The policy change was associated with an increase in monthly mifepristone users from 17.9 to 2730.5, a level increase of 2432.9 users ($P < .001$) without a significant slope change (**Table**). Mifepristone users filling prescriptions at mail-order pharmacies had a level increase of 2668.7 users ($P < .001$) and accounted for 97.8% of users in the postpolicy period. The largest increases were for APPs and PCPs, with level increases of 1377.1 and 738.1 users ($P < .001$), respectively. Increases were greatest in states where abortion is legal with telehealth permitted, which exhibited a level increase of 2398.4 users ($P < .001$) and accounted for 99.2% of all mifepristone users filling at pharmacies in the postpolicy period, of which only 1.8% were through retail pharmacies. In contrast, in states where abortion is legal with telehealth restrictions, 60.6% of mifepristone users filled at retail pharmacies.

Discussion | The FDA's removal of the REMS in-person dispensing requirement for mifepristone was associated with a large increase in individuals filling mifepristone prescriptions at pharmacies, almost exclusively through mail order for individuals in states where abortion is legal and telehealth prescribing is permitted. Although obstetricians/gynecologists may perform most in-person (medication and procedural) abortions,[5] the findings suggest this policy change may have facilitated a growing role for other PCPs and APPs in medication abortion through the use of mail-order pharmacies.[6]

This study provides important insights that can guide federal and state policy efforts. A limitation is that these data lack information on mifepristone dispensed in person at clinics or mailed by clinics directly to patients and do not capture visit type (telehealth vs in person) for prescriptions filled at pharmacies, precluding the ability to evaluate the aggregate impact of the REMS policy change on mifepristone use. Study findings suggest that removing in-person dispensing requirements may increase access in states with telehealth restrictions through retail and mail-order pharmacies. Efforts to identify and address barriers in the implementation of mifepristone dispensing at retail pharmacies in states without a total ban are needed.

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Mortality in US Immigration and Customs Enforcement Detention

US Immigration and Customs Enforcement (ICE) is the federal agency tasked with enforcing immigration law, including detention of individuals suspected of violations. Under guidelines such as the Performance-Based National Detention Standards, those who are detained who require medical attention are evaluated and treated by facility medical personnel. Amidst reports of detention crowding and substandard care,[1,2] the objective of this study was to estimate annual mortality rates among individuals detained by ICE from fiscal year (FY) 2004 through January 19, 2026, and to summarize age and cause of death patterns over time.

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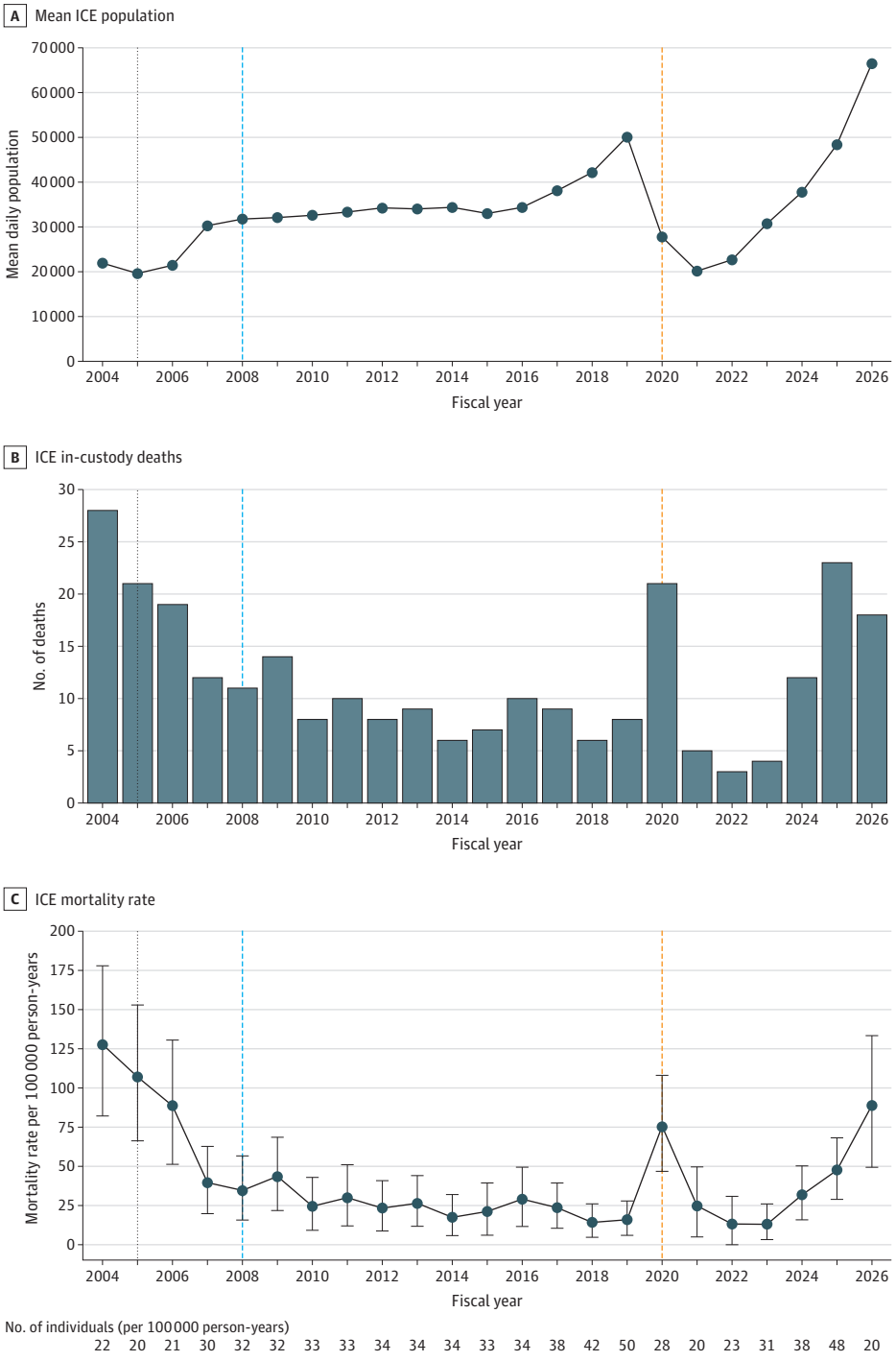
Supplemental content

Methods | This retrospective repeated cross-sectional study obtained detainee death and population data from public and official sources for FY 2004 through partial FY 2026 (eMethods in Supplement 1). Information on deaths was obtained via a

Figure. Annual ICE Mean Daily Population, In-Custody Deaths, and Mortality Rates, 2004-2026



Deaths were drawn from ICE Freedom of Information Act records for fiscal year (FY) 2004 to 2017, ICE Detainee Death Reporting for FY 2018 to 2025, and official ICE release records through January 19, 2026. Denominators were annual mean daily population from ICE statistics; FY 2026 person-time was scaled to the elapsed partial fiscal year (October 1, 2025-January 19, 2026). Vertical markers denote expedited removal adoption in 2005, introduction of Performance-Based National Detention Standards in 2008, and the onset of the COVID-19 pandemic in 2020. Whiskers in panel C indicate 95% CIs.

Freedom of Information Act release for FY 2004 through FY 2017 and ICE Detainee Death Reporting for FY 2018 to FY 2025.[3,4] For FY 2026, deaths were identified from official ICE Detainee Death Reporting postings and official ICE Newsroom detainee death notifications; data were censored as of January 19, 2026. FY was defined as October 1 through September 30. Deaths after transfer to a hospital were included if they occurred while ICE custody remained active. Deaths that occurred after ICE custody ended were excluded. Mortality rates were annualized using the FY mean daily population.[5] For partial FY 2026 (October 1, 2025, to January 19, 2026), person-time was scaled (111/365) to FY 2026 mean daily population. Causes of death were grouped into prespecified clinical categories using reproducible keyword rules (eMethods in Supplement 1). Analyses were conducted in Python 3.11 (Python Software Foundation). The institutional review process

Table. Clinical Characteristics of ICE In-Custody Deaths by Fiscal-Year Period

Characteristic	2004-2008	2009-2012	2013-2016	2017-2020	2021-2026[a]	Overall
Deaths, No.	91	40	32	44	65	272
Person-years, No.	125 054	132 294	135 782	158 227	180 004	731 361
Mortality rate per 100 000 person-years	72.8	30.2	23.6	27.8	36.1	37.2
Age at death, median (IQR), y	46.0 (34.0-55.5)	47.5 (30.8-55.3)	42.0 (30.8-50.0)	46.5 (37.0-56.0)	44.0 (36.0-55.0)	45.0 (34.0-55.0)
Male sex, No. (%)	83 (91.2)	36 (90.0)	28 (87.5)	40 (90.9)	62 (95.4)	249 (91.5)
Female sex, No. (%)	8 (8.8)	4 (10.0)	4 (12.5)	4 (9.1)	3 (4.6)	23 (8.5)
Death in hospital/medical facility, No. (%)	16 (17.6)	4 (10.0)	1 (3.1)	2 (4.5)	12 (18.5)	35 (12.9)
Cause-of-death category, No. (%)						
Other/undetermined[b]	55 (60.4)	23 (57.5)	15 (46.9)	8 (18.2)	32 (49.2)	133 (48.9)
Cardiovascular	20 (22.0)	8 (20.0)	6 (18.8)	10 (22.7)	12 (18.5)	56 (20.6)
Infectious (including COVID-19)	8 (8.8)	6 (15.0)	5 (15.6)	14 (31.8)	9 (13.8)	42 (15.4)
Suicide	0	2 (5.0)	4 (12.5)	10 (22.7)	7 (10.8)	23 (8.5)
Neurologic	8 (8.8)	1 (2.5)	2 (6.2)	2 (4.5)	5 (7.7)	18 (6.6)

[a] Data are from FY 2004 through FY 2026 (partial; through January 19, 2026).

[b] Other/undetermined includes pending, not stated, natural causes without specific etiology, and causes not matching prespecified cardiovascular, infectious, neurologic, or suicide categories.

at the University of California, San Francisco, determined this analysis of publicly available data to be nonhuman participants research. This report follows the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.[6]

Results | Data sources identified 272 deaths in ICE custody. Annual deaths ranged from 3 (FY 2022) to 28 (FY 2004); annual mortality rates ranged from 13.0 (FY 2023) to 127.7 (FY 2004) deaths per 100 000 person-years (**Figure**). After a prolonged decline from early study years, mortality rates increased to 75.6 (95% CI, 46.8-115.6) in FY 2020 (n = 21), which included the first year of the COVID-19 pandemic, 13.0 (95% CI, 3.5-33.3) in FY 2023 (n = 4), 31.8 (95% CI, 16.4-55.5) in FY 2024 (n = 12), 47.5 (95% CI, 30.1-71.3) in FY 2025 (n = 23), and 88.9 (95% CI, 49.4-133.4) in partial FY 2026 (n = 18) (Figure).

The median (IQR) age at death was 45 (34-55) years and remained similar over time (**Table**). Those who died were predominantly male (n = 249 [91.5%]). Causes of death changed over time: infectious causes (including COVID-19) represented 8.8% (n = 8) of deaths in FY 2004 to FY 2008 and tripled to 31.8% (n = 14) in FY 2017 to FY 2020. No suicides were recorded in FY 2004 to FY 2008, while 10 suicides, representing 22.7% of deaths, occurred in FY 2017 to FY 2020. Cardiovascular causes remained frequent across periods (18.5%-22.7%). Unclassified or undetermined causes were common in all periods, ranging from 18.2% to 60.4%. Deaths in hospitals or medical facilities accounted for 12.9% overall, with values ranging from 4.5% to 18.5%.

Discussion | This retrospective cohort of ICE in-custody deaths observed substantial year-to-year variability in mortality rates, with a steep decline early in the study period and an increase in recent years. The decline in deaths from FY 2004 to FY 2011 (127.7 to 30.0) might reflect both expanded medical standards under the Performance Based National Detention Standards and shifts in detainee composition. The standards, introduced in 2008 and revised in 2011, stipulated improved screening, triage, and continuity of care, while the population shift included fewer individuals entering detainment via border arrest and more transfers from local jail or prison settings that had already completed initial health screening.[7] Recent increases in mortality occurred alongside major operational changes reported in 2025, including disrupted or terminated oversight mechanisms,[8] rapid detention expansion with reports of overcrowding,[2] and potentially delayed medical care (eg, prescription payment processing) associated with the termination of US Department of Veterans Affairs' claims-processing support.[9] These fluctuations raise questions regarding the consistent implementation of existing standards for health services in these facilities.

The limited granularity in these public data hampers development of targeted recommendations for addressing increases in mortality in ICE custody, because population-risk composition, access to care, and transfer or release pathways are incompletely captured.

This study has important limitations, including reliance on publicly reported deaths and denominators, no adjustment for individual-level comorbidities or facility-level case mix, possible underascertainment of deaths occurring after transfer to a hospital if ICE custody had ended before death, and exclusion of ICE-involved deaths outside custody. Denominator information by age, sex, and facility type was not available. National evaluations have also documented broader undercounting and cause-classification discrepancies in deaths in custody.[10] More complete, auditable mortality surveillance in ICE detention is needed, including standardized follow-up after hospital transfer and after release, routine public release of denominator details for key clinical strata, and independent validation of reported causes of death.

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COMMENT & RESPONSE

Screening for Breast Cancer

To the Editor Individualized, risk-based approaches to cancer screening aspire to resolve shortcomings of the traditional population- and age-based approach.[1] Yet, until now, reliable evidence was not available to appropriately evaluate whether tailoring breast cancer screening according to cancer risk can increase benefits and reduce harms compared with the current approach. We therefore commend the WISDOM (Women Informed to Screen Depending on Measures of Risk) study, which provided crucial insights into risk-based breast cancer screening's effects.[1] However, we are concerned about the limited potential of risk-based screening for reducing harms, notably overdiagnosis, which involves diagnosis of cancers that do not progress to become symptomatic or harmful.[2]

This concern stems from the risk-based framework's primary focus on intensifying screening of those at high risk while marginally reducing screening among low-risk individuals, who are unlikely to benefit from screening but who are nevertheless subject to harms, including false-positives, unnecessary biopsies, overdiagnosis, and overtreatment.[2,3] This is exemplified in the WISDOM study's risk stratification and risk-specific screening recommendations, which categorized all women between ages 50 and 69 years as at average risk or higher by default.[1] These women were subsequently recommended to have breast cancer screening every 2 years if at average risk or more frequently if at elevated or highest risk.[1] As stated in the WISDOM study's protocol, this minimum level of screening was selected to ensure that all women met US Preventive Services Task Force breast cancer screening recommendations.[4]

Although such risk-based screening may increase benefits, such as reducing late-stage cancers,[1,4] it does not reduce overdiagnosis and other harms, revealed by the WISDOM study's risk-based trial group having higher biopsy rates compared with the control group (1371 vs 1272 per 100 000 person-years) and nearly identical rates of ductal carcinoma in situ (91 vs 92 per 100 000 person-years),[1] the diagnosis of which is a major contributor to overdiagnosis.[5] Reducing regular breast cancer screening among low-risk individuals who are unlikely to benefit is realistically the only way a risk-based approach will succeed in reducing harms.

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