Policy on Care for Vulnerable Populations in a Pediatric Dental Setting

Latest Revision

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Purpose

The American Academy of Pediatric Dentistry (**AAPD**) is committed to the improvement of health care 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 vulnerable populations and the challenges they face in achieving optimal oral health as well as to advocate for culturally-safe care[1] and improved access to dental services.

Methods

This policy was developed by the Council on Clinical Affairs and adopted in 2020.[2] This update is based on a review of current dental and medical literature, including search of the PubMed/MEDLINE database with the following terms: (*evidence based dentistry* [**MeSH**] OR *dentistry* [MeSH]) AND (*vulnerable populations* [MeSH] OR *special health care needs* [**Tiab**] OR *sexual and gender minorities* [MeSH] OR *gender diverse* [Tiab] OR *lgbtq* [Tiab] OR *homeless youth* [MeSH] OR *child, foster* [MeSH] OR *military children* [Tiab] OR *immigrant children* [Tiab] OR *incarcerated youth* [Tiab] OR *mental health* [MeSH]); limits: within the last 10 years, human, English. This resulted in 296 articles of which 27 were reviews or systematic reviews. Papers for review were chosen from this list and from references within selected articles.

Background

Vulnerable populations are communities at increased risk of health problems and health disparities for many reasons including geography, finances, medical status, age, and societal discrimination.[3,4] 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.[5-7]

Socioeconomic factors (eg, poverty) and their intersection with other social and structural determinants (eg, racism, insurance eligibility) significantly impact children's oral health and consequent oral health disparities.[8,9] An increased awareness of vulnerable populations and the challenges they face may help inform oral health care professionals' approach to patient care. These groups include lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and otherwise identified (**LGBTQIA+**) youth, military-connected families, homeless youth, those in the foster care system, youth in juvenile detention systems, youth with mental health disorders, individuals with special health care needs (**SHCN**), Indigenous peoples, children affected by armed conflicts, and immigrants. This list is by no means comprehensive, and future revisions to this policy will continue to include updated discussion of populations at risk for poorer oral health due to sociopolitical, economic, and environmental vulnerabilities.

Many pediatric dentists take active roles in their communities as advocates for children's health. Awareness of social determinants of oral health[9] and culturally-safe approaches to patient care can result in higher quality delivery of dental services. Oral health care professionals may seek out resources that would benefit their patients as individuals and as a community and develop networks to aid vulnerable populations in obtaining needed health and social services.

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 health care, and sociodemographic factors. In 2020, over 400,000 arrests were made of youth younger than age 18.[10] The number of youth in residential placement varies, but recent census data reports more than 24,000 juveniles may be assigned to residential placement on any given day.[11] Lack of housing stability, disruptions in education, and other sequelae of poverty correlate with higher rates of arrests among youth from low socioeconomic backgrounds.[12] Incarcerated youth have higher rates of

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **ADHD:** Attention deficit hyperactivity disorder. **ECC:** Early childhood caries. **LGBTQIA+:** Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and otherwise identified. **MeSH:** Medical subject heading. **SHCN:** Special health care needs. **Tiab:** Title and abstract.

health-risky behaviors, particularly in the realm of mental and sexual health.[13,14]

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. Although recent studies on the oral health of incarcerated youth are lacking, significantly higher rates of untreated decay and low rates of preventive measures among incarcerated compared to non-incarcerated youth have been reported.[15] High urgency of treatment need for dental problems including infection, tooth and jaw fractures, and severe periodontal disease was found in over 6% of the subjects included in 1 study.[15]

Health care professionals may have implicit biases toward youth in custody that can delay diagnosis or treatment.[16] Challenges in caring for youth in detention facilities include scheduling appointments, security concerns, transportation considerations, lack of legal guardian's involvement, and availability of providers.[16]

Awareness of these barriers to care can aid oral health care professionals when coordinating treatment for incarcerated youth. Connecting patients to other health care services within the facility, particularly when oral manifestations of systemic diseases are recognized in youth who have not yet been evaluated by a physician, may be necessary.[14.] Ideally, efforts to establish a dental home and reinstate insurance coverage would be made prior to release from the facility.

Once released from detention facilities, juveniles may face hardships in establishing care and preventive services due to lack of family involvement and external support, difficulties adjusting to their previous environment, problems accessing previous health care medical records, and challenges in obtaining insurance coverage.[12] Connecting with social services in their communities can facilitate ongoing care for previously incarcerated youth.

Children with mental health conditions or behavioral disorders

One out of every 5 children in the US has been diagnosed with a mental health disorder.[17] 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**), anxiety, behavior problems, and depression.[18] According to recent US data, approximately 6 million children under the age of 18 have been diagnosed with ADHD, 5.8 million with anxiety, and 2.7 million with depression.[17] In 2018-2019, over 50% of children ages 3 through 17 diagnosed with a mental health condition received treatment of their disorder.[18] 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.[19]

People with behavioral or mental health conditions are susceptible to worsened oral health.[20] 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.[21] Such risk factors may lead to 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.[20] Children and adolescents with ADHD may be prone to dental injuries and bruxism habits.[22-25] Xerostomia is a known side effect of multiple psychotropic medications.[20] Patients at risk for xerostomia may benefit from education 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.[26] Eating disorders can result in detrimental oral health behaviors with consequences including severe erosion of enamel and increased risk of dental caries.[27] Awareness of intraoral signs of eating disorders allows oral health care professionals to be prepared to discuss concerns with patients and their families.

The patient's mental health condition—as well as psychiatric management including behavior modification strategies,[28,29] medications,[30,31] and home hygiene practices—is an important consideration for oral health care professionals. Connections with mental health provider networks can facilitate counseling-service referrals of patients with mental health concerns that have not yet been addressed by a mental health professional.[32]

Individuals with special health care needs

Individuals with SHCN are among the many vulnerable populations who suffer profound health disparities.[33-36] Those who treat individuals with SHCN need specialized knowledge, training, awareness, and willingness to accommodate patients beyond routine measures.[37] Studies regarding utilization rates of preventive dental services by children with SHCN compared to those without SHCN have been mixed.[38] Nonetheless, dental care continues to be one of the most common unmet health care needs among this population.[33-35,38-42] In fact, low-income children with the most severe health care conditions are more likely to have unmet dental needs.[34,43] Individuals with SHCN face many barriers to obtaining adequate oral health care including competing medical priorities, difficulties finding a knowledgeable and willing oral health care professional, 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.[33-36,44,45] Addressing financial, geographic, and social barriers have been identified as strategies to address oral health disparities experienced by children with SHCN.[39] An integral part of the specialty of pediatric dentistry is to provide comprehensive preventive and therapeutic oral health care to individuals with SHCN.[46]

Failure to accommodate patients with SHCN could be considered discrimination and a violation of federal and/or state law.[47] Therefore, when the treatment needs of an individual with SHCN are beyond the scope of practice of the oral health care professional, referral to a practitioner who is comfortable, knowledgeable, and appropriately trained to manage the patient's individual oral health care needs is indicated.[48]

LGBTQIA+ youth

LGBTQIA+ individuals and their families may face disparities stemming from inequitable laws and policies, encounter societal discrimination, and lack access to quality health care[49] (including oral health care[50,51]). Willingness and preparedness of oral health care professionals to treat individuals who identify as LGBTQIA+ helps promote positive oral health attitudes and inclusivity for all children.

Many LGBTQIA+ individuals face stigma and discrimination[49] and experience stress and anxiety in health care settings.[52] Dental fear among transgender individuals has been associated with prior experiences and fears of discrimination.[53] For these reason, some patients may not feel comfortable disclosing their sexual orientation or gender identity or expression.[54,55] Oral health care professionals can create a welcoming office environment for patients who identify as LGBTQIA+. Strategies to create a supportive environment and atmosphere of belonging for patients and families include the use of inclusive language such as avoiding stigmatizing words, actively listening for individual and community preferred terms and language, and utilizing person-first language.[56] Inclusive patient forms and documents create a respectful and supportive environment that helps patients feel acknowledged.[56]

Professional education regarding oral health and oral health disparities of individuals identified as LGBTQIA+ is lacking.[51] In a 2016 survey of US and Canadian dental schools, 29% of responding schools did not offer any such content, and 12% did not know if content was covered.[55] Proper training of health care professionals to manage the unique needs of these individuals[49,57-59] and more evidence-based research regarding related health and health disparities are needed.[60]

Immigrant and refugee children

One in every 4 children in the US is part of an immigrant family (ie, the child is foreign born or resides with a foreign-born parent.)[61] Immigrant and refugee children present unique needs and can encounter barriers to oral health as a vulnerable population.[62] Children who grow up in a multicultural setting can experience differences in their oral health if there are discrepancies between parental or cultural views and the mainstream culture.[63] Language barriers, lack of insurance coverage, difficulties finding available oral health care professionals, reduced oral health literacy, as well as cultural views can create barriers to accessing oral health care and increase caries risk.[9,63-66]

Acceptance of health interventions as well as responses to health information can be affected by an individual's or family's culture.[67] Understanding and considering these factors can aid oral health care professionals 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.[63] Delivering oral health information that considers a gain-framed or loss-framed approach based on cultural background and acculturation can improve responsiveness.[68] 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.[68] Immigrant families with less exposure to the mainstream culture may respond better to loss-framed messaging.[68] 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. Efforts to understand the cultural backgrounds of immigrant patients and families helps improve delivery of care. Oral health education delivered by culturally-appropriate oral health workers or community members can improve early childhood oral health knowledge, attitudes, and behaviors of parents and caregivers.[69,70]

Children affected by armed conflicts are at risk for negative health consequences.[71] The impact of war, family separation, and other forms of aggression on children's systemic, behavioral, developmental, and psychological health can be devastating, and the physical, social, and environmental ramifications of violence and displacement are long lasting.[71] Increased access to and provision of oral health care for affected families may be achieved through both public and private pathways, such as inclusion of oral health into primary care, research inquiries that seek to better understand the oral health needs of refugee populations, increased support for social services, expansion of insurance eligibility, development of emergency protocols to address urgent dental concerns, and prevention programs to provide oral health education in a culturally-safe manner.[72] A trauma-informed care approach is important to help dental professionals determine optimal behavior guidance modalities for patients who may suffer from resultant psychological distress.[73]

Indigenous children

Indigenous children in the US, specifically American Indian and Alaska Natives, have considerable oral health disparities that are amplified by poor access to care.[74,75] Dental caries occurs earlier, with a higher prevalence, and at a greater severity in Indigenous children than among the general population.[74,75] The 2014 *Indian Health Service Oral Health Survey of American Indian and Alaska Natives* reported 21% of 1-year-olds and 40% of 2-year-olds had early childhood caries (**ECC**).[76] The dependence on general anesthesia to treat patients with ECC is high among Indigenous children in North America.[74,75,77] Limited data exist on the overall number of American Indian

and Alaska Native children undergoing dental surgery under general anesthesia for caries, but data from Alaska suggests that 73% of Alaska Native children had undergone general anesthesia to treat ECC.[74,75] In the more remote Indigenous regions of Canada, the rate of dental treatment under general anesthesia for children younger than 5 years exceeds 200 per 1000 children per year, a rate 15 times higher than the overall annual Canadian rate.[77] Early access to preventive oral health care is essential for these Indigenous children.[74,75] Oral health promotion may be more effective if it is culturally appropriate and delivered through channels recommended by community members.[78] Thorough discussions regarding the risks and benefits of newer treatment approaches (eg, silver diammine fluoride) with Indigenous parents can facilitate their acceptance of these treatments.[79]

Military-connected children

Military-connected children face challenges and vulnerabilities caused by the unique requirements of military life. Providing care to this population requires appropriate knowledge, understanding, and appreciation of military culture.[80] The armed services represent a culturally, geographically, and ethnically diverse population with 30.4% of the force represented by racial minorities, and 19.3% of service members are females.[81] In 2018, over 1.5 million dependent children were reported to be living in active duty, guard, and reserve families.[81] Along with the approximately 2 million children of veterans, the total number of military-connected children in the US is nearly 4 million.[82]

Military-connected children may experience physical separation from a parent due to participation in deployments, missions, training exercises, unaccompanied orders, and military schools.[80,83] Deployment and its dangers can threaten a child's sense of security and result in complex psychosocial burdens.[80,81,83-86] Studies show children have an increase in stress, emotional-behavioral challenges, and mental health visits and a decrease in academic performance during parental deployment.[87,88] Adolescents who have a deployed parent are more likely to report binge drinking, prescription drug abuse, marijuana and other substance use, peer victimization, weapon carrying, and suicidal ideations compared to teens from non-military families.[84,87] Military-connected children experience an increased risk of child maltreatment during parental deployment and return/reintegration; however, overall rates of child maltreatment are generally similar to the civilian population.[83,87-89]

Military-connected families may move locations every 2 to 4 years, a rate 2.4 times more frequent than their civilian counterparts.[83] Frequent relocations involve changing schools, social networks, and medical and dental homes. Such transitions may interfere with continuity of care and leave some medical or dental problems unresolved. Military-dependent youth require coping strategies to adjust to relocation and deployment of family members while also confronting age-appropriate developmental stages (eg, autonomy, independence).[84] Such changes can make these children and adolescents more susceptible to health-risky behaviors[90] and depression.[91] Socioeconomic status may mediate care-seeking behavior among military families.[92] Some military-connected children may experience marginalization and victimization,[91] while others face challenges in communities where there is a lack of sensitivity to or preparation for dealing with military-connected difficulties.[85]

Frequent changes in military insurance plans and perceived low reimbursements may deter some dental offices from accepting or continuing care after changes in coverage.[93] In one study, disparities in access to nonroutine medical care for children with SHCN were found between those from military-connected children versus civilian families.[93]

Military-connected children may have an increased risk for caries[94] because consistent dental homes with preventive dental care may be lacking and fluoride exposure may be suboptimal. Sporadic dental care may be common because of frequent relocations. Inconsistent fluoride exposure may be expected if children have a history of residing in international or nonfluoridated communities. Children in single-parent or dual-military families also may be at an increased risk for caries as parents face challenges in meeting the health needs of their children. During work, training, or deployments, military-connected children may be enrolled in extensive childcare and after-school programs or cared for by extended family members where they have more frequent exposure to cariogenic foods. Familiarity with military culture and sensitivity to their oral health barriers may facilitate improved delivery and continuity of dental care as families relocate for new military assignments.

Foster care and homeless children

Children who are homeless or in foster care present unique needs and can encounter significant barriers to oral health care as a vulnerable population. Approximately 368,500 children are in foster care in the US, and some remain in foster care until adulthood.[95] Abuse, neglect, and family disruption are the most common reasons why youth are placed in foster care.[95] 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.[96,97] 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.[96-98] Youth in foster care were reported more likely to experience caries in both the primary and permanent dentition than other children who were enrolled in Medicaid.[96]

An estimated 1.5 million children experience homelessness annually in the US.[99] Point-in-time data from the US Department of Housing and Urban Development found that of the approximately 260,000 people in families with children who experienced homelessness on a single night in 2024, 56% were

children younger than age 18.[100] Risk factors for homelessness during adolescence include strained family relationships, history of abuse, mental health concerns, substance misuse, behavioral problems, history of foster care, and running away.[99,101,102] Unaccompanied youth and runaways are vulnerable[102,103] to human trafficking, risky sexual behaviors, teen pregnancy, and substance misuse. Difficulties in storing oral hygiene products, maintaining a healthy diet, and accessing safe drinking water and frequent relocation increase oral health risks for homeless families.[104] Homeless youth face challenges in obtaining dental care including transportation and consent for treatment and may have limited general dental knowledge.[105] 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.[106]

Policy statement

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

- delivery of empathetic oral health care in an environment that is sensitive to the social determinants of oral health and heightened vulnerabilities of each individual patient.
- advocacy for programs and policies that support vulnerable populations in obtaining improved access to health care services.
- pre- and postdoctoral programs as well as continuing education courses that include training oral health care professionals in cultural safety and social concerns for vulnerable populations.
- interprofessional networks that will aid vulnerable populations in accessing important health care resources.

References

1. Bozorgzad P, Negarandeh R, Raiesifar A, Poortaghi S. Cultural safety: An evolutionary concept analysis. *Holist Nurs Pract.* 2016;30(1):33-38. DOI: 10.1097/HNP.0000000000000125
2. American Academy of Pediatric Dentistry. Policy on care for vulnerable populations in a dental setting. *The Reference Manual of Pediatric Dentistry.* American Academy of Pediatric Dentistry; 2020:32-38.
3. Desai N, Romano ME. Pediatric and adolescent issues in underserved populations. *Prim Care.* 2017;44(1):33-45. DOI: 10.1016/j.pop.2016.09.007
4. Waisel DB. Vulnerable populations in healthcare. *Curr Opin Anaesthesiol.* 2013;26(2):186-192. DOI: 10.1097/ACO.0b013e32835e8c17
5. Bersell C. Access to oral health care: A national crisis and call for reform. *J Dent Hyg.* 2017;91(1):6-14.
6. Institute of Medicine, National Research Council. Improving Access to Oral Health Care for Vulnerable and Underserved Populations. The National Academies Press; 2011:47. Accessed September 2, 2024. https://www.nap.edu/catalog/13116/improving-access-to-oral-health-care-for-vulnerable-and-underserved-populations
7. Vanderbilt AA, Isringhausen KT, VanderWielen LM, Wright MS, Slashcheva LD, Madden MA. Health disparities among highly vulnerable populations in the United States: A call to action for medical and oral health care. *Med Educ Online.* 2013;18:1-3. DOI: 10.3402/meo.v18i0.20644
8. American Academy of Pediatric Dentistry. Policy on diversity, equity, and inclusion. *The Reference Manual of Pediatric Dentistry.* American Academy of Pediatric Dentistry; 2025:61-64.
9. American Academy of Pediatric Dentistry. Policy on social determinants of children's oral health and health disparities. *The Reference Manual of Pediatric Dentistry.* American Academy of Pediatric Dentistry; 2025:47-51.
10. Arrests of youth declined through 2020. Office of Juvenile Justice and Delinquency Prevention. Accessed February 25, 2025. https://www.ojjdp.gov/ojstatbb/snapshots/DataSnapshot_UCR2020.pdfA
11. Puzzanchera C, Sladky TJ, Kang W. Easy access to the census of juveniles in residential placement. Office of Juvenile Justice and Delinquency Prevention; Updated August 28, 2023. Accessed February 21, 2025. https://www.ojjdp.gov/ojstatbb/ezacjrp/asp/Age_Sex.asp
12. American Academy of Pediatrics. Healthcare for youth in the juvenile justice system. *Pediatrics.* 2011;128(6):1219-1235. DOI: 10.1542/peds.2011-1757 Erratum in: *Pediatrics* 2012;129(3):595. DOI: 10.1542/peds.2011-3723
13. Golzari M, Hunt SJ, Anoshiravani A. The health status of youth in juvenile detention facilities. *J Adolesc Health.* 2006;38(6):776-782. DOI: 10.1016/j.jadohealth.2005.06.008
14. Perry R, Morris R. Healthcare for youth involved in the correctional system. *Prim Care Clin Office Pract.* 2014;41(3):691-705. DOI: 10.1016/j.pop.2014.05.007
15. Bolin K, Jones D. Oral health needs of adolescents in a juvenile detention facility. *J Adolescent Health.* 2006;38(6):755-757. DOI: 10.1016/j.jadohealth.2005.05.029
16. Savage RJ, Reese J, Wallace S, et al. Overcoming challenges to care in the juvenile justice system: A case study and commentary. *Pediatr Rev.* 2017;38(1):35-43. DOI: 10.1542/pir.2016-0066
17. Green CM, Foy JM, Earls MF; Committee on Psychosocial Aspects of Child and Family Health, Mental Health Leadership Work Group. Achieving the pediatric mental health competencies. *Pediatrics.* 2019;144(5):e20192758. DOI: 10.1542/peds.2019-2758
18. Data and statistics on children's mental health. January 31, 2025. Center for Disease Control and Prevention. Accessed March 13, 2025. https://www.cdc.gov/children-mental-health/data-research/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/data.html

References continued on the next page.

19. Funk M, Drew N, Freeman M, Faydi E; World Health Organization. Mental Health and Development: Targeting people with mental health conditions as a vulnerable group. World Health Organization; 2010. Accessed September 9, 2024. https://apps.who.int/iris/bitstream/handle/10665/44257/9789241563949_eng.pdf?sequence=1&isAllowed=y
20. Kisely S, Sawyer E, Siskind D, Lalloo R. The oral health of people with anxiety and depressive disorders – A systematic review and meta-analysis. *J Affect Disord.* 2016;200:119-132. DOI: 10.1016/j.jad.2016.04.040
21. Slack-Smith L, Hearn L, Scrine C, Durey A. Barriers and enablers for oral health care for people affected by mental health disorders. *Aust Dent J.* 2017;62(1):6-13. DOI: 10.1111/adj.12429
22. Other concerns and conditions. Attention-deficit/hyperactivity disorder (ADHD). Center for Disease Control and Prevention; October 22, 2024. Accessed September 9, 2024. https://www.cdc.gov/adhd/about/other-concerns-andconditions.html
23. Sabuncuoglu O, Irmak MY. The attention-deficit/hyperactivity disorder model for traumatic dental injuries: A critical review and update of the last 10 years. *Dent Traumatol.* 2017;33(2):71-76. DOI: 10.1111/edt.12307
24. Souto-Souza D, Mourão PS, Barroso HH, et al. Is there an association between attention deficit hyperactivity disorder in children and adolescents and the occurrence of bruxism? A systematic review and meta-analysis. *Sleep Med Rev.* 2020;53:101330. DOI: 10.1016/j.smrv.2020.101330
25. Thikkurissy S. McTigue DJ, Coury DL. Children presenting with dental trauma are more hyperactive than controls as measured by the ADHD rating scale IV. *Pediatr Dent.* 2012;34(1):28-31.
26. López-Gil JF, García-Hermoso A, Smith L, et al. Global proportion of disordered eating in children and adolescents: A systematic review and meta-analysis. *JAMA Pediatr.* 2023;177(4):363-372. DOI: 10.1001/jamapediatrics.2022.5848
27. Valeriani L, Frigerio F, Piciocchi C, et al. Oro-dental manifestations of eating disorders: A systematic review. *J Eat Disord.* 2024;24;12(1):87. DOI: 10.1186/s40337-024-01050-8
28. Aminabadi NA, Najafpour E, Erfanparast L, et al. Oral health status, dental anxiety, and behavior-management problems in children with oppositional defiant disorder. *Eur J Oral Sci.* 2016;124(1):45-51. DOI: 10.1111/eos.12236
29. Sujlana A, Dang R. Dental care for children with attention deficit hyperactivity disorder. *J Dent Child.* 2013;80(2):67-70.
30. Cockburn N, Pradhan A, Taing MW, Kisely S, Ford PJ. Oral health impacts of medications used to treat mental illness. *J Affect Disord.* 2017;223:184-193. DOI: 10.1016/j.jad.2017.07.037
31. Schermann H, Schiffmann N, Ankory R, et al. Methylphenidate use and restorative treatment needs in young adults with attention deficit hyperactivity disorder. *Spec Care Dentist.* 2024;44(2):556-562. DOI: 10.1111/scd.12885
32. Culmer NP, Smith TB, Berryhill MB, et al. Mental health screening and referral to treatment in dental practices: A scoping review. *J Dent Educ.* 2024;88(4):445-460. DOI: 10.1002/jdd.13444
33. Chi DL, McManus BM, Carle AC. Caregiver burden and preventive dental care use for US children with special health care needs: A stratified analysis based on functional limitation. *Matern Child Health J.* 2014;18(4):882-890. DOI: 10.1007/s10995-013-1314-x
34. Chi DL. Oral health for U.S. children with special health care needs. *Pediatr Clin North Am.* 2018;65(5):981-993. DOI: 10.1016/j.pcl.2018.05.007
35. Iida H, Lewis CW. Utility of a summative scale based on the Children with Special Health Care Needs (CSHCN) Screener to identify CSHCN with special dental care needs. *Matern Child Health J.* 2012;16(6):1164-1172. DOI: 10.1007/s10995-011-0894-6
36. Joshua P, Zwi K, Moran P, White L. Prioritizing vulnerable children: Why should we address inequity? *Child Care Health Dev.* 2015;41(6):818-826. DOI: 10.1111/cch.12264
37. American Academy of Pediatric Dentistry. Definition of special health care needs. *The Reference Manual of Pediatric Dentistry.* American Academy of Pediatric Dentistry; 2025:15.
38. Lee JN, Scott JM, Chi DL. Oral health behaviours and dental caries in low-income children with special healthcare needs: A prospective observational study. *Int J Paediatr Dent.* 2020;30(6):749-757. DOI: 10.1111/ipd.12656
39. Bastani P, Mohammadpour M, Ghanbarzadegan A, Rossi-Fedele G, Peres MA. Provision of dental services for vulnerable groups: A scoping review on children with special health care needs. *BMC Health Serv Res.* 2021;21(1):1302. DOI: 10.1186/s12913-021-07293-4
40. Chavis S, Canares G. The transition of patients with special health care needs from pediatric to adult-based dental care: A scoping review. *Pediatr Dent.* 2020;42(2):101-109.
41. Children and youth with special health care needs. NSCH Data Brief June 2022. Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau. Accessed September 6, 2024. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/nsch-data-brief-childrenyouth-special-health-care-needs.pdfA
42. Obeidat R, Noureldin A, Bitouni A, et al. Oral health needs of U.S. children with developmental disorders: A population-based study. *BMC Public Health.* 2022;22(1):861. DOI: 10.1186/s12889-022-13237-2
43. Sarvas E, Webb J, Landrigan-Ossar M, et al. Oral health care for children and youth with developmental disabilities: Clinical report. *Pediatrics.* 2024;154(2):e2024067603. DOI: 10.1542/peds.2024-067603

44. Duker LIS, Henwood BF, Bluthenthal RN, Juhlin E, Polido JC, Cermak SA. Parents' perceptions of dental care challenges in male children with autism spectrum disorder: An initial qualitative exploration. *Res Autism Spectr Disord.* 2017;39:63-72. DOI: 10.1016/j.rasd.2017.03.002
45. Ignelzi M, Brickhouse T, Caffrey E, et al. Hidden crisis: Pediatric oral health in rural America. Research and Policy Center, American Academy of Pediatric Dentistry; 2023. Accessed October 29, 2024. https://www.aapd.org/globalassets/ruralpediatricoralhealth_aapd_rpc.pdf
46. American Academy of Pediatric Dentistry. Overview: Definitions and scope of pediatric dentistry. *The Reference Manual of Pediatric Dentistry.* American Academy of Pediatric Dentistry; 2025:7.
47. Americans with Disabilities Act of 1990, as Amended. US Dept of Justice Civil Rights Division. Accessed August 8, 2024. https://www.ada.gov/pubs/ada.htmAc
48. American Academy of Pediatric Dentistry. Policy on transitioning from a pediatric to an adult dental home for individuals with special health care needs. *The Reference Manual of Pediatric Dentistry.* American Academy of Pediatric Dentistry; 2025:185-188.
49. Rafferty J; American Academy of Pediatrics Committee on Pyschosocial Aspects of Child and Family Health; Committee on Adolescence, Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness; et al. Ensuring comprehensive care and support for transgender and gender diverse children and adolescents. *Pediatrics.* 2018;142(4):e20182162. Reaffirmed August 2023. DOI: 10.1542/peds.2018-2162 Erratum in: *Pediatrics.* 2023; 152(4):e2023063756. DOI: 10.1542/peds.2023-063756
50. Griner SB, Yockey RA, Forschner CN. Oral healthcare visits among sexual minority adolescents ages 14-18, 2019, USA. *J Public Health Dent.* 2023;83(2):207-211. DOI: 10.1111/jphd.12546
51. Haley CM, Macri D, Perez HL, Schwartz SB. LGBTQ+ and dental education: Analyzing the present and recommendations for the future. *J Dent Educ.* 2022;86(9): 1191-1197. DOI: 10.1002/jdd.13100
52. Strutz K, Herring A, Halpern CT. Health disparities among young adult sexual minorities in the U.S. *Am J Prev Med.* 2015;48(1):76-88. DOI: 10.1016/j.amepre. 2014.07.038
53. Heima M, Heaton LJ, Ng HH, Roccoforte EC. Dental fear among transgender individuals – A cross-sectional survey. *Spec Care Dentist*. 2017;37(5):212-222. DOI: 10. 1111/scd.12245
54. Levine DA; American Academy of Pediatrics Committee on Adolescence. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics.* 2013;132(1):e297-313. DOI: 10.1542/peds.2013-1283
55. MacDonald DW, Grossoehme DH, Mazzola A, Pestian T, Schwartz SB. "I just want to be treated like a normal person": Oral health care experience of transgender adolescents and young adults. *J Am Dent Assoc.* 2019;150(9): 748-754. DOI: 10.1016/j.adaj.2019.03.025
56. Haley CM, Doubleday AF. Inclusive language to support health equity and belonging in dentistry. *Dent Clin North Am.* 2025;69(1):17-28. DOI: 10.1016/j.cden.2024.08.001
57. Haffeez H, Zeshan M, Tahir MA, Jahan N, Naveed S. Health care disparities among lesbian, gay bisexual, and transgender youth: A literature review. *Cureus.* 2017;9(4): e1184. DOI: 10.7759/cureus.1184
58. Mercer J, Mabry J, Donly K, Michalek J, Jayaraman J. A survey of attitudes and training of pediatric dentistry residents and faculty in the United States regarding the LGBTQ patient population. *Pediatr Dent.* 2023;45(4): 307-315.
59. Salter RO, Barham L, Young DL, McIntosh C, Butler CJ. Integrating lesbian, gay, bisexual, transgender, and queer (LGBTQ) competency into the dental school curriculum. *J Dent Educ*. 2024;88(6):823-831. DOI: 10.1002/jdd.13 476
60. Hillenburg KL, Murdoch-Kinch CA, Kinney JS, Temple H, Ingelhart MR. LGBT coverage in U.S. dental schools and dental hygiene programs: Results of a national survey. *J Dent Educ.* 2016;80(12):1440-1449.
61. Kids Count Data Center: Children in immigrant families in the United States. Annie E. Casey Foundation. Last updated January 2024. Accessed February 21, 2025. https://datacenter.aecf.org/data/tables/115-children-in-immigrant-families?loc=1&loct=1#detailed/1/any/false/1095/any/445,446
62. United Nations High Commissioner for Refugees. The UN Refugee Agency. Integration Handbook: Health. Accessed March 14, 2025. https://www.unhcr.org/handbooks/ih/health/health-care 25.
63. Tiwari T, Albino J. Acculturation and pediatric minority oral health interventions. *Dent Clin North Am*. 2017;61 (3):549-563. DOI: 10.1016/j.cden.2017.02.006
64. American Academy of Pediatric Dentistry. Caries-risk assessment and management for infants, children and adolescents. *The Reference Manual of Pediatric Dentistry.* American Academy of Pediatric Dentistry; 2025:325-331.
65. Folayan MO, Schroth RJ, Ayouni I, et al. A scoping review linking early childhood caries to violence, neglect, internally displaced, migrant and refugee status. *BMC Oral Health*. 2023;23(1):747. DOI: 10.1186/s12903-023-03459-0
66. Reza M, Amin MS, Sgro A, et al. Oral health status of immigrant and refugee children in North America: A scoping review. *J Can Dent Assoc.* 2016;82:g3.
67. Gómez LM, Theriot A, Cárdenas JM, et al. Acceptance of behavior guidance techniques in pediatric dentistry between American and Colombian parents. *J Dent Child (Chic).* 2024;91(2):55-59.
68. Brick C, McCully SN, Updegraff JA, Ehret PJ, Areguin MA, Sherman DK. Impact of cultural exposure and message framing on oral health behavior: Exploring the role of message memory. *Med Decis Making.* 2016;36(7):834-843. DOI: 10.1177/0272989X15570114

References continued on the next page.

69. Velez D, Palomo-Zerfas A, Nunez-Alvarez A, Ayala GX, Finlayson TL. Facilitators and barriers to dental care among Mexican migrant women and their families in North San Diego County. *J Immigr Minor Health.* 2017; 19(5):1216-1226. DOI: 10.1007/s10903-016-0467-2
70. Villalta J, Askaryar H, Verzemnieks I, Kinsler J, Kropenske V, Ramos-Gomez F. Developing an effective community oral health workers–"Promotoras" model for Early Head Start. *Front Public Health.* 2019;7:175. DOI: 10.3389/fpubh.2019.00175
71. Shenoda S, Kadir A, Pitterman S, et al. The effects of armed conflict on children. *Pediatrics.* 2018:142(6): e20182585. DOI: 10.1542/peds.2018-2585
72. FDI World Dental Federation. Addressing oral health needs in refugees: Policy and collaboration strategies. FDI World Dental Federation; 2024:1-10. Accessed March 14, 2025. https://www.fdiworlddental.org/sites/default/files/2024-06/Adressing%20Oral%20Health%20needs%20in%20refugees%20-%20Final.pdf
73. American Academy of Pediatric Dentistry. Behavior guidance for the pediatric dental patient. *The Reference Manual of Pediatric Dentistry.* American Academy of Pediatric Dentistry; 2025:379-399.
74. Holve S, Braun P, Irvine JD, et al. Early childhood caries in Indigenous communities. *Paediatr Child Health.* 2021; 26(4):255-258. DOI: 10.1542/peds.2021-051481
75. Holve S, Braun P, Irvine JD, et al. Early childhood caries in Indigenous communities. *Pediatrics.* 2021;147(6):e 2021051481. DOI: 10.1093/pch/pxab023
76. Phipps K, Ricks TL. The oral health of American Indian and Alaska Native children aged 1-5 years: Results of the 2014 IHS Oral Health Survey. Indian Health Service; 2015:7.
77. Schroth RJ, Quiñonez C, Shwart L, Wagar B. Treating early childhood caries under general anesthesia: A national review of Canadian data. *J Can Dent Assoc.* 2016;82:g20.
78. Kyoon-Achan G, Schroth RJ, Sanguins J, et al. Early childhood oral health promotion for First Nations and Métis communities and caregivers in Manitoba. *Health Promot Chronic Dis Prev Can.* 2021;41(1):14-24. DOI: 10.24095/hpcdp.41.1.02
79. Kyoon-Achan G, Schroth RJ, DeMaré D, et al. Indigenous community members' views on silver diamine fluoride to manage early childhood caries. *J Public Health Dent.* 2020;80(3):208-216. DOI: 10.1111/jphd.12370
80. Lemmon K. Caring for America's children: Military youth in time of war. *Pediatr Rev.* 2009;30(6):e42-48. DOI: 10.1542/pir.30-6-e42
81. 2023 demographics: Profile of the military community. US Dept of Defense, Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy; 2023. Accessed February 23, 2025. https://download.militaryonesource.mil/12038/MOS/Reports/2023-demographics-report.pdf
82. Hanson D, Woods T. The state of post-9/11 veteran families. The Urban Institute; 2016. Accessed September 9, 2024. https://www.urban.org/sites/default/files/publication/85986/the_state_of_post-11_veteran_families_final_last_11_21 _2016.pdf
83. Huebner CR; American Academy of Pediatrics Section on Uniformed Services, Committee on Psychosocial Aspects of Child and Family Health. Health and mental health needs of children in US military families. *Pediatrics.* 2019;143(1):e20183258. DOI: 10.1542/peds.2018-3258
84. Milburn NG, Lightfoot M. Adolescents in wartime U.S. military families: A developmental perspective on challenges and resources. *Clin Child Fam Psychol Rev.* 2013; 16(3):266-277. DOI: 10.1007/s10567-013-0144-0
85. Paley B, Lester P, Mogil C. Family systems and ecological perspectives on the impact of deployment on military families. *Clin Child Fam Psychol Rev.* 2013;16(3):245-265. DOI: 10.1007/s10567-013-0138-y
86. Wadsworth SM. Understanding and supporting the resilience of a new generation of combat-exposed military families and their children. *Clin Child Fam Psychol Rev.* 2013;16(4):415-420. DOI: 10.1007/s10567-013-0155-x
87. Alfano CA, Lau S, Balderas J, Bunnell BE, Beidel DC. The impact of military deployment on children: Placing developmental risk in context. *Clin Psychol Rev.* 2016;43: 17-29. DOI: 10.1016/j.cpr.2015.11.003
88. Trautmann J, Alhusen J, Gross D. Impact of deployment on military families with young children: A systematic review. *Nursing Outlook.* 2015;63(6):656-679. DOI: 10.1016/j.outlook.2015.06.002
89. Rentz ED, Marshall SW, Loomis D, et al. Effect of deployment on the occurrence of child maltreatment in military and nonmilitary families. *Am J Epidemiol.* 2007; 165(10):1199-1206. DOI: 10.1093/aje/kwm008
90. Klein DA, Adelman WP, Thompson AM, Shoemaker RG, Shen-Gunther J. All military adolescents are not the same: Sexuality and substance use among adolescents in the U.S. military healthcare system. *PLoS One.* 2015;10 (10):e0141430. DOI: 10.1371/journal.pone.0141430
91. Astor RA, De Pedro KT, Gilreath TD, Esqueda MC, Benbenishty R. The promotional role of school and community contexts for military students. *Clin Child Fam Psychol Rev*. 2013;16(3):233-244. DOI: 10.1007/s10567-013-0139-x
92. Chaffin JG, Moss D, Martin G, Leiendecker T, Mascarenhas AK. Children's utilization of the U.S. military dental insurance. *Mil Med.* 2013;178(7):816-818. DOI: 10.7205/MILMED-D-13-00089
93. Seshadri R, Strane D, Matone M, Ruedisueli K, Rubin DM. Families with TRICARE report lower health care quality and access compared to other insured and uninsured families. *Health Aff.* 2019;38(8):1377-1385. DOI: 10.1377/hlthaff.2019.00274

94. Smythe SJ, Shulman ER, Patrissi G, et al. Prevalence of dental caries in USAF family members age 3-15. *Pediatr Dent.* 1990;12(3):172-179.
95. The AFCARS Report: Preliminary FY 2022 estimates as of May 9, 2023 – No. 30. US Dept of Health and Human Services; 2023. Accessed February 23, 2025. https://acf.gov/sites/default/files/documents/cb/afcars-report-30.pdf
96. Morón EM, Tomar SL, Souza R, Balzer J, Savioli C, Shawkat S. Dental status and treatment needs of children in foster care. *Pediatr Dent*. 2019;41(3):206-210.
97. Negro KS, Scott JM, Marcenko M, Chi DL. Assessing the feasibility of oral health interventions delivered by social workers to children and families in the foster care system. *Pediatr Dent.* 2019;41(1):48-51.
98. Muirhead V, Subramanian S-K, Wright D, Wong FSL. How do foster carers manage the oral health of children in foster care? A qualitative study. *Community Dent Oral Epidemiol.* 2017;45(6):529-537. DOI: 10.1111/cdoe.12316
99. Grattan RE, Tryon VL, Lara N, Gabrielian SE, Melnikow J, Niendam TA. Risk and resilience factors for youth homelessness in Western countries: A systematic review. *Psychiatr Serv.* 2022;73(4):425-438. DOI: 10.1176/appi.ps.202000133
100. de Sousa T, Henry M. The 2024 Annual Homelessness Assessment Report (AHAR) to Congress. Part 1: Point-in-Time Estimates of Homeless. December 2024. US Dept of Housing and Urban Development; December 2024. Accessed February 23, 2025.https://www.huduser.gov/portal/sites/default/files/pdf/2024-AHAR-Part-1.pdf
101. Bassuk E, DeCandia C, Beach C, Berman F; American Institutes for Research. America's Youngest Outcasts: A Report Card on Child Homelessness (2014). The National Center on Family Homelessness at American Institutes for Research; 2014:11-74. Accessed February 23, 2025. https://www.air.org/sites/default/files/downloads/report/Americas-Youngest-Outcasts-Child-Homelessness-Nov2014.pdf
102. American Academy of Pediatrics Council on Community Pediatrics; Briggs MA, Granado-Villar DC, et al. Providing care for children and adolescents facing homelessness and housing insecurity. *Pediatrics.* 2013;131(6):1206-1210. Reaffirmed February 2022. DOI: 10.1542/peds.2013-0645
103. Teen homelessness statistics. Covenant House. Accessed February 23, 2025. https://www.covenanthouse.org/homeless-issues/youth-homelessness-statistics
104. Caring for the oral health of children experiencing homelessness. Office of Head Start; May 2023. Accessed February 23, 2025. https://headstart.gov/oral-health/brush-oral-health/caring-oral-health-children-experiencing-homelessness
105. DiMarco MA, Huff M, Kinion E, Kendra MA. The pediatric nurse practitioner's role reducing oral health disparities in homeless children. *J Pediatr Health Care*. 2009;23(2):109-116. DOI: 10.1016/j.pedhc.2007.12.013
106. US Department of Health and Human Services. Part 1351–Runaway and Homeless Youth Program. Title 45-Public Welfare. Code of Federal Regulations. Administration for Children and Families. Accessed June 3, 2025. https://www.govinfo.gov/content/pkg/CFR-2018-title45vol4/xml/CFR-2018-title45-vol4part1351.xml

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
- 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