A need for health services for children with disabilities in Europe. A commentary

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There is an extensive series of reports reviewing the limitations of health services for youngsters with intellectual/developmental and progressive disabilities in many of the countries throughout Europe. While continued research and documentation is essential, the need is to translate these findings into the delivery of actual care for these individuals.

Living conditions. Many children with disabilities often face a bleak existence behind institutional walls, isolated from their families and communities, and suffer from stigma and discrimination. Children in institutional care are at risk of attachment disorder and developmental delay. The reality is that many countries in Europe still rely on this form of care for children with disabilities [Browne et al., 2006]. In addition, millions of children, including many with disabilities, are living in extreme poverty.

Wide-spread need. The limited attention to the general medical, dental and social needs of children with disabilities is not restricted to particular areas or countries in Europe. For example, regarding the oral health needs:

1) Dental treatment needs of children and teenagers with disabilities is extremely high in Greece. Oral hygiene status is particularly poor for youngsters with intellectual disabilities. Malocclusion is greatest for the groups of youngsters with cerebral palsy [Mitsia et al., 2001].

2) Children with special needs in Denmark, when receiving dental services, are older when treated and have fewer teeth treated than patients without special needs [Haubek, 2006].

3) The number of pediatric dentists in Sweden has remained constant for the last 20 years, but the number of children referred to paediatric practitioners has increased by 28% since 1983. The number of medically compromised children and children with disabilities increased from 6% to 22% in 2003. There is an urgent need to increase the number of pediatric specialists to ensure the quality of care for children and adolescents, especially those with special needs [Klingberg et al., 2006].

Beyond research. Research is the *sine qua non* of any effort to advance the knowledge in a field of science and/or service. But a point must be reached when the information that is gained is transferred from the laboratory, research paper or conference presentation to productive applications.

An approach in the United States - the need for training

Oral health of children with disabilities. A national telephone survey of the families of children with special care needs detailed that, “The service most commonly reported (health service) as needed but not received was dental care: more than 8 percent of children with special needs but did not obtain this service” [Department of Health and Human Services, 2004].
The setting for change. Despite the fact that currently there are more than 50 million United States residents with special needs (with projections for increasing numbers), there are no specific accreditation requirements for schools of medicine to address the obligation to prepare graduates to provide services for these individuals. By contrast, in 2004 the Commission on Dental Accreditation adopted the standard for schools of dental and dental hygiene, that, “Graduates must be competent in assessing the treatment needs of patients with special needs.” Specifically, “patients with special needs” has been defined in this standard as “those patients with medical, physical, psychological, or social situations that make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations” [Commission on Dental Accreditation, 2004]. Studies prior to this change in dental school requirements highlighted the reality that about half of graduating dental students had never treated a patient with intellectual disabilities or had inadequate didactic or clinical experience to provide necessary service for patients with special needs [Wolff et al., 2004]. The relationship between inadequate educational preparation in medical and dental schools and the difficulties experienced by this patient population in gaining access to community based health services was emphasized in an additional report [Fenton et al., 2003].

Is it any wonder that many practitioners are reluctant to provide needed care for youngsters and adults with disabilities given,
1) limited if any formal educational preparation to care for patients with special needs,
2) particularly limited financial incentives, and
3) the increased complexities of care for individuals with intellectual/developmental and other disabilities (e.g. lack of operating room times for those patients with disabilities in need of general anesthesia, lack of coordination of dental and medical services, and the use of restraints).

Directions. Extensive research has documented the limitations in the available services for this population. The need is to transform this information into the delivery of care. To this end essential steps include:
1) increasing the public’s awareness of the needs of these individuals with disabilities,
2) providing educational experiences for practitioners who will be delivering the needed care, and
3) assure necessary financial support for such a program.

Essentially, the need is adopted the view that, instead of “Let someone else do it,” “Let’s all do it.”

References