Overcoming barriers to dental care for adults with intellectual and developmental disabilities

It is well documented that adults with intellectual and developmental disabilities (IDD) experience an increased burden of dental disease, which is negatively impacted by the lack of competent, willing dental providers to meet their needs.[1,2] Dental practitioners report many barriers to caring for this diverse and vulnerable population, including time limitations, insurance reimbursement, and lack of training.[2,3] Furthermore, there are few dedicated facilities that are designed and specially equipped to easily treat adult patients with special needs. The needs of patients with IDD are rightfully at the forefront of political discourse. It is incumbent upon the dental profession to strive to overcome these barriers and better meet the needs of patients who are so often overlooked.

The primary barrier reported by general dental practitioners to caring for adult patients with IDD is lack of focused training.[4] This shortcoming in dental education is becoming more widely recognized. In the United States the Commission on Dental Accreditation (CODA), which provides requirements for dental education nationwide, updated its standards for predoctoral dental education in 2019. While it is certainly an improvement from previous guidelines, it can be argued that this standard still falls short of requiring adequate preparation of graduating dental practitioners to care for this population. One of the challenges in providing adequate training in the treatment of adult patients with IDD is finding the opportunity for learners to directly care for individual patients. There is a common saying among dental practitioners who treat adults with IDD that "If you've seen one patient with IDD, you've seen ONE patient with IDD." The more exposure that can be afforded to learners, the more prepared and confident they will feel in treating their complex patients in their practice lives. While any patient encounter is certainly a valuable one, CODA's intent that "Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques including the use of respectful nomenclature, assessing the treatment needs compatible with the special need, and providing services or referral as appropriate" falls far short of adequately preparing undergraduate dental learners.[5]

Addressing the shortcomings of predoctoral education is one part of this complex equation, but what of the practicing clinician? Waldman et al[6] commented in a 2011 editorial that "The barrier in the case of access to care is not one's ability to learn how to provide dental care to patients with special needs, but one's desire to provide dental care to patients with special needs." It is of course unethical, not to mention illegal, to refuse care to a person because of their disability. Some practitioners state that they do not possess the skill to adequately meet the needs of these patients. Arguably, there are minimal unique skills required to treat adult patients with various behaviors. A willingness to treat patients unconventionally is a skill that all dental practitioners possess. We are faced with challenges on a daily basis that require a creative solution, from repairing restorations that should be crowned to offering less-than-textbook treatment options to patients with financial constraints. These skills translate easily to the treatment of adult patients with IDD.

There are many straightforward behavior guidance techniques that can be used in a private practice setting for patients with difficulty cooperating for routine dental care. Some patients require desensitization to the new dental setting. This can be performed in short increments, extending the duration over time, and may not need the dental practitioner to be present. Identifying practice staff who have the skills and desire to work with patients with IDD can be helpful in desensitizing patients with anxiety or IDD. One of the most useful tasks for the dental practitioner to complete is evaluation of home hygiene followed by education and motivation of the caretaker. Simple recommendations such as brushing by quadrant, using a foam bite block, standing behind the person during brushing, and using fluoride supplementation can be immensely helpful in improving oral health. Additionally, newer restorative methods with glass ionomer or silver diammine fluoride can be useful for patients who have difficulty cooperating for more technique-sensitive materials. If a patient becomes uncooperative at the prospect of a local anesthesia injection, frequently restorations can be completed without anesthesia. Furthermore, a low-dose

prescription for a benzodiazepine or use of nitrous oxide (for patients without contraindications) can allow for a less stressful environment if other behavior guidance techniques have failed.

There is no doubt that there are some individuals who can only receive dental care safely under general anesthesia due to challenging behaviors, however, there is a crisis in available operating room time. Therefore, it is compulsory for practicing dental practitioners to make room in their practices for adults with special needs. Continuing dental education courses that focus on the treatment of this unique population are available, but sparse. Providing treatment is frequently more straightforward and far more rewarding than anticipated. We began our careers in dentistry to help meet the needs of our community, and there is no population with greater need than our adult patients with intellectual and developmental disability.

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References

1. Devinsky O, Boyce D, Robbins M, Pressler M. Dental health in persons with disability. Epilepsy Behav 2020;110:107–184.
2. Morgan JP, Minihan PM, Stark PC, et al. The oral health status of 4,732 adults with intellectual and developmental disabilities. J Am Dent Assoc 2012;143:838–846.
3. El-Yousfi S, Jones K, White S, Marshman Z. A rapid review of barriers to oral healthcare for vulnerable people. Br Dent J 2019;227:143–151.
4. Lim M, Liberali S, Calache H, Parashos P, Borromeo GL. Perspectives of the public dental workforce on the dental management of people with special needs. Aust Dent J 2021;66:304–313.
5. CODA accreditation standards for dental education programs. www.ada.org/coda. Accessed 20 Dec 2021.
6. Waldman HB, Castillo JL, Larrabure G, Perlman SP. Dentistry for Peruvian residents with special needs: a commentary. Spec Care Dentist 2011;31:226–228.

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