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# Situating Dental Health in the Wider Social Context of Mass Incarceration and Structural Violence

My Community Based Learning Initiative Project was a visit to UIH Family Partners to learn about dental health issues men in their fatherhood programs face. Dental healthcare may be a cosmetic standard in part, but poor dental healthcare has devastating consequences. Physical dental problems are serious, even life threatening, and poor dental health also causes emotional issues and affects the way one is perceived in society. In his song, "Crooked Teeth," hip hop artist J. Cole raps, "They tell me I should fix my grill cause I got money now. I ain't gon' sit around and front like I ain't thought about it" but continues, " I keep my twisted grill, just to show the kids it's real. We ain't picture perfect but we worth the picture still." In not fixing his teeth, he acknowledges that dental care is an issue for people in his community. This positive show of solidarity notwithstanding, more serious dental issues make obtaining employment and supporting oneself very difficult. Naomi Murakawa explains concisely but cogently, "rotten teeth become the physical marker of decline"(Gottschalk 130). A program participant my group was able to speak with said he does not like to talk a lot, let alone smile, and he commented, "sometimes the way you look prevents you from getting a job." Moreover, a client specialist at UIH told my group that he had just spoken with two men in two weeks who said they didn't do well in interviews because they had abscesses and didn't want to

open their mouths due to the physical condition of their teeth (their abscesses gave off an odor) and the lack of confidence and self-esteem that goes with that.

There are myriad ways to situate poor dental health within its wider social context; for this paper, a social context that particularly interests me is situating poor dental health care in the context of involvement in the criminal justice system. Poor dental health compounds already existing barriers of reentry into society and self-sufficiency. The health problems, low self esteem, and cultural stigma of missing or rotting teeth further block men who have been incarcerated from obtaining employment and having a chance to support themselves and contribute to society. I will also center lack of proper dental healthcare more broadly within the context of structural violence. Paul Farmer, who calls for the need to address structural violence, argues that, "Social factors including gender, ethnicity (race), and socioeconomic status may each play a role in rendering individuals and groups vulnerable to extreme human suffering" (Farmer 42). One of the main ideas this course has critiqued is that biomedicine is a neutral force of good and along with that, this course has also questioned that all human lives are treated as having the same value and confronted biomedicine's inability to address structural violence. Countless examples, from Vita to "Island of Flowers" and "When I Walk," show that certain populations, namely the poor and minorities, don't benefit from equal standards of living including medical care; in this context, specifically dental healthcare. In line with Farmer's idea that in a lens of examining structural violence, we need "more systemic analyses of power and privilege in discussions about who is likely to have their rights violated and in what ways" (Famer 47), I will explore how those affected by mass incarceration are certainly one large segment of society that is not equally valued.

Why is mass incarceration an important context to consider? Firstly, it is an important and troubling phenomenon in it of itself; Michelle Alexander notes in her book, The New Jim Crow, Mass Incarceration in the Age of Colorblindness, "The United States now has the highest rate of incarceration in the world, dwarfing the rates of nearly every developed country." The sheer numbers are staggering. "Federal, state, and local governments in the United States currently hold about 2.3 million people in prisons and jails and supervise another 5.1 million people on parole or probation…these figures translate to about one in 100 American adults behind bars and about one in 33 American adults under some form of correctional control" (Schmitt and Warner 2). Moreover, Alexander notes the troubling racial implications of mass incarceration: "No other country in the world imprisons so many of its racial or ethnic minorities" (Alexander 6). She asserts the disturbing reality that, "for reasons largely unrelated to actual crime trends, the American penal system has emerged as a system of social control unparalleled in world history" (Alexander 8). The relevance of this social context framing for dental healthcare is evident in returning to J. Cole's "Crooked Teeth," where he raps in the third verse, "Look at the nation, that's a crooked smile braces couldn't even straighten Seem like half the race is either on probation Or in jail." This is not an exaggeration: Alexander writes, "In Washington, D.C., our nation's capitol, it is estimated that three out of four young black men (and nearly all those in the poorest neighborhoods) can expect to serve time in prison. Similar rates of incarceration can be found in black communities across America" (Alexander 7).

In terms of mass incarceration's relationship to UIH and dental health, as soon as I read that UIH works with men that face "multiple systemic barriers to self-sufficiency,"

I thought of the formerly incarcerated. It turns out that was a reasonable connection to make; approximately 75% of the people UIH serves have been incarcerated, according to an informational packet they gave us. More specifically, I thought of the obstacles the formerly incarcerated face upon reentry. While reentry may literally mean the process of leaving prison and returning to society, reentry is unfortunately not that simple. Alexander explains, "Through a web of laws, regulations, and informal rules, all of which are powerfully reinforced by social stigma, [the formerly incarcerated] are confined to the margins of mainstream society and denied access to the mainstream economy. They are legally denied the ability to obtain employment, housing, and public benefits" (Alexander 4). James B. Jacobs reiterates in The Eternal Criminal Record that "In addition to facing legally imposed forfeitures, disqualifications, and ineligibilities, people with criminal records face extensive discretionary (de facto) discrimination, especially employment discrimination. Given the importance of legitimate employment for desisting from further criminal conduct, de facto discrimination is a serious obstacle to postconviction success" (Jacobs 275). In other words, the formerly incarcerated are systematically denied the means to employment and self-sufficiency, and poor dental healthcare is a further compounding barrier. Many people get caught up in cycles of debt from fines, court costs, and restitution, and without an ability to make money, often return to behavior deemed criminal with no other choice. The client specialist we talked to at UIH lamented that the system is set up for people to go back to prison, and mentioned someone who does get supplemental security income but has to live off of $160 a month after paying the rent and has a $27000 surcharge for driving without a license who is thinking about going back to selling drugs because he has no options. Education is one of the best

weapons of obtaining good employment and fighting recidivism, but health care is a huge part of the issue as well when dental issues exacerbate barriers to employment.

It is important also to think about this context of reentry challenges and mass incarceration in larger terms of structural violence. Marie Gottschalk argues in a chapter on reentry in her book, Caught The Prison State and the Lockdown of American Politics, that a tendency to "[frame] reentry in narrow human capital terms focuses public attention on correcting the reported inadequacies of offenders and ex-offenders. It deflects public policy away from correcting the deeper structural problems in the U.S. economy" (Gottschalk 80). In a similar vein, a focus on fixing dental health care with analyses focusing on individuals with poor dental health not properly educating themselves or their children on dental hygiene ignores the structural violence and healthcare disparities in the United States.

An article from the Journal of the California Dental Association called "Promoting oral health through community engagement" emphasizes individual behavior, saying that "The most important contribution… [to healthy lives (40 percent in a pie-chart of factors that lead to long and healthy lives in general, which they deem analogous to dental health specifically)] arises from personal behaviors performed at the discretion of the individual" (465 Glassman). The article calls for a need to overcome obstacles to oral health prevention asserting "it is clear that the most effective strategy for improving the oral health of the population is one that would result in changes in individual behaviors known to promote oral health" (Glassman 466). While the need "for a broader emphasis on influencing individuals' daily behaviors through health promotion activities and community organizations" (Glassman 466) is not a problem in it of itself, it

is problematic to focus exclusively on the individual rather than systemic or institutional barriers to oral health. Paul Farmer contends, “to explain suffering, one must embed individual biography in the larger matrix of culture, history, and political economy.” Poor dental health from a lack of tradition of oral hygiene stems for example, from poverty. The client specialist we spoke to said he grew up in poverty and explained that the standard for dental health was only going to the dentist for pulling teeth, when you were really in trouble. Also, for those in economically depressed communities in which parents are forced to work multiple jobs to support themselves, there is not a lot of parental enforcement for daily brushing of teeth. Going back to the wider context of incarceration, even if someone isn’t incarcerated themselves, the ripple effects or intergenerational affects of incarceration and disinvested communities are crippling. The program participant we were able to meet at UHI said he didn’t visit the dentist like he should have growing up in foster care; he wasn’t incarcerated, but both of his parents were since he was born.

Gottschalk opines, “The deeper socioeconomic and other factors that prevent offenders and ex-offenders from securing gainful employment that lifts them out of poverty and keeps them out of prison often are rendered invisible or inconsequential” (Gottschalk 81) which is equally true for dental health. The very fact that undergraduate students are being asked to formally prove the need for dental health for the population at UIH is proof that it is not a national priority.

One can also identify deeper socioeconomic factors that situate poor dental healthcare in the context of structural violence, and in doing so, there are several that feed off one another as part of intersectional marginalization. Poverty and mental health

problems go hand in hand with self-medication and addiction that is criminalized rather than treated and then leads back to incarceration. In other words, inadequate mental healthcare and addiction as a criminal rather than a public health concern is another facet of the way that dental health can be situated in terms of mass incarceration and structural violence. The incarcerated are particularly vulnerable to mental illness: "About one-quarter of state prisoners have a recent history of mental health problems" (Gottschalk 82). Moreover, prisons essentially function as this country's mental health facilities. Gottschalk notes, "As of 2012, ten times as many people with severe mental illnesses were housed in U.S. prisons and jails compared to the number of people with such illnesses who were residing in state psychiatric hospitals" (Gottschalk 82). Furthermore, this directly relates to the formerly incarcerated men at UIH because "The prevalence of psychiatric symptoms is about twice as high among formerly incarcerated men compared to the general population" (Gottschalk 82). Not all people with mental health problems face addiction but there is a connection between mental health, self-medication, and addiction and "Sixty percent of all state prisoners report using illegal drugs in the moth prior to their offense" (Schmitt and Warner). What's more, addiction problems exacerbate poor dental health. So, in situating inadequate healthcare, one must consider that addiction is not treated as a public health issue but one of criminality. Incarceration is not rehabilitative so most formerly incarcerated not only have not received adequate treatment and counseling for addiction, but have dental health problems resulting from addiction on top of that and no dental health care.

Another part of the larger context of structural violence that the formerly incarcerated with poor dental health face are the low quality halfway houses that partner

with UIH. One of these is called Bo Robinson, and recently, two men from there died of an overdose. A subsequent investigation has found very low quality standards of care for the men there which is not a discovery being made for the first time. An article on the incident notes a previous New York Times article that "documented rampant drug use, violence and understaffing at the halfway house" (Foster). Therefore, structural violence in the institutions of halfway houses, which are an extension of the penal system that are systematically inadequate and abusive, is another wider context for the men with dental healthcare issues at UIH.

You can situate the lack of dental health care among the disadvantaged population that UIH works with even more largely as a symptom of a capitalist society where the poor are chronically marginalized and disadvantaged. There is a dental health center right next to where the UIH program is located but their goals are fiscally, not socially oriented; their mission is to make money, not improve society. Since Obamacare, men can use expanded Medicaid to get dental healthcare but deductibles can still be several hundred dollars. It is hard for UIH to find organizations to partner with to help the men they work with get dental healthcare because of these deductibles and long waiting periods, and dentists don't want to work pro-bono. This framing of structural violence in terms of capitalism intersects with addiction because another neighbor to the UIH program is a liquor store that opens every day of the week at 7:30 a.m. A program manager we spoke to wondered how the owners could feel okay about that, and wished there could be a rule mandating them to wait until at least the afternoon to open to give the men he works with a fighting chance to participate in his program. But the capitalist

model isn't based on ethical or moral ideals but a moneymaking imperative above all else.

Food deserts in under resourced communities in which healthy food options are limited and unaffordable is another element of structural violence exacerbating the possibilities of dental health for under resourced communities. While this may seem obvious, one of the major findings of a study, "The relationship between lifestyle and self-reported oral health among American adults" is that "individuals who had poor diets were more likely to report bad teeth and have bad oral experiences than those who had excellent diets" (Liu). Going back to the article from the California journal of medicine, it is dangerous to reduce health to lifestyle choice when the 'choices' of people in under resourced communities are limited.

One can even argue that NGOS are a part of structural violence. We learned at our visit that there are a stunning 2630 nonprofits in Mercer County alone, which by itself demonstrates the failing of public institutions to provide services to Americans and value all American lives equally. But even the non-profit organizations that are there to assist the disadvantaged operate in a problematic way. Firstly they are not collaborative; the program manager complained that, "everyone operates in a silo." What's more, when funders dictate how NGOS are supposed to help, structural violence is taken a step further when the already more powerful and economically resourced dictate and thus limit the flexibility of program possibilities for creating solutions.

In closing, an understanding of mass incarceration and the anthropological concept of structural violence illuminates dental healthcare's wider social context. Lack of dental healthcare presents people with serious health issues and affects one's job

prospects because of societal stigma of missing or rotten teeth. This barrier to employment is unfortunately only one of myriad already existing barriers for the formerly incarcerated. Lack of mental health care and addiction treatment, inadequate institutions that are extensions of the penal system, and the American capitalist environment in which the poor are chronically disadvantaged, all intersect among other factors in the larger context of structural violence.

This paper represents my own work in accordance with University regulations.

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