

Policy on Care for Vulnerable Populations in a Dental Setting

Adopted

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Purpose

The American Academy of Pediatric Dentistry (AAPD) is committed to the improvement of healthcare for all children and adolescents, regardless of their race, ethnicity, religion, sexual or gender identity, medical status, family structure, or financial circumstances. Additionally, the AAPD is committed to increased access to dental services and improved oral health for all children and adolescents, including those from vulnerable and underserved communities. The intent of this document is to increase awareness of the challenges that vulnerable populations face in achieving optimal oral health, to educate providers regarding the importance of culturally-sensitive care, and to encourage oral health professionals to advocate for improved access to dental services for vulnerable communities.

Methods

This policy was developed by the Council on Clinical Affairs. This document is based on a review of current dental and medical literature, including search of the PubMed® and Google Scholar databases combining the word dental with the following terms: vulnerable populations; special health care needs (SHCN); lesbian; gay; bisexual; transgender; lesbian, gay, bisexual, transgender, questioning (LGBTQ); homosexuality; sexual minority; gender diverse; homeless children; foster children; military-connected AND children; immigrant; incarcerated youth; mental health; fields: all; limits: within the last 10 years, human, English. Data from 67 articles met these criteria. Papers for review were chosen from this list and from references within selected articles. Expert opinions and best current practices were relied upon when clinical evidence was not available.

Background

Vulnerable populations are communities that have limited access to healthcare for many reasons including geography, finances, medical status, age, and societal discrimination. Such vulnerability may be temporary or permanent, and status may be improved or exacerbated by social and economic policies at the state and federal levels. Negative health sequelae of limited access to care among vulnerable populations include disproportionately poor oral and systemic health status and lower utilization rates of preventive services.¹⁻³

While the negative oral health consequences for some vulnerable populations have been established, there are additional groups that typically have been emphasized less in studies of oral health. This document allows for a broader concept of vulnerability and lends additional information to providers regarding support for such communities. These groups extend beyond the better understood vulnerabilities of poverty and special health care needs and include LGBTQ youth, military-connected families, families without consistent housing, youth with mental illness, and immigrants. While by no means comprehensive in its list of vulnerable groups, this document discusses barriers to care that may be applicable to additional populations.

Many pediatric dentists take active roles in their communities as advocates for children's health beyond the responsibilities of providing healthcare. It is important that dentists maintain an awareness of the various social determinants of oral health⁴ and approach care for their patients with cultural sensitivity. Dentists should be aware of the particular vulnerabilities of their patients when it comes to their health and are encouraged to advocate for and seek out resources that would benefit their patients as individuals and as a community.

Youth in the juvenile justice system

Adolescents who have passed through the juvenile justice system constitute a vulnerable population due to higher rates of health risky behaviors, limited access to healthcare, and sociodemographic factors. Over 850,000 arrests of youth younger than 18 were made in 2016.⁵ The number of youth in residential placement varies, but recent census data reports more than 40,000 juveniles may be assigned to residential placement on any given day.⁶ Lack of housing stability, disruptions in education, and other sequelae of poverty correlate with higher rates of arrests among youth from low socioeconomic backgrounds.⁷ Incarcerated youth have higher rates

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **ADHD:** Attention deficit hyperactivity disorder. **LGBT:** Lesbian, gay, bisexual, or transgender. **LGBTQ:** Lesbian, gay, bisexual, transgender, questioning. **SHCN:** Special health care needs. **TGD:** Transgender or gender diverse.

of health risky behaviors, particularly in the realm of mental and sexual health.^{8,9} Nationwide, it was found that two-thirds of juvenile detention facilities hold youth without criminal charges who are awaiting community mental health services.¹⁰

The oral health of youth in juvenile detention centers may be compromised by a lack of comprehensive treatment and continuity of care and concomitant health risky behaviors. There is a dearth of current studies on the oral health of incarcerated youth. One study of a detention center in Texas found significantly higher rates of untreated decay and low rates of preventive measures among its residents compared to non-incarcerated youth.¹¹ Urgent dental problems including infection, tooth and jaw fractures, and severe periodontal disease were found in over six percent of the subjects included in the study.¹¹ Juvenile detention and confinement facilities are required to provide a dental examination by a licensed dentist within 60 days of admission.¹² Beyond the examination, however, youth in detention facilities may have dental needs that are addressed only on an emergency basis, without access to routine care and without family, school, or community resources to facilitate management of their dental needs.

Dental providers offering care within detention facilities may have explicit biases toward youth in custody, and they may doubt the truthfulness of symptoms reported by these patients. Biases and doubts may cause a delay in diagnoses or treatment.¹³ Additional challenges in caring for youth in detention facilities include scheduling appointments, security concerns, transportation considerations, lack of legal guardian presence, and availability of providers.¹⁴ Once released from detention facilities, juveniles may face hardships establishing care and preventive services due to lack of family involvement and external support, difficulties adjusting to their previous environment, problems accessing previous medical records, and challenges in obtaining insurance coverage.⁷

Dental providers should be aware of these challenges when treating incarcerated youth. Ideally, efforts to establish a dental home and to reinstate insurance coverage should be made prior to release from the facility. Providers are encouraged to connect with social services in their communities to facilitate ongoing care for previously incarcerated youth. Incarcerated youth should be provided with the same standard of care as non-incarcerated individuals and should receive comprehensive dental examinations within a defined amount of time in detention. Efforts should be made by dental providers to connect patients to other healthcare services within the facility, particularly when oral manifestations of systemic diseases are recognized in youth who have not yet been evaluated by a physician.⁸

Youth with mental health conditions or behavioral disorders

One out of every five children in the United States has been diagnosed with a mental health disorder.¹⁴ Mental health conditions vary in terms of cause, incidence, and severity. The most commonly diagnosed mental health conditions in

children are attention deficit hyperactivity disorder (ADHD), behavior problems, anxiety, and depression.¹⁵ According to recent data, over six million children under the age of 18 have been diagnosed with ADHD, 4.4 million with anxiety, and 1.9 million with depression.¹⁵ Unfortunately, only about 20 percent of those children diagnosed with a mental health condition receive treatment for their disorder.¹⁶ Worldwide, people with mental health disorders may be subject to social stigmatization and discrimination, higher rates of physical and sexual violence, and limitations to their participation in civic life and public affairs. Their ability to access essential health care and social services, including emergency services, may be challenging.¹⁷

People with behavioral or mental health conditions are susceptible to worsened oral health. Those with depressive disorders may experience fatigue and lack of motivation for self-care that impedes proper home oral hygiene. Anxiety or depression can lead to lower self-esteem and dental fears that make one less likely to seek professional dental care.¹⁸ Such risk factors may cause increased rates of dental decay and tooth loss, which in turn exacerbate mental health conditions by contributing to social withdrawal, low self-esteem, and difficulty with functions such as eating and speaking.¹⁹ Children and adolescents with ADHD may be prone to dental injuries and bruxism habits.²⁰⁻²² Xerostomia is a known side effect of multiple psychotropic medications.¹⁹ Those patients at risk for xerostomia should be educated on proper fluoride use and increased frequency of water intake. Eating disorders may start in childhood and more commonly in adolescence and have the highest rate of mortality of any mental health condition.²³ Eating disorders can result in detrimental oral health behaviors with consequences including severe erosion of enamel and increased risk of dental caries.²⁴ Dentists should be aware of intraoral signs of eating disorders and be prepared to discuss concerns with their patients and families.

Dentists should consider the mental health of their patients and inquire about their psychiatric management, including behavior modification strategies²⁵, medications, and home hygiene practices. They are encouraged to connect with mental health provider networks and refer patients for counseling for concerns that have not yet been addressed by a mental health professional.

Individuals with special health care needs

Individuals with SHCN are among the many vulnerable populations who suffer profound health disparities.²⁶⁻³¹ Those who treat individuals with SHCN need specialized knowledge, training, awareness, and willingness to accommodate patients beyond routine measures.³² Although children with SHCN utilize preventive dental care at equal or higher rates when compared to children without SHCN, dental care continues to be the most common unmet healthcare need among this population.²⁶⁻²⁹ In fact, low-income children with the most severe healthcare conditions are more likely to have unmet dental needs.^{26,27} Individuals with SHCN face many barriers to obtaining adequate oral health care

including competing medical priorities, difficulties finding a knowledgeable and willing provider, residing in rural locations, transportation issues, inadequate insurance, and caregivers factors such as depression, low levels of functioning, and financial burdens of caring for an individual with SHCN.²⁶⁻³⁰ An integral part of the specialty of pediatric dentistry is to provide comprehensive preventive and therapeutic oral health care to individuals with SHCN.³³ Failure to accommodate patients with SHCN could be considered discrimination and a violation of federal and/or state law.³⁴ Therefore, when the needs of an individual with SHCN are beyond the skills of the dentist, the patient should be referred to a practitioner who is comfortable, knowledgeable, and appropriately trained to manage the patient's individual oral health care needs.

LGBTQ youth

LGBTQ is an initialism that is used to describe those individuals who identify as lesbian, gay, bisexual, transgender, or questioning.³⁵ TGD also may be used to describe individuals that identify as transgender or gender diverse.³⁵ LGBTQ and TGD individuals and their families may face disparities stemming from inequitable laws and policies, encounter societal discrimination, and lack access to quality health care.³⁵ Individuals identified as lesbian, gay, bisexual, or transgender (LGBT) present to dental providers with unique oral health needs³⁶ and are at greater risk for poor health conditions.³⁷ It is, therefore, imperative that dental offices be willing and prepared to treat individuals of all backgrounds, including those who identify as LGBTQ or TGD.

Many LGBTQ or TGD individuals face stigma and discrimination³⁵ and experience stress and anxiety in healthcare settings.³⁷ Dental fear among transgender individuals has been associated with prior experiences and fears of discrimination.³⁸ For these reasons, some patients may not feel comfortable disclosing their sexual orientation, gender identity, or expression.^{39,40} Providers are encouraged to create a welcoming office environment for patients who identify as LGBTQ or TGD. Examples include using gender neutral terms^{39,40} and placing a rainbow decal or button that is easily seen by patients. Intake forms can be modified to include questions about the patient's preferred pronoun, sex at birth, preferred gender, and legal and preferred names³⁹ and should ask for parent rather than mother/father information. These efforts demonstrate inclusion of parents and legal guardians who are in same-sex relationships and indicate that the office is open and welcoming to individuals of diverse sexual orientation, gender identity, or expression.⁴⁰

Professional education regarding oral health and oral health disparities of individuals identified as LGBTQ is lacking. In a 2016 survey of United States and Canadian dental schools, 29 percent of responding schools did not offer any LGBT content, and 12 percent did not know if content was covered.³⁹ Proper training of health care providers to take care of these individuals^{35,41} and more evidence-based research regarding LGBT health and health disparities are needed.⁴²

Immigrant youth and families

Immigrant children and families present unique needs and can encounter barriers to oral health as a vulnerable population. In 2017, 18.2 million children in the United States lived with one immigrant parent.⁴³ Children who grow up in a multicultural setting can experience differences in their oral health if there is a difference between parental or cultural views and the mainstream culture.⁴⁴ Children who have recently immigrated are at an increased risk for caries.^{44,45} Language barriers, insurance coverage, available providers, as well as cultural views can create barriers in accessing oral health care.⁴⁴ Acceptance of health interventions as well as responses to health information can be affected by an individual's or family's culture.⁴³ It is important that providers understand and consider these factors when treating immigrant children and families.

Oral health messages can be developed with special consideration to a community's cultural beliefs, motivation, and knowledge. Acceptance of oral health care recommendations and treatment may be improved by training community members to participate in the delivery of care to families.⁴⁴ Involvement of a greater network or community members in the delivery of care can foster trust in the dental provider. Delivering oral health information that considers a gain-framed or loss-framed approach based on cultural background and acculturation can improve responsiveness.⁴³ Immigrant families with greater exposure to the mainstream culture may respond more positively to gain-framed messaging. An example of a gain-framed message would be if one brushes twice daily, the individual will have better oral health.⁴⁶ Immigrant families with less exposure to the mainstream culture may respond better to loss-framed messaging.⁴⁶ An example of a loss-framed message would be if one does not brush twice daily, the individual risks having poor gingival health and caries. Dental providers should make efforts to understand the cultural backgrounds of immigrant patients and families and utilize many approaches to improve their delivery of care.

Military-connected youth

Military-connected youth face challenges and vulnerabilities caused by the unique requirements of military life. Providing care to military-connected youth requires appropriate knowledge, understanding, and appreciation of military culture.⁴⁷ The armed services represent a culturally and ethnically diverse population with 31 percent of the force represented by racial minorities,⁴⁸ and 16.4 percent of service members are females.⁴⁸ In 2018, over 1.5 million dependent children were reported to be living in active duty, guard, and reserve families.⁴⁸ Along with the approximately two million children of veterans, the total number of military-connected children in the United States is nearly four million.⁴⁸

Military-connected children may grow up without the physical presence of a parent due to frequent deployments, missions, training exercises, and school.⁴⁷ Deployment and its dangers can threaten a child's sense of security and can result in complex psychosocial burdens.⁴⁷⁻⁵¹ Military-connected

families experience frequent relocations involving the changing of schools and social networks. Some evidence suggests that military-connected children cope well with relocation and experience lower risk behaviors when compared to civilian counterparts.⁵⁰ Conversely, other resources point to more risk behaviors and depressed mood as a result of parental military service.⁵² Some military-connected children may experience marginalization and victimization⁵² while others face problems in communities where there is a lack of sensitivity to or preparation for dealing with military-connected difficulties.⁵¹ Child maltreatment and neglect are concerns for military-connected children.⁵³ Some studies demonstrated an elevated risk while others show risk comparable to civilian populations.⁵³⁻⁵⁶

Reestablishing medical and dental homes is a common challenge military-connected families face. Although military families have health insurance coverage, a recent study found military-connected children are more likely to have special health care needs and behavioral health needs when compared with civilian peers.⁵⁷ Furthermore, frequent relocations may interfere with continuity of care and leave some medical or dental problems unresolved. A study on dental care in military children found socioeconomic status of the service member influenced care seeking behavior.⁵⁸ Frequent changes in military insurance plans may deter some dental offices from accepting or continuing care after changes in coverage.

Military-connected children may have an increased risk for caries due to deficiencies in protective and biological factors. A consistent dental home with regular dental care may be lacking, and fluoride exposure may be suboptimal. Sporadic dental care may be more common because of frequent relocations. Inconsistent fluoride exposure may be expected if children have a history of residing in international or non-fluoridated communities. Children in single parent or dual military families also may be at an increased risk for caries. During work, training, or deployments, military-connected children may be enrolled in extensive childcare and after school programs or be cared for by extended family where they have more frequent exposure to cariogenic foods. Dentists caring for military families are encouraged to be thorough in their discussion of dietary choices and to help connect families to other dentists upon relocation.

Foster care and homeless youth

Youth who are homeless or in foster care present unique needs and can encounter significant barriers to oral health care as a vulnerable population. Approximately 415,000 children are in foster care in the United States, and some remain in foster care until adulthood.⁵⁹ Abuse, neglect, and family disruption are the most common reasons why youth are placed in foster care.⁵⁹ Foster parents are often unable to locate dentists who accept Medicaid, and studies have found that foster children suffer from relatively poor health, unresolved or worsening health conditions, and lack of access to medical and dental care.^{60,61} Foster caretakers' own knowledge, attitudes, and experiences influence dental management and behaviors of the foster child.

Foster caretakers often are challenged with the inability to consent for needed dental care and rely on social services to assist with obtaining consent from legal authorities.⁶⁰⁻⁶² A recent study found that youth in foster care were more likely to experience caries in both the primary and permanent dentition than other children who were enrolled in Medicaid.⁶⁰

Every year, more than 2.5 million children will experience a period of homelessness in the United States.⁶³ Approximately 40 percent of homeless in the United States are under the age of 18.⁶⁴ The main cause of youth homelessness is physical, sexual, and/or emotional abuse from parents or guardians.⁶³ As many as 20,000 homeless youth are forced into prostitution by human trafficking.⁶⁵ Approximately half of youths who age out of foster care or the juvenile justice system will be homeless within six months.⁶³ Youth who are homeless face challenges in obtaining dental care including transportation, consent for treatment, and general dental knowledge.⁶⁶ A homeless minor may be able to provide consent for treatment based on individual state laws. The 2018 Federal Runaway and Homeless Youth Act allows for some youth to have legal rights for treatment decisions.⁶⁷ Homeless youth have a higher caries rate than those who have Medicaid.⁶³ Provision of dental services for youth in foster care or who are homeless should be made available whenever possible. This usually requires additional measures on behalf of the dental health professional in order to provide appropriate dental procedures in a safe and empathetic environment.

Policy statement

Recognizing of the challenges faced by vulnerable populations in achieving optimal oral health status, the AAPD supports:

- advocacy for programs and policies that support vulnerable populations in obtaining improved access to healthcare services.
- pre- and postdoctoral programs as well as continuing education courses that include training dentists in cultural sensitivity and social concerns for vulnerable populations.
- inter-professional networks that will aid vulnerable populations in accessing important healthcare resources.

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ADDITIONAL RESOURCES

- American Academy of Child and Adolescent Psychiatry
<https://www.aacap.org>
- Association for Children's Mental Health
<http://www.acmh-mi.org/>
- Autism Speaks
<http://www.autismspeaks.org>
- Families USA
<http://www.familiesusa.org>
- Family Voices
<http://www.familyvoices.org>
- Medical Home Portal
<http://www.medicalhomeportal.org>
- Migrant Clinicians Network
<http://www.migrantclinician.org>
- Military One Source
<https://www.militaryonesource.mil>
- National Coalition for Homeless Youth
<http://www.nn4youth.org>
- National Commission on Correctional Healthcare
<http://www.ncchc.org>
- National Immigration Law Center
<http://www.nilc.org>
- National Juvenile Justice Center
<http://www.njjn.org>
- National Organization on Disability
<http://www.nod.org>