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THE JAIL HEALTH-CARE CRISIS

The opioid epidemic and other public-health emergencies are being aggravated by failings in the criminal-justice system.

By Steve Coll February 25, 2019

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As a child growing up in Pueblo, Colorado, Jeremy Laintz travelled widely with his father, an aeronautics engineer at Lockheed Martin, who sometimes took his four kids along on business trips. Family vacations included tours of aerospace facilities and, on one occasion, a trip to watch a space-shuttle launch at Cape Canaveral. Laintz's mother managed a bakery, and Laintz, the youngest child in the family, recalled enjoying a warm home life. He played soccer and football, and spent summers hunting and fishing on a ranch that his family owned in North Dakota. As a teen-ager, though, he slipped into trouble—he was arrested first for driving under the influence, and then, in his late teens, for felony car theft. He spent a year in prison, where he learned to weld, and a few more years in halfway houses. Then, in 2003, he moved to Alaska, where he joined a Christian fellowship and took seasonal jobs welding, repairing roofs, and working in a fish-processing plant. He often made good money, and his life seemed back on track.

Six years later, though, when he was thirty, he returned to Colorado and, while working in a warehouse, tore a tendon in his wrist. A doctor prescribed opioids for the pain, and Laintz immediately started abusing them. Then a friend persuaded him to try heroin, and soon he was addicted. He was arrested on a charge of possession and, while out on bond, in early October of 2016, failed to show up for a court-ordered drug test. He was arrested again and booked into the Pueblo County jail.

As part of the standard booking procedure, medical personnel at the jail evaluated him. Pueblo County had a contract with Correctional Health Partners, a doctor-owned, for-profit company based in Denver, to provide health services; there was a medical facility on site, supplied with basic equipment. Laintz told company nurses on duty that he used heroin and suffered from hepatitis C, an affliction common among intravenous drug users. Correctional Health staff prescribed loperamide (for diarrhea) and meclizine (for nausea and vomiting) to ease his withdrawal while he awaited sentencing, a lawyer representing Laintz said.

A week later, though, according to filings in a recent lawsuit, Laintz submitted a written request for medical help, noting that he was experiencing a level of pain "so bad I don't know what is going on," and that he could "hardly breathe" and "hardly move." A Correctional Health E.M.T. gave him over-the-counter medication for "possible chest pain or anxiety/panic attack." On October 15th, a Saturday, when his mother visited, Laintz complained to her, too, of severe pain. The following Thursday, he was sentenced to ninety days in jail. When his mother returned, a week later, he told her that he was still in "rough shape," so she called the Correctional Health unit. His father also went to speak to the county sheriff, who oversaw the jail.

A physician's assistant examined Laintz again, and found that he had low blood pressure and an elevated pulse. According to court documents, she told him to try "relaxation and breath control." After he told deputies that he was

too weak to walk to the dining hall, they allowed other inmates to bring him food in his cell. On November 1st, an administrator at Correctional Health left a voice-mail message for Laintz's mother reporting that, according to the medical staff, "everything is pretty much normal." He suggested that Laintz had been deliberately hyperventilating to produce his symptoms, in an attempt to be sent to the hospital. "There is no medical reason for him to go," the administrator said, and asked her to tell her son "to quit hyperventilating and to coöperate with us."

That evening, however, a sheriff's deputy noticed that Laintz looked pale and was having difficulty breathing. The deputy declared an emergency, but, rather than send him to a hospital, a Correctional Health physician's assistant ordered treatment with intravenous fluids in the jail's medical facility. When Laintz insisted on being taken to the hospital, a sergeant at the jail overruled the assistant and sent Laintz in a police car to the St. Mary-Corwin Medical Center. There, according to his lawyer, doctors diagnosed dehydration, sepsis, pneumonia, and acute renal and respiratory failure. They put him in a medically induced coma and intubated him, then had him airlifted to a hospital near Denver, where he spent a month undergoing multiple procedures, including the partial removal of a lung. He also lost part of six toes to gangrene.

Laintz is suing the county and Correctional Health Partners for "deliberately indifferent policies." The county declined to comment on pending litigation. In a court filing on February 12th, Correctional Health disputed Laintz's account, saying that "at no time" did its personnel fail to "address and treat his medical needs." Madison Barr, a spokeswoman for the company, had previously told me that she also could not comment on the lawsuit, but she pointed out that increasing numbers of people are entering jails with medical problems related to chronic conditions, such as addiction, and that, at the time of their booking, "these conditions don't necessarily show symptoms."

There are more than three thousand jails in the United States, usually run by sheriffs and county offices, which house some seven hundred thousand people. They are typically waiting to make bail—or, if they can't, to go to trial or enter a plea—or are serving short sentences. Barr is right about the crisis of chronic health conditions among them. According to a study released in 2017 by the Bureau of Justice Statistics, nearly half the people held in jails suffer from some kind of mental illness, and more than a quarter have a severe condition, such as bipolar disorder. The same year, the bureau reported that about two-thirds of sentenced jail inmates suffer from drug addiction or dependency; that number was based on data from 2007-09, so it does not take into account the recent catastrophic rise of opioid addiction. That epidemic and other public-health emergencies, in jails across the country, are being aggravated by failings in the criminal-justice system.

Jails have a much higher turnover rate than prisons, where inmates generally serve long sentences. Prison wardens face their own problems, serving

populations that suffer from chronic diseases and conditions related to aging, in addition to high rates of addiction and mental illness. Yet the crisis is particularly acute in jails, because large numbers of people booked into custody are in a state of distress or, like Laintz, will suffer withdrawal, which can require close monitoring and specialized treatment that jail wardens are not equipped to provide. Many jails are in rural or poor counties, where administrators complain that they have neither the resources nor the expertise to hire, train, and supervise doctors and nurses in the particular demands that their facilities require. Increasingly, they have turned to for-profit companies operating in the field known as "correctional health care," which pledge to deliver quality care while containing costs.

The growth of for-profit firms providing medical services to the incarcerated is part of a trend that started in the nineteen-eighties, during the Reagan Administration, toward privatization in the general management of correctional facilities. The trend accelerated after the passage of tough sentencing laws in the nineties—notably the Violent Crime Control and Law Enforcement Act of 1994—which caused the number of people held in jails and prisons to jump from about three hundred thousand, in 1980, to more than two million today. More than a third of that population is African-American. According to a 2018 study from the Pew Charitable Trusts, more than half the states hire private companies to provide at least some of their prison health care. There are no comprehensive statistics about the prevalence of private health-care companies in jails. But, according to the National Commission on Correctional Health Care, which accredits programs in correctional facilities around the country, about seventy per cent of the jails that it inspects outsource their medical services, and for-profit companies have a sizable share of those contracts.

People held in correctional facilities are entitled to a judicially mandated standard of care, but no large-scale studies have been conducted to compare

the quality of treatment provided by private companies with that provided by government-run services. The evidence available from lawsuits filed against the companies is troubling, however. With the help of Gabrialle Landsverk and Alejandra Ibarra Chaoul, postgraduate researchers at Columbia University's Graduate School of Journalism, I reviewed complaints, depositions, and affidavits in lawsuits filed against jail operators and correctional-health-care companies.

We focussed on two of the largest nationwide providers, Corizon Health, which is based in Brentwood, Tennessee, and Wellpath, which is headquartered in Nashville. The two companies have been sued about fifteen hundred times during the past five years—according to the federal and state court records that we collected—over matters including alleged neglect, malpractice, and, in dozens of cases, wrongful injury or death. (Corizon was the defendant in more than a thousand of the cases.) Most of the suits were filed pro se, or without the help of a lawyer; petitioners had legal counsel in only about a quarter of them. More than a hundred ended in settlements, but, owing to confidentiality agreements, it is often not clear whether the company or the local government made a payment, or, if so, for how much.

Corizon reports that it is responsible for the care of about a hundred and eighty thousand people on a day-to-day basis. Wellpath, which until last November was known as Correct Care Solutions (the company changed its name after merging with a competitor), says that it is responsible for about two hundred and fifty thousand people on any given day. Executives from both companies told me that the lawsuits shouldn't be seen as indicative of over-all problems with how they treat patients. Many cases involve flimsy or inconclusive evidence and don't result in findings of liability. Donna Strugar-Fritsch, a prison-health-care consultant based in San Francisco, who advises state and local governments on providing medical services to prisoners, said that, for the companies, managing suits alleging poor treatment is "just a cost

of doing business in this industry."

Patrick Cummiskey, Wellpath's chief strategy officer, told me that the company is concerned, above all, with maintaining good health among inmates, and that it believes that providing quality care will reduce its financial risks in the long run. He also pointed out that Wellpath routinely indemnifies state and local governments from all legal costs in cases involving alleged medical mistakes. "We bear the risk of malpractice," he said, so "we're incentivized to provide quality care."

In some states, though, public-interest lawyers have brought class-action suits alleging inadequate health care against the entire system. In Arizona, civil-rights groups filed a class-action suit in 2012. A year later, after the state passed legislation privatizing prison health care, it signed a contract with Corizon to provide medical services in its prisons. In 2015, a federal district court, seeking to resolve the suit, approved a settlement in which the state pledged to overhaul care. But, last June, Judge David Duncan found that "widespread and systemic failures remain," and held the state in contempt, issuing it fines of more than a million dollars. Martha Harbin, who has served as Corizon's director of external relations, said in an e-mail that the company does "not agree with the judge's description" of its performance in Arizona. Last month, the state, which has also disputed the judge's finding, announced that, as of July, it is awarding the contract to another company.

In December, in a case in which a federal judge is supervising a settlement designed to improve medical services at Baltimore's city jail, the State of Maryland, which oversees the facility, said in court documents that Wexford Health Sources, the company it hired to provide the services, had failed to respond to directions to improve its performance. It had allegedly provided "unreliable" reports, and operated while "critically short of care providers and clerical staff," leaving "key clinical and leadership positions vacant for lengthy periods." Wexford lost the contract, though it is not a party to the litigation,

and a spokesperson for the company said that it and the state "had a difference in opinion" about how to best provide health care to inmates.

Taken as a whole, evidence from cases across the country suggests that four decades of policy failures in both health-care and criminal-justice reform have left a largely neglected population vulnerable and, at times, at risk, and that for-profit companies, which were promoted as a solution, have instead become an integral part of a troubled system.

The standard of care that incarcerated people have a right to receive was established in the landmark case of Estelle v. Gamble, in 1976. J. W. Gamble was an inmate in the Huntsville Unit of the Texas prison system. On November 9, 1973, a six-hundred-pound bale of cotton fell on him while he was on work assignment in a textile mill. He complained repeatedly of severe back pain, and prison doctors gave him pain relievers, but they did not take any X-rays. After refusing to work, he was moved to solitary confinement. He filed a pro-se lawsuit, in the form of a twenty-four-page handwritten complaint, objecting to the quality of medical care he had received.

A federal judge dismissed the suit, but Gamble appealed to the Fifth Circuit Court of Appeals, which appointed Daniel K. Hedges, a corporate litigator in Houston, to represent him. Hedges never met his client, but he argued that Gamble's treatment was unconstitutional, because of the Eighth Amendment's prohibition of cruel and unusual punishment. The case made its way to the Supreme Court, where Hedges again argued it. Justice Thurgood Marshall, writing for an eight-to-one majority, found that "deliberate indifference to serious medical needs of prisoners" was indeed inconsistent with Eighth Amendment guarantees, and ordered that Gamble's care be reëvaluated.

Gamble himself did not benefit from the ruling: after his case was returned to the Fifth Circuit, the appellate court found that his care had not been

sufficiently poor to justify compensation. (A few years later, he was killed by a fellow-prisoner.) Still, practitioners of prison medicine today like to point out that, thanks to Gamble's suit and Marshall's opinion, the incarcerated are the only people in America with a constitutional right to health care.

The Estelle decision was handed down just as the American Medical Association was leading a drive to reform health care for the incarcerated. It conducted a survey of conditions in hundreds of jails, in which operators reported dilapidated and ill-equipped facilities. Many lacked emergency medical equipment. Some didn't even have first-aid kits. The standard of care set by Estelle was modest, calling only for an absence of "deliberate indifference." But, building on the decision, the A.M.A. sought to establish uniform standards, which, in turn, led to the creation, in 1983, of the National Commission on Correctional Health Care.

Estelle also spawned a wave of civil-rights litigation seeking to enforce the Eighth Amendment protection; this gradually led to improvements in the judiciary's definition of a required standard. Today, prisoners are typically entitled to what a judge for the First Circuit Court of Appeals defined, in 1987, as "adequate" care at a level "reasonably commensurate with modern medical science." (The irony remains that inmates' rights to health care have expanded, while citizens on the outside still have no universal right to care.)

Litigation, though, is not always the best way to improve public policy. David Cloud, who works on prison-health-care issues for the Vera Institute, a nonprofit research group that focusses on criminal justice, told me, "I definitely don't want to discount the importance of litigation, because it's so critical." Still, he added, correctional health care is more than an arena that requires legal accountability when failures occur. Its troubles affect many people beyond those who are incarcerated. Jails may hire private companies in the interest of saving taxpayer dollars. But, if people suffering from addiction or chronic illness are released back into communities without having received

adequate treatment, "they're still going to draw on taxpayers—just somewhere else."

Companies that contract to provide health care to the incarcerated are tapping into an enormous business opportunity—annual spending now exceeds ten billion dollars—and they are obligated to their owners to seek profit. David Fathi, the director of the National Prison Project, at the American Civil Liberties Union, told me that companies therefore have compelling incentives to cut costs and staff, which can result in "denying care in what is literally a captive market." He added, "I don't mean to suggest that government-run prison health care is perfect. It's often appallingly deficient. But, at least when a government is providing the service, there is some measure of oversight. There is some measure of democratic control." Apart from the court-enforced standards that have evolved since Estelle, "you don't have that with the private companies."

Day to day, correctional-care companies treat people on site for complaints like headaches and minor injuries. Nurses wheel carts through cellblocks to dispense over-the-counter and prescription medications; people who are sick can either call out for help or submit written requests. Nurses, nurse practitioners, physician's assistants, and administrators typically staff jail infirmaries around the clock. In larger, urban jails, doctors, psychiatrists, and social workers may also work on site. In rural counties, they appear perhaps once or twice a week for consultations. When no doctor is present, one is usually on call to consult by telephone in emergencies. In situations requiring surgery or other complex procedures, correctional-care companies are supposed to send patients to a hospital.

The companies negotiate multiyear contracts with each jail and prison that they serve. Medical staff, prescription drugs, and outside services such as hospital stays constitute the major costs. Often, the companies receive a per-diem, per-individual rate, so profits depend on holding costs below that

amount. Sometimes contracts include provisions that increase a company's potential profit if it holds down transfers to hospitals or to other outside providers. Medicare and private health-insurance companies follow similar incentives to contain costs, prioritize preventive care, and avoid unnecessary tests and procedures. But a distinct feature of correctional health care is that, if incarcerated people believe that their health—or their life—is in jeopardy, they can't just drive themselves to an emergency room. As Fathi put it, "Market forces don't operate in the prison context for the reason that prisoners have absolutely no consumer choice."

The potential effects that contract incentives might have on health care have featured in a number of lawsuits in recent years. One case involved a forty-four-year-old man named Kenneth McGill, who was booked into the jail in Jefferson County, Colorado, after violating probation for a D.U.I. conviction. He had been there two months when, in September of 2012, he began to experience facial drooping and dizziness—symptoms, he thought, of a stroke. He and other inmates reported his symptoms to the deputies on duty and to a nurse with Correctional Healthcare Companies, which had a contract to provide medical services at the jail. (The company has no connection to Correctional Health Partners; in 2014, it was acquired by Correct Care Solutions, the company that became Wellpath.) According to court documents, company staff waited more than twelve hours before sending McGill to a hospital. Doctors there determined that he had had a stroke—he says that he still suffers from vertigo and from a loss of mobility in his right arm—and he sued the company.

Anna Holland Edwards, one of McGill's attorneys, told me that, at the trial, she and her colleagues pointed to a provision in Correctional Healthcare's contract which stipulated that the company had to pay the first fifty thousand dollars in costs when an inmate went to the hospital. "There's nothing wrong with being a for-profit company," she said in her closing argument. "But the

intersection of profit and health care has its problems." She continued, "The company gets to decide whether the care is provided and know that they're the ones that have to pay for it when it is." (A spokesperson for the county later disputed that its contract with Correctional Healthcare discouraged hospitalization.) The jury awarded McGill eleven million dollars, including more than seven million in punitive damages against Correctional Healthcare. The parties then settled for an undisclosed amount.

David Perry, Wellpath's chief legal officer, said that Correctional Healthcare's "way of doing things was different in some respects from ours." But he also argued that provisions requiring companies to pay for off-site costs, though common, don't encourage cost-cutting, because, if a company fails to provide quality services, "eventually your clients will hold you accountable for it."

Martha Harbin, of Corizon Health, told me that maximizing on-site care "respects the taxpayer dollars used to pay for correctional health care," and reduces the risk of people escaping from hospitals. (Escapes from hospitals are, in fact, a recurring problem.) But, she said, "we don't hesitate to send people off site if the evidence points to that need. If they have to go, they have to go."

Many of the nurses and doctors I spoke with who work in jails described their careers as a moral calling. They serve people on the margins of society: it is not unusual for them to encounter patients who haven't visited a doctor in years. Ned Higgins, a psychiatrist in South Carolina who has worked on contract for Wellpath, told me that he finds working in county jails inspirational. "We're helping the seriously mentally ill," he said. "The vast majority of inmates, patients, that I see were off their medicine when they got arrested. I see our mission as to get them back on their medicine and get them off street drugs. I think we do that very well." Specialists in the field agree. "People really are trying to provide high-quality health care, and jail environments are really tough," Brent Gibson, a physician who is the chief

health officer of the National Commission on Correctional Health Care, said. "Nobody wants a bad health-care outcome."

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Still, a significant amount of the serious neglect documented in lawsuits arises from the fact that jails have become a primary provider of medical care for the severely mentally ill. Rhonda Levand was confronted with the sometimes harsh consequences of that reality in the case of her daughter, Raynbow Gignilliat. In 1992, when Gignilliat was seventeen and in her junior year of high school, in Marietta, Georgia, she was given a diagnosis of bipolar disorder. Eventually, she graduated from college, got married, had three sons, and worked as a paralegal, a substitute teacher, and a freelance writer. She didn't always take her medications, Levand told me, and "every year she would go through a little cycle where she was a little bit manic." But then she would right herself.

In 2013, Gignilliat and her husband divorced, which seemed to trigger a new crisis for her and led to a number of short hospital stays. Levand by then was living near Albuquerque, New Mexico, where she now works as a

paraprofessional special-education teacher and a receptionist. That October, she invited her daughter to stay with her. Gignilliat had never been violent with her before, Levand said, but on October 27th she started "pushing and shoving" her, and upending furniture and breaking things in the house. Levand called the police, and Gignilliat was arrested for aggravated battery and property damage, and was taken to the Sandoval County Detention Center.

The health services at the jail were provided by Correctional Healthcare, the company that was later acquired by Wellpath. Medical staff noted that Gignilliat had mental-health needs, but she refused to take medication. "If they don't consent to take the medicine, they don't force them," Levand told me. In fact, neither the company nor the jail had legal authority to do so; in New Mexico, such action requires state-court approval. Medical or jail staff could have petitioned a judge to name a "treatment guardian" for Gignilliat, but did not. Levand could have petitioned, too, but says she didn't know that this was an option.

After a social worker referred Gignilliat to a physician's assistant for psychiatric evaluation, corrections officers placed her in a segregated cell, according to a legal complaint. She was allowed to leave it only to take a shower or to consult with a social worker or with medical staff; some days, she refused a shower and did not leave her cell at all. By mid-December, she had become deeply delusional, and the warden finally transferred her to the emergency room at the University of New Mexico Hospital. A doctor there diagnosed bipolar disorder and psychosis, treated her with anti-anxiety medication, and persuaded her to eat—according to Levand, she had lost about twenty pounds. She was then sent back to jail, where she again went unmedicated.

Two weeks later, Gignilliat was transferred to the New Mexico Behavioral Health Institute. Staff there obtained a court-appointed treatment

guardianship, and, in late January of 2014, she was administered medication, and her condition stabilized. At the end of March, the district attorney dropped the criminal charges against her, and she went back to Georgia. Photographs taken there show her smiling as she embraces her children. Yet, on June 12th, she swallowed a fatal dose of pills; she died two days later, at the age of thirty-nine.

The next month, Levand filed suit on behalf of Gignilliat's children. Sandoval County and Wellpath, which inherited the liabilities in the case from Correctional Healthcare, said that, since Gignilliat's suicide took place more than two months after she was released, they bore no responsibility. However, court papers filed by Levand describe starkly the daily suffering that her daughter endured while in segregation. Ultimately, the county and the company agreed to a confidential financial settlement. David Perry said that Wellpath rarely pursues jury trials, because "it is very expensive to litigate cases, notwithstanding how justified you believe your position to be."

The situation that Gignilliat encountered is not uncommon: few local jails have dedicated mental-health facilities, and operators often resort to managing people by placing them in segregation. Yet even in jails that do provide dedicated care the quality can be poor. In the summer of 2013, Bradley Ballard was detained in New York City's jail on Rikers Island for a parole violation. He was thirty-nine years old and suffered from diabetes, but he had previously received a diagnosis of schizophrenia, and was assigned to the mental-health unit. Under a contract signed with the city in 2001, Corizon Health shared responsibility for medical services at Rikers and oversaw the mental-health facility.

In September, according to a legal complaint, Ballard was moved to solitary confinement, after dancing provocatively in front of a female corrections officer. For six days, medical personnel and jail guards looked in on him, but did not offer him any assistance. He was then discovered lying naked and

covered in his own waste. He had mutilated his genitals, and died hours after being found, from sepsis and diabetic ketoacidosis.

In 2014, civil-rights lawyers filed a lawsuit on behalf of Ballard's mother and his estate. The New York State Commission of Correction, in reviewing the case, said that the performance of the company and of the city's Department of Corrections was so "incompetent and inadequate as to shock the conscience." The city paid nearly six million dollars, reportedly the largest settlement involving the death of an inmate in the city's custody. (Corizon did not contribute any of the funds, because, according to Martha Harbin, the contract stipulated that the city would bear financial responsibility for all malpractice claims.) Corizon's contract expired at the end of 2015, and it was not renewed. A group of New York-based nonprofit health-care providers has since taken over the provision of medical services at Rikers. The Department of Corrections Commissioner, Cynthia Brann, said in a statement that, with the new arrangement, the city has "taken major steps to overhaul the delivery of healthcare in our jails."

Both jail operators and private health-care companies recognize that it would be better to treat mentally ill people, especially those who are nonviolent, in specialized hospitals or in dedicated units in jails. But building those facilities and hiring counsellors and psychiatrists to staff them requires government funding that many operators don't have. There are "never enough beds" to accommodate such cases, Patrick Cummiskey, of Wellpath, told me. Jails are "absolutely the wrong place" to treat mental illness, he said, yet they "have become the largest mental-health provider in most communities." David Perry said that Wellpath no longer bids on contracts in counties where there is a "disproportionate number of mental-health cases" and inadequate local resources to handle them. "We don't get involved," he said. "You're just setting yourself up for this problem." Poor care for mentally ill prisoners, he added, reflects taxpayers' unwillingness to fund dedicated facilities and programs, not

"our company's quality."

Opioid addiction, too, is an area in which jail health care is increasingly relied on by default. Last year, according to a preliminary estimate from the Centers for Disease Control and Prevention, more than seventy-two thousand people died from overdoses—almost two hundred people a day. The C.D.C. has also reported that overdoses now constitute the leading cause of death among Americans under the age of fifty. And many people suffering from addiction pass through jails on charges related to their habit.

Madaline Pitkin was one of them. She grew up in Portland, Oregon, and attended Catholic school, where she was a good student. She was "very spirited," her father, Russell Pitkin, told me. "She was always into competition and sports and was always trying to improve herself." She enrolled at the University of Oregon, but wasn't happy there, so she switched, for a time, to Portland Community College. According to the *Oregonian*, which ran a series of articles on her case, she sometimes paid her bills by working as a barista or, at Christmas, as one of Santa's elves.

At some point in her twenties, she drifted into heroin addiction, and, in April of 2014, she was arrested on a warrant for an earlier arrest and for possession. During her booking at the Washington County jail, which, until May of 2015, had a contract with Corizon Health, she told a nurse that she used a gram of heroin a day. A week later, at the age of twenty-six, she died of dehydration, after vomiting and suffering diarrhea as she went through withdrawal. Company personnel allegedly failed to provide an I.V. to keep her hydrated, and did not respond adequately to her four handwritten pleas for help. In her final request, on April 23rd, she wrote, "I haven't been able to keep food, liquids, meds down in six days. I feel like I am very close to death. . . . Please help me."

Last December, a federal judge approved a ten-million-dollar judgment

against Corizon and Washington County for Pitkin's family, the largest known amount that the company has been ordered to pay. (Corizon had fully indemnified the county.) Steve Rector, who became Corizon's C.E.O. last year, said in a statement, "The lessons we've learned from this case have been catalysts for significant changes we have made and are still making to our clinical program." The Washington County Sheriff's Office said that Pitkin's death was a "tragedy," and that it has reformed health care at the jail, with a new private company.

Nancy Fishman, a criminal-justice policy expert at the Vera Institute, told me that "every sort of convocation of sheriffs or jail administrators or law enforcement" these days is consumed by the opioid crisis and its impact on jail health care. She added, "There's just a sort of general sense that we're being overwhelmed, and we don't know what to do." Brent Gibson, of the National Commission on Correctional Health Care, said that "not everyone accepts that substance abuse is a chronic disease." Some jails treat addiction as a "moral problem," and treat opioid withdrawal only with drugs that alleviate its symptoms.

In other jurisdictions, sheriffs and administrators do follow the recommendations of public-health advocates who argue that the best way to defeat addiction is to guide people toward long-term treatment, with access to methadone or to similar drugs that can allow them to either safely maintain their opioid use or gradually reduce and cease it. The National Commission recommends that prisons and jails adopt a comprehensive treatment plan that includes medications to ease withdrawal and others, such as buprenorphine, that safely satisfy cravings for drugs.

The commission also advises psychological counselling and in-detention meetings with recovery groups, such as Narcotics Anonymous. But the resources to support such public-health approaches are small in comparison with the vast sums spent on jails and prisons themselves. David Cloud, of the

Vera Institute, said that many rural and poor counties "don't even have medications or treatment providers in the community" to address opioid addiction, let alone in their jails.

On August 18, 2016, Sally Yates, then the Deputy Attorney General in the Obama Administration, released a memorandum directing the Federal Bureau of Prisons to begin "the process of reducing—and ultimately ending—our use of privately operated prisons." The memorandum did not address for-profit correctional-health-care companies directly, but it was the boldest turn away from the country's partially privatized incarceration system in decades. The Presidential election was less than three months away, and Hillary Clinton, who was then leading Donald Trump comfortably in most polls, tweeted her support, suggesting that the order would stand if she won the White House. The share prices of the country's two largest private-prison builders and operators, GEO Group and Corrections Corporation of America (since renamed CoreCivic), fell by nearly forty per cent in a single day. After Trump was inaugurated, one of the first acts of his Attorney General, Jeff Sessions, was to rescind the Yates order. (After the election, according to the Washington *Post*, GEO hired two people who had worked in Sessions's Senate office to lobby for the company's interests.)

Opponents of privatized detention have argued, on philosophical and constitutional grounds, that certain governmental powers—such as those to wage war, to use lethal force in the name of the law, and to hold people in detention—should not be hired out to profit-seekers. Yates's decision was made on a more pragmatic basis: drawing on the findings of a study produced earlier that August by the Justice Department's Inspector General, she asserted that the government is better at running prisons than corporations are. Private companies, she wrote, "simply do not provide the same level of correctional services, programs and resources; they do not save substantially on costs," and "they do not maintain the same level of safety and security."

The concurrent rise of for-profit health care in jails and prisons has not been accompanied by the kind of public debate, congressional scrutiny, or scholarly research that has informed other fields of health policy. Yet there are notable public and nonprofit alternatives. In some European Union countries, where universal access to health care is fully established, prison and jail health care is often administered by state health services. In the Netherlands, for example, a specialized public service treats prisoners on the basis of an "equivalence principle," meaning that the care provided should be the same as if they were free citizens.

In this country, some physicians and health-care specialists advocate for greater investment in community treatment centers—residential and nonresidential facilities that seek to treat and stabilize individuals suffering from addiction or mental illness through medication, peer counselling, and social services, and where nonviolent offenders suffering from these conditions might be directed, as an alternative to jail. Other practitioners argue that prison health services in the United States work best when they are provided by nonprofits that also deliver medical services for the general population (as is now the case in New York City). Since the late nineteen-eighties, four states—Texas, Georgia, New Jersey, and Connecticut—have contracted prison medical services to their state university systems, whose facilities also serve the public.

Newton Kendig, a physician specializing in infectious diseases and a clinical professor of medicine at George Washington University, in Washington, D.C., has spent most of his career overseeing health care in prisons. He told me that contracting with public universities has advantages—for example, specialists on a medical-school faculty can consult on prisoners' cases. The University of Texas has pioneered the use of telemedicine, or videoconferencing, to treat the incarcerated. But the university model hasn't always succeeded. Last July, after a woman gave birth in her cell at the York

Correctional Institution, in Niantic, Connecticut, where health care was overseen by the University of Connecticut, and where there had been other complaints about care, officials transferred responsibility for prisoner health care statewide back to the state corrections agency.

I met Kendig last summer in his office at George Washington's medical school, where he is currently leading an initiative to draw on academic medical expertise to improve health care for inmates. Now in his early sixties, he told me that he had chosen to practice in correctional health because he "wanted to care for at-risk populations." He served as the director of medicine for Maryland's correctional facilities, and then, in 1996, he joined the United States Public Health Service Commissioned Corps, which is overseen by the Surgeon General. After twenty years of service, he retired as a rear admiral and an Assistant Surgeon General.

The Commissioned Corps is another public model that might be adapted to provide an alternative to privatization. It is a uniformed medical civil service of more than six thousand physicians, public-health specialists, and other professionals. Among other duties, members design and manage medical and mental-health programs for federal prisoners. They also work for the C.D.C., to monitor and respond to epidemics, and provide medical expertise during emergencies, such as hurricanes.

Kendig told me that the corps's public-service mission, the opportunity it provides to work for diverse federal agencies, and its generous government pensions have helped it to recruit and retain talented personnel devoted to prison health care, which is, as he put it, a "highly structured and paramilitary environment" that requires a "special person" to embrace it for a career. "The advantage of the public model is that public service gives you stability," he continued. "The turnover in the private sector is very high." However, the Trump Administration and Republicans in Congress have proved hostile to expansions of publicly funded medical services. Last year, the Administration,

as part of its drive to reduce nonmilitary federal spending, proposed cutting the corps's budget by forty per cent.

There are, nevertheless, signs that the country is moving toward a new consensus on criminal-justice reform. That includes support within the Republican Party for public policies that may improve medical services for the incarcerated. A major advancement in the field was reached in May of last year, when the Texas state legislature passed the Sandra Bland Act.

On July 10, 2015, Bland, a twenty-eight-year-old African-American woman, was stopped in her car by a police officer in Waller County, northwest of Houston, for failing to signal a lane change. In an encounter captured by the officer's dashboard camera, Bland argued with him, and he escalated the confrontation, finally pulling out a Taser and shouting, "I will light you up!" He arrested her and booked her into the county jail. During her processing, Bland said that she had attempted suicide earlier that year, following a miscarriage. Three days later, she hanged herself in her cell.

A grand jury indicted the officer on a perjury charge, but prosecutors dropped it in exchange for his agreement to never again work as a policeman. Bland's family reached a settlement with the county, which reportedly paid close to two million dollars. The law enacted in her name requires authorities to make a "good-faith effort" to divert anyone who is arrested and is suffering from acute mental illness or addiction away from jail and into treatment, particularly if the illness or addiction is related to the reason that the person was arrested. The "good-faith" standard for sheriffs and jail operators is a soft one, but lawmakers have created incentives for judges to grant bail to the afflicted, and have provided ninety-two million dollars in new funding for mental-health services and monitoring of people judged to be suicide risks.

The Bland Act was introduced by Democrats, but, after some police-reform measures were removed, it passed unanimously in the Republican-led

legislature, and was signed by Governor Greg Abbott, a conservative Republican. That bipartisan support reinforced what I heard from sheriffs and jail-health specialists elsewhere: that the effort to address the unnecessary suffering and loss of life caused by inadequate mental-health and addiction treatment must transcend the current polarization of national politics. Health care isn't the only sector of criminal-justice reform in which cross-party coalitions have formed. In December, President Trump signed the First Step Act, which passed in the Senate in a vote of eighty-seven to twelve, and which the House of Representatives approved in a vote of three hundred and sixty to fifty-nine. Among other things, the law is intended to reduce the nation's incarceration rates by lowering mandatory sentences for nonviolent drug offenders.

Kenneth L. Favier, a theologian and a public-health specialist, argues in his 2017 book, "Humane Health Care for Prisoners," that a "radical revision" of the criminal-justice and mental-health systems is needed, to transfer "large numbers" of people suffering from mental illness "into community treatment settings as well as prevent such persons from being arrested and incarcerated in the first place."

Historically, sweeping changes in civil rights have occurred only after a moral awakening among at least a vocal minority of the public. So far, the articulation of a better ethic of prison medicine is mostly consigned to a small body of specialized literature, including Favier's book. His core principle succinctly echoes European policies and standards, as well as the standards advocated in civil-rights lawsuits since Estelle v. Gamble. He writes that, except for "understandable and acceptable" constraints required for the administration of safe custody, "it should not matter that one is a prisoner."

The powerlessness of prisoners makes that a difficult standard to attain, as Jeremy Laintz discovered in Pueblo County. After his hospitalization and surgeries, he entered an in-patient rehabilitation facility in Denver, to

learn how to walk again and to strengthen his damaged lung. When he got out, in April of 2017, six months had passed since he was first sentenced to serve three months in jail. He moved in with his parents, started taking buprenorphine, and volunteered for a time at a local needle exchange. Laintz is now forty, and, when I spoke to him on the phone recently, he told me that he is unable to walk for ten minutes without needing to sit down. He is not working.

He had done time before, and he understood that, when he went to jail, he would lose many of the rights that are taken for granted by people on the outside. Yet he had always trusted that, if he ever found himself in need of urgent help, he would be taken seriously. On this occasion, he said, "they treated me the whole time like I was lying to them." But he also felt fortunate: his parents believed him when he said that he was in pain, and they pushed to get him help. Other people have no such advocates. "I know there are people dying," Laintz said. "I was almost one of them." ♦

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Steve Coll, a staff writer, is the dean of the Graduate School of Journalism at Columbia University. His latest book is "Directorate S: The C.I.A. and America's Secret Wars in Afghanistan and Pakistan." *Read more »*

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