Policies and Providing Dental Care for Children with Mental Retardation and Other Disabilities

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The passage of the Americans with Disabilities Act legislation, de-institutionalization of residents of state institutions resulting in increased community group residential arrangements, and community-political activism is increasing pressure on community private practitioners to provide needed dental services for children with special needs. However, government and private insurance allocations do not reflect the increased costs associated with providing services for children with special needs. In particular, Medicaid cost containment efforts have resulted in limiting practitioner ability and willingness to provide care for children with MR/DD. By contrast, Medicare medical services are available for the permanently disabled of all ages. But, dental services for children are required only under the Medicaid EPSDT program. Most states provide minimal dental services for adults. As a result, low income children with special needs just “age out” of dental care. Other factors which impact on the availability of services include: 1) dental school education programs which provide limited student training for the care of children with special needs, and 2) there is no national or regional oral disease prevalence data for children with MR/DD. If it is the community dentist’s responsibility to provide care for children with special needs, then it is the responsibility of 1) accrediting bodies to ensure that dental students are trained adequately, and 2) government agencies to develop needed prevalence data and provide essential financial support for services and programs.

Primary Prevention of Cleft Lip and Palate Anomalies. Let's Do It!
An overview of historical studies, present knowledge and doable projects of cleft prevention.

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Cleft lip and palate anomalies represent a major problem in oral health worldwide. Every 2 minutes one child with cleft is born - 660 every day and 235,000 each year worldwide. These numbers will increase, unless we will invest our scientific knowledge and finances into prevention.

Our research (Czech study 1982,1995: decrease of recurrences by 65% with multivitamins and 10mg of Folic Acid *(FA)* periconceptionally; California study 1995: decrease of occurrences by 27-50% when at least 0.4mg of *FA* was in mothers diet periconceptionally) and historical tudies show that a significant proportion of nonsyndromic clefts *(NSC)* can be prevented if appropriate steps are taken.

Although still more studies are needed to clarify roles of genetic and environmental factors and their interactions (our pilot study from Argentina showed significantly higher proportion of C677T MTHFR mutation in *NSC* compared to controls) enough scientific knowledge already exists that a significant proportion of *NSC* are preventable.

We will present data and the project of cleft prevention that is doable and achievable through education, research, and available methods of prevention.