consistent with the finding that 36 of the deaths recorded between January 2025 and March 2026 occurred among people held for three months or less. ICE previously operated a Family Case Management Program (FCMP), a community-based alternative to detention for families with medical vulnerabilities, pregnant and nursing women, and domestic violence survivors, which was ended in 2017. The Biden administration launched the Family Expedited Removal Management (FERM) program in 2023 as a successor model for asylum-seeking families, scaling it to cities across the country, though it did not fully replicate FCMP's scope for medically vulnerable populations. Both models demonstrate that community-based case management is operationally feasible and substantially less costly than facility detention. Expanding such programs' use for pregnant women, nursing mothers, people with serious chronic conditions, and families with young children would directly reduce exposure to the healthcare risks documented here.

ICE's legal obligation to provide necessary medical care applies regardless of how many people are detained. Individuals held in civil immigration custody must be afforded adequate medical care, yet the federal government has repeatedly fallen short of this requirement. Rising death rates, collapsed payment infrastructure, facility staffing shortfalls, and the elimination of oversight mechanisms designed to identify and address failures, all reflect a system under significant strain. Federal courts have repeatedly found that individual detainees are being denied constitutionally adequate care, and congressional investigators have documented systemic patterns of neglect across facilities nationwide. Even in times of immigration influxes or greater focus on immigration enforcement, these obligations continue – a larger detained population does not relieve the federal government of that obligation. How the federal government reconciles its legal obligations with the realities of the system it has built will have direct consequences for the tens of thousands of people in ICE custody.