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Why Prison Dental Care Matters: Legal, Policy, and Practical Concerns

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Abstract

Even when controlling for demographic characteristics, prisoners are far more likely than people in the general population to suffer from periodontal disease, to have unresolved oral health issues, to have decayed teeth, and/or to be missing teeth. Correlates of poor oral health, such as poor nutrition and smoking, are more prevalent among people of lower socioeconomic status, and this same population is at a higher risk than others for offending and incarceration. For some, prison is the only time in their adult lives when they will have seen a dentist. There are few free dental clinics in communities, regardless of economic climate, and there are almost none that serve adults. Dental care is expensive, and dental insurance is rarely provided to employees in lower income jobs. Therefore, many will enter correctional facilities having been financially precluded from seeking dental care even if they had wanted it. [*excerpt*]

Keywords

Dental Health, Inmates, Prision

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Why Prison Dental Care Matters: Legal, Policy, and Practical Concerns

Anne S. Douds, Eileen M. Ahlin, Nicholas S. Fiori, Nicholas J. Barrish[*]

PART I: WHY PRISON DENTAL CARE IS IMPORTANT

Even when controlling for demographic characteristics, prisoners are far more likely than people in the general population to suffer from periodontal disease, to have unresolved oral health issues, to have decayed teeth, and/or to be missing teeth.[1] Correlates of poor oral health, such as poor nutrition and smoking, are more prevalent among people of lower socioeconomic status, and this same population is at higher risk than others for offending and incarceration.[2] For some, prison is the only time in their adult lives when they will have seen a dentist. There are few free dental clinics in communities, regardless of economic climate, and there are almost none that serve adults.[3] Dental care is expensive, and dental insurance is rarely provided to employees in lower income jobs.[4] Therefore, many will enter correctional facilities having been financially precluded from seeking dental care even if they had wanted it.

Attention to dental health is often overlooked among persons involved in

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1. James H. Clare, *Dental Health Status, Unmet Needs, and Utilization of Services in a Cohort of Adult Felons at Admission and After Three Years' Incarceration*, 9 J. CORR. HEALTH CARE 65, 66 (2002); James M. Mixson et al., *Oral Health Status of a Federal Prison Population*, 50 J. PUB. HEALTH DENTISTRY 257, 257 (1990); Kenneth Bolin & Daniel Jones, *Oral Health Needs of Adolescents in a Juvenile Detention Facility*, 38 J. ADOLESCENT HEALTH 755, 755 (2006); Marsha Cunningham et al., *Dental Disease Prevalence in a Prison Population*, 45 J. PUB. HEALTH DENTISTRY 49, 49 (1985); Andrew P. Wilper et al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 666 (2009).

2. Christer Priwe & Peter Carlsson, *Oral Health Status of Male Swedish Citizens at Admission to Prison*, 24 J. CORR. HEALTH CARE 382, 392 (2018); Henrie M. Treadwell et al., *Short Report: Implications for Improving Oral Health Care Among Female Prisoners in Georgia's Correctional System*, 90 J. DENTAL HYGIENE 323, 323 (2016).

3. Burton Edelstein, *The Dental Safety Net, Its Workforce, and Policy Recommendations for Its Enhancement*, 70 J. PUB. HEALTH DENTISTRY S32, S33 (2010).

4. Jihong Liu et al., *Disparities in Dental Insurance Coverage and Dental Care among US Children: The National Survey of Children's Health*, 119 PEDIATRICS 512, 513 (2007).

correctional systems. This is true both during periods of incarceration and as returning citizens post-incarceration. Newly incarceration individuals must adapt to their new surroundings, including adjustments to their loss of control over personal choices, autonomy, and privacy. Incarcerated people may want to take care of their oral health while incarcerated, but there are significant fees associated with the purchase of hygiene products and other items that could ease the transition to jail or prison or contribute to comfort during their sentence.[5] While seemingly miniscule in cost when in the community, incarcerated persons make very little money, and their budgets must cover snack foods, razors, phone cards, leisure items, and clothing beyond standard-issue wear.[6] Cost can be prohibitive for many and choices must be made. For example, in Pennsylvania state correctional institutions, toothpaste can cost upwards of $3.95 and denture adhesive is $3.19.[7] Faced with the need to weigh the costs of items such as a razor versus a toothbrush, many may continue past bad habits. In additional, many incarcerated people cannot afford prison fees associated with dental services as a result of policy decisions concerning the cost of such treatment. Almost 20 years ago, just over half of surveyed prisons required a co-pay from inmates for any dental procedure.[8] It appears that the same practice remains in place in many institutions.[9]

Upon release from prison, returning citizens may face more pressing concerns than dental care as they begin the reentry process and reintegrate with the community.[10] Basic necessities such as food, clothing, and shelter take priority. Immediately adjacent to these concerns are the need for employment, supervision requirements with probation/parole officers, and reestablishing connections with family and friends. Dental care, like health care more generally, continues to be a drain on scarce funds. For incarcerated individuals, attention to basic oral health needs often moves to the backburner while more urgent needs are prioritized, such as navigating the daunting process of securing housing, employment, and social services.[11]

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5. *See e.g.,* Andre Matevousian, *Commissary List*, BUREAU OF PRISONS (June 18, 2014) https://www.bop.gov/locations/institutions/dub/DUB_CommList.pdf; Stephen Raher, The Company Store:
A Deeper Look at Prison Commissaries, PRISON POL'Y INITIATIVE (May 2018) https://www.prisonpolicy.org/reports/commissary.html.

6. Matevousian, *supra* note 5. Raher, *supra* note 5.

7. *Commissary Lists*, PA. DEP'T OF CORR., www.cor.pa.gov/Inmates/Pages/Commissary-Catalogs.aspx (last visited Apr. 4, 2020).

8. Nicholas S. Makrides & Jay D. Shulman, *Dental Health Care of Prison Populations*, 9 J. CORRECTIONAL HEALTH CARE 291, 291 (2002).

9. *Id.* at 296.

10. Anne S. Douds, et al., *Decayed Prospects: A Qualitative Study of Prison Dental Care and Its Impact on Former Prisoners*, 41 CRIM. JUST. REV. 21, 25 (2016).

11. Nicholas Freudenberg, *Community Health Services for Returning Jail and Prison*

The lack of dental care among justice-involved populations may also be attributable to a lack of awareness about the importance associated with oral hygiene.[12] Good oral hygiene is linked to overall health and well-being. Periodontal disease is linked to cancer, cardiovascular disease, diabetes, and pregnancy complications such as low birthweight and preeclampsia.[13] Justice-involved populations are more likely than others to come from backgrounds that did not prioritize, or could not afford, preventive care and/or dental care.[14] Incarceration could be an educational opportunity for persons housed in correctional institutions to learn about the importance of good oral care and how to manage their oral health.

Poor dental health care among justice-involved populations is not only a function of prior history or education about its importance. Lifestyle factors also play a major role in the occurrence and persistence of bad oral hygiene. It is well-known that drug use substantially reduces physical and oral health. For example, use of methamphetamines (meth) is positively related to an increase in dental caries, tooth loss, and visits to dentists, and it also visibly portrays the negative effects resultant from lack of care.[15] Not too long ago, meth was a topic of much discussion and scholarly research highlighted the negative consequences resulting from its use. Most notably, meth use contributes to deleterious oral health so much so that "meth mouth" imagery has been widely used as a marketing tool to discourage substance use.[16] Media campaigns focusing on vivid images of oral consequences of meth usage were effective at connecting drug use to a decline in oral health.[17]

Less obvious, though arguably equally important, poor dental health care can have a range of unintended consequences that can negatively impact justice-involved populations and their attempts to alter their life trajectories. Poor dental health and orthodontic needs can have a detrimental effect on self-confidence and self-esteem.[18] Missing or rotten teeth, bad breath, and an

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Inmates, 10 J. OF CORRECTIONAL HEALTH CARE 369, 374 (2004).

12. Douds et al., *supra* note 10 at 29.

13. Yasusei Kudo et al., *Oral Environment and Cancer*, 38 GENES & ENV'T 1, 4 (2016); Muhammed Ashraf Nazir*, Prevalence of Periodontal Disease, Its Association with Systemic Diseases and Prevention*, 1 INT'L J. HEALTH SCI. 72, 76 (2017).

14. *See e.g.,* Bruce B. Wallace & Michael I. MacEntee, *Access to Dental Care for Low-Income Adults: Perceptions of Affordability, Availability and Acceptability*, 37 J. CMTY. HEALTH 32, 34 (2012) (discussing the limited accessibility of dental care for low-income populations).

15. E. Marcia Boyer et al., *The Relationship Between Methamphetamine Use and Dental Caries and Missing Teeth,* 89 J. DENTAL HYGIENE 119, 119 (2015).

16. *See* Naomi Murakawa, *Toothless: The Methamphetamine "Epidemic," "Meth Mouth," and the Racial Construction of Drug Scares*, 8 DU BOIS REV.: SOC. SCI. RES. ON RACE 219, 222 (2011) (describing various use of "meth mouth" marketing to deter drug users).

17. *Id.*

18. Patricia R. dos Santos et al., *Influence of Quality of Life, Self-Perception, and Self-*

unkempt smile negatively impact how people feel about themselves.[19] It can also influence how they engage with others as people may shy away from intimate, face-to-face conversations with someone whose teeth are unappealing.[20] These types of interactions can have adverse consequences on life chances when considering the importance of social interactions in several life domains. One prominent and important life aspect particularly relevant to formerly incarcerated persons is employment. There are a host of collateral consequences associated with spending time in a carceral facility. An added burden of poor oral health care before and during a carceral stay can magnify an already difficult situation facing persons who have recently been released to the community and were essentially out of the workforce for a period of time.

Research involving a group of men recently released from a state correctional facility highlights the importance of confidence to be gained by having clean, straight teeth.[21] Men who received proper dental care, often at the hands of generous benefactors, immensely and positively benefited by the confidence they garnered from oral health care.[22] Examples of such betterment included securing employment and becoming married.[23] Other scholars have found similar psychosocial benefits and costs associated with dental care among justice-involved populations.[24]

Those in charge of prison policy also bear some responsibility for problems with dental care in carceral settings. Research and policy discussions about prison health often emphasize medical care, and deemphasize dental care.[25] Thus, legislatures and personnel in prisons often neglect dental care in comprehensive health care planning for prisoners.

Given the significance of dental health to prisoners' potential reintegration into society, what are the parameters of correctional institutions' responsibilities for inmates' oral health? Moreover, what *should* prison and correctional entities be doing to improve prisoners' oral health and, relatedly,

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Esteem on Orthodontic Treatment Need, 151 AM. J. ORTHODONTICS & DENTOFACIAL ORTHOPEDICS 143, 143 (2017); Puneet Kaur et al., *Impact of Dental Disorders and its Influence on Self Esteem Levels Among Adolescents*, 11 J. CLINICAL & DIAGNOSTIC RES. 5, 5 (2017).

19. Puneet Kaur et al., *Impact of Dental Disorders and its Influence on Self Esteem Levels Among Adolescents*, 11 J. CLINICAL & DIAGNOSTIC RES. 5, 5 (2017).

20. *Id.* at 7.

21. Douds et al., *supra* note 10 at 25.

22. *Id.* at 31.

23. *Id.* at 31–32.

24. Danelle Albright et al., *Reducing Barriers to Re-Entry: Assessing the Implementation and Impact of a Pilot Dental Repair Program for Parolees*, Univ. N.M. 29, 49 (2011); Dominique Moran, *Prisoner Reintegration and the Stigma of Prison Time Inscribed on the Body*, 14 PUNISHMENT & SOC'Y 564, 575–76 (2012).

25. *See* Elizabeth A. Mertz, *The Dental-Medical Divide*, 35 HEALTH AFF. 2168, 2168 (2016) (discussing the slow reform in addressing and discussing dental care in prison health).

their long-term likelihood of success in society? Part II addresses these questions by describing current law on prison dental care and the minimum level of care the law allows (or requires) from dental care providers in correctional settings.

PART II: PRISON DENTAL CARE LAW

Persons, such as prison guards and prison health care providers, who operate "under color of state law" cannot act with "deliberate indifference" to inmates' knowable, identifiable, and sufficiently serious medical and dental conditions.[26] *Estelle v. Gamble* and its progeny establish that "deliberate indifference to serious medical needs[27] of prisoners constitutes the 'unnecessary and wanton infliction of pain' . . . proscribed by the Eighth Amendment."[28] This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs, or by prison personnel intentionally denying or delaying access to medical care, or prison personnel intentionally interfering with treatment once prescribed.[29] *Flanory v. Bon* and *Hoptowit v. Ray* made it clear that prison dental care is subject to the same "deliberate indifference" standard as other forms of health care in prison settings.[30]

The *Estelle*/*Bon/Hoptowit* inquiry on the constitutionality of prison dental care practices, as developed through extensive caselaw, requires a three-pronged analysis of (a) whether an inmate's dental condition is sufficiently serious to warrant scrutiny; (b) whether, objectively, the correctional personnel in charge of the inmate knew or should have known about the serious dental condition; and (c) whether, subjectively, the correctional personnel were "deliberately indifferent" to the seriousness of the condition and the need for treatment of it.[31] Negligence is not sufficient to satisfy the third prong.[32] To prevail on these kinds of claims, plaintiffs must establish that prison dental care providers (or those tasked with arranging for dental

26. Estelle v. Gamble, 429 U.S. 97, 103 (1976); Flanory v. Bonn, 604 F.3d 249, 253 (6th Cir. 2010); Hoptowit v. Ray, 682 F.2d 1237, 1253 (9th Cir. 1982).

27. *See Hoptowit*, 682 F.2d at 1253. (illustrating 'medical needs' include dental needs).

28. *See Gamble,* 429 U.S. at 104. (quoting Gregg v. Georgia, 428 U.S. 153 (1976)).

29. *See generally* McGowan v. Hulick, 612 F.3d 636, 640–41 (7th Cir. 2010); Hartsfield v. Colburn, 371 F.3d 454, 457 (8th Cir. 2004); Farrow v. West, 320 F.3d 1235, 1247 (11th Cir. 2003); Harrison v. Barkley, 219 F.3d 132, 137–38 (2d Cir. 2000); Chance v. Armstrong, 143 F.3d 698, 700–02 (2d Cir. 1998); Dean v. Coughlin, 623 F. Supp. 392, 405 (S.D.N.Y. 1985); Heitman v. Gabriel, 524 F. Supp. 622, 627 (W.D. Mo. 1981); (supporting that denying or delaying medical care, including dental care, may constitute deliberate indifference).

30. *Flanory*, 604 F.3d at 1253; *Hoptowit*, 682 F.2d at 1253.

31. *Gamble,* 429 U.S. at 103.

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

care) acted willfully, wantonly, or intentionally.[33] This is a high burden of proof, but one that has nonetheless yielded a substantial body of law on prison dental care. The *Estelle*/*Bon/Hoptowit* inquiry has existed for decades. To provide fresh insights and clarifications, the following provides a step-by-step analysis of each prong based upon cases decided within the past five years.[34]

Sufficiently serious dental condition. Plaintiffs seeking relief through the courts must establish that they have, or had, a dental condition that is/was serious enough to trigger Eighth Amendment analysis.[35] Historically, "seriousness" has been established either by the nature of the underlying dental condition and/or by whether a delay in treatment or intentional mistreatment exacerbated circumstances and caused the condition to become serious.[36] Seriousness is necessarily a fact-specific standard, and several illustrative cases provide some sense of what is sufficiently serious to trigger constitutional scrutiny. For example, many courts have held that failing to ameliorate inmates' acute oral pain that arises from dental problems constitutes unconstitutional conduct.[37] Sustained pain, likewise, is almost always a sufficiently serious dental condition to warrant review.[38] On the other hand, cases that do not involve allegations of acute or sustained pain usually fail to meet the sufficiency test.[39] For example, failure to provide "routine" dental care such as cleanings, glue removal, or filling of cavities that are not painful may not be sufficiently serious misconduct.[40]

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33. *Gamble*, 429 U.S. at 10; *see e.g.,* Sepulveda v. UMass Corr. Health Care, 160 F. Supp. 3d 371, 386 (D. Mass. Feb. 5, 2016) (finding that negligent delay in filing a cavity did not rise to the level of deliberate indifference, however a two-month delay in delivery of pain medication did constitute deliberate indifference); *see also* Formica v. Aylor, No. 7:14-cv-00449, 2016 WL 4524233, at *7 (W.D. Va. Aug. 26, 2017) (stating a two-week delay in treatment of non-emergency dental problem was not willful).

34. This discussion does not examine administrative prerequisites to these kinds of cases, such as requirements set forth in the Prison Litigation Reform Act, 42 U.S.C. § 1997e, and issues concerning exhaustion of remedies. Boyce v. Ill. Dep't of Corr., No. 16-1710, 661 Fed. Appx. 441 (7th Cir. 2016); Fletcher v. Corizon Health Servs., No. 1:14-cv-00532-BLW, 2016 WL 7007481 (D. Idaho Nov. 29, 2016).

35. Salahuddin v. Goord, 467 F.3d 263, 280 (2d Cir. 2006).

36. *Id.* at 280 (citing Smith v. Carpenter, 316 F.3d 178, 185–186 (2d Cir. 2003)).

37. *See* e.g., Chance v. Armstrong, 143 F.3d 698, 700–02 (2d Cir. 1998) (holding that plaintiff's Eight Amendment claim survived a motion to dismiss where he "alleged that, as the result of the defendants' actions, he suffered extreme pain, his teeth deteriorated, and he [had] been unable to eat properly.")

38. Hartsfield v. Colburn, 371 F.3d 454, 457 (8th Cir. 2004); Farrow v. West, 320 F.3d 1235, 1244–45 (11th Cir. 2003).

39. Walker v. Akridge, No. 1:15-cv-28-WTH-GRJ, 2018 WL 3245013, at *11 (N.D. Fl. Feb. 26, 2018).

40. *See generally id.* at *6; Jones v. Strow, No. 19-cv-4013-MMM, 2019 WL 5580945, at *3 (C.D. Ill. Oct. 29, 2019); Malloy v. Peters, No. 16-16374, 753 Fed. Appx. 737 (11th Cir. 2018); *See also* Szemple v. U. of Med. & Dentistry of N.J., No. 10-00258 (JMV) (JBC), 2017 WL 4538929, at *10 (D.N.J. Oct. 11, 2017) (holding that a dentist who testified that

Sufficient seriousness also may arise from systemic or programmatic failures, such as failing to provide toothpaste to inmates for an extended period of time;[41] failing to provide timely dental cleanings or screenings; or having an "extraction only" or "pull and pay" policy.[42]

Interestingly, there is not consensus on whether actual injury is required for a condition to be considered "serious." Some courts seem to require that an actual, permanent injury occurred[43] or that the condition manifest in significant pain.[44] Other courts take a more traditional approach, inquiring whether the alleged condition creates "an excessive risk to an inmate's health or safety"[45] or "substantial risk of damage to his future health."[46]

From a policy perspective, it is almost impossible to develop exhaustive guidance on what conditions trigger prison personnel's duty to respond. But it can be surmised from these current cases and prior, similar research[47] that conditions involving pain, conditions that could entail secondary medical problems, and conditions that prevent inmates from eating[48] should be treated. Part III provides more thorough discussion of best practices and policy recommendations.

Objective knowledge of the condition and of the need for treatment. The second step of the *Estelle/Bon/Hoptowit* inquiry asks whether correctional personnel "knew or should have known"[49] about the serious dental condition. Because this standard has been developed under the common law, it is

her practice fell below the standard of care should not be granted summary judgement).

41. Board v. Farnham, 394 F.3d 469, 483 (7th Cir. 2005); *but see* Bailey v. Batista, No. CV-16-22-GF-BMM-JTJ, 2017 WL 3189887, at *2 (D. Mont. July 27, 2017) (holding no valid claim for Eight Amendment right to humane conditions of confinement exists for insufficient amounts of toothpaste where some was being provided).

42. Tuduj v. Newbold, No. 15-cv-01294-NJR, 2016 WL 3916965, at *2 (S.D. Ill. July 20, 2016); *but see* McDowell v. Pfister, No. 13-C-3375, 2017 WL 359199, at *4 (N.D. Ill. Jan. 23, 2017) (finding policy of "no root canals" is not unconstitutional); ANNE S. DOUDS & EILEEN M. AHLIN, RETHINKING AMERICAN CORRECTIONAL POLICY: COMMON SENSE CHOICES FROM UNCOMMON VOICES 117 (Routledge, 2017).

43. *Szemple*, 2017 WL 4538929, at *7.

44. Estelle v. Gamble, 429 U.S. 97, 104 (1976).

45. Burrell v. Green, No. 17-0439, 2017 WL 2691976, at *4 (E.D. Pa. Nov. 28, 2017).

46. *Id.*; *see also* Johnson v. Lombardi, No. 2:16-cv-04129-NKL, 2016 WL 6542859, at *2 (W.D. Mo. Nov. 3, 2016) (denying a motion to dismiss in light of "unnecessary and in bad faith rescheduled or delayed dental appointments" and extractions that were "more painful than necessary").

47. *See, e.g.,* Anne S. Doud & Eileen M. Ahlin. *Do NCCHC Dental Standards Have Any Teeth*?, 22 J. CORRECTIONAL HEALTH CARE 180, 182–83, 186 (2016) (analyzing standards that apply to dental care for inmates from twenty-two cases).

48. *See* Edwards v. Clark, No. CV 316-019, 2018 WL 232465, at *5 (S.D. Ga. May 22, 2018) (deciding defendant dentist was not entitled to summary judgement against claims brought by plaintiff inmate who had no teeth was refused dentures after continual pain and weight loss from inability to consume food because his gums were continuously sore and swollen).

49. Flanory v. Bonn, 604 F.3d 249, 253 (6th Cir. 2010).

necessarily a fact-specific standard and must be gleaned from the robust body of cases that define its parameters. Actual knowledge is almost always sufficient to meet this prong; if a correctional staffer or a person who provides health care actually knew that an incarcerated person was not receiving necessary dental care and was suffering as a consequence, this step in the analysis is satisfied.[50] But the standard becomes confusing at times by the "should have known" element, which may suggest a negligence standard in cases involving private parties.[51] With correctional health care claims against persons employed "under color of state law," negligence has never been enough to satisfy the "deliberate indifference" element.[52] Modern cases concur.[53] It is not always clear when actual knowledge exists versus whether the obviousness of the condition is such that constructive knowledge should be imputed to the actor. Only actions that are deliberate, intentional, or constructively intentional are prohibited in prison dental care cases.[54] The objective element of this inquiry thus bleeds into the subjective element, discussed below.

Subjective, deliberate indifference to the need for treatment. If the court finds that the first two prongs are satisfied, then the third step of analysis under *Estelle/Bon/Hoptowit* asks whether, subjectively, the correctional personnel were deliberately indifferent to that serious dental condition.[55] "Deliberate indifference" has become the catch-all heuristic device for referencing the rule announced in *Estelle v. Gamble*, but it is actually the third stage of more comprehensive analysis.[56] It also requires consideration of

50. *See id*. (noting in order to establish deliberate indifference (an easier standard to meet than actual knowledge) to a serious medical need it must be shown that the person: (1) was subjectively aware of a serious risk of harm and (2) disregarded that risk (3) by following a course of action which constituted more than mere negligence).

51. Farmer v. Brennan, 511 U.S. 825,, 836 (1994).

52. *See id.* at 835 (stating that "deliberate indifference describes a state of mind more blameworthy than negligence").

53. *See* Elias v. Navasartian, No. 1:15-cv-01567-JLO-GSA-PC, 2017 WL 1806739, at *2 (E.D. Ca. May 5, 2017) (writing that "negligence is insufficient to establish a constitutional deprivation under the Eighth Amendment"); *see also* Venable v. Stainer, No. 1:16-cv-00589-AWI-GSA-PC, 2018 WL1335548, at *4 (E.D. Ca. Mar. 15, 2018) (writing that "an Eighth Amendment claim may not be premised on even gross negligence by a physician"); *see also* Payne v. Sevier Cty., No. 3:41-CV-346-PLR-CCS, 2016 WL552351, at *4 (E.D. Tenn. Feb. 10, 2016) (writing that "deliberate indifference requires more than mere negligence"); *see also* Powell v. Marlais, No. 14-cv-05308-JST, 2016 WL5462443, at *8 (N.D. Ca. Sept. 29, 2016) (writing that "mere negligence, or even gross negligence, is not enough").

54. *See* Talbert v. Corr. Dental Assocs., No. 16-1408, 2017 WL 3255140, at *2 (E.D. Pa. July 31, 2017) (noting "deliberate indifference. . .requires obduracy and wantonness. . .which has been likened to conduct that includes recklessness or a conscious disregard of serious risk").

55. Flanory, 604 F.3d 249, 253 (6th Cir. 2010).

56. *Gamble*, 429 U.S. 97, 103, 104 (1976).

intent, either actual or constructive. As noted above, an intentional refusal to provide dental care would obviously meet this third prong. However, conduct that unintentionally, but recklessly, caused injury might also meet this third prong. For example, delay in response or treatment may rise to the level of subjective, deliberate indifference where the delay is lengthy or avoidable.[57] However, personnel will not be held liable where delays in treatment are due to circumstances beyond their control and/or where delays arose in part from inmates' malingering or other conduct.[58] Moreover, the delay must rise above the level of mere negligence so as to be egregious, willful, or wanton.[59]

Much of the caselaw on prison dental care focuses on timeliness of treatment, as discussed above. Excessive delays, particularly when an inmate is experiencing pain, generally will support claims under the *Estelle/Bon/Hoptowit* standard.[60] On the other hand, choice in treatment, or claims for better or different treatment, rarely are successful.[61] Inmates do not have the right to their preferred form of treatment so long as the treatment provided was clinically responsive and minimally adequate.[62] They also do

57. *See* Brooks v. Colo. Dep't of Corr., No. 16-1469, 715 Fed. Appx. 814, 822 (10th Cir. 2017) (reasoning a seven-month delay in needed dental care may support claim for deliberate indifference).

58. *See* Ramirez v. Sanchez, No. 15-cv-4787, 2018 WL 2118199, at *11 (N.D. Ill. May 8, 2018) (writing that "Plaintiff must demonstrate that each defendant personally participated in or caused the unconstitutional actions"); *see also* Burns v. East Baton Rouge Parish Prison, No. 14-0245-JWD-EWD, 2017 WL 4214143, at *4 (M.D. La. Sept. 6, 2017) (holding deliberate indifference is not met when the plaintiff failed to "respond when his name was called out at sick call").

59. *See e.g.,* Sepulveda v. UMass Corr. Health Care, 160 F. Supp. 3d 371, 386 (D. Mass. Feb. 5, 2016) (finding that negligent delay in filling a cavity did not rise to the level of deliberate indifference, however a two-month delay in delivery of pain medication did constitute deliberate indifference); *see also* Formica v. Aylor, No. 7:14-cv-00449, 2016 WL 4524233, at *7 (W.D. Va. Aug. 26, 2017) (stating a two-week delay in treatment of non-emergency dental problem was not willful).

60. *See, e.g.,* Long v. Mohr, No. 2:15-cv-01616, 2016 WL 1222410, at *3 (S.D. Ohio Mar. 29, 2016) (holding a one-year delay in treatment was sufficient to support a § 1983 claim); *see also* Sherron v. Corr. Care Director, No. 1:15-cv-852, 2016 WL 6069183, at *4 (M.D.N.C. Oct. 17, 2016) (holding that repeated delays in plaintiff receiving dental care resulting in continuous pain survived a motion to dismiss); Johnson v. Lombardi, No. 2:16-cv-04129-NKL, 2016 WL 6542859, at *1 (W.D. Mo. Nov. 3, 2016) (holding that rescheduled and delayed appointment resulting in unnecessary pain was sufficient under the Estelle/Bon/Hoptowit standard); Dent v. Burrell, No. 3:16-cv-1263-NJR, 2016 WL 6947980, at *5 (S.D. Ill. Nov. 28, 2016) (holding that a delayed extraction may be a valid claim).

61. Littek v. Clark, No. 7:16-cv-00072, 2016 WL 5328119, at *1 (W.D. Va. May 5, 2016) (denying preliminary injunction for allegation of failing to provide treatment).

62. *See* Talbert v. Corr. Dental Assocs., No. 16-1408, 2017 WL 3255140, at *2 (E.D. Pa. July 31, 2017) (holding there is no right to anesthesia despite fear of needles); Weatherspoon v. Bien, No. 1:14-cv-734, 2016 WL11475276, at *7 (W.D. Mich. Feb. 2, 2016) (stating that an inmate's claim for "different" care "falls far short of supporting an Eighth Amendment claim"); Allen v. Asselmeier, No. 15-cv-334-MJR-DGW, 2016 WL 183321, at *2 (S.D. Ill. Jan. 15, 2016) (holding there is no right to tooth reconstruction rather than extraction); Ciaprazi v. Jacobson, 13-civ-4813, 2016 WL 4619267, at *4 (S.D.N.Y.

not have a right to alternative treatment where similar outcomes likely would result.[63]

Relationship between government actor and injured person. Finally, there is no respondeat superior liability for these types of cases, and plaintiffs must establish that identifiable defendants had "personal involvement" in the alleged mistreatment.[64] Claims against government actors will not be sustained unless the prison personnel's relationship to the deliberately indifferent conduct is proximate to the aggrieved conduct.[65] There must be a nexus between government actors' actions (or lack thereof), and the inmates' injuries.[66] This nexus requirement, or proximity requirement means that treatment providers may be liable, and so may be non-clinicians who administratively process grievances.[67] This final requirement may be a subset of the objective and subjective elements described above, but it is worth separate analysis because of the express rejection of respondeat superior liability in these cases. The second and third steps of this inquiry require ascertainable knowledge of the condition and willful disregard of it; thus, government actors within an administrative system or in a chain of command cannot be held liable unless it is readily determinable that they actually knew about the dental problem and willfully failed to respond to it.[68] This, by definition, means that actors distanced from the problem by subordinates or other actors over whom they have supervisory authority, essentially are shielded from legal responsibility.[69] Similarly, non-clinician correctional personnel who deny or delay access to dental treatment in reasonable reliance upon clinicians' recommendations may not be found to have the requisite subjective intent.[70] Finally, and perhaps not surprisingly given the nexus

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Sept. 6, 2016) (holding that only offering an extraction was not a violation of the Eighth Amendment).

63. Lake v. Wexford Health Sources, 848 F.3d 797, 798 (7th Cir. 2017).

64. *Sepulveda*, 160 F.Supp. 3d at 394; *see also Ciaprazi*, 2016 WL4619267, at *4 (noting commissioner was not personally involved in inmate's dental care); *see also* Ramirez v. Frauenheim, No. 1:15-cv-01931-BAM-PC, 2016 WL5930416, at *3 (N.D. Ill. Oct. 11, 2016) (noting supervisors cannot be liable "under the theory of respondeat superior"); *see also* Barber v. Wisconsin Dep't of Corr, No. 16-cv-339-JDP, 2016 WL 7235857, at *1 (W.D. Wis. Dec. 14, 2016) (granting leave to amend to identify specific defendants); *see also* Ramirez v. Sanchez, No. 15-cv-4787, 2018 WL 2118199, at *7 (N.D. Ill. May 8, 2018) (noting that defendants must have "personally participated in or caused the unconstitutional actions").

65. Burrell v. Green, No. 17-0439, 2017 WL 2691976, at *4 (E.D. Pa. Nov. 28, 2017).

66. Sharma v. D'Silva, 157 F. Supp. 293, 301 (S.D.N.Y. 2016).

67. King v. Cox, No. 3:16-cv-00177-MMD-WGC, 2018 WL 4444058, at *7 (D. Nev. May 25, 2018).

68. *Id.* at *8.

69. Payne v. Sevier Cty., No. 3:41-CV-346-PLR-CCS, 2016 WL552351, at *4 (E.D. Tenn. Feb. 16, 2016).

70. *Id.* at *4–5.

requirement, facilities cannot be sued without including at least one living actor in the lawsuit who worked on behalf of that entity.[71]

Case law on prison dental care provides parameters for the bare minimum of dental care that prisons must provide.[72] Presumably, policymakers seek to provide more than the bare minimum either as a matter of social justice, as a component of rehabilitation, or as a natural effort to aid reintegration. Perhaps for all three of these reasons and others, a standard of care is desirable. Part III examines formal policies, with particular attention paid the Federal Bureau of Prisons' 2016 revisions to its prison dental care policies. Part III also highlights some of the best and worst state-level policies as aspirational and cautionary tales. If the caselaw tells practitioners and policymakers what they cannot do under threat of legal liability, the following policies suggest what prisons can and should do to promote quality and appropriate prison dental care.

PART III: POLICIES AND PROGRAMS TO PROMOTE BEST PRISON DENTAL CARE PRACTICES

Correctional institutions' mission is to "stabilize and maintain the inmate population's oral health."[73] Consistent with case law, this succinct mission statement signals that correctional dental care should not necessarily be used to improve inmates' dental status or provide cosmetic or elective services.[74] Dental care should be "conservative," both fiscally and clinically.[75] Prison dental care practices are guided by the Federal Bureau of Prisons (BOP) policy that governs the federal prison system and provides guidance for state systems.[76] States have their own policies, usually maintained by their departments of corrections, and many jurisdictions also have local-level policies that set administrative and practical standards. All states appear to at least implicitly require that their dental services comply with American Dental Association (ADA), American Correctional Association (ACA), and Centers for Disease Control and Prevention (CDC) standards, and some states such as Montana expressly adopt these standards in their state-level

71. Miller v. Blue Ridge Reg'l Jail, No. 7:17-cv-00161, 2018, WL3341792, at *4 (W.D. Va. July 6, 2018).

72. *See* Paul Wallin, *Prisoners Lose Right to Sue When Medical or Dental Needs are Denied (Peralta v. Dillard, 2014),* WALLIN & KLARICH, https://www.wklaw.com/prisoners-lose-right-to-sue/ (last visited Mar. 12, 2020) (discussing California state policy of required minimum of care).

73. FED. BUREAU OF PRISONS, U.S. DEPT. OF JUST., PROGRAM STATEMENT: DENTAL SERVICES 1 (2016) [hereinafter BOP PROGRAM STATEMENT: DENTAL SERVICES].

74. *Id.* at 16.

75. *Id.* at 1.

76. *Id.* at 3.

policies.[77]

To ground the policy discussion, it is helpful to look at federal policy, which was updated significantly in 2016 by the BOP's amended Program Statement.[78] Revisions to BOP policy made several substantive changes as described below that bring recommended practices more in line with some of the realities revealed through litigation and field work.[79] These changes may improve inmate care, while others appear to provide *de jure* standards for what most practitioners knew were *de facto* norms, such as extended deadlines for when services such as initial screenings must be provided.[80] Some states maintain policies consistent with BOP's regulations; other states provide far more services than the BOP requires; and still other states appear to demand less from their dental programs. Examples of each are provided below. No two systems are identical, but the following provides examples of policies across the country illustrative of what have been deemed best (and worst) practices so as to provide policy guidance.

Administration and Timing. The 2016 BOP policy statement extends the mandatory time for an initial dental screening (upon admission to a correctional facility) from 14 to 30 days.[81] Colorado and other states also follow a 30-day rule for initial screenings, but other states such as Hawaii, North Carolina, and Ohio require at least an initial screening within seven days of admission to prison.[82] The changes also ease some other administrative burdens by eliminating requirements that facilities maintain local policies and procedure manuals or that they provide certain weekly, monthly, and quarterly reports.[83] The lengthier timelines acknowledge the difficulties of providing dental services on strict schedules in carceral settings where access to patients and clinician availability are adversely impacted by security protocols. Early care can set the stage for expectations of dental care, its importance, and the frequency that it will be administered during stays.[84]

77. STATE OF MONT. DEP'T OF CORR., POLICY DIRECTIVE: SUBJECT OFFENDER DENTAL SERVICES 2 (2018).

78. BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73.

79. *Id.*

80. *Id.*

81. *Id.* at 2.

82. HAWAII DEP'T OF PUBLIC SAFETY, 10.1E.06, CORRECTIONS ADMINISTRATION POLICIES AND PROCEDURES: ORAL CARE (2018); STATE OF N.C DEP'T OF PUBLIC SAFETY, DIVISION OF ADULT CORR. AND JUV. JUSTICE, TX V-6, CARE AND TREATMENT OF OFFENDER-DENTAL SERVICES 1 (2014); Michael Rigby, *Reformed Dental Care Will Have Ohio Prisoners Smiling*, PRISON LEGAL NEWS (Nov. 15, 2007), https://www.prisonlegalnews.org/news/2007/nov/15/reformed-dental-care-will-have-ohio-prisoners-smiling/.

83. BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 1.

84. Imara de Almeida Castro Morosini et al., *Performance of Distant Diagnosis of Dental Caries by Teledentistry in Juvenile Offenders*, 20 TELEMEDICINE AND E-HEALTH 1, 1 (2014).

By addressing dental care immediately, problems can be identified and triaged to handle more pressing needs first to minimize chances of protracted pain, suffering, and complications.

Costs and Mandatory Payments. Most states require that inmates remit a co-pay for dental services unless they are indigent. Illinois requires a $2.00 co-pay that can be waived for indigent inmates who need medically necessary dental care.[85] Iowa generally requires a $3.00 co-pay for dental services, and Mississippi charges $6.00.[86] Alabama provides a broad range of health care regardless of whether the inmate can pay. Alabama prisons can charge a co-pay for dental care, but Alabama policy expressly states that "[n]o inmate shall be denied care because of a record of non-payment or current inability to pay for health services."[87] It should be noted, however, that Alabama's "policy on the books" may not reflect the "policy in action," and Alabama's prisons currently are the subject of federal civil rights investigations and a scathing report from the Southern Poverty Law Center.[88]

Dentures. Some of the more notable clinical changes under the 2016 BOP policy relate to delay and dentures. Inmates with sentences of more than three years have a right to dentures, and those with lesser sentences must be reviewed on a case-by-case basis.[89] Dentures present a relatively unique challenge constitutionally[90] and clinically. Some states have express denture policies. Alaska, for example, labels dentures a "category three" or "routine" need, and dentures are provided only if "medically necessary" as established by a medical clinician.[91] Inmates must pay a $50 co-pay for dentures in Alaska.[92] Delaware has a five-level inquiry for prioritization of which inmates can receive dentures (after being incarcerated for at least sixth months in a specified type of facility) and conditions receipt upon inmates' personal oral hygiene.[93] Mississippi provides dentures and other prosthetics

85. 31 Ill. Reg. 9845 (July 31, 2007).

86. STATE OF IOWA DEP'T OF CORR., POL'Y & PROC.: DENTAL SERVICES OVERVIEW HSP-1001 1 (2019) [hereinafter DENTAL SERVICES OVERVIEW]; MISS. DEP'T OF CORR., INMATE HANDBOOK 14 (2011) [hereinafter INMATE HANDBOOK].

87. STATE OF ALA. DEP'T OF CORR., POLICY NO. 703: INMATE COPAYMENT FOR HEALTH SERVICES 1 (2013).

88. *Cruel Confinement: Abuse, Discrimination and Death Within Alabama's Prisons Special Report*, SOUTHERN LAW POVERTY CTR. (June 5, 2014), https://www.splcenter.org/20140604/cruel-confinement-abuse-discrimination-and-death-within-alabamas-prisons.

89. BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 2.

90. Anne S. Douds & Eileen M. Ahlin, *Do NCCHC Dental Standards Have Any Teeth?*, 22 J. CORRECTIONAL HEALTH CARE 180, 180 (2016).

91. STATE OF ALASKA DEP'T OF CORR., POLICY NO. 807.12: DENTAL SCOPE OF SERVICES 4 (2018).

92. *Id.*

93. STATE OF DEL. DEP'T OF CORR., POLICY NO. E-06: ORAL CARE 5-6 (2019).

when medically necessary.[94] For some cases, dentures may seem superfluous though there are additional benefits beyond the obvious aesthetics. Persons with a full set of teeth are able to enjoy a wider breadth of food options including nutritious fresh fruits and vegetables, and animal-based protein items that are often inaccessible when oral functions are compromised.[95] A soft food diet for persons with few or no teeth may also impact self-esteem as they are reminded of their dental status with each meal.

Education and Training. The BOP 2016 policy promotes inmate education and self-advocacy. All inmates must be given a handbook during intake that explains "dental clinic hours of operation, access to care (sick call protocol and national dental routine waiting list), method to request continued care when transferring, inmate co-pay policy, availability of commissary items, and any applicable local dental policies."[96] Hawaii and other states also provide for inmate education on best oral hygiene practices as a matter of state policy.[97] Virginia has perhaps the most comprehensive state-level education policy and states:

Oral Health Education A. Personal oral hygiene is an individual responsibility and an essential component in maintaining good dental and general health. B. As health providers, dental staff are responsible for the recognition, diagnosis, and documentation of oral diseases, and for providing the information necessary for self-care and prevention. C. Areas of information should include the following: 1. Offender education: an elementary understanding of the relationship of dental plaque and oral health. a. It is important that the offender is aware of their personal responsibility in maintaining good oral hygiene and that successful continuation of treatment will be dependent upon the offender's practice of good oral hygiene habits. b. Offenders are required to demonstrate that they are practicing adequate and proper oral hygiene prior to the delivery of routine dental care. c. The treating dentist may discontinue routine care at any time when it becomes apparent that the offender is not practicing proper oral hygiene. 2.Brushing: technique, type of brush, how often 3. Flossing: technique, type of floss, how often 4. Diet and nutrition: relationship of plaque formation and dental pathology to the intake of simple carbohydrates and the frequency of intake, and the importance of a balanced diet high in fruits and vegetables.[98]

Oklahoma also has fairly robust policy guidance on inmate oral health

94. INMATE HANDBOOK, *supra* note 86, at Chapter IV.

95. *Eating Without Teeth or Dentures—What You Need to Know*, 1ST FAMILY DENTAL (Jun. 28, 2017), https://blog.1stfamilydental.com/eating-without-teeth-or-dentures/.

96. BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 5.

97. HAW. DEP'T OF PUBLIC SAFETY, POLICY NO. 10.1E.06: CORRECTIONS ADMINISTRATION POLICIES AND PROCEDURES: ORAL CARE 3 (2018)

98. VA. DEP'T OF CORR., POLICY NO. 720.6: HEALTH SERVICES OPERATING PROCEDURE: DENTAL SERVICES 4 (2019).

education.[99] Pennsylvania mandates that all inmates receive information about "dental hygiene items available from the Commissary" and "oral hygiene educational materials", and instructs inmates to "brush three times each day with a soft toothbrush and a toothpaste approved by the American Dental Association (ADA); floss daily [][get] proper nutrition; and avoid[] tobacco products."[100] Education and training is an easy and economical fix to the ongoing issues related to dental care among persons who are incarcerated. Materials to support these efforts can be emailed to eliminate paper waste and costs, online trainings and information dissemination may be feasible within institutions with greater technological infrastructure, and at a bare minimum inmate and correctional officer handbooks could be supplemented with essential pamphlet literature to encourage oral hygiene.

Electronic Medical Records. The BOP policy requires that facilities move to electronic medical records (EMRs), which imposes a substantial one-time cost but appears to be designed to reduce paperwork burdens and increase efficiency.[101] Patient waitlists and dental records all should be moved to EMRs per BOP and many states' policies.[102] Wisconsin policy requires use of Dentrix software.[103] It is hypothesized, that EMRs increase efficiency, decrease clinical and administrative errors, decrease delays in screening and treatment, and facilitate some of the innovations described in Part IV.[104] If used across state institutions, EMRs can facilitate inmate transfers and continuity of care when changes in institutional location or classification occur.[105] EMRs would reduce the need to physically transfer medical/dental records.[106]

Extraction Versus Repair and Preservation. The BOP does not have an official "extraction only" policy[107] Consistent with federal caselaw, decisions about extraction versus restoration are left to clinicians' discretion.[108] Some state prisons still follow "extraction only" policies, pursuant to which they

99. OKLA. DEP'T OF CORR., POLICY NO. OP-140124: DENTAL SERVICES 1 (2019).

100. PA. DEP'T OF CORR., POLICY NO. 13.2.1: ACCESS TO HEALTH CARE PROCEDURES 4–5 (2019).

101. Patricia Fontaine et al., *Systematic Review of Health Information Exchange in Primary Care Practices* 23 J. AM. BOARD FAM. MED., 655, 655–67 (2010).

102. *Id*. at 663.

103. DIV. OF ADULT INST. POL'Y & PROC., NO. 500.40.03 DENTAL RECORD KEEPING STANDARD FORMAT 2 (2019).

104. James Fricton & Hong Chen, *Using Teledentistry to Improve Access to Dental Care for the Underserved*, 53 DENTAL CLINICS 537, 537 (2009).

105. *Id.* at 545–46.

106. *Id.*

107. "Extraction only" policies state that prison dental care providers cannot perform fillings or otherwise attempt o restore teeth. A tooth with a cavity or other damage must either be left in the mouth as it is or extracted.

108. MICH. DEP'T OF CORR. POL'Y DIRECTIVE, POLICY NO. 04.06.150: DENTAL SERVICES 2 (2018).

will not fill, crown, or otherwise attempt to salvage teeth.[109] Other states, such as Arizona and Colorado, have protocols for prison dentistry, periodontics, and endodontics that describe a variety of recommended approaches to oral care other than extraction.[110] Delaware expressly disfavors extraction: "Whenever possible teeth will be restored with a restoration rather than extracted."[111] An extraction only policy is a substantial barrier to long-term dental care; it is irreversible and should be proceeded with caution. Persons who receive extractions will likely not be able to replace their tooth with an implant due to costs and lack of insurance. Saving teeth rather than pulling them is more humane and restorative to persons who are incarcerated.

Fluoride. A few states, including Hawaii and Montana, document that inmates have the right to fluoride treatments.[112] Fluoride is a prophylactic procedure that strengthens teeth and assists in the prevention of dental caries.[113] Inclusion of such minimally invasive preventative care is easy to implement with substantive long-term benefits.[114]

Inmate-Clinician Ratios. BOP 2016 staffing standards suggest that facilities have one dentist for every 1000 inmates.[115] California, which is under a judicially mandated Stipulation Agreement pursuant to a class action lawsuit about prison dental care, maintains a 1 to 2000 ratio of dental hygienists to inmates, and a 1 to 600 dentist to inmate ratio.[116]

Orthodontics and Other Advanced Care. States such as Delaware, Hawaii, and North Carolina provide orthodontic, prosthodontic, and endodontic care for inmates, while states such as Iowa and Michigan expressly prohibit orthodontic care during incarceration and others, such as Oklahoma, place tight restrictions on any of these more advanced forms of care.[117] Orthodontic

109. *See e.g., id.* (noting the Department will only provide minor oral surgery, including extraction of teeth beyond repair to offenders in correctional facilities).

110. RICHARD PRATT, ARIZ. DEP'T OF CORR.: DENTAL SERVICES TECHNICAL MANUAL 7 (2019); COLO. DEP'T OF CORR., REGULATION NO. 700-04: DENTAL SCOPE OF SERVICES 2 (2019).

111. STATE OF DEL. DEP'T OF CORR., *supra* note 93, at 4.

112. STATE OF MONT. DEP'T OF CORR., *supra* note 77, at 2.

113. Domen Kanduti et al., *Fluoride: A Review of Use and Effects on Health*, 28 MATER SOCIOMED. 133, 133 (2016).

114. *See id.* at 136 (reporting brushing teeth twice a day with fluoride toothpaste prevents cavities).

115. BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 5.

116. S*ee* Perez v. Cate, 632 F.3d 553, 554 (9th Cir. 2011) (discussing a state inmate who filed a class action under the Prison Litigation Reform Act alleging that prison officials violated Eighth Amendment in their lack of provision of dental care); *Inmate Dental Services Program*, CAL. DEP'T OF CORR. & REHAB. SERVS., https://www.cdcr.ca.gov/dhcs/inmate-dental-services-program/ (last visited Mar. 10, 2020).

117. *See e.g.,* STATE OF IOWA DEP'T OF CORR. POLICIES & PROCEDURES, POLICY NO. HSP-1001: DENTAL SERVICES OVERVIEW 5 (2016) (stating the initiation of orthodontic treatment is one of the services not provided by the IDOC); *see generally* STATE OF DEL. DEP'T OF CORR., *supra* note 93; HAW. DEP'T OF PUBLIC SAFETY, supra note 97; N.C. DEP'T OF

and related dental care may not fit within current carceral budgets. If it is available in a limited capacity such advanced care should be prioritized for inmates with shorter sentences or nearing release to facilitate reentry efforts by improving self-presentation upon release.[118]

Prioritization of Care. BOP and most state policies establish categories of care, ranging from routine to emergency.[119] The names, number, and descriptions of these categories vary by jurisdiction, but most consistently describe routine care as either optional, limited to "eligible" inmates,[120] or not required (but a few states such as Delaware create a right to a cleaning after six months of incarceration).[121] Most of these standards direct facilities to rely upon clinicians' professional opinions in classification of conditions, and most acknowledge that clinically identified emergencies must be handled immediately.[122] In between routine and emergencies, standards vary greatly, but BOP policy summarizes the prioritization process common to most prison systems as "[t]he replacement of teeth is a lower priority than relief of pain and treatment of active dental/oral disease and should be initiated only after all active disease has been treated and risk is managed."[123] Prophylactic care that may require an influx of costs when established, may reduce overall spending in the long-term by curbing the need for higher priced dental care due to lack of oral hygiene.[124]

Professionals and Alternative Staffing. All federal prisons have dental services available, and many employ dentists.[125] States such as California

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PUB. SAFETY, supra note 119; MICH. DEP'T OF CORR. POL'Y DIRECTIVE, supra note 108; OKLA. DEP'T OF CORR., supra note 99.

118. *See* AMY SOLOMON ET AL., URBAN INST. JUSTICE POL'Y CTR., LIFE AFTER LOCKUP: IMPROVING REENTRY FROM JAIL TO THE COMMUNITY 21 (2008) (noting that people leave jail and often face challenges finding and maintaining employment because there is a lack of access to necessary medication, addiction treatment, and health care services).

119. N.C. DEP'T OF PUB. SAFETY, HEALTH SERVICES POLICY & PROCEDURE MANUAL 1 (May 2014); *see Correctional Managed Health Care Policy Manual: Dental Treatment Levels of Care*, TEX. DEP'T OF CORR., https://www.tdcj.texas.gov/divisions/cmhc/cmhc_policy_manual.html (last visited Mar. 10, 2020) (describing patient-inmates' access to services from minor ailments requiring a sick call to more serious ailments requiring treatment services).

120. *See e.g.*, OHIO DEP'T OF REHAB. & CORR., NO. 68-MED-12: DENTAL SERVICES 7–8 (2016) (stating categories vary from Emergency Care at Category 1 to Prosthodontic Care for inmates with a stay greater than three years at Category 4).

121. STATE OF DEL. DEP'T OF CORR., *supra* note 93, at 4.

122. OHIO DEP'T OF REHAB. & CORR., *supra* note 120, at 3, 7.

123. BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 16.

124. *See Oral Health*, WORLD HEALTH ORG. (Sept. 24, 2018), https://www.who.int/news-room/fact-sheets/detail/oral-health (noting that "dental treatment is costly, averaging 5 percent of total health expenditure and 20% of out-of-pocket health expenditure in most high-income countries" but that "long-term exposure to an optimal level of fluoride results in substantially lower incidence and prevalence of tooth decay across all ages").

125. *See* BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 5 (noting that

have been experimenting with increasing the number of hygienists in order to reduce the necessary number of dentists and save money.[126] Some states allow interns from dental schools,[127] private professionals who work as contractors,[128] and inmates who are qualified agents to help with dental care of other inmates.[129] Such practices can broaden availability of care to reduce the provider to inmate ratio while being fiscally responsible and addressing dental care needs. It also offers a mutually beneficial opportunity providing steady work to dental students and other paraprofessionals; particularly in terms of tele-dentistry. Remote care through tele-dentistry would offer work for dental professionals while reducing time to access care and diagnostics.[130] Tele-dentistry would also buffer the consequences associated with dental care deserts where there is an absence of qualified providers in a region.[131] Prisons are often located in less populated rural regions with reduced access to care.[132]

However there are barriers to tele-dentistry. A report on California's efforts to expand telehealth care "identified multiple barriers to wider deployment of telehealth including confusing or contradictory definitions of telehealth, the uncertainty of payment for services, difficulties in developing and sustaining provider networks, the challenge of integrating technology among providers, and lack of training resources."[133]

While such endeavors as the ones outlined here are promising, it is equally important to educate professionals about correctional work to reduce stigma surrounding work with justice-involved populations. Dental professionals may express reluctance to work in a seemingly dangerous environment and receive the lower pay associated with public work, as opposed to private

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there are staffing guidelines for dental clinics at federal prisons and the Chief Dental Officers are responsible for ensuring dental care at each facility).

126. *Inmate Dental Services Program*, *supra* note 116.

127. *See* Fiorella Candamo et al., *Teaching Dental Students About Incarceration and Correctional Dentistry: Results from a National Survey*, 83 J. DENTAL EDUC. 299, 300 (Mar. 2018) (writing that 60% of the responding dental schools provided services to incarcerated populations).

128. *See e.g.,* BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 4 (local dentists may be used to ensure dental services)

129. *See e.g., id*. at 7 (discussing the inmate apprenticeship program).

130. Buddhika Senanayake et al., *Telemedicine in the Correctional Setting: A Scoping Review*, 24 J. TELEMEDICINE & TELECARE 669, 669–70 (2018).

131. *See Facts About Teledentistry*, AM. TELEDENTISTRY ASS'N, https://www.americanteledentistry.org/facts-about-teledentistry/ (last visited Mar. 11, 2020) (reporting that 20% of Americans live in rural areas that do not have access to a dentists).

132. *See generally* Tracy Huling, *Building A Prison Economy in Rural America*, in INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT (Marc Mauer & Chesney-Lind, eds., The New Press) (2002), https://www.prisonpolicy.org/scans/huling_chapter.pdf.

133. Paul Glassman, et al., *Using Telehealth Technologies to Improve Oral Health for Vulnerable and Underserved Populations*, 40 J. CAL. DENTAL ASS'N 579, 583 (2012).

practice.

PART IV. RECOMMENDATIONS AND NEW DEVELOPMENTS

As evidenced by the caselaw and policies described above, the overarching problem with prison dental care can be summarized with one word: delay. Delay in inmate reporting of problems.[134] Delay in securing an initial appointment.[135] Delay in diagnosis.[136] Delay in interim/temporary treatment.[137] Delay in remediation of chronic conditions.[138] Delay in referrals.[139] Delay in routine care.[140] Delay in delivery of dental care supplies.[141] There has been a notable increase in the use of telemedicine in a variety of healthcare settings, and a recent systematic review indicates that prisons are beginning to take advantage of teleconferencing, tele-diagnostics, and tele-clinical observations.[142] There are innumerable ideas for how to improve prison dental care. But if there is one mantra that should pervade all planning it is this: reduce delay. Policies need to be developed that reduce delays in education, awareness, and self-care among inmates; to reduce delays in initial assessments and prophylaxis delivery; to reduce delays in emergency, urgent, routine, and preventive care; reduce delays in identifying qualified clinicians; and reduce delays in gathering data on all of these issues. As Makrides and colleagues suggest, strategic planning needs to occur that takes a holistic approach, not just to the prison dental care system, but also to include inmates, providers, and community partners.[143] The authors are developing a sequential intercept model for strategic planning of prison dental care.[144] In the meantime, however, they offer the following insights for guiding law and policy.

First, there remains a need to understand inmates' oral health needs more

134. Harrison v. Barkley, 219 F.3d 132, 137–38 (2d Cir. 2000); Chance v. Armstrong,143 F.3d 698, 700–02 (2d Cir. 1998); Dean v. Coughlin, 623 F. Supp. 392, 405 (S.D.N.Y. 1985); Heitman v. Gabriel, 524 F. Supp. 622, 627 (W.D. Mo. 1981); McGowan v. Hulick, 612 F.3d 636, 640–41 (7th Cir. 2010); Hartsfield v. Colburn, 371 F.3d 454, 457 (8th Cir. 2004); Farrow v. West, 320 F.3d 1235, 1235 (11th Cir. 2003).

135. *McGowan*, 612 F.3d at 640.

136. *Hartsfield*, 371 F.3d at 456.

137. *Farrow*, 320 F.3d at 1236.

138. *Chance,*143 F.3d at 702.

139. *McGowan*, 612 F.3d at 637.

140. *Dean v. Coughlin*, 623 F. Supp. at 405.

141. *Id.* at 396.

142. Senanayake et al., *supra* note 130, at 672–73.

143. Nicholas S. Makrides & Jay D. Shulman, *Editorial: The Oral Health Needs of the Incarcerated Population: Steps Toward Equal Access*, 107 AM. J. PUB. HEALTH S46, S47 (2017).

144. *Id*.

fully.[145] Current research sheds light on the issue, but national data with more granular detail are necessary for proper policymaking.[146] Makrides and colleagues also outline important action items. They recommend adding inmates to the Surgeon General's annual National Health and Nutrition Examination Survey (NHANES); moving to electronic medical records (EMRs) in correctional institutions; developing guidelines for clinicians and a priori program outcome measures; and improving partnerships with dental care stakeholders within and outside correctional systems.[147]

Inmate related delays. Given that inmates arrive into prison with higher rates of oral health troubles than those in the general population, it is probably safe to assume that life circumstances caused them to either undervalue oral health, to be undereducated on the importance of oral health for physical and social health, and to have missed opportunities to see a dentist regularly or otherwise enjoy regular oral health care.[148] It also is safe to assume that a large percentage of them will have compromised oral health as a result of drug abuse.[149] With these prior assumptions, planning is possible. Time lost to these delays cannot be recaptured, but it can be remediated through education and simple interventions. It is also possible that job skills and counseling can impact their behaviors, as well.

Inmates need to be accountable for their care, as well. Several studies suggest that many delays, at least in part, arise when inmates fail to follow the rules,[150] fail to keep appointments,[151] or fail to follow prescribed interventions.[152] These behaviors can be managed with proper education, perhaps as simple as brochures on how to seek dental care as recommended

145. *Id.*

146. *Id*.

147. *Id.*

148. *See id.* at S46 (noting "[m]any inmates come from disadvantaged backgrounds, and enter prison with histories of substance abuse and mental illness").

149. *Id.*; Kathryn M. Nowotny, *Health Care Needs and Service Use Among MalePprison Inmates in the United States: A Multi-Level Behavioral Model of Prison Health Service Utilization,* 5 HEALTH & JUST. 1, 9 (2017); Raija Vainionpää et al., *Oral Health and Oral Health-Related Habits of Finnish Prisoners*, 3 BDJ OPEN 1–5 (2017).

150. *See* King v. Cox, No. 3:16-cv-00177-MMD-WGC, slip op. at 1 (D. Nev. May 25, 2018) (noting that rules, as used here, can mean anything from internal policies about how dentist appointments are requested or how wait lists are maintained); s*ee also* Bell v. Wexford Health Sources, No. 17-cv-1301-JPG-RJD, 2018 WL3145850, at *3 (S.D Ill. June 4, 2018) (discussing failure to comply with exhaustion requirements concerning administrative remedies); *see also* Watford v. Newbold, No. 17-cv-1252-MJR-SCW, 2018 WL5914820, at *1 (S.D. Ill. June 19, 2018) (illustrating a more problematic issue, whether inmates have been or are being disingenuous).

151. S*ee* BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 9 (discussing that the BOP anticipates this problem and removes inmates from the routine dental care eligibility list after two "failed" (missed) appointments).

152. *Id.* at 12.

by the BOP.[153] Encouraging, and requiring, inmates to assume responsibility for their dental care can pave the path of ownership when they return to the community to spur a desire for continued care.

System related delays. System related delays, or those that arise from the policies and procedures surrounding delivery of dental care in a dangerous environment, are numerous, relatively unique to prison settings, and thus complex.[154] Starting at the most basic level, delays arise because of the archaic "chit" system by which inmates must submit a request for a dental appointment, in writing, on a prescribed form.[155] Often, the forms cannot be located, and inmates frequently do not have access to writing instruments to complete the forms.[156] Offering more frequent opportunities to report dental concerns through free-standing kiosks or correctional officers circulating regularly throughout the facility to gather requests as part of their dedicated duties can facilitate access to care.

Another set of delays arise when clinicians only dedicate a certain number of days to service a given prison.[157] It is not realistic to expect smaller prisons and jails to maintain a dentist on staff, nor is it realistic to think that smaller communities (where prisons usually are built) have enough dentists in town to sustain an on-call system.[158] Therefore, delays in care often arise because there is no dentist available.[159] For example, if an inmate develops a fever due to an infected tooth on Tuesday, but the dentist only visits on Mondays, it will be hard to figure out how to get him or her the care they need in sufficient time so as to not exacerbate the problem. Protocols can be developed, and community partnerships forged, to anticipate these kinds of delays and get care from alternative sources.

Institutionalization related delays. Prison is prison. Thus, prison dental care planning must consider the literal and metaphorical confines of the prison environment. Security is paramount, and often appointments cannot

153. *Id.* at 13.

154. Patterson v. Pearson, 19 F.3d 439, 440 (8th Cir. 1994).

155. DOUDS & AHLIN, *supra* note 42.

156. *See* Laura Rogers et al, *Bending Bars: A Dialogue Between Four Prison Teacher-Researchers*, 3 Survive & Thrive: A J. for Med. Hum. and Narrative as Med. 73, 80 (2017) (describing an inmate's account on the lack of pens and pencils); *see also* Hayden P. Smith et al., *Working with Prisoners Who Self-Harm: A Qualitative Study on Stress, Denial of Weakness, and Encouraging Resilience in a Sample of Correctional Staff*, 29 Crim. Behav. & Mental Health 7, 11 (2019) (describing how pens and pencils can be used to cause harm in prisons); *but see* MO. DEP'T OF CORR., INMATE INFORMATIONAL HANDBOOK 82–88 (2012), https://www.bop.gov/locations/institutions/spg/SPG_aohandbook.pdf (listing pens and pencils as acceptable personal items for inmates).

157. James E. Robertson, *Correctional Case Law: 2010*, 36 Crim. Just. Rev. 232, 234 (2011).

158. DAVID REDEMSKE, PROVIDING HEALTHCARE IN THE PRISON ENVIRONMENT 92 (2018).

159. Robertson, *supra* note 157.

be kept, or dentists cannot visit, when inmates get into fights or prisons go on lock-down.[160] These delays are the least avoidable and also the least likely to give rise to liability because prison guards are obligated to follow established procedures during counts, fights, and emergency situations.[161] Everyone concerned understands that prison requires security protocols that do not exist in any other clinical settings. But planning can happen that anticipates these events and makes alternative arrangements to ensure follow-up is pursued and care is received.

Similarly, inmates transfer among facilities for a variety of reasons.[162] They may move from a short term, pre-trial facility (jail) to a prison if convicted. They may move when prisons are consolidated or re-designated by classification level (e.g., minimum, medium, maximum security).[163] Inmates may also move due to an increase or decrease in the level of security they require or a space may become available in a treatment or job training program.[164] Additionally, they may move upon their own request to be closer to home or as their sentence dwindles toward release. Delays arise in records transfers that can cause inmates to miss months of medical and dental care.[165] Regardless of the reason, transfer delays could be ameliorated if facilities used electronic medical records (EMRs). There are definitely problems with interoperability of various institutions' EMRs, or whether one system "talks" to the other, but those kinds of technological problems should dissipate as more facilities adopt technology and explore means of deploying it efficiently.[166]

Delays due to clinician/practitioner availability are ubiquitous as health and dental care deserts persist throughout the United States.[167] These provider shortages in the community transfer to carceral settings as some prisons do not have dedicated medical staff and rely on practitioners from the community or struggle with filling open positions as they compete with a robust private job market. Prisons that share practitioners with the

160. AM. BAR ASS'N, *Standards on Treatment of Prisoners* https://www.americanbar.org/groups/criminal_justice/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners/ (last visited Apr. 6, 2020); U.S. DEPT. OF JUST., FED. BUREAU OF PRISONS, PROGRAM STATEMENT: VISITING REGULATIONS 1 (2006)

161. AM. BAR ASS'N, *supra* note 160.

162. LIS, INC., INTERSTATE TRANSFER OF PRISON INMATES IN THE UNITED STATES 12 (2006).

163. *Id.*

164. *Id.*

165. DOUDS & AHLIN, *supra* note 42, at 126–27.

166. R.S. Evans, *Electronic Health Records: Then, Now, and in the Future*, Yearb Med. Inform. 48–61 (2016)

167. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, 2018 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 1 (2019), https://www.ahrq.gov/research/findings/nhqrdr/nhqdr18/index.html.

community may also face logistical delays as dentists and hygienists may not reside in the rural location where prisons tend to be built. Misunderstandings about payment requirements may arise that delay care, as well. Prison personnel and clinicians may be confused about alleged pre-pay requirements, which at least one court has found to be unconstitutional. But as discussed above, payment policies vary by state. In *Formica v. Aylor*, the prison's *Inmate Handbook* specifically prohibited denying medical services due to an inmate's inability to pay.[168] Directives about when dental care should be allowed or refused based on ability to pay are not clear in other jurisdictions.

Data collection delays may present themselves at various time points throughout the course of inmate diagnostics and classification. At entry to prison, new inmates should receive a screening to identify immediate needs and determine appropriate housing location. There are many moving parts to the diagnostic and classification system and security prevails. Pressing medical care needs would be a close second, with dental care trailing behind. The copious amounts of data that need to be gathered, collated, and interpreted is overwhelming and decision must be made to triage which priorities to tackle first.

Ending on an optimistic note: Promising innovations. Three developing innovations respond to the concerns outlined above in one or more respects. Tele-dentistry and virtual clinics are the most promising and the most scalable. But corrections-community partnerships also hold promise, and inmate apprenticeship programs signal willingness to think outside the box but inside the walls, a much-needed intellectual flexibility in correctional health care. Each of these four programs are discussed in turn.

Virtual clinics. California Virtual Dental Home project is a promising option to improve access to dental care in carceral settings.[169] Dental hygienists or assistants are on site, and they either confer synchronously or use a "store and forward" model.[170] The remote dentists determine a course of treatment, then supervise the hygienist or assistant in real time as they undertake procedures.[171] This approach is not appropriate for complex cases, but it would fit many of the situations that contribute to the unacceptable delays in routine and urgent care.[172] The software used in this particular program is cloud-based Denticon.[173] A similar endeavor is the Apple Tree

168. Claire Angelique Nolasco & Michael S. Vaughn, *Section 1983 Liability Against Prison Officials and Dentists for Delaying Dental Care,* CRIM. JUST. POL'Y REV. 1, 8 (2019).

169. Paul Glassman et al., *Using Telehealth Technologies to Improve Oral Health for Vulnerable and Underserved Populations*, 40 J. CAL. DENTAL ASS'N 579, 581 (2012).

170. *Id.* at 580.

171. *Id.* at 581.

172. *Id.* at 582.

173. *Id.* at 581.

project in Minnesota.[174] To provide care to populations facing physical, financial, or geographic access barriers, "dentists make decisions using live videoconferencing, digital radiographs, Diagnodent readings, and high-resolution intraoral video and still images."[175] Decisions made using this program generally matched those made during videoconferences and follow-up face-to-face examinations.[176] A program like this could be effectively used to examine inmates at a low cost before having a dentist see them face-to-face. BOP policy anticipates that all facilities will move to EMRs.[177] This is a noble goal. But in reality, there are severe political, practical, and cost constraints on developing EMR programs in prisons.[178]

Partnerships with educational institutions. Among 30 respondents to a survey of dental schools in the United States, 67 percent included dental care of incarcerated people in their curriculum, and eight percent had clinical programs that served correctional institutions.[179] Most commonly, fourth-year students at these schools undertook externships and provided oral exams, prophylaxis, and extractions in community-based settings that also served prisons.[180] Just over half of all 30 respondents said that "graduates of [their] institutions are prepared to care for patients who are incarcerated."[181]

Although promising and practical, educational partnerships present challenges, as well. First, who will supervise the clinical intern? While adding capacity to the dental workforce, the addition of interns in a sense adds additional labor costs and burden. Oversight of clinical interns remains a problem in many institutions and supervising an intern can increase the supervisor's workload. Moreover, BOP's Commissioned Officers Student Extern Program (COSTEP) policy may compound that potential time and administrative burden by limiting externships to "short-term engagements" and through other conditions set forth in the annually-reviewed externship Memoranda of Understanding (MOUs).[182]

Inmate Education. Correctional facilities can distribute educational materials during admission and orientation, and again at first medical appointment. Diet and nutrition education, with explanation of the relationship between diet and dental care, may positively affect oral health.

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174. *Id.* at 582.
175. *Id.* at 582–83.
176. *Id.* at 583.
177. BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 23.
178. Glassman, supra note 169, at 583.
179. Fiorella Candamo et al., *Teaching Dental Students About Incarceration and Correctional Dentistry: Results from a National Survey*, 82 J. DENTAL EDUC. 299, 302–03 (2018).
180. *Id.* at 301.
181. *Id.*
182. BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 6.

A study in Scotland found that prisoners given education on how diet, oral care, and other habits such as smoking affect oral health retained this information and generally showed more knowledge about oral health.[183] However, such programming had little effect on oral health-related attitudes and no effect on oral health-related behaviors.[184] Instead, the length of time of current imprisonment was far more predictive of oral health behavior.[185] A similar study in Texas state prisons provided inmates with several preventive appointments with the goal of assessing and treating current oral conditions as well as educating inmates on how to take personal responsibility for their oral hygiene.[186] This study found that, in order to attain acceptable oral hygiene (defined as having less than 20% of tooth surfaces covered in plaque) inmates needed an average of 2.15 appointments.[187]

Inmate Apprenticeship Programs. Ideally, trusted inmates can mitigate staffing problems and gain valuable job skills training by serving as dental assistants or orderlies in dental clinics. The BOP acknowledges an Inmate Dental Assistant Apprenticeship Program and requires that all inmates who are "chair-side dental assistants" must be certified through the "Department of Labor Dental Assistant Apprenticeship Program, or a similar certification program in the local community approved by the institution's education department."[188] In reality, inmate dental assistants can only do so much. They cannot engage in any direct patient care; they cannot handle pharmaceuticals or dangerous equipment; and they cannot access or see any patient records.[189] But even with those confines, there are creative ways that inmates could be helpful while at the same time learn useful skills to increase their employability after release. The certification alone has marketable value, and the fact that they were trusted to serve in a dental clinic signals to future employers that they are more trustworthy than otherwise might appear.

CONCLUSION

Prison dental care law and policy are moving towards more cost effectiveness but also towards greater understanding of the implications of oral health and successful reintegration following incarceration. Future research should consider best practices for interventions to improve access to care. As importantly, prison dental care programs should emphasize the

183. Tahira Akbar et al., *The Health-Promoting Prison: Can it Improve Oral Health?*, 50 INT'L J. HEALTH PROMOTION & EDUC. 169, 175 (2012).

184. *Id.*

185. *Id.*

186. Pamela J. Myers, *Gauging the Effectiveness of a Preventive Dental Program in a Large State Prison System*, 6 J. CORRECTIONAL HEALTH CARE 207, 208–09 (1999).

187. *Id.* at 219.

188. BOP PROGRAM STATEMENT: DENTAL SERVICES, *supra* note 73, at 7.

189. *Id.* at 8.

importance of good oral health to incarcerated persons so that they can take ownership of their dental care and more effectively plan for return to communities.