EXPERT LEGAL & CLINICAL ANALYSIS BY AN FNP AND VETERAN TEXAS ATTORNEY WITH FEDERAL-COURT EXPERIENCE

NURSING INSIGHTS

From floreslawfirm.com

VOLUME 3 • INCARCERATION AND HEALTHCARE



Cover: ICE Aurora Contract Detention Facility, Aurora, Colorado. Photo: U.S. Immigration and Customs Enforcement.

Mass Incarceration, Medical Neglect, and the Fight for Human Rights in America

Joe A. Flores, JD, MSN, FNP-BC, CCRN-K, LNC

FAMILY NURSE PRACTITIONER • VETERAN TEXAS ATTORNEY • FEDERAL-COURT EXPERIENCE • NATIONWIDE PROFESSIONAL CONSULTATIONS

LOCKED UP, SICK
COVID-19, before and after, and the most incarcerated nation on Earth

LONG FEDERAL TIME
Users, addiction, and low-level sellers: the pros and cons

BOTH SIDES OF THE BORDER
Drugs, labor, guns, cartels, and two presidents

FOLLOW THE MONEY
HSBC, the 2008 crisis, and global laundering

A WORD FROM THE PUBLISHER

From Publisher Joe A. Flores

JD, MSN, FNP-BC, CCRN-K, LNC

Why a nurse practitioner and trial lawyer is asking America to look behind the walls: who we lock up, how we treat them, and who profits from the systems that fill the cells.

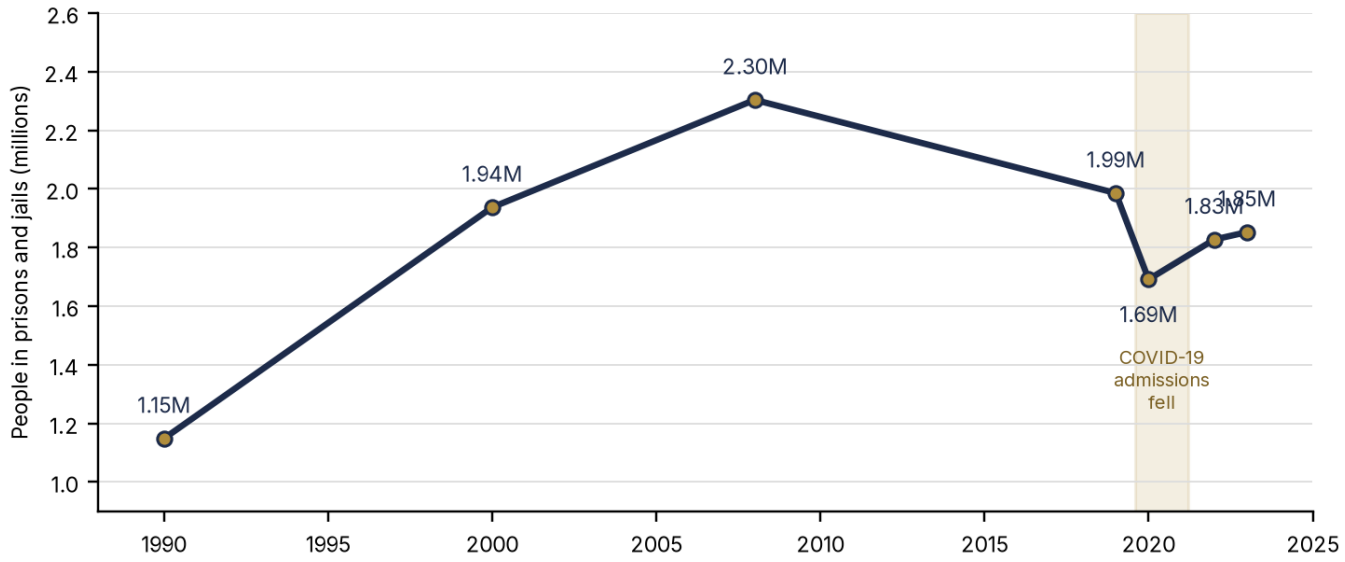


Figure. People held in U.S. prisons and jails, 1990–2023. Data: Bureau of Justice Statistics, as compiled by the Center for Economic and Policy Research (1990–2008), and BJS Correctional Populations statistical tables (2019–2023).

In 1990 the United States held about 1,148,702 people in its prisons and jails. By 2000 that number had climbed to 1,937,482, and by 2008 it reached roughly 2.3 million. That was the year the Pew Charitable Trusts announced that, for the first time, more than one in every 100 American adults was behind bars: 2,319,258 people. Pew also found that one in nine Black men between the ages of 20 and 34 was incarcerated. In the early 1970s the nation held about 360,000 people. The growth was not an accident of crime alone. It followed policy choices: mandatory minimums, longer sentences, the war on drugs, cash-bail systems, and the steady criminalization of addiction, poverty, and mental illness.

The numbers have moved since then, but the basic picture has not. The Bureau of Justice Statistics counted 1,852,900 people incarcerated at the end of 2023. That number fell sharply during COVID-19, when admissions collapsed and courts slowed, but it has been rebounding ever since. According to the World Prison Brief, the United States holds more people than any other country on Earth, at about 542 people per 100,000 residents. Pew's later research added a lesson policymakers should not ignore: many states reduced imprisonment and crime at the same time. Public safety and fewer prison beds are not enemies.

Michelle Alexander's *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* gave the country a language for what many families already knew. Alexander argues that mass incarceration works as a system of racialized social control. After release, a criminal record can legally bar a person from jobs, housing, public benefits, juries, and sometimes the ballot box. Readers need not accept every conclusion in the book to see the problem it documents. The burden of the drug war has fallen unevenly, and its collateral consequences last for decades.

The message of this edition

As a nurse practitioner, I have cared for patients whose conditions do not pause for a booking photo: diabetes, heart failure, seizures, withdrawal, psychosis, pregnancy. As an attorney, I have read the records that follow when care fails. The central mes-

sage of *Nursing Insights* is simple: **people in custody remain patients**. When the government takes control of a person's body, it takes on the duty to provide care. That duty covers county jails, federal prisons, and immigration detention centers alike, including those that hold children.

This third volume follows that principle across seven features. The first covers the clinical and constitutional duties of correctional healthcare. The second looks at COVID-19 behind bars, before and after the pandemic, along with the prison-industrial complex and detention of children. The third, new to this edition, examines long federal sentences imposed on drug users, people living with addiction, and low-level sellers. It gives both sides a fair hearing and asks when treatment would serve public safety better than a cell. Two features cross the border. They examine the supply-and-demand engine connecting U.S. drug consumption and Mexican trafficking, and the global banking channels, HSBC among them, that move the profits. A balanced report on illegal entry and ICE detention closes the analysis. Then comes practical advice for nurses, families, and counsel.

I have tried to present every side fairly. Border security is a legitimate national interest. Cartels inflict real terror on Mexican and American communities. Victims of drug crime deserve protection. But a nation can enforce its laws and still refuse to let a cell become a death sentence. Each article closes with references in APA style and the legal authorities in Bluebook form, so you can check every claim yourself.

Thank you for reading, sharing, and holding our institutions to the standard of care that every human being deserves.

— Joe A. Flores, JD, MSN, FNP-BC, CCRN-K, LNC

Publisher • Flores Law Firm • Corpus Christi, Texas •

floreslawfirm.com

REFERENCES

Alexander, M. (2010/2020). *The new Jim Crow: Mass incarceration in the age of colorblindness* (10th anniv. ed.). The New Press. https://thenewpress.org/books/the-new-jim-crow/

Bureau of Justice Statistics. (2025). *Correctional populations in the United States, 2023: Statistical tables*. U.S. Department of Justice. https://bjs.ojp.gov/library/publications/correctional-populations-united-states-2023-statistical-tables

Schmitt, J., Warner, K., & Gupta, S. (2010). *The high budgetary cost of incarceration*. Center for Economic and Policy Research. https://cepr.net/documents/publications/incarceration-2010-06.pdf

Pew Center on the States. (2008). *One in 100: Behind bars in America 2008*. The Pew Charitable Trusts. https://www.pew.org/en/research-and-analysis/reports/2008/02/28/one-in-100-behind-bars-in-america-2008

The Pew Charitable Trusts. (2017). *State reforms reverse decades of incarceration growth*. https://www.pew.org/en/research-and-analysis/issue-briefs/2017/03/state-reforms-reverse-decades-of-incarceration-growth

The Pew Charitable Trusts. (2014). *Weighing imprisonment and crime*. https://www.pew.org/en/research-and-analysis/articles/2014/09/weighing-imprisonment-and-crime

The Sentencing Project. (2025). *Mass incarceration trends*. https://www.sentencingproject.org/reports/mass-incarceration-trends/

World Prison Brief. (2026). *Highest to lowest: Prison population total*. Institute for Crime & Justice Policy Research. https://www.prisonstudies.org/world-prison-data/highest-lowest/highest-lowest-prison-population-total

VOLUME 3 • FALL 2026

Inside This Issue

2 **A Word From the Publisher**
Incarceration from 1990 to today, Pew research, and The New Jim Crow

5 **Care Does Not End at the Jailhouse Door**
Correctional healthcare as a clinical, constitutional, and public-health duty

10 **The Most Incarcerated Nation on Earth**
COVID-19 before and after, the prison-industrial complex, and children in detention

14 **Sentenced Sick: Addiction, Low-Level Sellers, and Long Federal Time**
The pros and cons, and alternatives for patients with complex medical needs

19 **Both Sides of the Border**
Supply and demand, cheap labor, guns, Portugal and the Netherlands, cartel terrorist designations, and two presidents

24 **Follow the Money**
How laundering works worldwide, the HSBC case, the 2008 crisis claim, and the banks that followed

28 **Illegal Entry, ICE, and the Reality of Immigration Detention**
Enforcement and civil-liberties views, side by side

32 **Expert Advice**
Warning signs, documentation, escalation, and guidance for families and counsel

35 **Join Our Team**
Become an LNC or explore the nurse-attorney path at www.attorneyteacheslnc.com

36 **Flores Law Firm**
Attorney advertising • 361-887-8670 • floreslawfirm.com

37 **The Standard of Care Must Cross Every Wall**
Closing reflection

39 **Vasquez Flores Home Health**
Back cover • 361-881-9922 • pvf27@me.com



ABOUT THE PUBLISHER

Joe A. Flores, JD, MSN, FNP-BC, CCRN-K, LNC

Joe A. Flores is a family nurse practitioner, legal nurse consultant, and veteran Texas attorney with federal-court experience. Based in Corpus Christi, he brings legal and clinical perspectives to healthcare accountability, patient advocacy, correctional healthcare, and civil rights.

As publisher of *Nursing Insights*, Flores offers expert analysis and professional commentary grounded in a central principle: **people in custody remain patients**. Through Attorney Teaches LNC, he helps nurses explore legal nurse consulting and develop their presence in the legal community.

Nationwide professional consultations are available. Legal representation is subject to applicable licensing and jurisdictional requirements.

floreslawfirm.com • www.attorneyteacheslnc.com

The views expressed in this publication are the author's professional opinions and educational commentary. They do not create an attorney–client or clinician–patient relationship and are not individualized legal or medical advice. All photographs other than the cover and back cover are public-domain or CC0 images, credited in their captions. Persons pictured in news photographs are not connected to any case discussed.

FEATURE • CLINICAL & CONSTITUTIONAL DUTY

Care Does Not End at the Jailhouse Door

Correctional healthcare as a clinical, constitutional, and public-health duty, and why the strongest protection for patients, nurses, and institutions is competent care, not defensive charting.

BY **JOE A. FLORES, JD, MSN, FNP-BC, CCRN-K, LNC** • ATTORNEY & FAMILY NURSE PRACTITIONER • FLORES LAW FIRM, CORPUS CHRISTI, TEXAS



Vital signs are evidence. A nurse checks a patient's blood pressure. In custody, the nurse's assessment may be the earliest objective record of an emerging emergency. Photo: Linda Bartlett, National Cancer Institute, public domain.

ABSTRACT

Incarceration limits liberty, movement, privacy, and autonomy. It does not erase a person's need for competent medical care, mental-health treatment, medication continuity, emergency evaluation, or humane treatment. This article reviews the legal framework of *Estelle v. Gamble* and *Farmer v. Brennan*, the role of 42 U.S.C. § 1983, and the line between negligence and deliberate indifference. It also covers intake, triage, medication reconciliation, escalation, documentation, and reentry planning.

Custody does not cure illness

A jail cell, prison unit, detention center, or holding facility can create the appearance of control. Doors lock. Movement is scheduled. Possessions are restricted. Yet physical custody does not make illness disappear. A person entering custody may bring diabetes, hypertension, asthma, epilepsy, cancer, HIV, hepatitis, tuberculosis exposure, chronic pain, pregnancy-related needs, serious mental illness, substance-use disorder, disability, or traumatic injury. Others arrive with no known diagnosis but develop acute symptoms after booking: chest pain, shortness of breath, fever, confusion, severe withdrawal, psychosis, suicidal ideation, dehydration, gastrointestinal bleeding, infection, or neurologic change.

The defining feature of correctional healthcare is not just the secure setting. It is that the facility controls the patient's access to care. A patient in the community may call 911, go to urgent care, contact a pharmacy, ask family for help, or seek a second opinion. A patient in custody may depend entirely on staff to recognize an urgent complaint, authorize movement, arrange evaluation, administer medication, obtain an order, or summon an ambulance.

This dependence transforms ordinary clinical processes into matters of profound safety. A missed medication may interrupt insulin, antiseizure therapy, anticoagulation, psychiatric stability, or medication for opioid-use disorder. A delayed triage decision may postpone recognition of sepsis, myocardial

ischemia, diabetic ketoacidosis, stroke, pulmonary embolism, or an emerging psychiatric emergency.

The Supreme Court held in *Estelle v. Gamble* that "deliberate indifference to serious medical needs of prisoners" may constitute cruel and unusual punishment under the Eighth Amendment. 429 U.S. 97, 104 (1976). When the state controls a person's ability to obtain care, it cannot knowingly disregard serious health needs. That doctrine does not turn every poor outcome into a constitutional violation, but it establishes a floor. The professional question is not only "What does the law require?" It is also "What does safe, ethical care require when the patient cannot obtain it independently?"

Correctional health is public health

The Centers for Disease Control and Prevention describes correctional health as spanning arrest, detention or incarceration, and reentry. People move continually between jails, emergency departments, clinics, shelters, homes, and probation systems. Health conditions do not stay behind facility walls.

People entering custody may have lived with poverty, unstable housing, gaps in insurance, interrupted primary care, trauma, and delayed diagnosis. A correctional facility may be the first place a condition is recognized. It may also be the next place where treatment is interrupted. The CDC identifies HIV, viral hepatitis, sexually transmitted infections, and tuberculosis as correctional-health priorities. Screening, treatment, infection control, and linkage to community care protect families and neighborhoods after release.

Release planning is a patient-safety intervention. A person who leaves custody without a medication supply, follow-up appointment, health records, or a connection to behavioral-health or addiction treatment faces avoidable risk. That risk is highest for those who need antiretroviral therapy, insulin, psychiatric medication, wound care, dialysis coordination, anticoagulation monitoring, or treatment for opioid-use disorder.

"A person in custody remains a patient."

The constitutional baseline

ESTELLE V. GAMBLE

Estelle arose from a Texas prisoner's claim of inadequate care after a work injury. The Court distinguished constitutional violations from malpractice. Negligence, inadvertent error, or disagreement about treatment does not automatically state a constitutional claim. 429 U.S. at 105–06. But intentional denial of, delay in, or interference with necessary care can. Read as an institutional warning, *Estelle* teaches that custodial authority creates corresponding responsibility.

FARMER V. BRENNAN

In *Farmer*, the Court held that an official may be liable when the official "knows of and disregards an excessive risk to inmate health or safety." 511 U.S. 825, 837 (1994). The risk must be sufficiently serious. The official must be aware of facts indicating a substantial risk and actually draw the inference. And the official must fail to take reasonable measures. Courts may consider whether a risk was obvious, repeatedly reported, documented, or reflected in abnormal findings. The healthcare record, staff communications, policies, prior complaints, and response timeline often become central evidence.

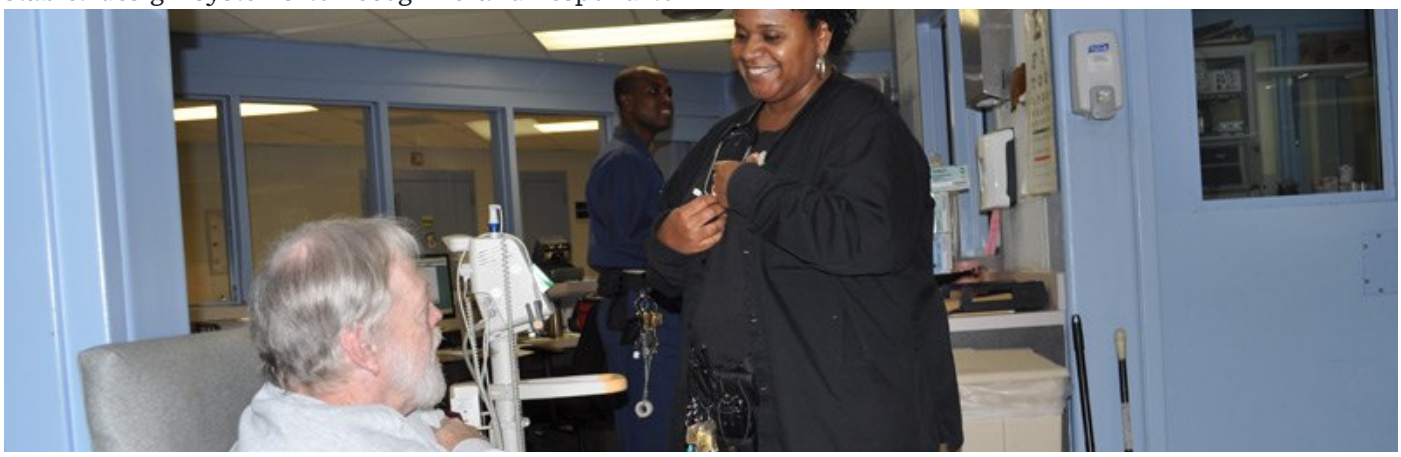
SECTION 1983

Most constitutional claims against state and local officials proceed under 42 U.S.C. § 1983. It supplies a cause of action against any person who, acting under color of state law, deprives another of federal rights. Plaintiffs may sue individual staff, supervisors, or governmental entities for policies, customs, inadequate training, or systemic failures. A civil-rights framework is not a clinical standard of care. The constitutional floor may be lower than best practice. A facility can avoid liability in one case and still fall short of professional, accreditation, or patient-safety expectations.

Pretrial detainees and legal complexity

Many people in local jails have not been convicted. In 2024, BJS reported that 68 percent of people held in jails at midyear were unconvicted. Their claims arise under the Fourteenth Amendment's Due Process Clause. In *Kingsley v. Hendrickson*, 576 U.S. 389 (2015), the Court applied an objective-reasonableness standard to a detainee's excessive-force claim. The federal circuits remain divided over whether that objective

standard extends to medical-care claims. Liability must be analyzed under the law of the specific circuit and the specific facts. The operational lesson is more stable: design systems to recognize and respond to serious need, not around the minimum needed to avoid a verdict.



Inside the walls. A correctional nurse provides care in a U.S. federal prison. Photo: U.S. federal government (Federal Bureau of Prisons), public domain.

Intake: the first clinical gateway

Intake may be the first chance to identify urgent illness, current medications, pregnancy, disability, substance use, suicide risk, infectious disease, recent hospitalization, or special monitoring needs. It should create an actionable clinical pathway, not a hurried checklist disconnected from later care. A strong intake process should cover:

- Urgent symptoms and emergency conditions
- Current and recent medications, including verification of critical medications
- Intoxication, withdrawal, and medication-for-opioid-use-disorder needs
- Suicide risk and mental-health status
- Chronic disease, pregnancy, disability, and mobility needs
- Communicable-disease and infection-control concerns
- Recent emergency visits, surgery, or specialist care
- Clear documentation of action, referral, monitoring, or provider notification

If a patient has chest pain, altered mental status, symptomatic hypertension, low oxygen saturation, unstable glucose, seizure activity, severe withdrawal, or acute psychiatric crisis, the right response may be emergent assessment, not finishing intake paperwork. The intake record also matters legally. A condition documented at booking may show institutional awareness. A medication listed at booking makes a later interruption something the facility must explain.

Clinical deterioration and the nurse's role

Nurses and nurse practitioners are often the first professionals to detect a meaningful change. They see patients at medication pass, sick call, intake, segregation rounds, chronic-care visits, and emergencies. A respiratory rate of 28, falling oxygen saturation, fever, or new lethargy should not be judged by whether the patient "looks sick." Repeated vomiting in a diabetic with missed insulin and tachycardia requires more than reassurance. Sudden withdrawal, pacing, food refusal, or hopelessness in a patient with a psychiatric history calls for focused evaluation and a safety plan.

1. **Recognize** what is abnormal or different from baseline.
2. **Assess** urgently and objectively: vitals, focused exam, history, medications.
3. **Interpret** the risk: respiratory, cardiac, sepsis, neurologic, metabolic, withdrawal, psychiatric, trauma.
4. **Intervene** within scope and protocol.
5. **Escalate** clearly: findings, history, actions taken, and the specific need.
6. **Reassess** the patient's response.
7. **Document** the complete sequence.

This structure prevents a common error: treating notification as the endpoint of care.

Documentation is a clinical intervention

A note should be timely, factual, and specific. It should show why the patient was seen, what the patient reported, and what was observed. It should record risk factors, actions taken, who was notified, what orders followed, and how the patient responded.

> **WEAK ENTRY**
>
> "Inmate not feeling well. Nurse assessed. Provider aware. Will monitor."
>
> **STRONGER ENTRY**
>
> "At 1435, patient reported worsening shortness of breath and chest pressure; diaphoretic with increased work of breathing. BP 168/96, HR 118, RR 28, T 38.4°C, SpO_2 90% RA. Oxygen initiated per protocol. Hx asthma and HTN; states rescue inhaler unavailable since booking. On-call clinician notified 1442; findings and response to oxygen communicated. Order for emergency evaluation and transfer. EMS activated 1446. Continuous observation pending transfer."

The second entry does not prove every decision was correct, but it makes the timeline, concern, communication, and actions visible. The goal is not volume. It is clarity.

Medication continuity is a safety obligation

Some therapies cannot be casually interrupted. These include insulin, antiseizure drugs, anticoagulants, antiretrovirals, psychiatric medications, inhalers, and medications for opioid-use disorder. Cardiovascular, immunosuppressive, renal, and antibiotic therapies and pregnancy-related treatments belong on the same list. A missed dose should trigger assessment, not just a chart entry. What was missed, and why? Is the drug time-sensitive? Is the patient symptomatic? Is provider notice required? Systems should track omissions by cause, such as pharmacy delay, transfer, unclear orders, custody movement, or staffing. A single lapse may reveal a recurring failure.

Mental health, suicide risk, and withdrawal

Jail admission, withdrawal, grief, shame, trauma, isolation, and legal stress can combine to create severe risk. BJS reported 1,200 deaths in local jails in 2019, and suicide remained a leading cause, at 49 deaths per 100,000 jail inmates. Suicide prevention needs ongoing observation, reassessment, access to qualified mental-health professionals, and a safe environment. Withdrawal from alcohol, benzodiazepines, or opioids can be medically dangerous. Staff must not dismiss it as misconduct or manipulation without assessment. The right response is clinical competence, not moral judgment.

Quality assurance and accountability

A program should not wait for a death, lawsuit, or news story to test its systems. Is intake timely? Is sick call triaged promptly? Are high-risk medications given consistently? Are abnormal vitals trended? Are transfers delayed? Can staff report concerns without retaliation? The National Commission on Correctional Health Care released updated 2026 jail and prison standards that convert ethical commitments into operational expectations. A policy that cannot be followed on a night shift, during a lockdown, or amid a staffing shortage is not yet a safety system.

Correctional walls may limit freedom. They must not become walls around clinical judgment, ethical responsibility, or human dignity.

REFERENCES

APA

Bureau of Justice Statistics. (2021). *Mortality in local jails, 2000–2019: Statistical tables*. U.S. Department of Justice. https://bjs.ojp.gov/library/publications/mortality-local-jails-2000-2019-statistical-tables

Bureau of Justice Statistics. (2025). *Jail inmates in 2024: Statistical tables*. U.S. Department of Justice. https://bjs.ojp.gov/library/publications/jail-inmates-2024-statistical-tables/web-report

Centers for Disease Control and Prevention. (2025). *Summary of CDC recommendations for correctional settings*. https://www.cdc.gov/nchhstp/director-letters/correctional-settings-recommendations.html

Centers for Disease Control and Prevention. (2026). *About correctional health*. https://www.cdc.gov/correctional-health/about/index.html

National Commission on Correctional Health Care. (2026). *NCCHC releases 2026 jail and prison standards*. https://ncchc.org/ncchc-releases-2026-jail-prison-standards/

BLUEBOOK

U.S. Const. amend. VIII.

U.S. Const. amend. XIV, § 1.

Estelle v. Gamble, 429 U.S. 97 (1976), https://supreme.justia.com/cases/federal/us/429/97/.

Farmer v. Brennan, 511 U.S. 825 (1994), https://supreme.justia.com/cases/federal/us/511/825/.

Kingsley v. Hendrickson, 576 U.S. 389 (2015), https://supreme.justia.com/cases/federal/us/576/389/.

42 U.S.C. § 1983, https://www.law.cornell.edu/uscode/text/42/1983.

FEATURE • MASS INCARCERATION & PUBLIC HEALTH

The Most Incarcerated Nation on Earth

COVID-19 exposed what decades of overcrowding, underfunded medicine, and for-profit detention had built. Here is the record before, during, and after the pandemic, and what it means for adults and children held in custody today.

BY **JOE A. FLORES, JD, MSN, FNP-BC, CCRN-K, LNC** • EXPERT ANALYSIS AND OPINION



The architecture of confinement. First-floor cell-block corridor, Philadelphia County (Moyamensing) Prison. Photo: Jack E. Boucher, Historic American Buildings Survey, Library of Congress, 1965, public domain.

1.85M
People in U.S. prisons and jails, year-end 2023 (BJS)

#1
World rank in total prison population; about 542 per 100,000 residents (World Prison Brief)

5.5×
COVID-19 case rate in prisons vs. the U.S. population in the pandemic's first months (JAMA, 2020)

6,200+
Children held in ICE detention in the second Trump term, per the Marshall Project (2026)

How America became the world's jailer

The United States did not always lead the world in incarceration. In the early 1970s it held about 360,000 people in prisons and jails, according to the Sentencing Project. By 2008 the count was about 2.3 million. Today the World Prison Brief ranks the United States first in the world in total prison population. Its rate of roughly 542 per 100,000 residents is several times that of most Western democracies. The Bureau of Justice Statistics counted 1,852,900 people incarcerated at the end of 2023.

Drug policy is central to that story. The Sentencing Project reports that about 45 percent of people in federal prison are held for drug offenses. Jails hold their own large population. BJS counted 658,700 people in local jails at midyear 2024, and 68 percent of them had not been convicted. Many remain there because they cannot afford bail. For a person with diabetes, heart disease, or opioid-use disorder, even a few days in jail can interrupt treatment and trigger a medical crisis.

Before COVID-19: a system already strained

Before the pandemic, correctional healthcare was already fragile. BJS reported 1,200 deaths in local jails

in 2019, with a suicide rate of 49 per 100,000. Facilities were aging, crowded, and poorly ventilated. Many relied on contracted medical vendors paid per person or by fixed contract, an arrangement critics say rewards cost control over care. Older prisoners, a product of long sentences, carried growing burdens of heart disease, cancer, dementia, and kidney failure.

During COVID-19: the walls became an incubator

When the virus arrived, these conditions made prisons ideal for transmission. Social distancing is impossible in a dormitory of 80 bunks. Masks, soap, and sanitizer were often rationed. Prisoners were sometimes barred from using alcohol-based sanitizer. Medical isolation often meant solitary confinement, which discouraged people from reporting symptoms.

The evidence is stark. A research letter in *JAMA* found that the COVID-19 case rate among people in prison was 5.5 times higher than in the U.S. population in the early months of the pandemic. Marquez and colleagues, also in *JAMA*, counted 394,066 cases and 2,555 deaths among people in federal and state prisons from April 5, 2020, to April 3, 2021. The CDC's early *MMWR* survey documented cases among both incarcerated people and staff across nearly every reporting jurisdiction. Staff carried the virus home, and released people carried it into communities.

The full toll became clearer later. Sugie and colleagues, writing in *Science Advances* in 2023, found that prison deaths rose from 4,206 in 2019 to 6,088 in 2020. Their models estimated a 77 percent increase in prison mortality. That was 3.4 times the 23 percent increase in the general population. Those numbers reflect more than the virus. They reflect delayed hospital transfers, suspended chronic-care clinics, and staff shortages that left sick people unseen.

COVID-19 did not create the crisis in correctional medicine. It revealed it.

After COVID-19: a dip, then a rebound

The pandemic produced the largest one-year decline in incarceration in modern history. BJS reports that the incarcerated population fell by 294,400 people (18.9 percent) to 1,691,600 in 2020. State and federal prisons dropped 15 percent, and the imprisonment rate fell to 358 per 100,000 U.S. residents, the lowest since 1992. Jails expedited the release of 208,500 people in the first half of 2020.

But the Prison Policy Initiative found that the drop came mostly from a roughly 40 percent fall in admissions, as courts closed and arrests slowed. It did not come from deliberate decarceration. As courts reopened, populations climbed again, from 1,691,600 in 2020 to 1,852,900 in 2023. The pandemic proved that large reductions were possible without collapsing public safety. It did not prove that the political will to sustain them exists.

WHAT THE PANDEMIC SHOULD HAVE TAUGHT US

- Ventilation, space, and infection control are healthcare infrastructure, not luxuries.
- Medical isolation must not be punitive solitary confinement.
- Compassionate release and home confinement are clinical tools for high-risk patients.
- Transparent reporting of deaths and cases is essential for accountability.
- Staff health and incarcerated people's health are linked to community health.

The prison-industrial complex: parasite or root?

"Prison-industrial complex" describes the web of government agencies, private companies, and political interests that benefit from incarceration. These include private prison operators, medical and food contractors, phone and commissary vendors, construction firms, and the unions and towns that depend on prison jobs.

Precision matters here. BJS counted 88,600 people in private prisons at year-end 2023. The Prison Policy Initiative estimates that about 8 percent of incarcerated people are held in privately operated facilities. It calls the private sector a "parasite" on the system rather than its "root." Most people are held in public facilities, by public employees, under laws passed by elected officials. Ending private prisons alone would not end mass incarceration.

Immigration detention is the exception. According to an ACLU analysis of ICE data, 90.8 percent of people in ICE detention are held in privately operated facilities. For-profit companies such as CoreCivic and GEO Group operate many of the largest centers. When detention populations rise, so do contract revenues.

Supporters say private contractors provide flexible capacity the government cannot build quickly. Critics say profit incentives discourage spending on medical staff, mental-health care, and oversight.

Children in detention: the most vulnerable patients

The Marshall Project reported in April 2026 that more than 6,200 children had been held in ICE detention during President Trump's second term. The average daily population was about 226 children, compared with about 24 per day during the final year of the Biden administration — roughly a tenfold increase. In August 2026, the *Texas Tribune* reported that at least 60 children had been held more than 100 days at the South Texas Family Residential Center in Dilley, Texas. That is far beyond the roughly 20-day limit courts have applied under the 1997 *Flores* Settlement Agreement. (The Flores case bears no relation to the publisher.) Texas Public Radio reported that 112 children were held at Dilley in July 2026 and that lawmakers had renewed calls to close the CoreCivic-operated facility, which has a capacity of about 2,400. ICE has said the facility meets federal detention standards and provides medical care, education, and recreation. *The New York Times* and the Associated Press have reported periodic decreases and increases in the number of detained children as policy and litigation shift.

Clinical perspective: Children are not small adults. Prolonged detention exposes them to developmental harm, interrupted vaccinations, untreated dental and mental-health conditions, and the trauma of uncertainty. Pediatric standards, including weight-based dosing, growth monitoring, developmental screening, and trauma-informed mental-health care, should apply in every facility that holds a child.

A balanced view

Supporters of strong incarceration policies point out that violent crime fell substantially from the early 1990s through the 2010s. They argue that incapacitating repeat offenders protects victims, especially in poor neighborhoods where crime is concentrated. Those are serious arguments. Victims are real, and communities deserve safety.

But Pew's research found that states vary widely in imprisonment growth and crime decline, with no consistent link between the two. Many states have since cut both imprisonment and crime. The National Research Council, as summarized by Pew, concluded that mandatory minimum sentences have "few if any deterrent effects." The policy question is not prison or no prison. It is who should be locked up, for how long, and with what standard of care.

What reform-minded professionals can do

- **Nurses:** document deterioration precisely, escalate early, and report unsafe conditions through protected channels.
- **Attorneys:** request medical records early, preserve video and logs, and evaluate both constitutional and state-law claims.
- **Policymakers:** fund medical staffing, require independent death reviews, and publish data.
- **Families:** keep a written list of diagnoses, medications, and prescribers, and send it to the facility's medical unit in writing.

REFERENCES

APA

American Civil Liberties Union. (2023). *ICE detention numbers fact sheet*. https://www.aclu.org/wp-content/uploads/2023/08/ICE-detention-numbers-fact-sheet-final-1.pdf

Bureau of Justice Statistics. (2021). *Correctional populations in the United States, 2020*. https://bjs.ojp.gov/library/publications/correctional-populations-united-states-2020-statistical-tables

Bureau of Justice Statistics. (2021). *Prisoners in 2020*. https://bjs.ojp.gov/library/publications/prisoners-2020-statistical-tables

Bureau of Justice Statistics. (2021). *Impact of COVID-19 on the local jail population, January–June 2020*. https://bjs.ojp.gov/library/publications/impact-covid-19-local-jail-population-january-june-2020

Bureau of Justice Statistics. (2025). *Prisoners in 2023*. https://bjs.ojp.gov/document/p23st.pdf

Bureau of Justice Statistics. (2025). *Jail inmates in 2024*. https://bjs.ojp.gov/library/publications/jail-inmates-2024-statistical-tables/web-report

Marquez, N., Ward, J. A., Parish, K., Saloner, B., & Dolovich, S. (2021). COVID-19 incidence and mortality in federal and state prisons compared with the US population, April 5, 2020, to April 3, 2021. *JAMA, 326*(18), 1865–1867. https://pmc.ncbi.nlm.nih.gov/articles/PMC8495600/

Saloner, B., Parish, K., Ward, J. A., DiLaura, G., & Dolovich, S. (2020). COVID-19 cases and deaths in federal and state prisons. *JAMA,*

324(6), 602–603. https://jamanetwork.com/journals/jama/fullarticle/2768249

Sugie, N. F., Turney, K., Reiter, K., Tublitz, R., Kaiser, D., Goodsell, R., Secrist, E., Patil, A., & Jiménez, M. (2023). Excess mortality in U.S. prisons during the COVID-19 pandemic. *Science Advances, 9*(48), eadj8104. https://pmc.ncbi.nlm.nih.gov/articles/PMC10691764/

Wallace, M., et al. (2020). COVID-19 in correctional and detention facilities—United States, February–April 2020. *MMWR, 69*(19), 587–590. https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm

Prison Policy Initiative. (2022, January 11). *BJS update*. https://www.prisonpolicy.org/blog/2022/01/11/bjs_update/

Sawyer, W., & Wagner, P. (2025). *Mass incarceration: The whole pie 2025*. Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2025.html

Flagg, A., & Heffernan, S. (2026, April 6). *Kids in ICE detention up 10x in Trump's second term*. The Marshall Project. https://www.themarshallproject.org/2026/04/06/ice-kids-detention-over-6200-trump

Texas Tribune. (2026, August 12). *Children held 100+ days at Dilley*. https://www.texastribune.org/2026/08/12/texas-immigration-ice-detention-children-dilley/

Texas Public Radio. (2026, July 28). *Lawmakers renew push to close Dilley as number of detained children rises*. https://www.tpr.org/2026-07-28/lawmakers-renew-push-to-close-dilley-as-number-of-detained-children-rises

The New York Times. (2026, March 20). *Children in ICE detention*. https://www.nytimes.com/2026/03/20/us/children-ice-detention-decrease.html

Associated Press. (2026). *Children in immigration detention at Dilley*. https://apnews.com/article/children-immigration-detention-dilley-trump-administration-ice-400c9dbe9c483f399a0a7bd97db95fe5

World Prison Brief. (2024). *Prison populations continue to rise in many parts of the world*. https://www.prisonstudies.org/news/prison-populations-continue-rise-many-parts-world-115-million-held-prisons-worldwide

The Pew Charitable Trusts. (2014). *Weighing imprisonment and crime*. https://www.pew.org/en/research-and-analysis/articles/2014/09/weighing-imprisonment-and-crime

The Pew Charitable Trusts. (2015). *Federal drug sentencing laws bring high cost, low return*. https://www.pew.org/en/research-and-analysis/issue-briefs/2015/08/federal-drug-sentencing-laws-bring-high-cost-low-return

BLUEBOOK

Stipulated Settlement Agreement, *Flores v. Reno*, No. CV 85-4544-RJK (C.D. Cal. Jan. 17, 1997).

Estelle v. Gamble, 429 U.S. 97 (1976).

U.S. Const. amend. VIII; U.S. Const. amend. XIV, § 1.

42 U.S.C. § 1983.

NEW FEATURE • FEDERAL DRUG SENTENCING & ADDICTION MEDICINE

Sentenced Sick: Addiction, Low-Level Sellers, and Long Federal Time

Federal law sends users, people living with addiction, and street-level sellers to prison for years, often under mandatory minimums. Here are the strongest arguments for and against that approach, and why patients with complex medical needs may be better served by alternatives to incarceration.

BY **JOE A. FLORES, JD, MSN, FNP-BC, CCRN-K, LNC** • VETERAN TEXAS ATTORNEY WITH FEDERAL-COURT EXPERIENCE • FAMILY NURSE PRACTITIONER



Where sentencing law is settled. The U.S. Supreme Court, seen from the Library of Congress. In Pulsifer v. United States (2024), the Court read the federal safety valve narrowly. Photo: Packer1028, Wikimedia Commons, CC0.

82 mo.
Average federal drug-trafficking sentence, FY 2024 (USSC)

96.5%
Federal drug-trafficking defendants sentenced to prison, FY 2024

142 mo.
Average drug sentence when the mandatory minimum applied without relief

129×
Overdose death risk in the first two weeks after prison release (NEJM, 2007)

Who is actually serving long federal drug sentences?

The public image of a federal drug defendant is a cartel boss or a kingpin with a warehouse of fentanyl. The data tell a more complicated story. The U.S. Sentencing Commission reports that federal drug-trafficking defendants in fiscal year 2024 received an average sentence of 82 months, nearly seven years. Of those defendants, 96.5 percent went to prison. More than half, 54.6 percent, were convicted of an offense carrying a mandatory minimum. Average sentences varied by drug: about 100 months for methamphetamine, 76 for fentanyl, 68 for crack cocaine, 66 for heroin, 64 for powder cocaine, 50 for oxycodone, and 37 for marijuana.

Mandatory minimums drive the longest terms. The Commission's FY 2024 data show that drug trafficking makes up 69.4 percent of all federal mandatory-minimum cases. Drug defendants who remained subject to the minimum at sentencing averaged 142 months, almost 12 years. Those who received relief averaged 68 months. Under 21 U.S.C. § 841(b), the quantity of

the drug, not the defendant's role, usually triggers the five- or ten-year minimum.

That design creates the central problem. The Commission has told Congress that drug quantity is a poor proxy for culpability. In testimony on its 2011 mandatory-minimum report and in later testimony, it noted that couriers made up about 23 percent of federal drug offenders and street-level dealers about 17.2 percent. Nearly half of these lower-level participants were still subject to mandatory minimums designed for "serious" and "major" traffickers. A courier paid a few hundred dollars to drive a car across a bridge can carry enough weight to trigger a ten-year sentence.

The overlap between selling and using

In my experience, the line between "user" and "dealer" is often thin. Many low-level sellers sell to support their own addiction. They split a supply with friends, run errands for a supplier in exchange for drugs, or let a trafficker use their home. Federal conspiracy law under 21 U.S.C. § 846 can hold a minor participant responsible for the quantity the whole conspiracy reasonably distributed. The result can be a person with severe opioid-use disorder, hepatitis C, and depression serving a decade in a federal facility.

The case for long federal sentences

A fair article must take the opposing side seriously. Prosecutors, police, and many families who have lost children to overdose make the following arguments.

ARGUMENTS FOR LONG SENTENCES

- **Incapacitation:** a person in prison cannot sell drugs on the street.
- **Lethality:** fentanyl is lethal in tiny amounts, and even a low-level seller can cause a death.
- **Protection of victims:** drug markets bring violence, guns, and exploitation into neighborhoods.
- **Leverage:** mandatory minimums encourage cooperation that helps prosecutors reach suppliers and cartel networks.
- **Deterrence and uniformity:** clear, fixed penalties send a message and reduce unequal sentencing between judges.
- **Accountability:** addiction does not excuse knowingly selling poison to others.

ARGUMENTS AGAINST

- **Role mismatch:** quantity triggers punish couriers and street sellers like the leaders above them.
- **Replacement effect:** arrested street sellers are quickly replaced, so supply barely changes.
- **Weak deterrence:** the National Research Council found mandatory minimums have "few if any deterrent effects."
- **Cost:** long terms consume prison budgets, including fast-growing medical budgets.
- **Disparities:** enforcement and charging fall unevenly on poor and minority communities.
- **Medical harm:** prisons are not designed to treat addiction and complex disease, and the release period is deadly.

What the evidence says about deterrence

The Pew Charitable Trusts reviewed federal drug sentencing in 2015 and found that it brings "high cost, low return." Pew cited the National Research Council's conclusion that mandatory minimums have "few if any deterrent effects." It also noted that street-level dealers are easily replaced, so imprisoning them does little to reduce drug availability. Street dealers in the federal system averaged 77 months in prison. Supporters respond that fentanyl has changed the calculation, and that incapacitating even one seller can save lives. That argument has emotional force. It assumes, however, that the seller is not replaced, an assumption the market data do not support.

Reforms and their limits

Congress has softened, but not eliminated, the system. The First Step Act of 2018 reduced the enhanced 20-year minimum for a repeat drug offender to 15 years and the mandatory life term to 25 years, according to the Congressional Research Service. It also narrowed the prior convictions that trigger enhancements. And it expanded the "safety valve," 18 U.S.C. § 3553(f), which lets judges sentence below the minimum for low-level, nonviolent offenders with limited criminal history.

In 2024, the Supreme Court narrowed that expansion. In *Pulsifer v. United States*, 601 U.S. 124 (2024), a 6–3 majority held that a defendant must satisfy all three of

the safety valve's criminal-history conditions. He must not have more than four criminal-history points, a prior three-point offense, or a prior two-point violent offense. Justice Gorsuch, joined by Justices Sotomayor and Jackson, dissented. In practice, many people with addiction-driven records, often a string of small possession and theft cases, remain ineligible.

A prison cell is the most expensive and least effective place to treat addiction.

The medical reality inside federal prisons

Long sentences create an aging, sicker prison population. The Justice Department's Inspector General found that the Bureau of Prisons spent about $1.1 billion on medical care in FY 2013, 17 percent of its budget. Institutions with the most aging prisoners spent about five times more per person on medical care, $10,114 compared with $1,916. Staffing shortages delayed care, and the Inspector General recommended expanding compassionate release for aging prisoners.

For people with substance-use disorder, the risks are acute. Withdrawal can be dangerous without medical management. Hepatitis C, HIV, endocarditis, chronic pain, and psychiatric illness frequently travel with addiction. Patients with cirrhosis, cancer, heart failure, dialysis needs, or advanced HIV need specialty care that correctional systems often struggle to coordinate.

THE DEADLY FIRST TWO WEEKS AFTER RELEASE

The most sobering statistic in this article comes from Binswanger and colleagues in the *New England Journal of Medicine*. In the first two weeks after release from prison, former prisoners died at 12.7 times the rate of other state residents. Their risk of death from overdose was 129 times higher. Tolerance falls during incarceration. A person who returns to a pre-arrest dose, now often contaminated with fentanyl, can stop breathing within minutes. A long sentence without treatment does not cure addiction. It postpones the danger and then concentrates it.

Alternatives that work better for complex patients

Alternatives to incarceration are not the same as "no consequences." They combine supervision, accountability, and treatment.

- **Drug courts.** The National Institute of Justice's Multi-Site Adult Drug Court Evaluation found that participants reported less drug use (56 percent vs. 76 percent) and less criminal activity (40 percent vs. 53 percent) than comparable offenders. They were also less likely to test positive (29 percent vs. 46 percent). The net benefit was an estimated $5,680 to $6,208 per participant, though the cost findings were not statistically significant. The impact was greatest for higher-risk participants.
- **Medications for opioid-use disorder (MOUD).** When Rhode Island offered methadone, buprenorphine, and naltrexone across its unified jail and prison system, overdose deaths among recently released people fell by 60.5 percent. That finding was published by Green and colleagues in *JAMA Psychiatry* in 2018. The authors estimated that treating 11 people prevented one overdose death.
- **Pretrial diversion and deferred adjudication.** These are especially suitable for users and first-time participants whose conduct was driven by addiction.
- **Probation with treatment conditions.** Community supervision can require counseling, testing, and MOUD while allowing continuity with community physicians and specialists.
- **Compassionate release.** Under 18 U.S.C. § 3582(c)(1)(A), as expanded by the First Step Act, defendants may now ask a court directly for a sentence reduction on "extraordinary and compelling" grounds. These include terminal illness and serious medical conditions that the prison cannot adequately manage.
- **Variance arguments.** Where no mandatory minimum applies, 18 U.S.C. § 3553(a) directs the court to impose a sentence "sufficient, but not greater than necessary." That includes considering the need to provide "medical care, or other correctional treatment in the most effective manner."

Who should be considered for alternatives?

In my professional opinion, the strongest candidates are people whose conduct was driven by addiction and who played minor roles. That includes defendants who used no violence and no weapon, and those with serious medical conditions that a community clinic can manage better than a prison infirmary. Those conditions include pregnancy, cancer, cirrhosis, HIV, end-stage renal disease, heart failure, and severe mental illness. Kingpins, armed traffickers, and people who sell to children or cause deaths present a different case. Public safety must remain the priority there.

Practical guidance for defense counsel and clinicians

- Obtain complete medical, pharmacy, and treatment records early, and have a qualified clinician summarize diagnoses, prognosis, and care needs.
- Document the addiction history, prior treatment attempts, and current MOUD prescriptions. Ask whether the patient can continue that treatment in custody.
- Evaluate safety-valve eligibility under § 3553(f) and *Pulsifer*, and whether a minor-role reduction may apply under the Guidelines.
- Present a concrete treatment plan with a provider, a schedule, and a supervision structure, not a general promise to "get help."
- Plan reentry: naloxone, a bridge supply of medication, a scheduled appointment within days of release, and housing.
- Every case differs. These are educational points, not a promise of any sentencing outcome.

A balanced conclusion

The country can be serious about fentanyl and serious about addiction at the same time. Leaders, armed traffickers, and those who knowingly prey on others deserve firm punishment. But federal law still treats too many sick people as if they were kingpins, at enormous cost and with little proof of benefit to public safety. Sentencing policy should follow the evidence. Reserve long prison terms for the most dangerous offenders. For users, people with addiction, and low-level sellers with complex medical needs, rely on drug courts, diversion, MOUD, and compassionate release. Treated patients are less likely to return to crime, and a person who survives the first two weeks after release has a chance to recover.

REFERENCES

APA

Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—A high risk of death for former inmates. *New England Journal of Medicine, 356*(2), 157–165. https://pubmed.ncbi.nlm.nih.gov/17215533/

Congressional Research Service. (2019). *The First Step Act of 2018: An overview* (R45558). https://www.congress.gov/crs-product/R45558

Green, T. C., Clarke, J., Brinkley-Rubinstein, L., Marshall, B. D. L., Alexander-Scott, N., Boss, R., & Rich, J. D. (2018). Postincarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system. *JAMA Psychiatry, 75*(4), 405–407. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5875331/

National Institute of Justice. (2011). *The multi-site adult drug court evaluation: Executive summary*. https://nij.ojp.gov/library/publications/multi-site-adult-drug-court-evaluation-executive-summary

Rossman, S. B., et al. (2011). *The multi-site adult drug court evaluation: Executive summary*. Urban Institute. https://www.urban.org/sites/default/files/publication/27361/412353-The-Multi-site-Adult-Drug-Court-Evaluation-Executive-Summary.PDF

Office of the Inspector General, U.S. Department of Justice. (2015). *The impact of an aging inmate population on the Federal Bureau of Prisons* (E&I 15-05). https://oig.justice.gov/reports/2015/e1505.pdf

The Pew Charitable Trusts. (2015). *Federal drug sentencing laws bring high cost, low return*. https://www.pew.org/en/research-and-analysis/issue-briefs/2015/08/federal-drug-sentencing-laws-bring-high-cost-low-return

Saris, P. B. (2015, October 21). *Testimony before the U.S. Senate Committee on the Judiciary*. U.S. Sentencing Commission. https://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/testimony/20151021_Saris_Testimony.pdf

U.S. Sentencing Commission. (2025). *Quick facts: Drug trafficking offenses, FY 2024*. https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Drug_Trafficking_FY24.pdf

U.S. Sentencing Commission. (2025). *Quick facts: Mandatory minimum penalties, FY 2024*. https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Quick_Facts_Mand_Mins_FY24.pdf

BLUEBOOK

Pulsifer v. United States, 601 U.S. 124 (2024), https://supreme.justia.com/cases/federal/us/601/22-340/.

Estelle v. Gamble, 429 U.S. 97 (1976).

21 U.S.C. § 841(b) (2018), https://www.law.cornell.edu/uscode/text/21/841.

21 U.S.C. § 846 (2018), https://www.law.cornell.edu/uscode/text/21/846.

18 U.S.C. § 3553(a), (f) (2018), https://www.law.cornell.edu/uscode/text/18/3553.

18 U.S.C. § 3582(c)(1)(A) (2018), https://www.law.cornell.edu/uscode/text/18/3582.

First Step Act of 2018, Pub. L. No. 115-391, §§ 401–403, 603, 132 Stat. 5194.

FEATURE • BOTH SIDES OF THE BORDER

Both Sides of the Border: Drugs, Labor, Guns, and Two Presidents

American demand pulls drugs north. American guns flow south. American employers depend on migrant labor. A balanced look at supply and demand, cheap labor, addiction policy versus the war on drugs, cartel terrorist designations, and the views of leaders in Washington and Mexico City.

BY **JOE A. FLORES, JD, MSN, FNP-BC, CCRN-K, LNC** • CORPUS CHRISTI, TEXAS, 150 MILES FROM THE BORDER



The busiest trade crossing in the hemisphere. Trucks on the World Trade International Bridge in Laredo, Texas, where legal commerce and smuggling share the same lanes. Photo: U.S. Customs and Border Protection, public domain.

A market, not just a crime

From South Texas, the border is not an abstraction. It is a bridge, a river, a family, and an economy. It is also the busiest drug market in the world. To understand cartels, start with a basic economic truth: supply follows demand. Mexican criminal organizations grow rich because millions of people in the United States buy their products, and because American banks, guns, and labor markets make the business possible.

The exponential American appetite

According to the United Nations Office on Drugs and Crime's *World Drug Report 2025*, about 316 million people worldwide used drugs in 2023. That is about 6 percent of people aged 15 to 64, up from 5.2 percent a decade earlier. Cocaine users grew from 17 million to 25 million, and global cocaine production hit a record 3,708 tons. The report observes that "use of most drugs is higher in North America than in other subregions."

Death statistics show the gap most clearly. The CDC's National Center for Health Statistics reported about 69,973 overdose deaths in the United States in 2025, down from 81,313 in 2024. That is an encouraging decline, but still staggering. The European Union Drugs Agency reported about 7,500 drug-induced deaths across the EU in 2023, a rate of 24.7 per million people aged 15 to 64. Using all ages, the U.S. rate in 2025 works out to roughly 205 deaths per million, about eight times the European figure. The European rate uses a narrower age range, so the comparison is approximate, but the scale of the difference is unmistakable.

Measure	United States	European Union	Portugal	Netherlands
Drug-induced / overdose deaths	≈69,973 (2025)	≈7,500 (2023)	105 (2023)	—
Rate per million	≈205, all ages	24.7, ages 15–64	6 (2019, ages 15–64)	18.8 (2016, ages 15–64)
Personal-use policy	Criminal (federal and most states)	Varies by country	Decriminalized since 2001	Tolerated cannabis sales; hard drugs prohibited

Sources: CDC NCHS (2026); EUDA (2025); Transform Drug Policy Foundation (2021); The Conversation (2026); EUDA Netherlands country report (2018). Rates are not perfectly comparable because age ranges and years differ.

Portugal: decriminalization with treatment

In July 2001, Portugal decriminalized personal possession of all drugs under Law 30/2000, limited to a ten-day supply. Trafficking remained a crime. People found with small amounts are referred to "dissuasion commissions," panels of legal, health, and social-work professionals that can steer them toward treatment or impose administrative penalties. The results have been widely studied. Portugal's drug-induced death rate was about 6 per million in 2019, compared with an EU average of 23.7, according to the Transform Drug Policy Foundation. A 25-year review published in *The Conversation* reported 105 overdose deaths in 2023. Injection-linked HIV diagnoses fell from 583 in 2005 to 19 in 2024, and more than 24,000 people were in treatment.

The model has critics. The *Washington Post* reported in 2023 that adult drug use had risen from 7.8 percent to 12.8 percent by 2022, that Lisbon's overdose deaths nearly doubled between 2019 and 2023, and that Porto had seen a 14 percent rise in crime. "We've normalized it," Porto's mayor, Rui Moreira, told the paper. A University of New South Wales review concluded that Portugal's benefits depended on sustained investment in treatment. When funding fell, problems grew. The lesson is not that decriminalization alone works. It is that decriminalization paired with well-funded treatment works better than prison alone.

The Netherlands: tolerance and its paradox

The Dutch *gedoogbeleid*, or tolerance policy, allows licensed coffee shops to sell up to five grams of cannabis, while cultivation and wholesale supply remain criminal. The EUDA's country report put Dutch drug-induced mortality at 18.84 per million in 2016, below the EU average of 21.8. But the Dutch National Police have described the Netherlands as Europe's primary drug-logistics hub, with the port of Rotterdam at its center. Lower domestic harm can coexist with enormous trafficking. Policy on users and policy on organized crime are different problems.

Addiction as a disease versus the war on drugs

The American war on drugs, declared in the early 1970s, treated drug use primarily as a crime. Fifty years later, the United States has high rates of incarceration and overdose. Supporters of enforcement respond that the problem is not too much enforcement but too little at the border and against cartels. They note that fentanyl's potency makes any tolerance dangerous. They point to Oregon, which decriminalized most possession under Ballot Measure 110 in February 2021 and recriminalized it as a misdemeanor through House Bill 4002, effective September 1, 2024, after public concern over disorder and overdoses. Even then, Oregon paired recriminalization with county deflection programs that steer people toward treatment. A balanced view holds both truths. Enforcement against trafficking organizations is necessary. Treating addiction as a crime has not reduced demand. As a clinician, I believe demand reduction through prevention, MOUD, and treatment is the part of drug policy the United States has underfunded the most.



Supply. CBP officers display what the agency called the largest fentanyl seizure in its history at the Nogales port of entry. Photo: U.S. Customs and Border Protection, public domain.



Labor. Workers harvest strawberries in Fort Valley, Georgia, 2019. Agriculture depends heavily on immigrant labor. Photo: U.S. Department of Agriculture, public domain.

Cheap labor: the other border economy

The Pew Research Center estimated a record 14 million unauthorized immigrants in the United States in 2023, including about 9.7 million workers, or 5.6 percent of the U.S. labor force. They are concentrated in agriculture, construction, food processing, hospitality, and home care. Employers benefit from their labor, consumers benefit from lower prices, and workers often accept wages and conditions that citizens avoid. Critics of high immigration argue that this labor supply depresses wages for low-income citizens, burdens public services, and rewards illegal entry. Advocates argue that the economy cannot function without these workers and that the legal immigration system offers too few visas to meet demand. Both sides agree that hiring without lawful status creates a vulnerable workforce that is easily exploited, sometimes by the same criminal networks that smuggle drugs.

The iron river: guns flowing south

The trade runs both ways. The U.S. Government Accountability Office found that 70 percent of firearms recovered in Mexico and submitted for tracing from 2014 to 2018 originated in the United States. The Mexican government estimated that about 200,000 firearms are trafficked south each year. A 2026 GAO report found that 68 percent of traced firearms, 82,785 guns, recovered in Mexico from 2020 to 2024 had a U.S. source. Mexico has strict gun laws, yet its cartels are armed with American rifles.

Why designate cartels as terrorist organizations?

On February 20, 2025, the State Department designated eight groups as Foreign Terrorist Organizations under 8 U.S.C. § 1189 and as Specially Designated Global Terrorists. They were Tren de Aragua, MS-13, the Sinaloa Cartel, the Jalisco New Generation Cartel (CJNG), Cárteles Unidos, the Cartel del Noreste, the Gulf Cartel, and La Nueva Familia Michoacana. The State Department cited kidnappings, extortion, bribery, assassinations, drone and explosive attacks, and the trafficking of fentanyl. It said the Sinaloa Cartel is "one of the largest producers and traffickers of fentanyl and other illicit drugs to the United States."

WHY SUPPORTERS FAVOR THE DESIGNATION

- Cartels use terror tactics: beheadings, car bombs, drones, and murders of journalists and officials.
- The designation unlocks material-support prosecutions under 18 U.S.C. § 2339B, plus sanctions and intelligence tools.
- It signals that fentanyl deaths are a national-security threat, not only a crime problem.
- It pressures banks and businesses to cut off cartel money.

WHY CRITICS HAVE CONCERNS

- Cartels seek profit, not political change, so terrorism law may be an imperfect fit.
- Businesses, farmers, and migrants who pay extortion under threat could face material-support exposure.
- Mexico views the label as a possible pretext for unilateral U.S. military action.
- Asylum seekers who paid smugglers tied to cartels may face new barriers.



Two presidents, one stage. President Donald Trump, Mexican President Claudia Sheinbaum, and Canadian Prime Minister Mark Carney at the FIFA World Cup draw at the Kennedy Center, December 5, 2025. Reuters and the AP reported it was Trump and Sheinbaum's first in-person meeting, followed by private talks on trade. Official White House Photo by Daniel Torok, public domain.

Leadership perspectives from both sides

WASHINGTON

President Trump has made cartels and fentanyl a centerpiece of his relationship with Mexico, mixing praise with pressure. In January 2026, after suggesting U.S. forces could strike cartels on Mexican soil, he said Mexico had to "get their act together" while calling Sheinbaum a "terrific person." In a September 2026 determination to Congress on major drug-producing countries, he acknowledged Mexico's seizures and lab closures. But he wrote that "Canada and Mexico need to do far more to stop the flows of deadly drugs into our country." He said Mexico "must take additional action against the narcoterrorist organizations that dominate vast areas of its territory." He also called for "exposing, arresting, and prosecuting" corrupt officials. He later described Mexico as the "epicenter" of cartel activity.

MEXICO CITY

President Sheinbaum has emphasized cooperation and sovereignty. In January 2026 she said U.S. troops in Mexico were "not on the table." Responding to the "epicenter" remark in September 2026, she said: "It's very difficult to live next to a country with such a high level of illicit drug use; or I could say: It's very difficult to live next to a country that produces so many weapons, but I'm not going to say that." She then explained why: "we have a good relationship with President Trump and the US government; so we're working in coordination and making progress."

COMMON GROUND

The two governments issued a joint statement on January 15, 2026, after a call between the presidents. They committed to "tangible actions" against cartels, a bilateral Security Implementation Group, and a Security Ministerial in Washington. They pledged to "stop the illicit flow of fentanyl and weapons from crossing our shared border," in a partnership "grounded in mutual respect for sovereignty." That sentence captures the balanced view. Drugs move north and guns move south. Neither country can solve the problem alone.

Mexico supplies what America demands, armed with what America sells.

What a balanced policy would include

- Aggressive enforcement against cartel leadership, money, and weapons on both sides of the border.
- Serious investment in U.S. demand reduction: prevention, MOUD, and treatment on demand.
- Firearms-trafficking enforcement at U.S. gun sales and southbound inspections.
- Legal labor pathways that match the economy's real needs, with enforcement against exploitative employers.
- Respect for Mexican sovereignty and shared intelligence, rather than unilateral action.

REFERENCES

APA

Centers for Disease Control and Prevention, National Center for Health Statistics. (2026, May 13). *Provisional drug overdose death counts* [Press release]. https://www.cdc.gov/nchs/pressroom/releases/20260513.html

Associated Press. (2026). *Overdose deaths fall again, CDC data show*. https://apnews.com/article/overdose-deaths-cdc-fentanyl-8e3a42544f57eea6a9af3be541178a4d

European Union Drugs Agency. (2025). *European drug report 2025: Drug-induced deaths*. https://www.euda.europa.eu/publications/european-drug-report/2025/drug-induced-deaths_en

European Monitoring Centre for Drugs and Drug Addiction. (2018). *Netherlands country drug report 2018*. https://www.euda.europa.eu/system/files/media/publications/documents/8877/netherlands-cdr-2018-with-numbers.pdf

Dutch National Police. (2022). *Drug-related serious and organised crime in the Netherlands*. https://www.politie.nl/binaries/content/assets/politie/onderwerpen/drugs/rapporten-over-drugs/national-police-of-the-netherlands_central-unit_-2022_-nsa-drug-related-soc-in-the-netherlands.pdf

Transform Drug Policy Foundation. (2021). *Drug decriminalisation in Portugal: Setting the record straight*. https://transformdrugs.org/blog/drug-decriminalisation-in-portugal-setting-the-record-straight

The Conversation. (2026). *Portugal decriminalized drugs 25 years ago, but the real lesson is what it built around this policy*. https://theconversation.com/portugal-decriminalized-drugs-25-years-ago-but-the-real-lesson-is-what-it-built-around-this-policy-289572

Washington Post. (2023, July 7). *Portugal's drug decriminalization faces challenges*. https://www.washingtonpost.com/world/2023/07/07/portugal-drugs-decriminalization-heroin-crack/

University of New South Wales, Drug Policy Modelling Program. (2024). *Was decriminalisation effective in Portugal?* https://www.unsw.edu.au/content/dam/pdfs/ada/sprc/research-reports/dpmp-drug-summit-2024-explainers/2024-11-was-decriminalisation-effective-in-portugal-v3.pdf

United Nations Office on Drugs and Crime. (2025). *World drug report 2025: Key findings*. https://unis.unvienna.org/unis/en/pressrels/2025/unisnar1499.html

U.S. Government Accountability Office. (2021). *Firearms trafficking: U.S. efforts to disrupt gun smuggling into Mexico* (GAO-21-322). https://www.gao.gov/products/gao-21-322

U.S. Government Accountability Office. (2026). *Firearms trafficking to Mexico* (GAO-26-108061). https://www.gao.gov/products/gao-26-108061

Passel, J. S., & Krogstad, J. M. (2025). *U.S. unauthorized immigrant population reached a record 14 million in 2023*. Pew Research Center. https://www.pewresearch.org/race-and-ethnicity/2025/08/21/u-s-unauthorized-immigrant-population-reached-a-record-14-million-in-2023/

U.S. Department of State. (2025). *Designation of international cartels*. https://www.state.gov/designation-of-international-cartels

Congressional Research Service. (2025). *Designation of Mexican cartels as foreign terrorist organizations* (IN11205). https://www.congress.gov/crs_external_products/IN/HTML/IN11205.web.html

Oregon Judicial Department. (2026). *Measure 110 statistics*. https://www.courts.oregon.gov/about/Documents/BM110Statistics.pdf

Drug Enforcement Administration. (n.d.). *Cartels*. https://www.dea.gov/cartels

U.S. Department of State. (2026, January 15). *Joint statement on U.S.–Mexico security cooperation*. https://www.state.gov/releases/office-of-the-spokesperson/2026/01/joint-statement-on-u-s-mexico-security-cooperation

Reuters. (2026, January 9). *Mexico's Sheinbaum urges closer U.S. coordination after Trump threatens land strikes*. https://www.reuters.com/world/americas/mexicos-sheinbaum-urges-closer-us-coordination-after-trump-threatens-land-2026-01-09/

France 24. (2026, January 12). *US troops in Mexico "not on the table," Sheinbaum tells Trump*. https://www.france24.com/en/americas/20260112-us-troops-mexico-not-on-the-table-sheinbaum-trump

Ferri, P. (2026, September 17). Trump steps up pressure on Mexico over drug trade. *El País*. https://english.elpais.com/international/2026-09-17/trump-steps-up-pressure-on-mexico-over-drug-trade-they-must-arrest-corrupt-officials.html

Şanlı, E. (2026, September 24). Sheinbaum hits back at Trump over cartel "epicenter" remark. *Yeni Şafak*. https://en.yenisafak.com/world/sheinbaum-hits-back-at-trump-over-cartel-epicenter-remark-3723667

Reuters. (2025, December 5). *Trump says he will talk trade with leaders of Mexico, Canada at World Cup draw*. https://www.reuters.com/world/americas/trump-says-he-will-talk-trade-with-leaders-mexico-canada-world-cup-draw-2025-12-05/

Associated Press. (2025, December 5). *Trump and Sheinbaum meet at World Cup draw*. https://apnews.com/article/trump-sheinbaum-meeting-world-cup-immigration-tariffs-9b3a3ab0e64ba435ce312c32dba9f70f

BLUEBOOK

8 U.S.C. § 1189 (2018), https://www.law.cornell.edu/uscode/text/8/1189.

18 U.S.C. § 2339B (2018), https://www.law.cornell.edu/uscode/text/18/2339B.

Foreign Terrorist Organization Designations of Tren de Aragua, Mara Salvatrucha, Cartel de Sinaloa, Cartel de Jalisco Nueva Generacion, Carteles Unidos, Cartel del Noreste, Cartel del Golfo, and La Nueva Familia Michoacana, 90 Fed. Reg. (Feb. 20, 2025) (FR Doc. 2025-02873), https://www.govinfo.gov/content/pkg/FR-2025-02-20/html/2025-02873.htm.

Or. H.B. 4002, 82d Leg. Assemb., 2024 Reg. Sess. (Or. 2024) (effective Sept. 1, 2024).

Lei n.º 30/2000, de 29 de novembro, Diário da República n.º 276/2000, Série I-A (Port.).

FEATURE • FOLLOW THE MONEY

Follow the Money: How Cartel Cash Moves Through the World's Banks

Drugs are the product. Money is the point. How laundering works worldwide, why the HSBC case became the global example of cartel money moving through respectable institutions, the claim that drug money propped up banks in 2008, and why the problem did not end there.

BY **JOE A. FLORES, JD, MSN, FNP-BC, CCRN-K, LNC** • EXPERT ANALYSIS AND OPINION



Placement begins with cash. CBP officers found $860,995 in concealed currency in an outbound vehicle at the Calexico West port of entry, August 2013. Bulk cash heading south is often the first step in a laundering cycle. Photo: U.S. Customs and Border Protection, public domain.

2–5%
Share of global GDP laundered each year, $800 billion to $2 trillion (UNODC estimate)

$881M
Drug proceeds laundered through HSBC for the Sinaloa and Norte del Valle cartels, 2006–2010 (DOJ)

$1.92B
HSBC forfeiture and civil penalties, 2012. No executive was charged.

$3.09B
TD Bank penalties, 2024, the first U.S. bank to plead guilty to laundering conspiracy

Why money is the cartel's weak point

A cartel that sells billions of dollars of drugs on American streets has a problem: most of that money arrives as cash, in small bills, in the United States. It must be returned to Mexico or Colombia, converted into usable wealth, and made to look legitimate. That process is money laundering. The United Nations Office on Drugs and Crime estimates that 2 to 5 percent of global GDP is laundered each year, between about $800 billion and $2 trillion. Without banks, money-service businesses, real estate, and trade networks, the drug trade could not function at that scale.

The three stages of laundering

Investigators and the Financial Action Task Force describe laundering in three stages. The stages often overlap.

- **Placement:** introducing dirty cash into the financial system. Methods include deposits split into amounts below reporting thresholds ("structuring"), cash-intensive front businesses,

casas de cambio (currency exchanges), and bulk cash smuggled across the border.

- **Layering:** moving money through transfers, shell companies, offshore accounts, and wires across countries to obscure its origin.
- **Integration:** returning the money as apparently legitimate wealth through real estate, luxury goods, investments, business loans, or trade.

TRADE-BASED LAUNDERING AND THE BLACK MARKET PESO EXCHANGE

One of the oldest schemes avoids moving cash across borders at all. In the Black Market Peso Exchange, a broker buys a cartel's U.S. dollars at a discount and pays the cartel in pesos in Mexico or Colombia. The broker then sells the dollars to importers who need them to buy American goods. The goods are shipped south, the importer pays in pesos, and the drug money disappears into ordinary trade.

THE NEW MODEL: CHINESE MONEY-LAUNDERING NETWORKS

In August 2025, the Treasury's Financial Crimes Enforcement Network (FinCEN) issued an advisory and trend analysis on Chinese money-laundering networks (CMLNs). It identified 137,153 Bank Secrecy Act reports describing about $312 billion in suspected activity from 2020 to 2024, including $53.7 billion related to real estate. In the scheme, cartels sell U.S. dollars to these networks. The networks resell them to Chinese nationals seeking to evade China's strict currency controls. Cartels get their money quickly, and the dollars never leave the United States. FinCEN Director Andrea Gacki called the networks "global and pervasive" and said "they must be dismantled."

The HSBC case: a global example

On December 11, 2012, the Justice Department announced that HSBC Holdings plc and HSBC Bank USA, N.A. had admitted to anti-money-laundering and sanctions violations. Prosecutors in the Eastern District of New York filed a four-count criminal information. It charged willful failure to maintain an effective anti-money-laundering program, willful failure to conduct due diligence on foreign correspondent accounts, and violations of the International Emergency Economic Powers Act and the Trading with the Enemy Act.

The admitted facts were extraordinary. HSBC Bank USA conceded that at least $881 million in drug-trafficking proceeds had been laundered through the bank. The money belonged to Mexico's Sinaloa Cartel and Colombia's Norte del Valle Cartel, among others, and moved from 2006 to 2010. HSBC rated Mexico as "standard," its lowest risk category. As a result, it did not monitor more than $670 billion in wire transfers or more than $9.4 billion in purchases of physical U.S. dollars from HSBC Mexico. Cartel associates reportedly used boxes sized to fit through teller windows. The bank also processed about $660 million in transactions prohibited by U.S. sanctions involving Iran, Cuba, Sudan, Libya, and Burma.

Assistant Attorney General Lanny Breuer said: "The record of dysfunction that prevailed at HSBC for many years was astonishing." HSBC agreed to forfeit $1.256 billion and pay $665 million in civil penalties to the Office of the Comptroller of the Currency ($500 million) and the Federal Reserve ($165 million), a total of about $1.92 billion. It entered a five-year deferred prosecution agreement with an independent compliance monitor.

The bank paid. The cartel money moved. No executive went to prison.

WHY IT TOOK YEARS

The warning signs came long before the settlement. A U.S. Senate Permanent Subcommittee on Investigations report, released July 17, 2012, found that HSBC Mexico moved about $7 billion in U.S. dollars into the United States in 2007 and 2008. It also found that Mexican authorities had warned the bank in February 2008. Senator Carl Levin called HSBC's culture "pervasively polluted." The investigation spanned years of internal reviews, regulator warnings, and Senate hearings before charges were filed. In December 2017, after the five-year term, federal prosecutors moved to dismiss the charges. Reuters reported that HSBC had "drawn a line" under the cartel case.

"TOO BIG TO JAIL"

The most controversial question was why no one was prosecuted. In July 2016, Republican staff of the House Financial Services Committee published a report titled *Too Big to Jail*. It found that senior Justice Department leaders, including Attorney General Eric Holder, overruled a recommendation from the Asset Forfeiture and Money Laundering Section to prosecute HSBC. The report says they feared that a conviction could cause a "global financial disaster." It also cited a September 10, 2012, letter from U.K. Chancel-

lor George Osborne warning U.S. officials about the consequences. The Justice Department has defended deferred prosecution agreements as tools that punish institutions while protecting employees, depositors, and markets. Critics say the outcome taught banks that laundering cartel money is a cost of doing business.

THE COURTS WEIGH IN

In 2013, Judge John Gleeson of the Eastern District of New York approved the deferred prosecution agreement but asserted supervisory authority to monitor its implementation. In 2017, the Second Circuit reversed on that point. It held that district courts lack supervisory power to oversee a DPA's implementation absent impropriety, and it declined to unseal the monitor's report.

Wachovia: the case before HSBC

In March 2010, Wachovia Bank entered a deferred prosecution agreement in the Southern District of Florida. Prosecutors found the bank had failed to monitor more than $420 billion in transactions with Mexican casas de cambio, including more than $373 billion in wires and more than $4 billion in bulk cash. At least $110 million was identified as drug proceeds. Wachovia paid $110 million in forfeiture and a $50 million fine, $160 million in total, under a 12-month agreement. The case reportedly began when a drug-sniffing dog alerted on an aircraft purchased with funds routed through the bank. Media accounts often cite "$378 billion laundered." That figure describes unmonitored volume, not proven laundering.

Did drug money prop up the banks in 2008?

The boldest claim came from Antonio Maria Costa, then head of the UNODC. In December 2009, he told *The Observer* that during the 2008 crisis, drug money was in some cases "the only liquid investment capital" available to banks on the brink. He said a majority of an estimated $352 billion in drug profits had been absorbed into the economic system. "Inter-bank loans were funded by money that originated from the drugs trade and other illegal activities," he said, adding, "There were signs that some banks were rescued that way."

This claim deserves a balanced reading. Costa named no banks and never published his evidence. *Le Monde* later reported that the UNODC would neither confirm nor deny his statement. Economists note that the Federal Reserve alone expanded its balance sheet by about $1.3 trillion between September and November 2008, dwarfing any plausible drug-money injection. A fair conclusion is that drug money almost certainly flowed through banks during the crisis, as HSBC and Wachovia show. But the idea that cartel cash "saved" the global financial system remains an unproven allegation, not an established fact.

TD Bank: the problem did not end

On October 10, 2024, TD Bank became the first U.S. bank to plead guilty to conspiracy to commit money laundering. It agreed to pay about $3.09 billion, including about $1.8 billion to the Justice Department and $1.3 billion to FinCEN. Attorney General Merrick Garland said the bank left $18.3 trillion in customer activity unmonitored. He said three laundering networks moved more than $670 million through its accounts, including about $470 million in cash tied to fentanyl and narcotics proceeds. Regulators imposed a $434 billion asset cap, and about two dozen individuals were prosecuted. That is a notable shift from HSBC, but critics still note how long the misconduct ran.

Lessons for professionals

- **Compliance is a front line.** Bank, real-estate, and healthcare compliance staff who file honest suspicious-activity reports are part of drug policy.
- **Individual accountability matters.** Corporate penalties without individual consequences may not change behavior.
- **Follow the money both ways.** Cartel profits fund the guns and corruption that kill people on both sides of the border.
- **Healthcare is not immune.** Clinics, pharmacies, and billing schemes can be used to launder money. Unusual cash payments and ownership structures deserve scrutiny.

REFERENCES

APA

United Nations Office on Drugs and Crime. (n.d.). *Money laundering: Overview*. https://www.unodc.org/unodc/es/money-laundering/overview.html

Reuter, P., & Truman, E. M. (2004). *Chasing dirty money: The fight against money laundering* (ch. 3). Peterson Institute for International Economics. https://www.piie.com/publications/chapters_preview/381/3iie3705.pdf

U.S. Department of Justice. (2012, December 11). *HSBC Holdings plc and HSBC Bank USA N.A. admit to anti-money laundering and sanctions violations, forfeit $1.256 billion in deferred prosecution agreement*. https://www.justice.gov/opa/pr/hsbc-holdings-plc-and-hsbc-bank-usa-na-admit-anti-money-laundering-and-sanctions-violations

U.S. Senate Permanent Subcommittee on Investigations. (2012). *U.S. vulnerabilities to money laundering, drugs, and terrorist financing: HSBC case history*. https://www.hsgac.senate.gov/subcommittees/investigations/hearings/u-s-vulnerabilities-to-money-laundering-drugs-and-terrorist-financing-hsbc-case-history/

South China Morning Post. (2012). *HSBC Mexican branches said to be traffickers' favourites*. https://www.scmp.com/business/companies/article/1103587/hsbc-mexican-branches-said-be-traffickers-favourites

Reuters. (2017, December 11). *HSBC draws line under Mexican cartel case after five years on probation*. https://www.reuters.com/article/business/hsbc-draws-line-under-mexican-cartel-case-after-five-years-on-probation-idUSKBN1E50Y9/

U.S. House Committee on Financial Services, Republican Staff. (2016). *Too big to jail: Inside the Obama Justice Department's decision not to hold Wall Street accountable*. https://financialservices.house.gov/uploadedfiles/07072016_oi_tbtj_sr.pdf

U.S. Attorney's Office, Southern District of Florida. (2010, March 17). *Wachovia enters into deferred prosecution agreement*. https://www.justice.gov/archive/usao/fls/PressReleases/2010/100317-02.html

Syal, R. (2009, December 13). Drug money saved banks in global crisis, claims UN advisor. *The Observer*. https://www.theguardian.com/global/2009/dec/13/drug-money-banks-saved-un-cfief-claims

Le Monde. (2011, April 7). *Embarras aux Nations unies*. https://www.lemonde.fr/livres/article/2011/04/07/embarras-aux-nations-unies_1504139_3260.html

Fox Business. (n.d.). *Did drug cartels save the global financial system?* https://www.foxbusiness.com/markets/did-drug-cartels-save-the-global-financial-system

U.S. Department of Justice. (2024, October 10). *Attorney General Merrick B. Garland delivers remarks announcing TD Bank's guilty plea*. https://www.justice.gov/archives/opa/speech/attorney-general-merrick-b-garland-delivers-remarks-announcing-td-banks-guilty-plea-bank

Reuters. (2024, October 10). *Canada's TD Bank to plead guilty to US charges it failed to properly monitor money laundering*. https://www.reuters.com/business/finance/canadas-td-bank-plead-guilty-us-charges-it-failed-properly-monitor-money-2024-10-10/

Financial Crimes Enforcement Network. (2025, August 28). *FinCEN advisory FIN-2025-A003*. https://www.fincen.gov/resources/advisories/fincen-advisory-fin-2025-a003

Financial Crimes Enforcement Network. (2025). *Financial trend analysis: Chinese money laundering networks*. https://www.fincen.gov/system/files/2025-08/4000-10-INV-144549-S3F6L-FTA-CMLN-508.pdf

Congressional Research Service. (2026). *Chinese money laundering networks* (R48786). https://www.congress.gov/crs-product/R48786

BLUEBOOK

United States v. HSBC Bank USA, N.A., No. 12-CR-763, 2013 WL 3306161 (E.D.N.Y. July 1, 2013), *rev'd on other grounds*, 863 F.3d 125 (2d Cir. 2017).

United States v. HSBC Bank USA, N.A., 863 F.3d 125 (2d Cir. 2017).

Bank Secrecy Act, 31 U.S.C. §§ 5311–5336 (2018 & Supp.), https://www.law.cornell.edu/uscode/text/31/subtitle-IV/chapter-53/subchapter-II.

31 U.S.C. § 5318(h) (anti-money-laundering programs).

18 U.S.C. §§ 1956–1957 (2018) (laundering of monetary instruments), https://www.law.cornell.edu/uscode/text/18/1956.

International Emergency Economic Powers Act, 50 U.S.C. §§ 1701–1706 (2018).

Trading with the Enemy Act, 50 U.S.C. §§ 4301–4341 (2018).

FEATURE • AN UNBIASED UPDATE

Illegal Entry, ICE, and the Reality of Immigration Detention

Enforcement, due process, and patient dignity in a civil-detention system that now holds more than 65,000 people on a given day. The facts, the competing views, and the clinical duty that applies regardless of status.

BY **JOE A. FLORES, JD, MSN, FNP-BC, CCRN-K, LNC** • EXPERT ANALYSIS AND OPINION



The line in South Texas. Border fence with drag tires used by agents to smooth the ground and detect footprints, South Texas, September 24, 2013. Photo: Donna Burton, U.S. Customs and Border Protection, public domain.

Immigration policy is often discussed in absolutes. One side describes all enforcement as inhumane. The other describes every person who enters or remains without authorization as a criminal threat. Neither framing captures the legal, clinical, or institutional reality. The United States has lawful authority to regulate its borders, decide who may enter, enforce federal immigration law, adjudicate asylum claims, and remove people who are legally removable after due process. At the same time, people in immigration custody keep their interests in due process, safe conditions, humane treatment, and clinically appropriate medical and mental-health care.

The relevant question for this publication is not whether immigration laws should be enforced. They are federal law. The questions are how enforcement occurs, who is detained, what process applies, how the data should be read, and whether people in custody receive safe and dignified care.

Unlawful entry and immigration violations

Under 8 U.S.C. § 1325, improper entry includes entering or attempting to enter the United States at a time or place other than one designated by immigration officers. It also includes eluding inspection and entering through willfully false representations. A first offense is a misdemeanor. Reentry after removal, under 8 U.S.C. § 1326, is a felony.

Not every immigration violation is a crime. Visa overstays are generally civil violations, and removal proceedings are civil administrative proceedings. "Undocumented," "unlawfully present," "inadmissible," "removable," "charged with a crime," and "convicted of a crime" are not interchangeable. A balanced discussion keeps them separate.

What ICE detention is, and is not

U.S. Immigration and Customs Enforcement, through Enforcement and Removal Operations, handles in-

terior enforcement, detention, alternatives to detention, and removals. The Congressional Research Service explains that the Immigration and Nationality Act authorizes, and in some cases requires, detention. Arriving asylum seekers may be detained under 8 U.S.C. § 1225. People arrested in the interior are detained under § 1226, which makes detention mandatory for certain criminal categories. People with final removal orders are held under § 1231. Immigration detention is civil, not punishment for a crime. But that does not make the loss of liberty minor. A detained person may be transferred across state lines, separated from family and physicians, and left uncertain for months.

Reading the border numbers carefully

Border "encounters" are often cited as if they counted unique people who entered and stayed. They do not. CBP's southwest-border data combine Border Patrol apprehensions between ports of entry with inadmissible people encountered at ports, and in earlier years Title 42 expulsions. One person may be encountered more than once. In March 2025, CBP reported 7,181 Border Patrol apprehensions at the southwest border, 95 percent below the 137,473 recorded in March 2024. Border crossings fell to historic lows after the change in administration. Supporters of current policy credit enforcement. Critics note that asylum access was also sharply restricted. Both observations can be true.

Who is in detention?

The Transactional Records Access Clearinghouse (TRAC) at Syracuse University reported that ICE held 65,765 people on July 11, 2026. It found that 46,436 of them, 70.6 percent, had no criminal conviction. TRAC's detention tables break the population down further: about 29 percent had a conviction, 31 percent had pending criminal charges, and 40 percent had neither.

ICE emphasizes a different measure. Its fiscal-year 2024 annual report states that 71.7 percent of its 113,431 administrative arrests involved people with criminal convictions or pending charges. Critics of TRAC, including reporting in *Just the News,* have argued that changes in how ICE data are tracked can make the share of people with criminal histories appear lower than it is. Both figures are accurate within their definitions. "No conviction" does not mean "no criminal charge." A "criminal history" can range from homicide to an old traffic offense.

THE ENFORCEMENT VIEW

- Congress wrote the immigration laws, and the executive branch must enforce them.
- Unchecked entry rewards smugglers and cartels and endangers migrants on the journey.
- Detention ensures people appear for hearings and comply with removal orders.
- Most ICE arrests involve people with convictions or pending charges.
- ICE Health Service Corps spends hundreds of millions of dollars a year, about $421.5 million in FY 2024 by ICE's account, on detainee healthcare.
- Lower border crossings reduce deaths in the desert and the river.

THE CIVIL-LIBERTIES VIEW

- Detention is civil, yet many detainees are held in jail-like conditions for months.
- Most people in detention on a given day have no criminal conviction.
- About 90.8 percent of detainees are held in privately operated facilities, which raises concerns about profit incentives.
- Transfers disrupt access to counsel, family, and established medical care.
- Families with children are held far longer than courts have allowed under the *Flores* settlement.
- Alternatives to detention cost less and keep many people in compliance.



Custody and care, side by side. ICE detention officers and ICE Health Service Corps medical personnel. The officers control movement, and the clinicians control assessment. Safe care requires both to communicate. Photo: U.S. Immigration and Customs Enforcement, public domain.

The clinical reality of immigration detention

Immigration detention raises the same healthcare issues as jails and prisons, plus added complications: language barriers, abrupt transfers, missing medical records, uncertain length of stay, and family separation. Detainees may have diabetes, asthma, hypertension, seizure disorders, pregnancy, cancer, tuberculosis, HIV, serious mental illness, or trauma from violence on the journey north. They may need interpreters, specialty referrals, hospital evaluation, and continuity of medication.

The clinical standard should not change with immigration status. Chest pain, shortness of breath, altered mental status, suicidal ideation, withdrawal, medication interruption, infection, or injury require the same response everywhere. Assess, intervene, communicate, escalate, reassess, and document. Professional interpreters, not other detainees or officers, should be used for clinical histories and consent.

PRACTICAL POINTS FOR FAMILIES AND COUNSEL

- Use ICE's online detainee locator promptly, and record the detainee's A-number.
- Send a written list of diagnoses, medications, doses, and prescribing physicians to the facility's medical unit, and keep a copy.
- Request medical records in writing, with the detainee's signed authorization.
- For urgent concerns, contact the facility in writing and consider contacting the ICE field office and counsel the same day.
- Ask counsel whether bond, parole, or an alternative to detention may be available. Every case differs, and results are not guaranteed.

A balanced conclusion

All of the following can be true at once. The United States has authority to enforce immigration law and regulate entry. Improper entry can carry criminal and civil consequences. Many immigration violations are civil, not criminal. Detention is a major deprivation of liberty even when it is legally civil. Border data require careful reading. ICE detention includes people with very different legal and criminal histories, and with very different medical needs. And every clinician and every detention system has a duty to provide safe, timely, humane care.

A person's immigration status may shape the legal process. It should never erase the patient's humanity.

REFERENCES

APA

American Civil Liberties Union. (2023). *ICE detention numbers fact sheet*. https://www.aclu.org/wp-content/uploads/2023/08/ICE-detention-numbers-fact-sheet-final-1.pdf

Congressional Research Service. (2019). *Immigration detention: A legal overview* (R45915). https://www.congress.gov/crs-product/R45915

Congressional Research Service. (n.d.). *Immigration detention* (IF11343). https://www.congress.gov/crs-product/IF11343

Just the News. (2026). *Immigration statistics database swapped tracking of detainees' criminal record*. https://justthenews.com/government/courts-law/immigration-statistics-database-swapped-tracking-detainees-criminal-record

Transactional Records Access Clearinghouse. (2026). *Immigration detention quick facts*. Syracuse University. https://tracreports.org/immigration/quickfacts/

Transactional Records Access Clearinghouse. (2026). *Detention statistics by agency*. https://tracreports.org/immigration/detentionstats/pop_agen_table.html

U.S. Customs and Border Protection. (2025, April). *CBP releases March 2025 monthly update*. https://www.cbp.gov/newsroom/national-media-release/cbp-releases-march-2025-monthly-update

U.S. Immigration and Customs Enforcement. (2024). *ICE releases fiscal year 2024 annual report*. https://www.ice.gov/news/releases/ice-releases-fiscal-year-2024-annual-report

BLUEBOOK

U.S. Const. amend. V.

8 U.S.C. § 1225 (2018), https://www.law.cornell.edu/uscode/text/8/1225.

8 U.S.C. § 1226 (2018), https://www.law.cornell.edu/uscode/text/8/1226.

8 U.S.C. § 1231 (2018), https://www.law.cornell.edu/uscode/text/8/1231.

8 U.S.C. § 1325 (2018), https://www.law.cornell.edu/uscode/text/8/1325.

8 U.S.C. § 1326 (2018), https://www.law.cornell.edu/uscode/text/8/1326.

Stipulated Settlement Agreement, *Flores v. Reno*, No. CV 85-4544-RJK (C.D. Cal. Jan. 17, 1997).

EXPERT ADVICE • NURSING INSIGHT, LEGAL LENS, DOCUMENTATION DESK

Expert Advice for Nurses, Families, and Counsel

Practical guidance from an FNP and veteran Texas attorney on recognizing deterioration, documenting the clinical story, keeping critical medications going, and knowing when to escalate.

BY **JOE A. FLORES, JD, MSN, FNP-BC, CCRN-K, LNC** • EXPERT ADVICE AND PROFESSIONAL OPINION



Assessment first. A U.S. Public Health Service officer with the ICE Health Service Corps checks a patient's vital signs at the Houston Contract Detention Facility, July 15, 2021. Photo: U.S. Immigration and Customs Enforcement, public domain.

Nursing insight: recognize deterioration before it becomes a crisis

In custody, a patient may not be able to self-refer, seek a second opinion, buy over-the-counter medication, or call family for advocacy. Nursing surveillance fills that gap. These warning signs call for focused reassessment:

- New or worsening shortness of breath, chest pain, cyanosis, or low oxygen saturation
- Altered mental status, confusion, agitation, lethargy, or loss of consciousness
- Fever with tachycardia, hypotension, severe pain, or signs of systemic infection
- Persistent vomiting, dehydration, inability to keep fluids down, or reduced urine output
- Signs of medication interruption, missed insulin, withdrawal, or an adverse drug reaction
- New neurologic deficits, seizures, severe headache, or sudden weakness
- Suicidal ideation, self-harm, psychosis, severe anxiety, or acute psychiatric decline
- Wounds, injuries, skin breakdown, pressure injuries, or signs of abuse

Custody status must never substitute for clinical reasoning. Symptoms, trends, risk factors, objective findings, and response to treatment should guide the nurse.

Legal lens: when medical neglect becomes a civil-rights concern

Liability may arise when serious medical needs are disregarded in ways that go beyond ordinary disagreement or inadvertent error. The analysis is fact-specific, but recurring concerns include:

- Failure to assess or respond to obvious signs of serious illness
- Unreasonable delay in referral, diagnostics, emergency transport, or specialist care
- Withholding or interrupting necessary medication without clinical justification
- Ignoring repeated complaints, prior diagnoses, abnormal vitals, or worsening symptoms

- Poor communication between custody and healthcare staff
- Incomplete, altered, vague, or late documentation
- Failure to follow policies, protocols, or provider orders

For nurses, the best protection is not defensive charting. It is competent, patient-centered care backed by timely assessment, clear communication, appropriate escalation, objective documentation, and reassessment.

Documentation desk: charting under pressure

> *Does the record show what the patient needed, what the nurse observed, what action was taken, who was notified, and what happened next?*
>
> 1. Presentation and chief concern
> 2. Objective findings and vital-sign trends
> 3. Relevant history, medications, and risks
> 4. Interventions performed
> 5. Provider, supervisor, or EMS notification, with times
> 6. Orders received and actions completed
> 7. Patient response and repeat assessment
> 8. Follow-up plan, transfer, or monitoring

Avoid "patient okay," "medical notified," "will continue to monitor," or "no distress" unless clinical findings support them.

Clinical checklist: before you call a patient stable

- A focused assessment is completed and documented.
- Vital signs are reviewed as trends, not isolated readings.
- Chronic diagnoses and current medications are considered.
- Missed doses, refusals, and interruptions are identified.
- Symptoms are reassessed after intervention.
- The right clinicians are notified of concerning findings.
- Emergency-transfer criteria are considered.
- Mental-health and suicide risks are addressed.
- Disposition and follow-up are clearly documented.

Medication continuity: the high-risk list

Verify these medications at intake and track every missed dose. Each is time-sensitive: insulin, antiseizure drugs, anticoagulants, antiretrovirals, antipsychotics and mood stabilizers, inhalers, MOUD (buprenorphine, methadone, naltrexone), transplant immunosuppressants, cardiac drugs, and antibiotics for active infection.

For families

- Write down diagnoses, medications, doses, allergies, and prescribers, and send the list to the facility's medical unit in writing.
- Keep copies and note dates, times, and names of everyone you speak with.
- Ask whether the facility will verify medications with the pharmacy or prescriber.
- In an emergency, ask staff to call 911 or transfer the patient, and contact counsel the same day.

For attorneys

- Send preservation letters for medical records, video, logs, phone records, and incident reports immediately.
- Obtain sick-call requests, MAR (medication administration record) entries, and transfer logs, not just the chart.
- Use a qualified clinician or LNC to build a minute-by-minute chronology.
- Evaluate constitutional claims and state-law claims, including notice and expert-report requirements under Texas law where applicable.

This section is educational. It is not legal or medical advice for any individual situation, and it does not create an attorney–client relationship. Every case differs, and results are not guaranteed.

REFERENCES

APA

Centers for Disease Control and Prevention. (2026). *About correctional health*. https://www.cdc.gov/correctional-health/about/index.html

National Commission on Correctional Health Care. (2026). *NCCHC releases 2026 jail and prison standards*. https://ncchc.org/ncchc-releases-2026-jail-prison-standards/

Bureau of Justice Statistics. (2021). *Mortality in local jails, 2000–2019*. https://bjs.ojp.gov/library/publications/mortality-local-jails-2000-2019-statistical-tables

BLUEBOOK

Estelle v. Gamble, 429 U.S. 97 (1976).

Farmer v. Brennan, 511 U.S. 825 (1994).

Kingsley v. Hendrickson, 576 U.S. 389 (2015).

42 U.S.C. § 1983 (2018).

Tex. Civ. Prac. & Rem. Code Ann. § 74.351 (West 2023) (expert reports in health-care liability claims).

PROFESSIONAL EDUCATION • ATTORNEY TEACHES LNC

Join Our Team

Turn your nursing experience into a legal-healthcare career.



Clinical skill is legal value. A nurse takes a patient's blood pressure. Photo: Bill Branson, National Cancer Institute, public domain.

Whether you want to be an LNC or become a nurse attorney you do not want to lose our 18 hour CME course or an affordable consultation with the author to discuss how to launch or create your presence in the legal community grow.

Click on www.attorneyteacheslnc.com

Nursing experience is a foundation in assessment, documentation, patient safety, standards of care, and advocacy. Those skills are valuable in litigation support, compliance, risk management, case review, and legal education.

The program offers 18 contact hours of nursing continuing education, described as ANCC- and AANP-accredited. Founding price at publication: $299 (regularly $750); see the website for current pricing.

Attorney Teaches LNC provides professional education and consulting information. Programs and consultations are not legal representation, individualized legal or medical advice, or a guarantee of employment, income, certification, referrals, or case outcomes.

What Legal Nurse Consultants do

- Medical-record review and chronology development
- Case screening and healthcare issue identification
- Personal injury, medical-negligence, correctional-healthcare, disability, and wrongful-death matters
- Compliance, policy, risk-management, and quality projects

Course topics include

- The LNC role versus expert testimony and legal representation
- Record review, organization, and chronologies
- Finding documentation gaps and clinically significant issues
- Building an LNC résumé, biography, and portfolio, and choosing a specialty
- Ethics, confidentiality, and conflict screening
- Responsible marketing and a professional LinkedIn presence
- Pricing, consultation structure, and business planning
- Pathways for nurses who may pursue law school

Schedule an affordable consultation

A consultation with **Joe A. Flores, JD, MSN, FNP-BC, CCRN-K, LNC** can help you assess whether legal nurse consulting fits your background. It can help you choose service areas, develop your biography and LinkedIn presence, approach law firms, start a portfolio, avoid early-career mistakes, and decide whether the nurse-attorney path is right for you.

Ready to build your Legal Nurse Consultant or nurse-attorney presence?
Do not miss the 18-contact-hour course or an affordable professional consultation with Joe A. Flores, JD, MSN, FNP-BC, CCRN-K, LNC.

Visit www.attorneyteacheslnc.com to begin your next professional chapter.

ATTORNEY ADVERTISING

Flores Law Firm

Where law and medicine meet.

When a loved one in custody is not getting the medical care they need, or when a healthcare professional faces a licensing, compliance, or employment problem, you need someone who understands both the medicine and the law.

Joe A. Flores, JD, MSN, FNP-BC, CCRN-K, LNC is a veteran Texas attorney with federal-court experience and a board-certified family nurse practitioner. He is the attorney responsible for this advertisement.

AREAS OF FOCUS

- Correctional and detention healthcare concerns
- Civil-rights review of medical-neglect claims
- Nursing and APRN licensing and board matters
- Healthcare compliance, Medicaid, and home-health law
- Healthcare employment and physician agreements
- Legal nurse consulting and clinical record review
- Nationwide professional consultations

CALL FOR A CONSULTATION

361-887-8670

Fax 361-887-8651

500 N. Shoreline Blvd., Ste. 1002
Corpus Christi, Texas 78401

floreslawfirm.com

> *People in custody remain patients. Clinicians remain professionals. Both deserve an advocate who speaks the language of medicine and the law.*

Attorney Advertising. Responsible attorney: Joe A. Flores, Flores Law Firm, 500 N. Shoreline Blvd., Ste. 1002, Corpus Christi, TX 78401. Joe A. Flores is a Texas and federal law practitioner available to assist on federal issues nationwide and has local associated counsel in each state. Every case is different, and results are not guaranteed. No attorney–client relationship exists until a consultation has occurred and the firm has accepted the representation in writing. Please do not send confidential information before that time. Representation outside Texas is subject to applicable licensing and jurisdictional rules.

CLOSING REFLECTION

The Standard of Care Must Cross Every Wall

A correctional facility may have locked doors, security protocols, limited resources, and complex operational demands. None of those realities erase the obligation to provide humane, clinically appropriate care. The same is true of a federal prison holding a man with cirrhosis serving ten years for a courier's role, and of a family detention center holding a child for a hundred days.

Nurses working in these settings deserve systems that support sound judgment, timely escalation, safe staffing, adequate training, ethical leadership, and clear accountability. Patients in custody deserve to be seen as patients first: people with symptoms, needs, histories, fears, and rights.

The walls of a facility should never become walls around conscience.

— Joe A. Flores, JD, MSN, FNP-BC, CCRN-K, LNC



Patients first. ICE Health Service Corps Lt. Matthew Madrid speaks with detained individuals in Artesia, New Mexico, June 30, 2014. Photo: U.S. Immigration and Customs Enforcement, public domain.

FLORES LAW FIRM

Federal & Texas Trial Attorneys



"When the Game is Chess...Not Checkers."

- **Serious Accidents**
- **Criminal Defense**
- **Federal Defense**
- **Health Law**

Joe A. Flores, JD, APRN, FNP-BC, CCRN-K

Federal and Texas Trial Lawyer
Practicing Family Nurse Practitioner
Expert Nurse and Consultant for Over Three Decades

SCAN OR VISIT

FLORESLAWFIRM.COM

Corpus Christi, Texas
Federal • State • Health Law

ATTORNEY ADVERTISING. Responsible attorney: Joe A. Flores, Flores Law Firm, 500 N. Shoreline Blvd., Ste. 1002, Corpus Christi, TX 78401, 361-887-8670. Joe A. Flores is a Texas and federal law practitioner available to assist on federal issues nationwide and has local associated counsel in each state. Every case is different, and results are not guaranteed. No attorney–client relationship exists until a consultation has occurred and the firm has accepted the representation in writing. Content is educational and is not legal or medical advice.

ADVERTISEMENT



Vasquez Flores Home Health

Compassionate care, in the comfort of home.

- Caring support for elderly, disabled, and veteran clients
- Personal-care and caretaker assistance at home
- Help with daily living, so loved ones can stay where they belong
- Led by a registered nurse with three decades of home-care experience
- Medicaid and private pay accepted

CALL TODAY

361-881-9922

pvf27@me.com

Serving families in Corpus Christi and South Texas

Services are subject to eligibility, assessment, and payer authorization. Photograph is for illustration only and depicts models. Advertisement. Vasquez Flores Home Health is a separate organization from Flores Law Firm.