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CHALLENGES TO ORAL HEALTH CARE FOR THE INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS

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ABSTRACT: Individuals with special health care needs are often neglected in providing dental services. This article reviews the oral health status and various challenges in utilization of dental health care services by faced the individuals with special health care needs.

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KEYWORDS: Challenges, Oral Health Status, Special Health Care Needs

INTRODUCTION

People with special needs are most underserved in our society. They have more dental diseases, more missing teeth, and more difficulties in obtaining dental care than other segments of the population. The combination of inadequate attention to prevention, greater disease burden, and scarce treatment results in pain, suffering and social stigma in these populations beyond that found in other segments of our society[1].

Individuals with special health care needs have been reported in literature to have poorer oral hygiene and periodontal status, more untreated caries and fewer remaining teeth.[2,3] Their oral health condition may be influenced by age, severity of impairment and living conditions.[4,5] They may have great limitations in oral hygiene performance due to their potential motor, sensory and intellectual disabilities, and so are prone to poor oral health. This group of individuals may also not understand and assume responsibility for or cooperate with preventive oral health practices. Those who are very young, those with severe impairments, and those living in institutions are dependent on parents, siblings or caregivers for general care including oral hygiene.

Oral Health Status

About 500 million people worldwide are disabled.[6] According to the recent data out of **21.9 million** disabled people in the India – that constitutes about **2.13 per cent of the total population** - 1.03 per cent are visually impaired, 0.16 per cent speech impaired, 0.12 per cent 'hearing' impaired, 0.59 per cent 'movement' impaired and 0.22 per cent 'mentally' disabled of the total national population. However, Disability sector feels that the Census result is highly underestimated. It claims that 5 % of population has one disability or the other.[7]

Researchers throughout the world have studied a wide range of disabling conditions. Reviews of epidemiological studies have indicated that persons with disabilities generally have more oral health problems and their oral treatment needs are greater than those of the general population.[6,8,9]

There is a wide range of dental caries rates among people with Special Health Care Needs; **DP Gupta et al, (1996)[10]** reported highest prevalence of dental caries in mentally retarded children followed by cerebral palsied, blind, epileptic, physically handicapped, children with Down's syndrome and deaf and dumb. **Tiller S (2001)[11]** assessed Oral health status and dental services use of adults with learning disabilities living in residential institutions and in the community and he reported mean DMFT score of 13.5 for all subjects.

Some of the reasons given for increased occurrence of dental caries and poor oral hygiene in this group of individuals are increased thirst, 'eating for consolation' or

'comfort' consumption of sweets and drinks, long-term consumption of medications in form of sweetened syrups and because of lack of oral hygiene practices.[3]

BARRIERS AND CHALLENGES

1. Dependency[12]

Persons with severe physical and mental disabilities who are dependent on caregivers for daily oral care characteristically have poor oral hygiene and a greater prevalence of periodontal disease. Caregivers play a pivotal role in dental disease prevention, yet many are not motivated to provide such care. Deterrents to adequate care include high staff turnover, low appreciation of oral health, fear due to resistive behaviour by patients, and lack of adequate training.

2. Barriers Related to Health Professional Workforce[12]

Barriers related to the health professional workforce are manifold and include issues of numbers, distribution, diversity, and competency of dentists, hygienists, and primary care health professionals. Education in special patient oral health care is needed at all levels, from advanced training for dental professionals, to interdisciplinary instruction for professionals in other health and social service fields, to ongoing courses for nurses' aides and personal attendants. The acute shortage of professional and nonprofessional personnel who can serve the oral health needs of persons with disabilities in community and institutional settings has been well documented.

A. Lack of Dental Professionals with Advanced Training[12]

The numbers of practitioners willing to treat patients with disabilities are less. Practitioners are selective in whom they would accept and indicates a greater reluctance to treat persons with developmental or psychiatric disabilities than with physical problems. Furthermore, a survey of 300 state institutions for persons with developmental disabilities revealed that more than 80 percent of 283 responding dentists were poorly prepared or unprepared for treating their facility's residents; for 85.9 percent of the dentists, training was "on the job." Responses by dental auxiliaries indicated even less preparedness.

B. Lack of Trained Caregivers[12]

Many persons with severe disabilities are completely dependent on caregivers for maintaining an adequate oral hygiene level. In institutional settings, such residents can be extremely uncooperative and present problems for attendant staff who generally view oral care as a low priority and an unpleasant task. They are uncomfortable with saliva and gingival bleeding and are afraid of disruptive behaviour. The task of oral hygiene procedures falls mostly on attendants who characteristically are poorly paid, poorly educated, place a low value on oral health, and have a history of poor dental care and oral hygiene themselves.

C. Lack of Number of Dental Professionals[13]

At present India is producing 12,000 dentists per annum with a dentist to population ratio of 1:15713, in contrast to the WHO recommended dentist to population ratio of 1:75000. With this ratio, the individuals with Special Health Care Needs take the last seat in receiving dental care. There are no dentists posted at community health centre and primary health centre levels in most of the states.

D. Un Even Distribution of Dental Professionals[14]

The geographic distribution of dental providers is increasingly problematic in meeting the needs of underserved populations. At the moment India has one dentist for 10,000 persons in urban areas and about 2.5 lakh persons in rural areas. Almost three-fourths of the total numbers of dentists are clustered in the urban areas, which house only one-fourth of the country's population. The number of dental colleges has increased to meet the demands of the society, but there is a massive flaw in the geographic distribution of the colleges. Out of these 161 colleges, fifty are situated in one state only, and out of these colleges around fifteen are situated in one city only. Only 2 percent of the specialists are being trained in community dentistry, whereas in a country like India where the majority of the population resides in the rural areas, there is greater need for these specialists.

E. Unwillingness by Dentist[6]

Private Practitioners do not feel to treat the patient with mental retardation or with some other disabilities as it requires more time and efforts. They tend to avoid these patients or react with frustration and apathy. Patients with such complex needs require the services of special programs, clinics, and facilities staffed by personnel with advanced training and experience.

F. Lack of Health Professional Training[12]

Barriers related to health profession training extend to dental and medical providers at both the pre- and postdoctoral levels. Accreditation educational guidelines for predoctoral dental education are very general and do not specify any requirements regarding individuals with special care needs.

G. Lack of recognition of the importance of oral health by special health care needs individuals and their caregivers[15]

Lack of knowledge and low expectations about oral health and its value influence care-seeking behavior and can result in care being deferred or neglected entirely. Among the elderly living independently, the most commonly cited reason for not seeking dental care is a lack of perceived need. Seeking help for a dental problem is less likely when there is a belief that tooth loss is inevitable or oral problems are part of the aging process. For the institutionalized elderly, often the decision whether or not to receive care is determined by others. **Warren, Hand, and Kambhu** investigated the role of nursing home residents' family members in the utilization of dental services for nursing home residents. "Utilization of dental services" was defined as consent for the completion of a comprehensive dental examination. Overall, the next of kin or guardian decision-makers accepted treatment for 64.2 percent of the residents. Resident characteristics that increased the likelihood of accepting an oral examination included being female, being ambulatory, having natural remaining teeth, and having a higher level of education. Other factors that influenced the decision were next-of-kin characteristics: perceived need, age, and relationship of resident to next of kin (relative vs. nonrelative). Little difference in rate of acceptance was found based on resident age. Family and caregiver's attitudes may be even more powerful in limiting access to care. Dolan and Atchison report that nursing home administrators pointed to lack of interest by the resident and lack of interest by the resident's family as barriers to care. In addition, consulting dentists to nursing homes identified apathy of nursing home administrators and staff as significant barriers.

H. Lack of recognition of the importance of oral health by Authorities[12]

A general lack of awareness of the relationship of the mouth to the rest of the body is pervasive across the health disciplines, social service agencies, and public policy-makers concerned with services for persons with disabilities. Dental diseases are not recognized as infections that must be treated as aggressively as infections elsewhere in the body. Non dental staff, administrators, and government agencies generally have insufficient knowledge of the importance of oral hygiene and timely professional intervention in preventing infection and progression of disease. Students in medicine, nursing, physical and occupational therapy, rehabilitation, and social work receive little or no training in the basics of oral diseases and their prevention. Attempts to insert this topic into a crowded curriculum tend to be met with resistance. At the legislative level, dentistry is not considered on a par with other health services. In the allocation of limited resources, whether for training or direct patient care, dentistry is given very low priority. Special patients and their care are not only underfunded, but are in large measure neglected. Adults with disabilities are particularly disadvantaged.

I. Lack of Effective Patient Self-Care or Caregiver Assistance with Oral Care[15]

Self-care, in general, and oral health care in particular, can be adversely affected by some chronic conditions like visual, manual, or shoulder and arm impairments can make effective cleaning of the teeth and mouth difficult. Increasing needs for help in other areas of life may overshadow a declining oral health situation. Most of the mentally disabled children are not able to use toothbrush in a proper manner and unable to perform oral hygiene procedures adequately which leads to poor oral hygiene and periodontal problems.[6] The caregiver, particularly if they are a spouse or other family member, may be so burdened with other needed care that oral concerns are not recognized.

J. Difficulty in Physical Access[12]

All too often, patients with disabilities have to travel great distances to a dental facility that is qualified and willing to treat them, placing an added burden on family members or caregivers who accompany them. Transportation issues appear to be worsening and in large measure reflect the lack of available providers for patients with special needs. In a study conducted by **Yuen H K et al (2010)[16]** subjects with spinal cord injury (SCI) indicated that they either had to call the dental office ahead of time to learn whether it is wheelchair accessible before making an appointment, or they were forced to go to another dental office when they discovered that the office layout (e.g., examination room and/or bathroom) was not wheelchair accessible.

K. Institutionalization[12]

Institutionalized individuals with disabilities comprise primarily two groups: persons with developmental disabilities and persons with psychiatric disorders. Poor oral hygiene and severe periodontal disease are characteristic of institutionalized persons with disabilities and compromising medical conditions. In recent years, institutions have been markedly downsized and the profile of remaining residents has changed. The residual population in institutions for the developmentally disabled is older, more fragile, with severe and profound mental retardation and associated maladaptive behaviour, sensory impairment, severe neuromuscular dysfunction, and complex medical problems. There are indications that the more difficult to manage population has deteriorating oral health and dental needs that may exceed available dental resources.

L. Homebound Status[12]

Although the majority of persons who are homebound are geriatric, this population also includes younger persons with a disability. Typical disabilities are traumatic brain injury, multiple sclerosis, and agoraphobia. Individuals face difficulty going outside the home to shop or visit a doctor's office. According to some studies, homebound persons perceive a high dental care need. Difficulties in getting to a dentist, paying for dental care, and poor health were cited as barriers to obtaining dental care. Although mobile dentistry can meet the dental treatment needs of this population, it requires appropriate equipment and clinicians willing and knowledgeable in providing this service.

M. Fear and Anxiety[12]

Dental care and fear or anxiety has been long linked in popular culture. Dental care can elicit anxiety among parents or primary caretakers. This anxiety is often evident to young children and can elicit negative expectations of dental care. Parental anxiety can occasionally translate into threats. Statements like, "behave yourself or I'll take you to the dentist", are still heard by dental professionals. Threats reinforce the notion that dental care is to be avoided if at all possible.

N. Financial Barriers[12]

Persons with disabilities, particularly those with severe disabilities, are deprived with respect to income and dental insurance, factors that are major determinants in the rate of utilizing dental services. Inability to pay for the cost of care, lack of dental insurance, and limited dental coverage by public funding place dental care out of reach for many persons with disabilities. In a study[73] more individuals with a disability reported not seeing a dentist due to cost versus people without disabilities (30% vs. 16%). In a study conducted by **Rouleau T and colleagues**[17] financial challenges were reported to be the primary problem followed by physical accessibility issues.

O. Communication Difficulties [18]

Difficulties in understanding and obtaining information from the patient, and conversely, problems associated with patients' poor comprehension.

Approaches to Improve Oral Health

Oral health of special needs populations can be promoted through a concerted interdisciplinary effort aimed at improving access to oral health services, increasing professional and nonprofessional training and research, and securing the necessary financial resources to support these endeavours. Dental preventive and stabilization services must be properly directed, based on epidemiologic findings and identification of disability-associated oral disease risk factors, and linked to the training of those who provide care to persons with disabilities. Health care professionals must be formally taught how to be effective team participants and be given the opportunity to practice the skills needed for teamwork. The goals can be met only through changes in fiscal, public health, and manpower policies that ensure adequate financial support, full recognition of the significance of oral health for total health and function, and a requisite number of trained providers. Establishing innovative programs that link health, social service, and educational institutions are essential to attaining a successful outcome.

CONCLUSION

For the millions of people worldwide with special care needs, dental care is often not a top priority and takes a back seat to more pressing medical issues. However, maintaining good oral health should be a priority for everyone through preventive measures because it is well said that **prevention is better than cure.**

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