CONFERENCE OF THE AD HOC COMMITTEE ON
DENTAL CARE FOR MENTALLY RETARDED CHILDREN

Sponsored by
The College of Dentistry, University of Tennessee

and
The United States Children's Bureau
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DENTAL CARE FOR RETARDED CHILDREN

The Children's Bureau is concerned about the difficulties that are experienced by parents of mentally retarded children in obtaining dental care for the children, both in private offices and in clinic programs.

Purpose

This conference has been called in order to establish guide lines for practicing dentists on dental care for the mentally retarded child, which will serve as a basis for consideration sometime during the next fiscal year by a big regional working conference which will be attended by representatives from dental public health, teaching and private practice, from the six states in the Southeastern Region of the country.

The states to be included are Florida, Georgia, Alabama, Mississippi, Tennessee and South Carolina. The participants at this conference will consider the guide lines which we hope to establish in this conference. They will be requested to digest them, dissect them, analyze them, and so modify them that they will then be acceptable to the man in private practice.

We hope that these guide lines, also, may serve as material for inclusion in a pamphlet which will be published by the Children's Bureau on dental care for the mentally retarded child.

It is the hope of the Bureau that from all of this will develop an increased recognition on the part of the practicing dentist of the dental needs of the mentally retarded child, and thereby, motivate him to increasing dental services for these children, and also providing higher quality care for children.

Something about the background of the Children's Bureau and its interest in the problem.

Background

The Children's Bureau is one of the agencies within the Welfare Administration of the United States Department of Health, Education and Welfare. The Bureau was created by Act of Congress in 1912 in order to investigate and report on all matters relating to the welfare of children in the United States. Through the years the Bureau has concerned itself not only with what was happening to the Nation's children, but also with why it was happening, and with how abuses could be checked.

The Bureau's continual interest in the "what", the "why" and the "how" has fostered the development of standards of care for children.

Since 1921, the Children's Bureau has been responsible for administering financial aid to the states to help them improve conditions for children and for mothers. The basis for financial aid from the Federal Government to the states for the improvement and extension of maternal-child health, crippled

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children's, child welfare services, rests very solidly upon the broad pedestal of Title V of the Social Security Act of 1935.

This Act, with subsequent Amendments thereto, continues to serve - even to this day - as the basis for the National Health Program.

The Children's Bureau is the Agency that administers these grants-in-aid under Title V to the states and to the territories. Through the years, this partnership between the Children's Bureau and State Health and Welfare Agencies has made possible provision of those community services that children need to have a good start in life.

The Social Security Act also gave the Bureau an opportunity to help the states develop demonstrations and special programs in areas where there were gaps in service. One of the gains achieved through stimulation provided by the Bureau has been in the area of mental retardation.

During the first six years of its existence, three of the major studies that were undertaken by the Bureau related to mental retardation. So it is obvious that the Children's Bureau has long been interested in this problem.

Before 1954, there were very few activities on behalf of mentally retarded children and their families in this country. Although children who were suspected of having mental retardation were being reported by Public Health Nurses, there were very few resources for even establishing a diagnosis. Consultation and guidance as to how to deal with these children generally was not available.

That year, 1954, however, marks a milestone, because it was during that year that a major step was taken by the Children's Bureau in providing a special project grant to California from maternal and child health funds for setting up a diagnostic clinic in the Children's Hospital in Los Angeles.

In 1956, the Congress was made aware of the problem created by mental retardation, and the possibilities that might result from providing services for these children. It appeared that the principal needs of mentally retarded children were first to find them early, then to provide complete evaluation, then to interpret the findings to the parents, and, finally, to use these findings as a basis for improving health and providing care.

It appeared, also, that these services that were lacking could best be provided thru program emphasis within the framework of maternal and child health programs administered by the Children's Bureau.

On this basis and to achieve these objectives, the Congress in 1957 increased the annual child health appropriation by $1,000,000.00 earmarked specifically for special projects serving retarded children.

State Departments of Health used these funds to establish demonstration services, training, and study projects that focused on prevention, diagnosis, evaluation, and supervision of children with mental retardation.

By the end of fiscal year 1957, twenty-five states and health departments had already established at least one such demonstration project. By the end of fiscal year 1959, forty-four states had such programs going. By the end of fiscal year 1960, special projects in service or training were in operation in fifty-two states and territories. Between 1960 and 1963, there was a 33% increase in the number of mental retardation projects demonstrating services in special clinics in this country.
Definition

We define the Mental Retardation Clinic as:
An out-patient medical facility providing comprehensive evaluation,
treatment and follow-up services primarily to children suspected of or
diagnosed as mentally retarded, by an inter-disciplinary team, of which
a physician takes the medical responsibility for all patients seen and
is in attendance at regularly scheduled hours.
Since 1957, the number of these clinics for mentally retarded children
has grown from four to one hundred thirty-two. About ninety-two of these are
supported by maternal and child health and crippled children funds.

Current Status

There is now a clinic program in every state and territory in this
nation with the exception of Wyoming, Montana, North and South Dakota, and
Guam.
Whereas in 1961, these Children Bureau-supported programs provided
services for 21,000 children, in 1962, 25,000 mentally retarded children
received services through these programs. In 1963, the number went up to
27,000, and in 1964, 29,000 children were evaluated and received some
service in these Children Bureau-supported clinic programs.
A third of all new admissions in these programs are under age five.
This may have some significance to us as dentists, and certainly it
does to the medical discipline because one of the principal objectives of
these programs is to reach children when they are very young. Although the
major emphasis in these programs has been focused on services, they have also
been providing training and orientation opportunities for a variety of pro-
fessional people.

Legal Basis

President Kennedy had a special and personal interest in mental retarda-
tion, and in October of 1963, he signed into Law the Maternal-Child Health and
The purpose of these Amendments was to help reduce the incidence of
mental retardation. This Act, which is known as Public Law 88-156, has five
major provisions. I would like to review very quickly those which pertain
especially to us here today.
The Act, among other things, authorizes annual increases in the Federal
Grants for maternal and child health and for crippled children services. By
1970, the grants in each program will be doubled. There will be $50,000,000.00
in each program. This bars the effect that new legislation may have upon these
grants.
During this current fiscal year, $35,000,000.00 has been appropriated by
the Congress for each of these two programs to be administered by the Chil-
dren's Bureau. Of this amount, $3,500,000.00 maternal and child health funds,
and $2,500,000.00 crippled children's funds have been earmarked for special
projects for studies in care, training and fellowships in the area of mental
retardation.
In addition to this earmarked money, the Appropriation Act carries a proviso that one-third of the increase in the regular apportionment each year in each fund, and this is a $5,000,000.00 increment per year since October, 1963 -- is to be identified with activity in mental retardation.

Maternity and Infant Care Projects

Public Law 88-156 also established a new program of grants for maternity and infant care projects. This grant, this year, is in the amount of $15,000,000.00. Next year it will be $30,000,000.00.

These grants are available to State Departments of Health, and with the consent of the State Department of Health, to local jurisdictions of health, in order to provide comprehensive pre-natal, hospital, and post-partum care for pregnant women of low social economic status and of high risks, and care for their infants.

Such programs should result in a decrease in pregnancy wastage, and in the incidence of prematurity. And because there is a demonstrated positive relationship between low birth weight and the occurrence of mental retardation, maternal and infant care projects should help prevent mental retardation.

This part of the Amendment dealing with maternity and infant care projects, also has implications for dental care. We are very much concerned with seeing that dental care is a part of these maternity and infant care projects.

The nucleus of service programs in mental retardation is a specialized team. This team will usually include a pediatrician who very often will double as the Medical Director of the program; a Public Health Nurse, and a medical social worker.

This is the basic team. In some clinics other people are included, speech therapists, nutritionists, might be included and other medical consultants, such as psychiatrists, as well as paramedical specialists may be used as needed.

One such clinic program functions right here in Memphis. We have invited the Medical Director of that program, Dr. Robert Jordan, to be present with us at this conference. He has graciously accepted, and he will serve this conference in three capacities, -- as a resource person, as a participant, and, also, to present in some detail the concept of the team approach. Dr. Jordan will be assisted in his presentation this morning by two of his team members, Miss Betty Foley, whom I have already introduced to you, who is a medical social worker, and Mrs. Maxine Chambers, who is a Public Health Nurse Consultant.

I believe we are going to get a picture of what these people are doing, something about the concept of the team approach to the problem of mental retardation, and some of the problems that they encounter in the course of their work.

DR. JORDAN: Our clinic started out in 1956. I think we were fortunate in getting one of the early grants that Dr. Miller mentioned, and we were, further, fortunate in being able to recruit some professional people fairly quickly so that we were actually seeing patients in the early spring, of 1957.

We had visited some other clinics in the country to see if we could avoid some of the pitfalls that may come to some people in getting started. We saw
some very excellent places in the East, and all of our staff members have visited one or more of these places.

The Children's Bureau realized that not only the medical specialties, but others had neglected the field of mental retardation. Particularly was this true of pediatrics.

I think a lot of the difficulty here was the fact that we were not communicating with the other specialists, other disciplines. We didn't know what they were doing for the handicapped and, particularly, the retarded. We had been given inadequate information in our medical training. All of the emphasis had been on metabolic disorders or acute defects, the use of vaccines, and not upon a broad approach to neurology and emotional problems that we have seen come about today. We were operating more-or-less in isolation and not communicating with the other disciplines in the way that we needed to. This included the teachers of special education and I think we were probably furthest from discussing with these people than we were with any others.

As we know now, and will say throughout our discussion, each discipline has something distinct to contribute to the evaluation of each child, and each child is an individual case and has to be approached as such. We cannot make generalizations that apply to all of them.

In general, we approach the evaluation of a child by having personal contact with the social worker that is assigned to the case. Then a physical examination by the pediatrician, and the two have a conference to decide what other people on the staff should see the child in question, and what laboratory and X-ray work should be obtained.

Practically always the psychologist sees the child, but sometimes we find that this has been an inappropriate referral, and we go no further than the social worker and pediatrician. But we never turn anyone down without a discussion between the two members, and unless there has been a discussion between members of the staff about the case.

We insist upon getting our referrals either from physicians or health or social agencies. We do not accept them from school teachers or parents. Some clinics do.

One of the main reasons that we think this is preferable, is that we get a certain amount of screening of our cases, and we set the stage for better follow-up with the referrer, if we have someone to send them back to, to help carry out the recommendations.

After each of the disciplines that is going to see a given patient has finished his evaluation, we schedule a conference in which we discuss the case, come to our mutual agreements and diagnoses and recommendations.

We always don't come to agreement very easily, I might add. We sometimes have to defer final agreement until we have had some more observation or some more testing. Then, after this, we have the family come in for a few minutes at the end of the conference to be sure whether we have any loose ends; whether we have any further information, and, also, I think most importantly, to let them see that we have sat down together and discussed their case.

I think that this impresses the family quite a bit to see the number of people who have been concerned with their problems. Particularly is this true of the fathers.
We make it a point, also, to involve those parents. Unless the father is out of the country or is deceased or some other excellent reason, we refuse to hold what we call an informing interview with the family unless both parents are present.

In the years we have been in operation, I think we have only failed twice on this score. One of these two was the wife of a physician who refused to get her husband in because he was too busy. Of course, this meant that he was also too busy to help her carry out any recommendations, and we, therefore, politely said, when he can come in we will be glad to sit down and tell the two of them, but we refused to discuss it with just one of them.

Another important procedure, I think, is that we do not schedule one or two day work-ups, except under very unusual circumstances. We have found it to be of value to have multiple appointments on different days, and screen them out a little bit. This has helped on scheduling work, but more importantly - it gave the family a chance to digest each evaluation. So that by the time we get around to holding an informal interview with them, many of them have gained quite a bit of insight into their problem and are much more ready to accept our diagnosis.

The disciplines included on our staff are these: The medical disciplines are pediatrics, psychiatry, pediatric neurology, ophthalmology and otology.

We, also, get other consultations outside of our clinic staff, such as orthopedics. We do have access to some dental consultation through the dental school.

We have had a number of conferences with the dental school and talked with some of the dental students in regard to the over-all problem of retardation, and there has been a service clinic for retardation in operation now approximately three years through the local United Cerebral Palsy Group in cooperation with us, and there has also been some offered through the Les Passes Center.

So there are two places in town that have offered dental care to retarded children.

The LeBonheur Hospital has been used for hospitalization of those who required an anesthetic in order to give them adequate dental care, and this has been quite a bit.

Because of the lack of space, we do not have at the present time a dental consultant in our clinic, but we have had plans for some time to do this; and, as soon as we get in a new building, we will have a dental consultant and space with equipment for offering evaluation and some service for demonstration purposes to the different disciplines that are dealing with handicapped children within our clinic area.

In addition, we have had from the beginning clinical psychologists available for the evaluation of the retarded. The psychologists give us valuable information in regard to intellectual functions, evidence about specific learning disabilities, whether there may be perceptual problems, and in some of the milder degrees of retardation whether there may be evidences of organic involvement as opposed to the question of how much emotional involvement may be present often in these individuals. Some of our toughest cases for evaluation involve communication problems and the
tters to identify the degree of emotional involvement as opposed to the 
amount of organic involvement which may be present.

Many times it is impossible to completely define what is observed in each 
of these areas. Quite a bit of observation is necessary.

At the present time, one who contributes a great deal to this is our 
Speech Pathologist.

We plan to have the services of a nutritionist. We have had some con-
sultation but do not, at the present time, have a staff member in this cate-
gory. Again, this is partly due to the lack of space and partly due to the 
difficulty in obtaining the services of such a person.

Cases of retardation usually have other diagnoses, as well as retardation.

Last year, we had occasion to analyze our cases and determine how many 
had at least one other diagnosis. Over 80% of our cases did have some other 
major problem. Most of these were either some eye problem, such as poor 
vision, or some learning disorder, such as a perceptual problem, and organic 
behavior problem or cerebral palsy, or a problem with epilepsy.

This meant that we were many times having to deal with some other major 
problem, because of the absence of some places in this community that these 
people might receive help. For example, if we received a patient from 
Arkansas, we would not be able to send this patient to the City hospital 
epilepsy clinic for care of a seizure problem. They would not be eligible.

Another by-product of the presence of a clinic like ours in a com-
munity is training.

I will go back a minute and say something about the early days in the 
Children's Bureau role and philosophize here a little bit.

When Dr. Fairless and Dr. Peabody and Mr. Hormuth visited us soon after 
we had gotten off the ground, we were discussing some of the things that were 
coming our way and what the guide lines should be. One of the things was, how 
far we should go in training of the disciplines that were represented on our 
staff.

At that time, the training aspect of people in these various disciplines 
was not felt to be one of our foremost functions. As a matter of fact, I 
think Miss Chambers, and I think Miss Foley, too, had to do a little bit of 
selling to make it so that we could spend time on this.

But I think as time went along, we saw that this was a natural by-product 
of what we should be doing, and the Children's Bureau has encouraged this 
activity.

We were sort of pushed into the training aspects of the program in each 
of the disciplines represented on our staff. This is something we did not 
foresee in the beginning and, yet, I think it has served several purposes that 
are important.

One of the most important is that it has helped in recruitment of people 
into the field of retardation in each of these disciplines.

There are five pediatricians whom we have influenced to get into the 
field of retardation. There are four or five social workers, we know of off-
hand, who have served as field placements in our clinic, who have gone over 
to get into the field of retardation. Two of them are now on our staff.

Another thing that it has done is to show, I think, the practicing physi-
cians in this region something of the value of the multiple discipline 
approach.
MISS FOLEY: A little bit about the multiple discipline approach, first. I think that we find that everyone of us on the staff brings to bear his own professional skill and competence on whatever problem the child and his family may be presenting to us -- problems in the child's development or in the child's learning.

We think separately about each situation and we do a lot of things together. Being part of a multiple discipline staff, housed together under one roof, certainly makes it possible for us to exchange ideas frequently, to make suggestions to each other, to become familiar with the other fellow's discipline. We learn to modify our judgments, usually agreeing upon what the specific problems are and what resources we can bring to bear on the problems.

I think that it is only in this way that we can really work most beneficially for the retarded and the handicapped child.

Many youngsters come to us who have had individual professional consultations. Maybe they have gone some place, to the psychologist, for testing; they have had a family pediatrician, possibly they have had a neurosurgeon in on the case. But at no point previous to coming to us have all of these people thought together about this child and his problems.

We are overwhelmed at times because our referrals have increased and increased so rapidly that they have more than doubled since the first of July. We know we cannot begin to meet the needs of all of the retarded, and we must develop some new approaches to the problem.

I think we see that part of it is educating other people, so in their own practice they can handle some of these things, themselves, because certainly not every child can have the opportunity of coming to a child development program, such as ours, and being seen by all these different people.

I don't know how much experience you all have had, in working with the retarded. Dr. McKnight has had a whole history with us and we, with him.

All of us on the clinic staff have been very involved in community activities. We found that we were seeing children who needed help, and this particular help wasn't available in the community. Then we made the effort to get some programs established, such as pre-school programs for the retarded, day care for severely retarded children, and sheltered workshop program, etc.

It is a fascinating job.

I think that we have felt for a long time we needed more help from dentistry than we have had or that we have been able to arrange. We are looking forward towards some future developments in this area.

I don't know, Miss Chambers, you might make an estimate, or Dr. Jordan, of the number of children we see who have some special dental problems who need help.

DR. JORDAN: It is very great. I think it is related to the two particular things. One, the degree of retardation and, two, the economic level of the patient who might be seen.

The severer the retardation and the lower the social economic level, the more likely they are to have greater dental problems.

We put emphasis on early case finding as much as possible, and this involves all kinds of professional people.

We feel it is very important to get into these problems at as early an age as possible. It does not matter what profession you are in. You may be the
one who has the first contact, although we feel that pediatricians and public health nurses and general practitioners are probably the ones who will be the so-called primary contact with a retarded individual, and have the opportunity to channel them into some evaluation process.

Therefore, we feel, that it is proper for pediatricians to be tied in with the diagnostic clinics as they are, rather than some other specialty, such as psychiatry.

MISS CHAMBERS: I would like to talk to the dentists about what the nurse does and give you some stories. We are fully convinced, that certainly, a team approach is really necessary.

The Public Health Nurse has preparation in the prevention of illness. I do feel, so far as the primary function of the nurse in relation to mental retardation, it still should be in prevention.

As Dr. Miller said, the primary prevention would be the maternal care - child health supervision, where the dentists work a lot in the Health Departments over the country and in accident prevention.

Secondary prevention, her role is in finding of the child early.

I think this has many applications for the dentists. I know we need their help early with that child. I just wish they could see the children earlier who are retarded so that we can get help from the dentists to help this mother in good dental hygiene and dental care.

Of course, when we get the child from five to six, he already is attached to so many things and has such terrible hygiene. It is terrible to try to start them and get it done. So they need your help and they need it early.

The nurse, in secondary prevention, out in the districts, finds this child early, refers him to an appropriate resource for help, and then she participates in the evaluation, and then is a very important person in giving services to this family and follow up.

One of her greatest contributions here is in servicing these families. Sometimes it is good to talk over these things with someone else and help ourselves arrive at decisions. The nurse does play a vital role there.

So far as my role on the team, I think I have two principal roles. One, as a consulting nurse. As a consultant nurse worked with supervising nurses or district nurses who would be serving all areas and working with this person who may have a case load of 250; may be working six schools. Think how many people we can reach by my using myself as a consultant. So I think this thing should be the primary role of the nurse on the team.

So I have found that I, much more than I had wanted to, have to involve myself in giving direct service to children and families and working with Health Department people to where they are able to come along and do more of this.

Also, this varies from community to community in relation to the prevention service of medicine in the Health Department. This, of course, is based on the particular needs of a particular community.

So, my role in direct service in the diagnostic evaluation, is to go into the home and observe the child and his family in their own environment.

You will agree as you see children in your office, and sometimes they act so awful, you think, he just can't be like this at home.
This is true. Often as we see children in the clinic, they may be very much more active and terrible to live with than they may be at home, or they may be just the opposite. So that we don't get a good picture always of what the child's like in the home or the parents have to live with and what the child has to put up with. So I think the home visit is very important.

Many of my visits are made at mealtime. I try to visit when all the family is home and, of course, visit by appointment. I find that this is no objectionable to parents. In fact, they usually recommend this. They often end up saying, nurse is really the only one who saw my child as he really is.

Then, I think, the nurse isn't so vitally interested in determining the degree of retardation; but rather, as we see them in the home, we watch how he can do in dressing and undressing; how he can take care of himself in hygiene, and all other little procedures. And we ask them, were your other children doing this, or were they doing more at the same age? It then helps them see where the child is functioning.

So I do think home visits are important. Another thing, it helps us to see what many problems they have.

I think the nurse has really a great deal to contribute in follow-up. Because of very limited time, I do very little follow-up, but it certainly needs to be done.

I won't commit the dentists, but I think probably this is true, that the more severe the handicap, the more they need the dentist and the nurse. I think 85% of the children we are talking about are only mildly retarded. These children are very much like other children as far as looking at them, and I doubt that their dental problems are any greater than the general run of population.

But the more severely handicapped have dental problems and need us much more.

What are some of the problems? Some of the ones I run into more often are problems around nutrition. Often times these people have been on a bottle for years. The other day I was seeing a boy 4 1/2 years old still on the bottle. The bottle is usually kept a long time.

Too, we find more of the severely retarded children have difficulty using their tongue, have difficulty using their jaws, and have a high palate. This interferes and presents special problems in getting food into the child. So we may have to think about special foods, how we can enrich diet and this sort of thing.

Of course, the child who cannot use his jaws well may not be able to open them well, and all sorts of things like this. But remember, this is the minority of the children.

How are we going to get cooperation in this approach? I think we need to know more from the dentists and have more from you in the early nursing education of nurses. I know I need more of this. On many of the visits I make, I think, if I could get the child to the dentist he could help so many children. How do you separate his teeth far enough and maintain that position and get in and see them cleaned inside?

Then, of course, in nutrition, we do need help with nutrition. State Health Departments have helped me, and now I am able to help more of the
families with this special feeding problem, a very interesting one and not too
difficult a one when you really get into it.

Something that hurts terribly in the more severely handicapped children
I see so often, is because we didn't get help to them early, but they will take
the child in and give them a general anesthetic, they will pull all their teeth.
Then the nurse does have problems in helping the family with nutrition.

This is why I advocate the early contact with the dentist so maybe he can
avoid that. Maybe more fluorine in water or topical applications, good oral
hygiene, can prevent this condition.

So, I don't know how you feel about the retarded. I don't know what
contacts you have had. But let me tell you a little bit about how I felt when
Dr. Jordan first called me to see if I would be interested in working with his

team.

I will tell you very frankly, these very severely handicapped children
were really repulsive to me. And you may feel the same way.

Dr. Jordan, when I told him this, said, I think you'd better see a psy-
chologist. So he gave me an appointment early. The psychologist wasn't dis-
turbed about this. I believe this is a very normal reaction. I think we would
be abnormal if we didn't have some of these feelings when we see these chil-
dren so terribly handicapped.

Still, we need to help the families. How do you feel the families feel,
the heartbreak and disappointment in having a child like this? They need us.
They need your help and mine. You will never find people more grateful for
help than these people are. So, I want you to know, when we call on the
dentists, we need you, we need your nursing education and direct service to
the people.

DR. JORDAN: I would like to make two comments before we stop in our
discussion here. One is, Miss Chambers has developed a form which she has
found useful with local Public Health Nurses. When she is not able to make
the home visit, she sends a form out to nurses, and they are able to make a
home visit and send back a good bit of information. Some of you may be
interested in seeing that form.

MISS CHAMBERS: You mentioned I worked in educational training of the
people. I made reference to that early. I think some of the dentists will have
some of these same feelings. Once they start working, they will want to teach
other dentists so they can help them.

I have found it is very productive, of course, with student nurses and
nurses in service.

DR. MILLER: Thank you, Miss Chambers, Miss Foley and Dr. Jordan.
(Recess)

DR. MILLER: Now, we are ready for some questions.

DR. ADELSION: What is the percentage of youngsters which you have seen
referred to institutionalization?

DR. JORDAN: We have to make the recommendation of institutionalization
much more often than we like to, and we have bent over backwards not to make
the recommendation. We try to keep them in the community if we can.

We may have to recommend institutionalization of a mildly retarded child
whose parents have died and who has no place else to go. We had this happen
twice last year.
On the other hand, recommending it and getting them are two entirely
different things. This county alone has, known to us, more applicants waiting
admission to state institutions for the retarded than for whom there are
places. How long it will be before they are admitted is a question.
MISS FOLEY: I think it is a small proportion, but I think in communities
like ours we see a larger proportion of severely retarded than exist in the
average community.

Problems are so apparent to professional people and families when they
are grossly retarded and handicapped.

Then, Dr. Jordan, you didn't mention this, we have been doing some
screening of applicants for our state school that will open in a couple of
years. So right now we are having a good many more referrals of people who
want to get on the waiting list, and we are helping with this.

DR. JORDAN: I think one of the things Miss Foley is saying, is that if
we took our percentage of recommendations, it would be a lot higher than the
actual percentage of retarded who need to go into institutions, because we
are obviously seeing the more severely handicapped ones rather than the mild
ones.

MISS FOLEY: When we opened we had such a long waiting list before we
began seeing patients, that in consultation with the Children's Bureau we
dropped our top age to ten.

Our clinic has expanded and we are seeing youngsters who have suspected
learning problems on an organic basis, and we take some older children in
those groups.

DR. ADELSON: What is the upper age?
MISS FOLEY: On paper our upper age limit for youngsters who have neuro-
logical difficulties is eighteen. However, our focus is really on elementary
age children.

DR. ADELSON: What about resources for the older?
MISS FOLEY: They are pretty limited but we had nothing in this com-
munity. We have just gotten a large grant from Vocational Rehabilitation to
our Board of Education, and we are now offering more vocational training and
special education classes than we ever had previously. This program has just
started.

DR. ADELSON: To what age is that?
MISS FOLEY: They take them up to twenty-one. In this program they hope
to place them in competitive jobs in business and industry and not shelter-
workshop type of employment.

DR. JORDAN: One of the things that has bothered us, too, in the clinic,
is the gap that exists between those who have gone as far as they can in
special education, and, yet, are not sixteen and are not eligible. You can't
employ them, at least, in this community in a shelter-workshop.

What do you do about a boy fourteen who has finished special education
and could work somewhere and yet, because he is not sixteen, is not allowed
to?

DR. OBERMAN: Dr. Adelson, of course, we have been talking about diag-
nosis, treatment, follow-up services. These are the kind of programs that the
Children's Bureau is supporting. However, the approach to the mentally

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A retarded child is considerably above and beyond that even though clinics, such as Dr. Jordan’s, have a significant role to play in the leadership in the community.

But this is not to say that there aren’t many other kinds of programs within Departments of Education, within the Vocational Rehabilitation Administration, and many other cooperating community agencies and governmental agencies.

Each state, now, perhaps you are aware, has been given a grant to formulate a statewide comprehensive plan for mental retardation. This varies from state to state.

So that your question really has quite a few implications and transcends much of what we have talked about so far today.

DR. ADELSION: One of the problems I have noted in communication was the fact that children have received a fine evaluation and special education, and then they sit around and do nothing. They are not recalled, because they are generally past the maximum age. I think nothing at all is done. All they do is tend to get obese.

MISS FOLEY: In our clinic, although they must be within our age limit to start our service, we don’t ever close our service to them.

We don’t do a complete study. But I think we have those on an even keel. But we don’t review the ones that come to us.

DR. ADELSION: Does your clinic function full time?

MISS FOLEY: Full time and beyond that.

DR. OBERMAN: Nevertheless, Dr. Adelson has touched on a very sensitive point, and, that is, even where there are 139 clinics, most of them are still involved in getting initial diagnostic and treatment services.

I think unless we make an impact and provide service in depth, it is going to be more than a matter of setting up new clinics. We are going to have much more community involvement and breaking down the type of service necessary, such as dental service, and obtain it from known clinic services, but using these clinics as the coordinating agencies.

DR. MILLER: We will have an opportunity to talk more about this very thing later. Dr. Adelson, we will also discuss whether it is prudent and more expeditious to concentrate on what we are doing, or increase the services, or expand and admit more kinds.

DR. ROSENSTEIN: I think we are supposed to lay down guide lines and plan a larger regional conference.

The statement that over 80% of your mentally retarded children have other diagnoses, I think, is something which is an important factor, and, probably, we find almost universal.

May I take another minute to say, in our CP Dental Clinic, we separated the mentally retarded patients. When I took our total group of patients and subtracted the ones who were in for orthopedics, cerebral palsey, and other things, about half of the remainder were mentally retarded.

Of the retarded children 78% had mental retardation -- with cerebral palsey and other things. If I were to add to those figures a few that have phenylketonuria, disarthria, seizures and emotional disturbance, it would easily reach over 80%. I think this is probably going to be a universal kind
of finding, no matter whether the program has a mentally retardation tag or cerebral palsey label or emotional disturbance. Although it may be different in that area.

If we are going to stress, as you did so well stress, the multiple discipline approach, we must explain our programs to the multiple handicapped. If we are going to aim a good bit of our approach to the private practice in dentistry, we must make available to him basic knowledge, not only in mental retardation, but cerebral palsey, too, and the other things found among disabilities, and so on. I think it would be important to recognize this at the beginning, even though the Regional Conference may be labeled a Conference for Dentistry for Retardation.

There must be recognition of the accompanying conditions that the mentally retarded child is going to have. So if we want the dentist to treat these children intelligently in their offices, they must know about the other conditions the children have, so that they can understand the children better.

DR. COHEN: What sort of impact do you think you make on your colleague, your pediatricians, as far as education, as far as interest, as far as assuming the responsibility of doctors in this?

DR. JORDAN: I think there are two ways of answering that. There are two aspects of this.

I think one is the impact it has on those who are already in practice, and the other is the message we are able to get across to those who will soon be in practice.

We get the senior medical students on rotation. Each one gets about ten hours of exposure to our clinic operations, and explanations, lectures, and so forth.

These five pediatricians that I talked about, who are actively working in the field of retardation, were from the students we have seen. On the other hand, I think some awareness of what can be available is important, no matter whether they are going to be surgeons or what they are going to be. The knowledge that they can find something in their area wherever they may be practicing and to refer patients is important.

There are a couple of examples that we might give, added to changes on the part of private practitioners in Memphis, as a result of some of our activities, to illustrate the answer to your question.

One is a pediatrician in one of the upper class neighborhoods of Memphis who has become quite interested in the organic behavior problem, visual perception problem type of patient, and has become enough interested that some of the schools in town have begun sending him patients who are having school problems, knowing that he will channel them in significant directions as indicated.

He has developed some proficiency in diagnosing these cases and knowing which ones to send on and which ones not to send on.

Dr. Jordan, I'll add a little further explanation of what our medical students do. When they come to us, we have a patient whose diagnostic study has been completed in the clinic, but we divide the group, there are, maybe, ten or twelve medical students, and one-third interview the father, one-third interview the mother, and one-third has the child. Then they come in to our
staff conference, and there is a spokesman for each group who tells of the interview, the parents' concern, the birth history, and then the physical examination of the youngster.

Then they hear our staff give our findings, and then we all discuss this together. This has been very productive.

We started out just letting them sit and listen to us. They were bored to death. As soon as they got to know a patient and the parents, they became very much interested. This has been a good teaching device.

I find, as far as working with the students, you cannot reach them until you really involve them with a case, until they get scared. In other words, if you have a lecturer, they come, but when they go on a visit with me and talk about it and see it and talk together, then you have them.

DR. SAUNDERS: I work with a school for handicapped children, a state residential school, where we have about 1700 children in residence. Also, we have just established in the last year at the same facility, an out-patient evaluation center, such as has existed here.

The first thing I noticed, when it was first written up for the Children's Bureau, there was no provision for dental evaluation. And when we put our explanatory pamphlets out, we said a dental consultation could be provided.

However, since that was written we have dental consultation. Every patient has been examined by the center.

We were talking about this 80%. I find that 100% of these parents and children need this type of consultation for recommendation for the future, in home and professional care, oral hygiene procedures, diet, fluorides, tooth-brushing, etc.

I feel that almost every child that you see needs a dental consultation.

I agree with Dr. Rosenstein that we must consider the multiple discipline and multiple handicapped approach.

DR. MILLER: I think we are using mental retardation as a handle with which to approach the problem of the multiple handicapped, or handicapped child in general.

I think the same guidelines which are established in the name of mental retardation could apply across the board to handicapped children in general. But because of the interest of the Bureau, this is a conference on establishing guidelines on dental care for mentally retarded children. I think we all understand this.

I was negligent, after I spoke at some length about the interest of the Bureau, in not asking if there were any questions among you people. Some of this was probably new to you -- the concept of the Children's Bureau, of a federal agency, involved in supporting programs for children.

Are there any questions on the Children's Bureau? Are there any further questions of Dr. Jordan?

DR. MESSORE: I would like to ask Dr. Jordan a question.

On the child receiving medical care not related to their mental or neurological problem, do you have difficulty getting these followed up by their family pediatrician?

DR. JORDAN: That is a real good question. Remember that we ask for physician or agency referrals, so that we have a source to go back to.
This is another reason for not accepting schoolteacher referrals. We try to get all of these things back into the hands of the referrer.

Let us say a child is terribly anemic. We may send him back to the referrer for the blood work and follow through. Or, let us say, we find on a routine pediatric examination that a child has some type of infection. We make a phone call and try to get them back immediately to the doctor who has taken care of them.

DR. MESSORE: What is your success along these lines, because I think the whole conference is based on the lack of care of these children, whether it is dental or medical?

DR. JORDAN: A certain amount of that is true, but being a Medical Center the competition here among the pediatricians is pretty great. We have about seventy pediatricians practicing here, so it is not hard to get a handicapped patient seen.

I think our greatest difficulty is getting adequate follow-up for other problems than the one we are seeing them for in the lower social-economic groups. Get them to go back to the city hospital clinics or somewhere else for this type of service is so many times pretty difficult.

MISS CHAMBERS: It is more of a problem in the lower social-economic group and even in a community of this size with these medical facilities.

I think it is important that the Public Health Nurse is active on the case. She takes up and helps this family to get and carry out recommendations and she continues medical supervision. It isn't always easy but we strive to see that the child does have total care.

DR. MINK: One other little kind of touchy area, perhaps -- do you ever refer back to a physician, other than the one that refers? Because, from your personal knowledge, you know that this physician wouldn't take care of them properly and you refer to someone else.

DR. JORDAN: This is a real interesting question. In the course of a work-up, a lot of patients realize that their doctor has not been the least interested in this problem, and they may ask us if we would suggest someone else.

There is one pediatrician in town who is even hesitant to refer patients. He doesn't want to get involved, even to that extent. We have seen him lose half a dozen patients that we know of, because he wouldn't refer them. So they went to some other doctor so they could get referred. This sort of thing happens.

The best way we get out of this, I think, is to just say, why don't you ask some of your friends in the Parents Council who they go to. So I think we get around this without directly doing it ourselves. They, when talking among other parents, usually find someone they can go to who handles it well.

MISS FOLEY: Dr. Jordan, I think you missed one point, to be perfectly honest. We find the pediatricians don't welcome back the patients who need help with tranquilizers. It's been a long, hard pull to educate them about the use of tranquilizers with youngsters with organic behaviour.

We are making some progress, but they want us to carry those, and we do have a medication clinic, and we do quite a bit of follow-up.

DR. JORDAN: We still don't take care of other problems for them. We may see a patient in the clinic that has some other problem, an acute ear
infection, and one of the pediatricians will say, no, I am not going to take
care of this ear infection, or whatever else it may be. Because they are in,
and he can't, we simply write him a prescription. But we insist they contact
their pediatrician.

DR. ADELSON: I know I have situations where I have to make a number of
calls to find men who are willing. You have many peculiar ethics where the
family physicians say it is not necessary and we say it is necessary. This,
in a way, is parallel to the situation in dentistry.

MISS FOLEY: Our own experience in the clinic goes right here to
Dr. McKnight when he made a contact with us several years ago. We worked
together on some problems. Then we had some problems with families who
can't afford private dental care. They couldn't find a dentist in town who
wanted to take care of the child.

They had tried the family dentist, and they had heard of one or two
others, but when they described the child on the telephone, he felt that he
couldn't take care of this child in his practice.

Dr. McKnight was helpful to us in giving us the names of several dentists
who were interested and concerned and willing to help these people. But that
is the way it had to be done.

DR. ROSENSTEIN: There is an extension of this into the dental area. Let
us say the nurse checks the child's mouth and sees the need for dental care.
Is your first thought to ask the family, do you have a family dentist who is
taking care of the child? In other words, you almost have to get a reply that
my child can get no care before you can route the patient. Isn't that right?

MISS CHAMBERS: This is always the procedure. We ask, do you have a
private dentist? Then, if they say, yes, we do, but he won't take care of this
child, or we can't afford it, our nurses are aware of facilities.

DR. POLLOCK: It's question might have a dental parallel, but that is not
what I am interested in. I am interested in taking information back on public
clinics.

What do you do about the more sophisticated recommendations you might
make concerning treatment procedures for patients within a rural area? Would
you make a recommendation for speech therapy?

DR. JORDAN: There are two or three different features about this. One
is, we have speech centers scattered within distances that they can get to.
For instance, Jackson, Tennessee, has a speech center. So, if someone is
from rural West Tennessee, they could either get to Jackson or here.

Another thing we have become involved in is the development of facilities
in some of these communities, and we get requests to go to places like Helena,
Arkansas, with regard to development of special education classes, and we try
to answer those requests.

Some staff member, really, one of our psychologists, went to Helena and
worked with them in regard to developing some special classes. So then, when
we recommend to a patient from Helena that he be enrolled in a special class,
we have some recommendation to make to them, rather than telling somebody from
Helena, come to Memphis and take advantage of what we have here.

MISS FOLEY: One thing we have been very much involved in is helping
parents to organize parents groups. In this way, they have put pressure on the
local people to develop some resources.
We suggest to parents in rural areas they might run an ad in the paper announcing a meeting in their home of parents of retarded children, and see if some parents would show up. We have formed several parents groups in small towns in this way.

In some of the areas, they already know two or three parents, and they set up a time and place for the meeting, and get the group going. And then the parents group puts pressure on the Board of Education to develop resources such as speech therapy, and on it goes from there.

DR. JORDAN: We feel some obligation to point out to people from areas that don't have facilities what we think would be ideal for their children.

DR. MILLER: This is all very interesting. I think we brought out the fact that there are parallels between the problems encountered in these clinic programs and dental care for these children. Problems in education and referral and care.

We mentioned something about care of children in rural areas, and Miss Chambers, in the course of her delivery, referred to the program available to the mentally retarded children through certain Health Department facilities.

The State of Tennessee presently is conducting a program of dental care for mentally retarded children who are enrolled in special classes throughout the state. I am going to ask Dr. Williams to say a little about this program.

DR. WILLIAMS: Thank you, Dr. Miller. I am only sorry that our Director is not able to speak to this one, because he gave birth to this study.

In Tennessee our philosophy has been that dental care should be insofar as possible provided by the general practitioner, who is best qualified to do this. In the past, we have had our indigent programs, school programs, primarily done by the local practitioner in what we call a cooperative dental program. Cooperative in that the funds for this program are provided jointly by the local county and the state funds.

So when it became apparent that funds could be used for treatment of the mentally retarded, this program is more or less an outgrowth of the one that we have had in operation, namely, that the local practitioners have been encouraged to participate in the care of the mentally retarded through the contact of men on our regional staff and local people in the County Health Department.

This is an arrangement whereby the children in the schools who have been designated as mentally retarded were screened and sent to those practitioners who are willing to receive them.

We have been encouraged, because many practitioners have agreed to work on the mentally retarded children. There was a little slowness in the beginning, but this has been picked up; and at the end of our first year, which was not a completed year, there were 38 counties involved. So in the larger counties, many dentists are cooperating. And also, in some of the smaller ones, one dentist who is doing a mentally retarded program in a smaller county, has seen over 200 children, rendered various treatment.

I asked him about some of his experiences in this, and he told me that very fortunately and very surprisingly to him there had only been four children that he was not able to render services to. I thought this was quite outstanding.
Most of the men who are working on the program are private practitioners. We have some specialists, one pedodontist, we have one in Nashville, who travels some 50 miles to participate. Primarily, it is the local dentists who have become interested and though early were a little squeamish about this, have entered into the program enthusiastically. We are keeping up with the funds pretty well, as you know, Dr. Miller.

DR. MILLER: I might mention, this is one area where some of the increase in maternal and child health fund granted to Tennessee by the Children's Bureau has been identified with mental retardation activity - to the extent of $40,000.00 in this particular case.

DR. ADELSON: Do I understand indigent children who are in the special education classes receive dental care by the private practitioners who are reimbursed by the State?

DR. WILLIAMS: Yes.

DR. ADELSON: As to all phases of treatment?

DR. WILLIAMS: Yes.

DR. ROSENSTEIN: Your reference to funds available from local and state funds -- state funds, a large portion, were made available to the State by the Children's Bureau?

DR. WILLIAMS: In this particular program.

DR. MILLER: This mental retardation program is funded by $40,000.00 of maternal and child health funds which were provided by the Children's Bureau, thru regular formula money to the State.

DR. ADELSON: In each case, it is determined just what area will be paid for by those funds, is that correct?

DR. MILLER: That's right. These funds are not dental funds. They are maternal and child health funds granted to the Department of Health within the State. Dental program is one of the activities which could be serviced with such money.

But the State is permitted a great amount of flexibility in determining who gets the service; how it is given; what areas of service; how much service; when to give the service, so on and so forth.

DR. MESSORE: Dr. Williams, do you have any facilities for patients who can't be taken by private practitioners?

DR. WILLIAMS: Yes. These funds are available for hospitalization.

DR. MESSORE: You have dentists on the staffs of the hospitals?

DR. WILLIAMS: Of course, yes.

DR. MESSORE: But there isn't any physical set up for a center or clinic?

DR. WILLIAMS: No, this is local.

MISS FOLEY: I have kind of a local question to ask Dr. Williams. Is all of this being spent in the rural areas? It seems to me we have too little available in the city.

DR. WILLIAMS: Not intentionally. We have urban programs.

DR. MILLER: I think these programs are available wherever there is local interest. They found somebody within the county or within the area who was willing to render this service for the particular children. I think these funds are available wherever they will be accepted, more or less.
DR. MINK: Do you seek out these dentists, or how do you go about finding those who are interested?

DR. WILLIAMS: On our staff we have ten dentists who are regionalized across the state. They are contacting their local dentists to encourage them to participate in the program.

DR. MINK: Do you have any special training for these dentists; any special courses, or anything that you give before they participate?

DR. WILLIAMS: No.

DR. MILLER: I think we ought to move along with this. We have yet to discuss the dental problems of these particular children.

The Children's Bureau is presently involved in publishing a list of the current mental retardation clinics in the country. We can send each of you, if you so desire, this list as soon as it is off the press.

DR. MESSORE: We would like all the information you can send us.

DR. MILLER: Dr. Pollack asked a little while ago about a definition of mental retardation. I have before me a definition that was prepared by the American Association on Mental Deficiency, as follows:

Mental retardation refers to the said subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.

Now, a little bit about the problems. It is estimated that 3% of the population in the United States are mentally retarded. There are estimated to be more than two million retarded children in this country, this means individuals under age twenty-one.

Ninety-six percent of these live in the community. It is further estimated that of the four million, one hundred thousand live births each year, one hundred twenty-three thousand babies will someday be tagged as mentally retarded.

(I think we brought out before the fact that many of these are not recognized until they reach school age.)

Now, of this number, a little better than 3%, will have IQ's below 25. These are the severely handicapped, severely retarded, who will require total life-long custodial supervision and care in an institution.

Nine and one-half percent of the one hundred twenty-three thousand, about eleven thousand seven hundred, will have IQ's ranging between 25 and 50. These are the trainables. Some of these still will require some assistance and some management.

The remainder, about 87.3%, will have IQ's ranging between 50 and 75. These are the educables. With education that is available or provided to these in special classes, this latter group could make for themselves some sort of a place in our society.

Nevertheless, the fact remains that all retarded children will - at one time or another - constitute a drain on the community and place a burden on society. While, as a group, the retarded fall below the average life expectancy, the number of years the average retarded individual lives has been increasing proportionately with the over-all increase in life expectancy.
Furthermore, the chances of survival of premature babies, and those with congenital defects, have been increasing.

Since mental retardation is associated with prematurity and is very often a concomitant of congenital defects, the number of children with mental retardation can be expected to increase each year.

It is estimated that -- Dr. Jordan said over 80% -- I think it is estimated that 75% of the mentally retarded have one or more additional physical handicaps, throughout the country.

Not very long ago, almost everyone believed that very little, if anything, could be done for persons with mental retardation. There were some special education classes in a few urban areas for school children who were damaged. Over the country, only about 75 state-supported, state-operated institutions were providing residential care for retarded children who could not function in the community. But, since 1954 there has been a trend towards expanding community programs for these children.

The purpose of providing comprehensive health care to the mentally retarded child is to assist him to attain his maximum potential as he grows up and as he tries to make a place for himself in society.

In the planning of these community programs, it is noteworthy to point out that physicians invariably have played the leading role. It is equally noteworthy, but - perhaps - in a derogatory sense, that in its planning the medical profession has failed to give much consideration to the dental needs of the retarded children.

This, coupled with the tragic fact that the dental profession, itself, has not put forth any great effort to develop new approaches for dealing with the dental needs of the mentally retarded, has resulted in a glaring omission of dental care from all too large a number of these programs for the retarded.

I have been attempting to collect information on dental services that are provided mentally retarded children in the clinic programs that are supported by the Children's Bureau.

If you will recall, as I said before, there are ninety-two such clinic programs in this country.

Of the ninety-two, we have received information on twenty-three programs. Of these, fourteen recognized dental disease to be a problem among mentally retarded children. Six of these programs stated that dental disease is not a particular problem, but I question the response from these six programs, because they were identical. Three programs gave no answer to the question.

It was further reported that the percent of parents of retarded children, who could not arrange on their own for dental care for their children, ranged between ten and ninety percent. One program estimated such difficulty for only ten percent of parents; one for fifteen percent; four for fifty percent; one for sixty percent; one for seventy percent; one for seventy-five percent; one for ninety percent.

One program reported simply that the majority of parents encountered such difficulty. Twelve gave no estimate. Of the twenty-three programs reporting only six included a dental component. The remainder left their patients either to private offices -- and we know that the services are not going to be available in private offices -- or to some official or voluntary agency. And there are not many of this category which will take the mentally retarded child.
The dental personnel engaged in these six programs that have an identifiable dental phase include two dentists full-time, two part-time, two dental assistants full-time, one oral hygienist full-time and one, part-time.

None of the twenty-three programs provide training for dentists in care of the mentally retarded child. What makes the omission of dental care from programs for retarded children especially lamentable is the fact that all mentally retarded children need dental care at one time or another.

We know, too, that many who need care are not ever able to get it.

There was a meeting of a Technical Committee on Mental Retardation in Washington last September, and this came up with certain recommendations and certain information that I think will be of some importance to all of us present. I would like to pass copies of these out now. There are two references to dentistry and dental care in the Minutes.

On page 5 and page 11 of this Report, you will find reference to dental care. So far as dental services, on page 5, are concerned, dental care is a necessary component of all programs for care for mentally retarded children.

They recommend dental care as a necessary component of comprehensive care of mentally retarded children. The dental problems of retarded children have usually been neglected, although they are inclined to be more severe than those of normal children. Because of the difficulties posed by retarded children, special training in dentistry for these children is necessary.

It was agreed that dental care should be a part of every program for the care of the mentally retarded, particularly in mental retardation clinics.

In determining how much care should be given within available funds and personnel, priorities would be necessary. Fluorides and other preventive programs should be undertaken. The Bureau will encourage the use of increased program funds for initiating and expanding dental services for the retarded.

On page 11, in the summary of suggestions for expanding mental retardation clinic programs, under 2, Item C, "dental care should be a part of every program for the care of mentally retarded with more attention needed in solving the problems of providing such care."

There have not been many studies conducted in this country on the dental needs of mentally retarded children. I think you all received a copy of a study of non-institutionalized mentally retarded children, that was conducted at Fergus Falls, Minnesota.

It was found that the average number of teeth attacked by caries of both the primary and permanent teeth, was lower for retarded children than for average children in the same age groups. However, only three percent of the deciduous teeth of five to nine year old retarded children had been filled, compared to more than forty percent for average children.

Only seventeen percent of the decayed permanent teeth of the retarded children had been filled compared to over fifty percent for the average children.

Lost teeth percentages were higher for the mentally retarded child. In addition, sixty-six percent of these children had more severe forms of periodontal disease. It was reported that the high prevalence and severity of periodontal disease is directly proportional to poor oral hygiene and inadequate and faulty toothbrushing habits.
Fifty-eight percent of the retarded children were found to be using a toothbrush only once a week or less. Diets of the retarded favored sweet food. In seventeen percent of the cases, sweet foods were used exclusively.

Forty-eight percent of the retarded children had malocclusions severe enough to require some orthodontic service.

Thirty-seven percent of these children had never been to a dentist. Only half of those who had been had any dental work done. That was usually of an emergency nature.

Sixty percent of the children were found to be cooperative during the dental examination and were deemed fully treatable in the dental office. Twenty-three percent were uncooperative or extremely fearful and were deemed to be treatable only with general anesthesia. The remainder were found to be partially treatable in the office.

The author of this study concluded that the mentally retarded child is desperately in need of dental services.

A report for 1961 from the Treatment Center at the Baltimore Children's Hospital states that of five hundred and fifty-seven children receiving dental care there, thirty-eight percent were mentally retarded. Seventy percent of the services for the retarded required general anesthesia to permit treatment. Forty-three percent of all patients had no prior dental care. Fifty-four percent of all patients required general anesthesia. The greatest treatment was provided for fillings and extractions.

Another report in the October, 1964 issue of Pediatrics Digest, on dental findings for the Mongoloid, states that delay in eruption and changes in the eruption sequence occur commonly in both permanent and primary teeth. Mongoloids are also reported to have a low incidence of dental caries, a relatively high percent being caries free. However, periodontal disease is rather severe for this group and is associated with early exfoliation of teeth.

It was stated that ninety-six percent of the Mongoloids showed some degree of bone loss compared with forty percent of the non-Mongoloid, mentally defective child, and six percent of a group of normal patients.

Another report which was circulated to you people was that from the Joseph Samuels Dental Clinic, and I might add that the report that was sent out was a concise form of a much more lengthy report. This report stated that the incidence and extensiveness of tooth decay is greater in retarded children than in normal children.

This report also goes on to state that according to the Woonsocket dental study, it was revealed it takes 3.3 dental man hours to correct dental defects in the average school child. The report goes on to state that it is estimated that at least ten dental man hours will be required to correct equivalent needs in the retarded child.

So, you see, we have these few reports. There are not too many studies that have been done on mentally retarded children. Some of these reports are conflicting in nature. We need much information about the dental needs of these people.

The reasons why dental care is generally not available to most retarded children might be summarized in the following.
First, many dentists are reluctant to accept retarded children as patients in their private offices. We all know that most dentists work on a strict schedule with definite blocks of time set aside for treatment procedures. Retarded children require extra patience in handling. It is extremely difficult to adhere too rigidly, in treatment, to a time schedule.

Furthermore, it is difficult to command an extra fee, to offset the extra time and effort that are required in treating a retarded child.

Secondly, many retarded children present special problems in management for which the average dentist is not equipped. The retarded children depending upon the severity of their retardation will require some amount of flexibility in management ranging from no special aids, to aids through medication, on to complete restraint. Most dental offices are not equipped to handle these particular problems when they do occur.

Third, training in dental care for the retarded and other chronically ill and handicapped children has not been provided in the schools of dentistry. It has only been within the past two or three years that training and care for special patients has been included as an identifiable part of the curriculum in some twelve or thirteen of the fifty schools of dentistry in the United States.

Fourth, there is a dearth of factual information of the dental needs of the mentally retarded child. Studies, to determine prevalence rates of dental disease for mentally retarded children, have been few in number and have involved too few children to yield meaningful information.

Five, the planners of programs for health supervision of retarded children have failed to include dentists in the planning. Thereby, overlooking the potential contribution that dental care can make to the total well-being of the retarded. Unless a dentist is involved in the actual planning, chances are that dental care may be either entirely omitted from the program, or, if provided at all, will be grossly inadequate to meet the needs of retarded children.

Six, the parents of retarded children often are apathetic about the dental needs of their children in the face of other competing medical needs. Fear that their child will create a scene in the dental office, or that the child will require the "expensive services of a specialist" has deterred many patients from seeking dental care.

Finally, as with all programs of new awareness, it is difficult to stimulate people to take the initiative in developing these new programs.

In spite of these blocks to care for the retarded child, it is our contention that dentistry has very much to contribute; that it has a definite stake in this problem; that it should be included in all programs for the health and rehabilitation of retarded children.

We have a few minutes remaining in which I will be very happy to entertain any questions.

DR. ADELSON: First, I don't see too much inconsistency between the Samuels Report and the report of Fergus Falls, namely, from the standpoint that two different types of communities were tested.

I think if we examine the nature of the retarded children in large urban communities as compared to smaller communities, we will find a higher number of more severely retarded children in the groups in larger urban areas.
I would like to say, the report on Fergus Falls has given me more trouble because of the fact everytime I have suggested dental services, I have thrown in my face they have fewer cavities than the average child.

I think it behooves us to be aware that the problems will differ from the larger communities to the smaller communities, and even from center to center, depending upon the lists, and numbers of referrals. The problems in Memphis will be different from the problems in Fergus Falls or Arkansas, I am positive.

This is important because it will mean that larger services may have to be set up or provided for and different types of services in different communities.

DR. MILLER: I still feel, if I may answer this, that there is some inconsistency in these reports. Also, there is a difference between caries prevalence and the need for services.

I think there is need for a nation-wide study, a good study throughout the country, to determine disease prevalence and dental treatment needs among the retarded as a group.

DR. POLLACK: I would like to add my support of something Dr. Adelson said. The biggest stumbling block in promoting a program in Baltimore for the mentally retarded is not the physician, is not the retarded, it is not the community, it is the Fergus Falls study.

DR. SAUNDERS: Several retarded have suffered from severe dental fluorosis. Any study from our school group would be completely different from any other study.

DR. COHEN: Wherever you go, whether it is a retarded child at home, or whether it is a retarded child in an institution, you are going to find dental neglect.

I think we cannot overlook the fact when we have severely retarded, it is my belief, that we will have more prevalence of decay, and I feel you will find this particular type kept at home more often in urban than in a rural community.

DR. MILLER: I would like to repeat, we feel very strongly there is need for a good study throughout the country to determine these things. Otherwise, we are just opinionating. We are just expressing our own thoughts.

DR. COHEN: Dr. Wiener and I have some figures in Massachusetts on institutionalized and non-institutionalized children. What you say is correct. The non-institutionalized children have a much higher percentage of caries prevalence.

DR. MILLER: I might say that the Children's Bureau is presently talking with the School of Public Health at the University of North Carolina to get them interested in developing and coordinating a nation-wide study in dental disease prevalence and dental needs of mentally retarded children throughout the country in a good systematic statistical way.

This study at Fergus Falls, of course, is based upon experience with a small group of non-institutionalized mentally retarded children in a small area, and it is very possible, of course, working with small numbers such as they use there, that a slight difference in a number could yield this big difference in percent.

We recognize that this was not a good study, but this is the kind of information which filters down to us. This is the only kind of information we have.
MRS. SCHIFFER: I wonder if Dr. Cohen's material is made up so that you can send it to us.

DR. COHEN: We are in the process of writing it up, but this involved a whole area north of Boston, the North Shore area. We did the survey for the North Shore Mentally Retarded Association. We also have figures from institutionalized patients. There is a considerable difference.

DR. MILLER: We would like to get this information.

DR. MESSORE: We are training dentists. We are, at present, training, particularly, our local dentists as a team member.

DR. MILLER: We know about the training aspect of your particular program, and this is something we would like to develop more of.

Too many of these programs, however, do not provide any dental service, let alone training in dental care for these children.

DR. ADELSON: I would like to add another reason for further necessity of a nation-wide survey. Many dental services are supported by local organizations, UCP, certain local chapters, NARC and HRC. Many of these are parent organizations.

One of the reasons that the Fergus Falls Report was so bad for dentistry and for dental services is that parents have a tremendous desire to show that they are the parents of children who are as close to normal as possible, in whatever areas they can find, or better than normal who are not handicapped. So this is why this particular report was bad from the standpoint of parent organizations.

They stand upon this one point and locked onto it and you couldn't dislodge it. This is another reason why I think it is absolutely necessary that we have a nation-wide survey.

DR. MILLER: I would like to get this in the form of a formal recommendation to the Children's Bureau. If you will, we will make this a formal recommendation from this Committee to the Children's Bureau -- that the Bureau undertake and support a nation-wide study of dental disease prevalence and dental needs of the mentally retarded as a group.

DR. ADELSON: I so move.

DRS. COHEN AND SELLINGSLOH: Seconded.

(Whereupon, the Motion having been duly made and seconded, was unanimously carried.)

DR. ROSENSTEIN: To get back to the Fergus Falls survey, an important finding was that these children were not getting the care that normal children got. I think that is the important thing which showed up in this survey.

(Whereupon, at 12:00 o'clock noon the hearing adjourned until 1:00 o'clock P.M.)

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At 1:00 P.M., March 8, 1965, the hearing resumed pursuant to adjournment, when and where the following proceedings were had:

DR. MILLER: Dr. Adelson has raised the question whether we are finished with outlining the dental problems of mentally retarded children. I don't think we have. I don't think we have even gotten into them yet.
We outlined the problem as we see it, on the basis of information that filters down to the Bureau, and we pointed out some of the blocks to care, as explanation of why, perhaps, so little care is obtainable by the mentally retarded child.

I am going to relinquish the floor to you gentlemen before too long, and let you hold forth all you want to. You will have an opportunity to discuss this problem and expand on it some.

We would like to get the benefit of your observations, your experiences, in this area. You have a much broader experience than I have had with mentally retarded children, and we would like to know what you people visualize as problems.

If I might say a few words about the agenda -- it was developed this way because, as we see it, in the quest for dental services, the mentally retarded child and his parents have an identifiable reciprocal relationship, first, to the community in which they reside, and then to the dental facility that they visit or are referred to for services, and also to the dentist who is selected to render the dental care for the child.

We have made an effort to group the topics for discussion under these three broad headings. We, also, must bear in mind that there will be some overlapping and some duplication. Because, also, we want to keep this discussion on an informal basis, we might not be adhering very strictly to the order of things, as listed in this agenda.

We will be using this agenda merely as a guide, as a point of focus, as a point of reference, to maintain continuity and direction.

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The House of Delegates of the American Dental Association has approved a set of principles which have been adopted as basic policy for the profession on dental health programs in general. One of the basic premises, which underlies these principles, states:

"The achievement of health is the responsibility of the individual's, the family's, and the community's" -- in that order.

For the retarded child, however, it might very well be that the community has a greater degree of responsibility in the promotion of health than either the individual or the family.

I think this might offer a good point at which to begin our discussion. I think we might consider the question, is mental retardation a community problem; is it a problem in public health; just whose problem is mental retardation?

DR. MINK: It has to be a community problem, because it involves educational assistance which taxpayers pay for and support. It involves public health.

DR. ADELSON: I don't think there is a question as to whether or not it is a community project. There is no question about it. Economically, educationally, from every standpoint, the community has to assume responsibility for retardation.

DR. SAUNDERS: It would seem, in my mind, that the population in these groups, at least with which I am familiar, is getting younger. We are getting
the children younger, and we are getting the most severe ones in our institution. And they are there for a lifetime. Our population is seventeen hundred. We have seven hundred bad.

DR. COHEN: I think what Dr. Saunders said is absolutely true, because if you have had any experience with pediatric hospitals, there has been a tremendous change in the past fifteen years.

In large pediatric units, now, the referrals involve three areas. They involve the birth defects (mostly brain-damaged children), acute surgical problems, and complications from infectious diseases.

If you look into the history of the family, you'll find - for some reason or other - that these children come from low income groups and all of these children, right from that point on, become a community problem. When they are severely brain-damaged, they are referred to a state institution. Then it becomes a community problem. It becomes a problem that involves not only the community, but the Federal Government. Everybody becomes involved in this problem. It runs the whole gamut -- Federal, State, County, and then the local community, and everybody has to participate in this.

DR. MILLER: On the basis of some of the things which were pointed out, I think we are all agreed that this is, in fact, a community problem, or a problem of public health.

First of all, there is a long term, life-long disability. It affects a good number of the people in the community.

The cost of management is usually beyond the average person's means and requires special handling and special facilities, which are not regularly available. Mental retardation cannot be treated or controlled in the usual manner.

I think these things make it the responsibility or concern of everyone in the community.

DR. POLLACK: I would like to know what you mean by public health? Are you speaking in a broad sense or a narrow sense?

DR. MILLER: Public health is the prevention and control of disease, and promotion of good health through organized community efforts. I think the connotation of "community" in the definition implies public health.

DR. COHEN: It doesn't make any difference who sponsors the program. It is a community responsibility, period.

DR. POLLACK: One question I have about the public responsibility is that the public health is only one community area. The others are the dental school, the dental profession.

DR. MILLER: We are going to get into the responsibilities of the community, and the responsibility of the various agencies within the community.

DR. ROSENSTEIN: I think there has been recognition of the responsibility of the community. Right now, I am thinking of the state, and I think in every state in the union there is a recognition of the fact that the severely retarded and severely handicapped individuals had to be brought to a place where they could receive the care that they could not receive at home. The care turned out to be mostly custodial care and, apparently, out of this grew the realization that they were not getting complete care.
They weren't getting the kind of care that would promote development of the potential within the individual to add to manpower reserve, such as may be necessary today in a time of high employability, and so on.

So that the training factor has become added to the care and medical care, and education.

I think that this developed through certain steps, and I am thinking now of a group in cerebral palsey which started at the behest of the parents.

Parents banded together because they knew their children weren't getting the care they needed. These parents then got medical people to set up standards, to set up institutions, and so on, and then they wanted dentists to form a local group. This then got on a national level.

I think to this group belongs a great deal of credit for the team approach, because the team approach has been a very effective one.

It is interesting to note that there has been a further development on the national level of the recognition of this responsibility.

DR. COHEN: The same is true with mental retardation. It was the parents who initiated the interest first. Working on a national basis, then on a state basis, and then on a local basis. They got started a little bit later than the cerebral palsey group.

The whole interest grew because of the parents' interest. It was neither the medical profession nor dentist profession nor any federal agency who started the interest. The interest was started by the parents of the children who were affected.

DR. POLLACK: This is not true in our community. The interest came from the medical and dental professions.

DR. MILLER: I think we can all agree that it doesn't matter where the leadership comes from, but the leadership must come from some agency or somebody. It can come from parents; it can come from physicians or from a group of dentists.

But to go back again, much of the interest of the federal agency springs from a failure of solution of the local problems by the people in the community. I don't think the Federal Government would want to get into programing at all. If it could be shown that the individual and his family, and the community -- can solve their own problems, then there is no need for Federal intervention. This is how these things are born. I don't think we have to spend too much time talking about the responsibility of the community, other than stating it is a community problem.

MISS FOLEY: While we found for certain that the primary retardation usually comes from the lower socio-economic brackets, this is borne out in our school system where the parents pay what they can on a child's upkeep to the state, the maximum being $120.00 a month.

Seventy percent of our total population at the mental state school can pay nothing, and only five percent pay the full $120.00.

When you get into this type of low socio-economic bracket, where I feel this thing centers somewhat, then it is going to have to be a community problem. Because these are people who cannot always help themselves.

DR. ADELSON: Dr. Chairman, it so happens in certain low socio-economic levels they can help themselves better than others.
DR. COHEN: Especially in a rural situation. It is the urban society that has made the problem of the retarded what it is. The retarded was able to live on the farm and more or less spend the rest of his life.

Now, in urbanization and the speed of our society, these people cannot cope anymore.

DR. LAW: We were talking about responsibilities, responsibilities for dental care.

For normal individuals, so-called, it has been said by the American Dental Association, and pretty well accepted, that care is the primary responsibility of the individual. Then the responsibility of the family and then the responsibility of the community.

As I recall, it seems to me, that if we directed our discussion to where these people differ from that type of responsibility, and what services they need to provide care for them, and who is responsible for these things, we might make a little more progress.

I think with the mentally retarded, for example, you can wipe out individual responsibility. They can't be responsible for themselves. A statement that this responsibility varies in this group from the accepted ADA group would be a good thing.

In the first place, this type individual cannot assume responsibility for his own care. So then, the second responsibility falls on the family. And what can the family do?

Obviously, there are some things they can do. They can provide services. When services are available, they can hunt them out and get the child to them. This is the type of thing.

DR. POLLACK: Let us take the family responsibility first, because we have already wiped out the individual responsibility. Now, the family responsibility is shifted from the ADA recommendation in terms of the mentally retarded. Their recommendation is for the normal.

As it applies to mentally retarded, I think because of the complexity and the cost of care, and the multitude of problems that the family has with the mentally retarded child, that the family responsibility here has changed from the family responsibility, as it involves the normal child. Therefore, we are left with the greater community responsibility for the mentally retarded than the ADA has recommended in terms of the normal child.

DR. MILLER: Does everyone agree with this?

DR. MINK: I am not sure I do totally. I don't think he can make such a blanket statement when we see from some of the studies sixty percent, or let us say forty percent of these children could be treated in a dental office under routine procedures. I don't think we can say their responsibility for dental care shifts.

DR. POLLACK: I say, it is shifted - not completely eliminated. With the normal child, I think the family has a greater responsibility than the community. With the handicapped child, the community has a greater responsibility than with the normal child. This is just a shift of emphasis.

DR. ROSENSTEIN: I think we all feel we have more responsibility with these children because they are more helpless.

DR. MINK: The first thing we are assuming, all other kids are getting good care, and we can't assume that at all. We are not really assuming that,
but if we are using the normal child and his dental care as a base line, so in some communities the retarded may be better off than the normal child.

DR. POLLACK: But only because the community has accepted the responsibility.

DR. ADELSON: I know, for example, that, oddly enough, in New York City the handicapped receive better care on an average, I think in one study done, than did the non-handicapped.

DR. MILLER: This might be true in a few isolated places in the country. Again, this varies from place to place, which was brought out this morning. What is true in New York City might not be necessarily true elsewhere. This is one thing which we have to establish and we have to find out. But I think we can safely say that, as a group, the mentally retarded have been neglected as far as dental care is concerned. I don't think there is anything to disprove that to this date.

DR. ROSENSTEIN: I have a feeling that we all feel this way, because these children, these patients, are more helpless. That it should be the responsibility at a community level, no matter how local or spread out, to help these children in every way possible, so that the total potential of the growing child is improved to a point where, as he grows older, he is going to be more able to take care of himself.

These children have been getting all the loving that they could get at home, but objective measures to help them grow up might have been lacking. It is in this regard, I think, the effort should be made, and dentistry is an important part of this, to help the child take care of his own mouth. This is part of growing up, too.

DR. ADELSON: Isn't it true that in essence the responsibility of the community is exactly the same for the handicapped as it is for the non-handicapped? That is what we should stress.

Because up to this time, the community has not accepted its responsibility to the handicapped, whereas in many cases, it has accepted its responsibility to the non-handicapped.

DR. POLLACK: I don't think it is the same. I think it is greater. The community is responsible in both areas. There is no question about it. But I think it is greater in terms of services for the handicapped.

DR. ADELSON: I am talking in terms of seeing that dental treatment is provided, making sure there are centers, or treatment areas, for the children. Therefore, they have the same responsibility for the handicapped. I don't mean specifically, but the responsibilities in those areas, are exactly the same, but this is not what they have lived up to.

What we are concerned about is that the responsibilities are exactly the same in these broad areas and should be accepted as such.

DR. MILLER: I think this is true. If we think about the community's role in such preventive measures as fluoridation, this will apply across the board and has a benefit for all the people in the community. Certainly, it will help the normal child, and it will help the mentally retarded child.

Facilities, which Dr. Adelson mentioned, public health, etc., should be open to all children. They should not exclude the mentally retarded.
DR. MESSORE: Dr. Adelson, in our clinic last year, we had 42,400 visits. Out of those, only 1,021 visits were for the mentally retarded. So you see how we are helping non-mentally retarded. That is just an example.

DR. ADELSION: The point I was trying to bring out, I guess, can be typified by an example.

The Department of Welfare runs a number of clinics in New York State, but they do not accept severely retarded children and, therefore, severely retarded children do not get treated.

When I said that the community has an equal responsibility towards the handicapped, then they must accept their responsibility for this group, too.

This was the point that I was trying to make. On a broad basic principle, they must accept equal responsibility.

DR. MILLER: I can understand the point you are trying to make, because we have experienced this in our crippled children's program in various states. The definition of crippled children is reserved for the agency, yet they all obtain money from the Children's Bureau for crippled children.

In some states, crippled children are defined as a child of normal mentality with certain handicaps. If he is not of normal mentality, he is not eligible for service through the crippled children's program.

DR. COHEN: I don't think we can make a blanket statement that the dental care for the mentally retarded child is the responsibility of the community. Because you fall into the same problem as you do with crippled children. For the number of indigent children there are in this country, we just couldn't possibly, we don't have the manpower, nor do we have the resources, to take care of this severe dental problem.

DR. LAW: This is true. Maybe at this stage of the game, we have to talk about the ideal. About community responsibility, I think that this same thing could be said for the individual, the family, the community, the profession.

The community has a responsibility to normal children and handicapped children of all types. This responsibility goes to adults -- to chronically ill, to aged to every group.

I think if we can accept that as a premise, what are we going to do about it?

DR. ROSENSTEIN: Your comments about the definition, community-sponsored clinics paid for by a big city, and these children not being accepted, I think it goes back to something a little deeper, and it is another aspect of our total problem.

I don't want to get ahead of it, but I think they would take care of those children if they could take care of them. But I think the dentists don't know how to handle them.

Out of ignorance of the conditions involved, the feeling is, we can't handle these children. Then they get referred to other centers that may be existing, and they may or may not be able to take care of all of them.

So, to me, it points up a very important positive direction that should be taken, and that is the education of the dental profession at every level.

DR. MILLER: This point is well taken. I think we are ready to summarize this. I don't think we want to belabor the point concerning the responsibility of the community in this field.
I think we are all agreed that the community is responsible for the health and welfare of all the people in it, to varying degrees, depending upon the differences in socio-economic status, and so on.

But certainly the community has a responsibility to all the people in it. Perhaps, a little bit more to certain special groups than to others. Just how far the community is to go with a special group, with this particular group of mentally retarded children, would vary with local conditions and local circumstances, the facilities they have, the people they have, the training of these people, and so on down the line.

But let us talk about the ideal situation, as Dr. Law suggested. Are there any specific lines that community action should follow in providing dental care for the mentally retarded child.

DR. POLLACK: I think you will have to identify more clearly which groups within the community we are not talking about, in terms of the discharge of this responsibility. Isn't that what you had in mind? Isn't that what you were talking about, Dr. Adelson, which socio-economic group has the responsibility?

DR. ADELSON: I was thinking, this morning, of the way Tennessee set this up, which strikes me as an excellent program. It is the first time I ever heard of it.

DR. POLLACK: You are talking about the part of the community receiving the benefits. I am talking about the part of the community accepting responsibility.

DR. ADELSON: I am not concerned about who would pay for the indigent care. I am concerned that they will pay for it.

Once again, I refer to the plan that operates in Tennessee, which I think is an excellent one.

DR. COHEN: Couldn't you say that the community has now the responsibility -- agreed -- to be resolved on a state and local level?

DR. MILLER: I think we can say this.

DR. COHEN: This covers the whole thing. Because the community program Tennessee has is not good for Massachusetts, and visa versa. Each state and each community has to solve its own problem.

DR. ROSENSTEIN: If we talk about the children, themselves, coming from different economic levels, a number of them go to private practitioners and should; therefore, information and education should be available for the profession doing this. But the dental profession shouldn't wait until the community gets programs ready, and then the dentists aren't ready to do it. I think the dentists should be concerned with it early and then, so far as those who can't get private care, there will be the multiple discipline clinic, whether they are school-affiliated or privately endowed or publicly endowed.

DR. ADELSON: Something specific that could be done is that a statement could come out of this Committee addressed to State Governments. Apparently, from what I understand, monies have been turned over to all State Governments, part of which can be allocated to dentistry for retarded children. If I am, correct, I think we should definitely make a statement as dentists that consideration should be given to the allocation of some of these funds for dental treatment of the indigent retarded child.
DR. COHEN: If you do that, I think you will also have to involve the State Dental Society.

DR. MILLER: How would you want to involve the State Dental Society?

DR. COHEN: I would involve them with the responsibility of seeing what money there is available, and seeing that dentists are educated to carry out this responsibility. This not only involves the State Society, but also the teaching institution.

DR. MILLER: I think you are making a point that the dental profession, should play a part in the planning.

DR. COHEN: Absolutely.

DR. MILLER: Should take part in the planning and the planning should not be done for the dental profession by other people.

DR. COHEN: If we had a strong statement indicating to all the State Dental Societies that this was the recommendation from the Children's Bureau that this should be done, I am quite sure you would get action.

DR. MILLER: Not from the Children's Bureau, but from this Committee.

DR. COHEN: From this Conference or from the Committee. I am sure something would be done.

DR. LAW: Are you saying that the State Dental Society participate in planning?

DR. COHEN: That is correct. Because the State Dental Society, when it gets down to it, is every member in this group.

DR. LAW: And this would go to the local Societies.

DR. ADELSON: I am a little hazy. In planning what?

DR. MILLER: The care program for mentally retarded.

DR. LAW: Are you classifying state institutions the same as community?

DR. COHEN: When I refer to mentally retarded children, I refer to both institutionalized and non-institutionalized.

DR. ADELSON: But you must separate them, Dr. Cohen, and we must discuss both, one and the other. Because the problems faced by both populations are totally different.

DR. COHEN: There is no question about it, but don't you understand if the State Society makes a recommendation for the state institutions, there would be an improvement for dental care?

DR. ADELSON: Then, I would recommend dental care programs for institutions.

DR. MILLER: I think we can be general at this point and later consider specifics.

I think we can lay down certain guide lines for community action across the board, and then tailor them to the specific situation or the specific area or the specific group.

DR. ADELSON: I will tell you that if you are looking for some action, I am not too keen on having the State Dental Societies participate in the planning. Because by the time we get a Committee Report back, two or three years have gone by in which the Committees have changed every year. Of course, I can't speak for Massachusetts.

DR. COHEN: I think this all depends upon the dentists and the institutions that are interested in taking care of the mentally retarded children.
Because if you make it known to the State Society, you want on that Committee some intelligent, aggressive people interested in mental retardation, you will get some action.

DR. ROSENSTEIN: I have seen this work in some of the district dental societies where a whole effort for the handicapped just got bogged down at a district level because people were appointed to that Committee, and the Chairman appointed by the President of the Society that year, and they chose nobody that had training; nobody that was in a program, and they did nothing. As for guidance, the Children's Bureau wants it from a University, probably, because they feel we must have the autonomy of the profession. But there should be a factor of guidance to a Society as to what general trends should be in helping and pushing personnel that can get something accomplished.

DR. COHEN: You see, if these recommendations come out from this Committee on a national basis, and we can get publicity for it, the State Societies all over the United States can't push this away.

DR. MINK: I doubt, frankly, if very many dental people are involved on most of these planning sessions. Here is where the State Dental Association could become involved.

DR. SAUNDERS: I think it is something interesting that the Texas Dental Society has already commissioned a Committee to go out and survey the dental situation in the state hospitals. But now that the State has already done this and gone on record and submitted their proposals and done their survey, since this has been done, nothing else has been done and the situation, I would say, is sitting in approximately the same position it was sitting five years ago.

Just to get the Dental Society to go out and make a survey and even make recommendations is no great panacea for our problems, because this has been done in our situation.

DR. MINK: We have done exactly the same thing, a thorough survey, and sent it to the Governor's Office, and no one has heard anything about it since then.

DR. ADELSON: The specific suggestion that I had made was that if there are monies which can be appropriated for the dental treatment of indigent retarded children, and yet are not, we should recommend that careful consideration be given to the allocation of these monies for dental treatment.

DR. POLLACK: The point is that the money is there. It is not being used for this, and should be used for dental care.

DR. MINK: How much responsibility do the dentists have for the care of indigents? Should they have any responsibility? This is part of the community responsibility.

DR. MINK: Do the local dentists have any responsibility to their community to do a certain amount of services for any of these people?

DR. ADELSON: I don't think it is fair for us to say that a dentist practitioner should allocate a certain amount of his spare time. But it is certainly fair for us to say, a dentist who wishes to treat these patients should be reimbursed for the indigents.

DR. SELLINGSLOH: We started out with a principle for the provision of dental care which was open to all classes and types, and it started out with individual, family, and community, in that order.
Why don't we propose a Resolution that would have the same ideas or principle for the provision of dental care for the mentally retarded, and simply omit the individual and say, family and community, in that order.

DR. SAUMERS: Is there something else we should consider especially on training, in that we should think real seriously of the fact that it is ridiculous to try to train everybody in the field of mental retardation.

I feel that the child and his parents and community would be better served in special centers by people who are knowledgeable of these people's special problems, rather than to try to teach everybody a little bit.

I did statistics on one group alone in the State of Texas, and that was the number of children suffering from cerebral palsy of whom approximately fifty percent had mental retardation. Taking the population at the dentist level in our State alone, it came out to the fact that a dentist, during his lifetime of practice, if he saw everyone in his community, would only see ten retarded people in his total practice life, which is one every four years on the average of a forty year practice.

Therefore, I feel like in many ways, we would be wasting our time and money to try to educate everyone in this field.

I do feel there should be special community-type centers depending on the size of the community. We are working with special problems in our States, due to low population density in a vast distance.

In New York or Long Island, you might have one center for the whole State. In our area, we have different problems in this line. But I think we should think more about specialized community centers with special individuals, and this is the program we are suggesting in our area right now in training, rather than taking individual dentists from all the 2,800 of them in the State of Texas and trying to make each one of them a semi-specialist, or knowledgeable about mental retardation. I would say there are at least 1800 who won't even see children. Therefore, we would be wasting one-third of our time right there.

DR. ADELSON: This is an area which is quite broad, and that is education of the profession. I think we would have to discuss whether we should follow the same technique that Dr. Jordan does, which is starting with the senior medical students.

Should this be done in dental school? Should care of the mentally retarded be part of the pedodontic post-graduate work? Should the students in children's dentistry have any exposure to this area, so that they would know where, how and what the problems are and how to refer them?

DR. COHEN: I don't think much is known about it, except a few sporadic reports. I think one of the things that might come out of this conference, something along this nature, ought to be done, and then I think we could be more specific about whether it would be advisable to train dental students, or whether they have a center like they have up in Providence, whether this might be more practical.

DR. ADELSON: I don't see what the incidence of dental decay has to do with the standpoint of management. I think we all agree that the retarded child might be somewhat different from non-retarded children. I think we are also agreed that many of the men in the dental profession would prefer not dealing with them.
If we had started on a senior dental school level, we may have stimulated more interest. If we started ten years ago, or twenty years ago, we may have had more men interested in this field than at present.

Let us say, we are starting. Now we can make a statement that says, we know the first two facts: The fact that they are somewhat different; the fact that there are fewer men in the profession interested. That, possibly, there should be some exposure within dental schools for this area. I don't think a survey of dental disease is necessary for this particular broad statement.

DR. COHEN: I had reference to whether we should have clinics to take care of it.

DR. MILLER: Let's go back to the community. Before the community can be expected to do either anything at all, or to do a better job with what they are doing, the people in it must be educated. The general public has to supply the funds, etc. How and by whom should education be provided?

DR. POLLACK: Federal Agencies take an active role, if I am not mistaken, in health education of the public. So they are one agency that certainly has the means at their disposal.

DR. ADELSON: Private charitable organizations, such as UCP, NARCP and HRC, frequently give out publicity for the education of the community.

DR. POLLACK: I think the professional societies also play a role in health education of the public. The physicians, nursing groups, all of these groups.

DR. SAUNDERS: They are the recipients of the educational process, as well as the public.

DR. MILLER: Can they contribute towards dental care for the mentally retarded?

DR. POLLACK: They can contribute towards the educational program for the mentally retarded.

DR. MILLER: What is the specific role of the physicians, the nurses, the other people?

DR. POLLACK: Let us face it, the physician is the leader in it.

DR. ADELSON: They need education. How many physicians have gone by rampant broken-down teeth and never have seen them?

DR. MILLER: Who is supposed to educate the physician?

DR. ADELSON: We are.

DR. POLLACK: At all three levels, the Federal level with their health education program and their resources to do it; second, the dental profession, itself.

DR. MILLER: How should the dental profession do it?

DR. MILLER: I think we can agree it is most important that we involve others, other than dentists, in this, if we are going to do a job of providing dental care for retarded children. Any one in disagreement with this?

DR. ADELSON: No. I think it is a question of steps. First, educate the profession that we wish to join with us. Two, then educate the community.

DR. POLLACK: In other words, by professions, he includes physicians and dentists and nurses, para-medical people.

MISS FOLEY: I think everybody is so late in attacking this problem. You can't state we need to start with the dental school, or we need to start with
the State Dental Association. I think we have got to come out at it in every direction.

I think this point about putting well-trained people in certain centers, is a real good one. I think that is part of it.

The dental school program is part of it. If you got the demonstration going, you are going to interest a lot of people in the problem, and they are going to learn something about you. If we had a couple of you in our clinic, I know we would learn as well as every patient that comes in. But I think you would have to do it through demonstration in centers that are multi-discipline, as well as interesting people already in practice, and working with the dental students.

DR. POLLACK: I believe the leadership role in this education program is the Federal Agency.

DR. ROSENSTEIN: Let me cite a local example. I don't say that this is the kind of thing that can be done all over the country. This took place, I believe, in an urban area.

A survey was made of the handicapped children in five classes in the city schools, and we arrived at the mean DMF, and the Department of Health, Bureau of Dentistry, had within that same general period surveyed the normal child, and arrived at a mean DMF.

We compared them, mean DMF, similarly, and they broke up the DMF's from the F's, and the F in the CP group was away down low; in the normal group, high.

The DM of the CP group in the five classes was away up high.

The UCP of New York City went on TV and sent out for contributions. They sponsored four institutional programs, that is, sponsored or partially sponsored a clinical activity, not a training activity. Ours was one of them.

Five or six years later, we re-surveyed the population. We found the F factor now in six classes in the schools was higher among the handicapped than the F factor of the normal children.

DR. MILLER: There are some people who don't know what you are talking about with your D and M and F. For their sake, will you explain.

DR. ROSENSTEIN: The DMF involves total experience in regard to dental decay of individuals or groups of individuals. It is used mostly for groups of individuals because a mean number and mean value can be easily ascertained. So when I said the DMF of all these handicapped children in the city schools, it meant a mean was arrived at. The terms represent the D for decay, the M for missing, and the F for fillings.

We had trained people involved in making these surveys, and we had the good fortune to be able to go back to the City School System and re-survey the population in a city where programs had been started to get care for these children.

We could even pinpoint the type of care that was given in the facilities, depending upon which medical clinics the children were going to.

But 6 years later, these cerebral palsied -- when I say a child with cerebral palsey, I always mean cerebral palsey and accompanying conditions -- had a better state of dental care than the normal school population had. This was the direct result of local public organization plus interested dentists.
Some of the dentists involved had training, some were in an advisory capacity to local UCP groups. This is where voluntary dentists from the local area joined or formed a guidance council to the local UCP, and gave them their time and effort; had meetings where the whole profession was invited, and so on.

DR. ADEISON: I wonder if you could clarify for me what was going to happen if this Committee comes out with a set of guide lines after the next meeting, or the meeting after.

Specifically, what are you going to do with, let us say, the seven or eight suggestions, and will they be printed, and if so, where? To whom will they be sent?

DR. MILLER: Among other things, the Children's Bureau publishes pamphlets, brochures for wide distribution across the country.

We could distribute these on a wholesale basis. We could mail them to every dentist or every physician in the country, if we saw the need for this.

These guide lines which are going to come out of this particular meeting, as I said earlier, will be fed to a large regional working conference involving people from six different states.

After they get through discussing these guide lines and modifying them and developing them to fit the level of the practicing dentist, the one who does the service, we are in hopes that we can use these guide lines to publish in the form of a pamphlet, and make it available to the profession.

We, also, are in hopes that this experience might stimulate those people who are going to represent dental public health, teaching, dental teaching, and private practitioners. These will be people who identify themselves with dental public health in general, or with handicapped children, such as the Chairman of the Council on Dental Health in the State Dental Society, or if there is a Committee on Handicapped Children, the Chairman of this Committee.

These are the kinds of people who will be attending this Conference, and we hope that they - in turn - will be stimulated to go back home to their respective states and develop similar conferences, calling in other people, and thereby engender an interest in the problem.

DR. ADEISON: Am I wrong in assuming, then, that this is preliminary to a Regional Conference which will then take the guide lines as set down here, after they have been discussed, and applied to local conditions? This is the point you lost me.

You said the guide lines. Are these the revised guide lines which have then been applied to local conditions but circulated?

DR. MILLER: We would like to get these down to the level where they will be acceptable to the practicing dentists, in general. The person who has not identified himself with mental retardation, per se, but the one to whom we look for the performance of the dental service.

We hope that the Regional Conference will come up with a set of guide lines that will be acceptable to these dentists. They will modify these guide lines and adapt them to their own particular region and their own particular state.

DR. ADEISON: Then you will only be covering guide lines suitable for six states. I am thinking now of whether our guide lines could not be used nationwide.
If we can come down with broad specific points of principle, then it can be used on a nation-wide level, and then the different areas can apply them and become more specific.

MRS. SCHIFFER: You were asking a question about the distribution.

DR. ADELSON: Quite a bit of it is sent to the NARC. Will this be done with the guide lines?

MRS. SCHIFFER: The Children's Bureau writes and distributes on many different levels. For instance, we have a publication called "Your Child From One to Three," which is about the sixth grade level. Dr. Oberman writes on the "Infant At Risk." That is geared to just the Pediatric Departments in medical schools. So we can write and distribute materials too. All these different materials and these guide lines, I would think, can go to the profession and to other places depending on the need that is seen.

We can have articles in our own publication, Children, or we can have articles in a dental journal. They can be distributed in many different ways.

For instance, we have a clinic exchange among all the retarded clinics in the country.

DR. POLLACK: But we are setting guide lines for discussions at a Regional level. The guide lines can be guide lines for any place.

MRS. SCHIFFER: When they are arrived at, then they can be distributed. There are many different ways that they can be distributed.

DR. POLLACK: They are guide lines for discussion, not for publication.

DR. LAW: Why don't you stop worrying about guide lines? Think what the responsibilities of these things are. Don't worry about who is going to read them.

DR. ADELSON: I would like to say, with any type of creative thinking, if it is directed towards a specific object, it will get better results than if it is directed towards a diffuse area.

That is the only reason I ask, what will be done with the results of this Committee, only so that we will know in what direction we are going.

DR. MILLER: We could just as well present the guide lines coming out of this Committee to a National Conference, but we are probing. We first have to get the idea across, that this is a problem; that it is a problem of the practicing dentist; that the provision of care is his responsibility; that we would like to see him do more for these children; we would like to see him take these children in his office; that we would like to see him participate in clinic programs and render more services for these children.

And as a pilot program, we are thinking to restrict this in one particular region to see what the effect will be of such a working conference. We can do this on a national basis if it works out in this region. We are planning to get general guide lines for general care of retarded children by the practicing dentists, thereby hoping to stimulate the dentists.

We would like to do it throughout the country, but it would be a tremendous undertaking. We are going to restrict it to one region in the country to see if it will do what we hope it will do.

DR. OBERMAN: I can only speak from the background of pediatricians, but I would like to pick up on the last part of your phrase, to the private practicing dentists. This may be a little too much to hope for at the present time.
We have been plugging away at pediatricians on mental retardation for years. It isn't down to the local pediatric level yet. We are getting there in stages. We are getting there by promoting certain types of activities and the accumulated weight is filtering down.

But I don't believe you are going to get down there that quick.

DR. MILLER: I also don't believe it is going to be that simple. But every bit we do in one direction, when combined at the end of a long period, may lead us to that goal.

DR. POLLACK: Does the Children's Bureau have any pamphlets for the family as far as dental care?

DR. MILLER: Not on dental care for the mentally retarded. This is one big gap that exists.

That is the reason Mr. Ellison is here. He is going to adapt what comes out of these Conferences into a pamphlet. Mr. Ellison is one of our writers.

DR. POLLACK: I made one for our place and I divided it into children with Mongoloidism, whose oral manifestations are so different from everyone else's, and the ones with cerebral palsey, and the ones with primary retardation. I know these are three large groups, but I can't go into a mimeographed sheet for every parent.

But I have had to formulate these types of things for our parents, and we run into a tremendous amount of ignorance of the parents, who acquire ignorance from other people who wonder why his Mongoloid is slow developing and why his gums bleed, and why he can't have orthodontia. I think that this is something that has to come out, and come out soon.

DR. MILLER: I think we should deal with broad generalities, rather than specifics. I don't think we want to get down to specifics here.

I think there are certain basic things which apply across the board. These are the things we will establish. So far as the specifics, that relate to a particular community, or a particular state, these can be resolved by those in that state.

DR. SAUNDERS: Couldn't we state that the family should be informed, dental care is necessary for these children and that these children do have dental problems, which are specific for them and them only.

I don't know what facilities there are which have reported births and incidence of mental retardation, and other pathological retardation. It seems to me these people should be contacted as fast as the diaper service contacts them, soon after the child is born. There should be help from our facilities.

DR. MILLER: There are certain responsibilities that are specific for certain groups and certain agencies within the community. Does anyone want to talk about the role of the State Health Department?

DR. JORDAN: It seems to me, maybe you all touched on this -- but as in some medical things, it seems to me education of the public that retarded children need dental care, as much or more than other children, would necessitate practicing dentists answering a request for this.

I don't know how far to go with this sort of thing in dentistry. But, certainly, a lot is done to educate the public about the need for vaccines and other things.
DR. MILLER: This could be part of the role of the State Health Department. The State Health Department is very actively concerned with health education of the public, or it should be, if it isn't.

Is there any other responsibility that the State Department of Health may have in this area?

DR. POLLACK: I think that they should include care for the mentally retarded, reaching the same groups as they provide dental care for indigents and not exclude it.

DR. MILLER: Such as this program we referred to awhile ago that Tennessee is doing for those in special classes in this State.

DR. MESSORE: I found out that the State Health Department is doing very little developing an educated public on dental health.

In Rhode Island, you cannot get them interested in emphasizing the importance of dental health to these retarded children. I practically wore myself out trying to get them interested.

DR. ADELSON: That may just be a local problem. What is the usual procedure that State Health Departments use in disseminating information for the education of the public?

DR. WILLIAMS: We, of course, vary the approach depending on the problem. We do have a Health Educator and his staff.

DR. ADELSON: I was wondering whether there is some universal method that all State Health Departments use to disseminate information. Is there a protocol?

DR. MILLER: There are several media, which are available in public health which are used across the board -- lectures, discussions, pamphlets, films, posters, TV, radio. They use all of these media.

Many of them employ Health Educators on their staffs. Some of them don't. It is the responsibility of the Children's Bureau to disseminate information. It is the responsibility of State Health Departments. It is the responsibility of Local Health Departments. It is the responsibility of the ADA.

It is true, also, that the problems that Dr. Messore outlined do not apply to all States. It is no problem in New York or some of the Western States where all they do is health education. One of the functions of all State Dental Programs is health education.

DR. POLLACK: Should we seek out available funds to finance health programs?

DR. MESSORE: The community should seek out funds.

DR. POLLACK: But the problem is that the locals don't know about the availability of these funds or how to secure them, and the State Health Department should.

DR. ADELSON: They already have funds which may be allocated for dentistry.

DR. POLLACK: Right, and the key thing is health education.

DR. ROSENSTEIN: I can't help but visualize what it takes to do dentistry. One is the patient, and we know there is the need. There are a lot of them clamoring for it.

The second one is the dentist, and we have got to get stuff to the dentist whether it is hitting them time and time again with information, and so on.
I realize that you can't circularize the entire dental profession, but - perhaps - a good segment of them might constitute the roster of the American Society of Dentistry for Children.

They are all in it because they are interested in dentistry for children. I would recommend when guidelines or information or something slanted towards the dentists becomes available, that this be a specific direction in which it be sent.

DR. MILLER: How about the local health agency? I think that case finding would resolve itself more to the local efforts than to the state.

In the implementation of programs, how about the responsibility of voluntary health groups? We heard a lot about UCP. There are other agencies. How about the United Givers Fund? What is their responsibility, if any, in the area of providing dental care for children? Do they have any responsibility?

DR. ADELSON: In addition to many others, it is relegated to the backseat. They have never really considered it.

DR. MILLER: How about the school system within the community?

DR. ADELSON: I think they fulfill their role in that they require school notes to be signed up to a point. Of course, this is, again, a local situation. I don't know how it works here in Tennessee. I don't know how it works in Rhode Island.

DR. MILLER: I don't care for details on how it works, but do they have a role in this?

DR. ADELSON: Of course, they do.

DR. POLLACK: Every child must receive physical examinations.

DR. ADELSON: There is no question that a child with a toothache can't perform as well as a normal child. Therefore, they have a responsibility.

DR. ROSENSTEIN: This would include children deemed educable.

DR. MESSORE: We are working on the principle of training the more educable patient to accept dental care in private offices.

The Director of Operation and Procedures of this program gave me figures just before I left. Fifty percent of those that they have been working on for five years that were more trainable or educable will now accept dental treatment from any dentist.

Now, that is an important thing in having a percentage established where you get a little nucleus established of men who know what they are doing. I don't want to go into details, because we don't want details, but we have a way of doing it.

One family, alone, I will use the last initial R, had three retarded children. At first we had to pre-medicate them and give them general anesthesia. You couldn't even put a mirror in their mouths.

Now, they walk into the main clinic downstairs with the normal children, and walk into any dental chair and accept dental treatment. They are ready for the private dentist.

That will help involve the private practitioner. You have got to start this program in dental school. You can't start it in a dental office. You have to work up into a dental office.

DR. BUGG: Since the schools have a responsibility to see that children perform to their maximum capacity, particularly the mentally retarded children,
they have a responsibility to see that the child is maintained in a good state of health, including dental health, including also, in addition to examinations which are part of the preventive dental measures in terms of health and education to the child.

This health education might take many forms -- control and education along nutritional lines, or early exposure to dental experiences in a modest way.

DR. ADEISON: Oddly enough, Mr. Chairman, I have found that dental health education is usually more prominent on the low IQ classes than in any other. Your dental health education in the special classes is better than in the regular classes.

DR. POLLACK: Here is another source in terms of a captive health education source, your PTA.

DR. MILLER: What should be the role of the Welfare Agency (Bureau of Family Services) in the provision of dental care for mentally retarded children.

DR. POLLACK: Aren't some of the programs under the Welfare done for the indigent?

DR. ADEISON: Yes, in New York State.

DR. POLLACK: So where applicable, welfare agencies should.

DR. MILLER: How about stimulating desire or an interest herein of the need for dental services, even though services are not asked for?

It is true that if you open up a clinic program and say, here it is, come and get it, only a certain percent of the population, normal or retarded, is going to come and avail themselves of the services.

DR. ADEISON: This is the question of publicity or education of the public, because the public is also made up of the families of retarded individuals.

When this problem is presented to the public and in such a way that it will bear a certain amount of stimulation value within it, that is when you will have more individuals coming for treatment than you could possibly handle.

I think that every individual in this room who has ever worked in an institution or has come into an institution has been somewhat astounded over what they have found in the mouths of the children. Furthermore, astounded by the fact that no one seemed to know that this existed.

As soon as the family is aware of the situation, you will have no problem in stimulation. The problem is to make them aware of it.

DR. MILLER: Does anyone else want to talk to this point, to the responsibility of the community in its relationship with mentally retarded children and with dental care for this group of children?

DR. POLLACK: We have been speaking about indigency. The indigency problem is greater in the mentally retarded, at least in our state. I hate to speak about it personally, but that is all I know about.

DR. MILLER: I think it should be made clear that the community does have a responsibility towards all the people in it with regard to health education, regardless of socio-economic status. Everyone should get the benefits of a health education program.
Preventive programs also would apply to everyone across the board. When it comes to providing care, communities can become selective. Perhaps, there should be a means test. But everyone should be able to obtain care.

If they can provide for themselves, this is the best way to do it. It is their responsibility. But if they cannot, then the community certainly has a responsibility to make care available to those who can't get it in the usual way.

DR. POLLACK: There is one other aspect, insurance.

Insurance carriers are always looking to drop these kids off policies. They have a lot of trouble in our community. As soon as there is a mentally retarded child, if it is written into the policy that they can drop it, they will; or as soon as the mentally retarded becomes of age, they won't carry them.

DR. ADELSON: I don't think that it is legal. Certainly not moral for any program to be drawn up and restrict any one from it on the basis of mental retardation. Physical disability, yes, but mental retardation, no.

DR. POLLACK: They don't restrict it to that but, for instance, they don't include hospital care.

DR. LAW: In fact, if they are commercial carriers, they can rate their policies any way they please. It is a free country.

DR. POLLOCK: Here is what I mean. The Dental Society in Maryland has drawn up a prepayment plan for dental care, and in it they include those services which might be particularly beneficial to the mentally retarded child.

DR. SAUNDERS: What are those dental services which include, specifically, the mentally retarded child?

DR. POLLACK: In patient-hospital care, for instance. Only in-patient hospital care refers to oral-surgical procedures only.

(Recess)

DR. MILLER: I think now we want to consider the parents of these children. What should be the responsibilities of the parents in their effort to obtain dental care for mentally retarded children?

DR. ADELSON: There was a word that you used this morning, which was "apathetic," which I really do not believe -- fearful, afraid of being rejected within the dental office by the practitioner, yes. But apathetic, no.

When I think back of all the family groups, the parents of the handicapped child who is at home have less apathy and take their responsibilities more seriously than any other group.

I, at least, have found this to be true. I think that I would like to hear the opinions of other men around the table.

DR. SAUNDERS: Can I repeat that thing which I told you a few minutes ago, and this is from our Medical Director, that the parents of the mentally retarded child, once they found out that the child is mentally retarded, undergo a mourning process as if they had actually lost someone in the family. It is very equal to a mourning process, except that they actually have a living monument to their problem which stays with them all their lives. They go through this life of over-protection and often - at times - rejection of these children.
To an outside appearance, they may be putting on a tremendous appearance of being over-concerned for their child; but - at other times - they have a tremendous rejection for this child. They won't pay any attention to this child for a long while and, then, bring in the biggest Teddy Bear you ever saw in your life. They go backwards and forwards in this situation.

A pediatrician said the first thing the parents will say when you bring them a child with Mongoloidism, where the defect is obvious, "My God, in a tremendous hospital like this, how in the world can you get the babies mixed up?"

DR. ADEISON: We are talking about two different areas. I think Dr. Saunders is talking about the initial impact.

DR. SAUNDERS: This impact continues throughout life. They still have this tremendous feeling of guilt. And the direction which they sometimes follow is over-protection.

DR. ADEISON: It is just this over-protection that works for our benefit, in that they do wish to do everything possible that they can.

But even after rejection of the birth is carried to an extreme, then the child is usually institutionalized. I am not saying that this is the only reason for institutionalization, but it has been my experience that the great majority of parents of handicapped children are far more concerned, once they are made aware of the problem, about getting dental treatment, oral hygiene, diet, etc.

I see slackness in diets and oral hygiene, but there is always this desire to do everything they can. We dentists can provide a service that the parents appreciate greatly. They can see it. Something specific has been done. Whereas, speech therapy is a long procedure taking a long period of time, the psychologist talks to the child, but it is very slow; here, something specific has been done. Pain has been removed.

The parents of handicapped, I would say, know their responsibilities, and take it far more seriously than the parents of non-handicapped, once they are made aware of the problem. This has been my experience.

DR. COHEN: There are exceptions, but the majority of parents are most grateful. As far as professional men are concerned -- I am speaking for myself -- it is probably the most rewarding experience I have ever had.

DR. SELLINGSLOH: In our part of the country, we observed the identical situation. Usually, they come in over-demanding, but the very fact their interest is intense is something that gradually you can reverse, and it will be a very favorable stimulant for the profession.

DR. MILLER: What, then, does the parent need to know regarding dental care?

DR. COHEN: The parent needs to know the same thing that he needs to know about normal children. Except, there is an additional problem in the handicapped.

DR. ADEISON: Plus one other factor. I think, that we all agree that there are a large number of handicapped who will be unable to have removable prostheses. That is because of mouth-breathing and large tongues, difficulty in swallowing, etc., or who will have difficulty in having removable prostheses made, or in adjusting to them. Therefore, it becomes of even greater importance, the salvation and retention of the dentition. We must add this factor to the education of the parents.
DR. MILLER: Are you assuming now that care is available to these children? How about where there is no care?

DR. ADELSON: I would agree that the responsibility of the parent is greater where the care is not available.

DR. MILLER: We were also talking about what the parents need to know.

DR. ADELSON: This is where the community must be educated as to where the facilities are. This goes right back to the community, rather than the family responsibility.

What they must know, of course, is, as Dr. Cohen said, exactly the same thing, plus a few additional things as parents of non-handicapped, plus where to take the children.

DR. SAUNDERS: I think it is imperative in these children that they should receive dental treatment early. Like Dr. Adelson says, they can't, many times, cope with removable prostheses; and, similarly, they have a problem with coping with some kind of orthodontic therapy.

For this reason, I certainly feel dental care has to be instituted early, as early or earlier as in any other patient.

Basically, if there is any situation in which early routine and continuous dental care is required, it is certainly with this group of children.

DR. COHEN: I just wanted to add this:

Coming back to what Dr. Adelson had to say, unfortunately, all of us - I am quite sure - are aware of the image dentistry has in the eyes of lay people. It is not a very good one. The image becomes even aggravated when people seek dental care.

We talk about mental retardation. The patient might go to three or four or five dentists, and then nobody knows, or is interested enough, to send them to a clinic like Dr. Rosenstein's, or a clinic like they have in Providence. So this patient has to seek out by asking a great many of their friends, and this doesn't help the image of dentistry.

Education of the dental profession itself would help the situation.

DR. POLLACK: So, in terms of the responsibilities of the family, they are - at least - the same as, but certainly greater than for normal children in terms of preventive practice, home hygiene, home care, nutrition.

The problem comes up in the discharge of the responsibility. That is another facet of it. They need more help in terms of seeking out service programs and finance.

DR. ADELSON: This is an area where the local dental societies can definitely be of help. I know that many, many calls come into the local dental society for referrals, and they should have the lists of the facilities available for the dental care of the retarded children.

DR. MILLER: The parent, then, should know where to seek care.

DR. ADELSON: That is correct.

DR. POLLACK: There should be an identifiable agency that the parent can refer to, to seek the service.

DR. ADELSON: Through Social Service within the voluntary diagnostic clinics, perhaps.

MISS FOLEY: You all act like there are these places available.

DR. ADELSON: If they are available.
DR. POLLACK: And if not, they should be made. Let us talk about the responsibility of the parents.

They should be the first ones to know that the child needs dental care and needs it early. The responsibility to be knowledgeable about this thing through education somebody is going to give them.

Would you settle for knowledgeability about dental care? Do you know the child has dental needs?

DR. MILLER: How about a knowledge of home care?

DR. MINK: I think the parent should be made aware it is important that they obtain medical care, but that prevention is even more important than in a normal child. We won't go into the specifics of home care, but the parent is going to have to play a role in taking care of the child a lot longer and more specifically than for a normal child. So the parent's role in home care is multiplied.

We had a family where the mother, when we finally got through to her, couldn't handle this boy. She would get him on the floor and sit down on him and brush his teeth twice a day. It was tremendous, the job she did. So, you can motivate them.

DR. ROSENSTEIN: This might imply that these families need to get educational alerting to these things that every family should know.

It may be with voluntary organizations that this alerting should be done. DR. MINK: The parents of the retarded child have so many other problems, if this trouble isn't cleared up real early. They are so involved in so many other things, that if we don't push the importance of dentistry early, they may not get to it until everything is pretty far gone.

DR. ADELSON: Once they have accepted the retardation, that is when there is very little problem in motivating them.

DR. MINK: A lot of these children are so borderline, until they get close to school age, that it is pretty late for that motivation.

DR. MILLER: We all know there is a difference between what the parent would want for this child and what the child actually needs in terms of care. Is there any difference in this area, as far as mental retardation is concerned?

DR. ADELSON: As far as I am concerned, I think they would find greater satisfaction from the standpoint of permanence, as opposed to aesthetics. I think you would find less of a problem with the parents of the handicapped. Ordinarily people are perfectly willing to sacrifice permanence of restoration. I don't think you would find this true in the parents of the handicapped. I think what they want is for their children to be free from pain and to be able to eat better.

DR. MINK: I think a parent comes to this. I have had several that are concerned. If they don't have any anterior teeth, that this will draw more attention to their child; that they think everybody already looks at when they walk down the street. I have had them bring them in in a basket wanting orthodontic treatment for crowded teeth.

DR. ADELSON: But, isn't it true, if you explain to the parent that this restoration will last for a longer period of time than one that looks better, which has to be replaced, you will have less difficulty with those parents than with a non-handicapped child?
DR. MINK: In a majority of the cases.

DR. SAUNDERS: Of course, these parents, once the child has the handicap, try to do everything they can in the child's over-all appearance.

Again, let us take the Mongoloid. We get a large number of requests from these parents, because they feel something should be done for these children's teeth, even what is basically impossible. In other words, they are always looking for the norm in the child.

They are grasping for any ray of hope. Therefore, many times they grasp for aesthetics, and grasp for orthodonture, where aesthetics and orthodontia just cannot be given.

DR. BUGG: They are no different than we are. We are grasping. We are trying to do the best we can and bring our skills to norm, if possible.

The question you are asking, is there something they are grasping for which cannot be found? The answer is, yes. Sometimes the parents hope for something that just cannot be provided.

DR. MILLER: What is the parent to do if he is turned away by the dentist, if he contacts the dentist for care for the child?

DR. MINK: This depends a great deal on the community. What is available? There are many places where they can be sent, these diagnostic institutions or treatment centers we have talked about. Probably state universities and dental schools get a lot of these types of people.

DR. POLLACK: It is the responsibility of the families to get together and try to do something.

MISS FOLEY: Many families will try over and over again at different agencies until they find someplace where their child can get treatment.

DR. MINK: If there is a dentist in the community, and word gets around that he will care for handicapped children, he has a tendency to get pretty busy.

DR. ADELSON: You said it was the responsibility of the families to go get together and do what?

DR. POLLACK: Take an active role in the seeking out of services to be made available to their children.

DR. ADELSON: In the formation and construction of facilities, and so forth?

DR. MINK: This is what might be referred to as an image in dentistry. So many of these people are bounced around until they wind up with a severe toothache, when somebody has to see them.

DR. POLLACK: They have to do a lot of detective work to find one. Especially if they are in a rural area. I have had patients come 150 miles and we had to hospitalize them because they couldn't interest a dentist. There were dentists in their area, but they just wouldn't communicate with other families, and the other families probably didn't have much information. Some patients go 150 miles to get dental care for their child, because no one will treat their child.

DR. LAW: We come back to the same fact. There are so few dentists that give complete care for the normal child, much less the handicapped child.

DR. MILLER: I think the problems we are going to identify are the same problems that concern everyone, perhaps with a little more emphasis, a little more need for focusing on the backlog, that has grown up, because of neglect.
But basically, I believe the guide lines and principles will be pretty much similar to those that apply to all children.

Dr. Adelson: More education of the community and of the profession is required.

Dr. Jordan: I would like to hear Mr. Hormuth and Miss Foley talk a little bit about how you feel towards these children; how the dentist feels towards them and how they counsel with the parents. A lot of parents reject these children. They don't want to bring them in. They don't want to keep bringing them back, and they don't want to be bothered a lot of times. And yet a lot can be done to make this child eat better, and so forth.

If the family acts pretty hostile towards you, as the dentist, how do you handle them? What is your responsibility to them?

Dr. Adelson: I have never had a hostile family but I have found frequently in a couple of institutions and medical diagnostic evaluation centers, that the parents get hostile because of the fact that they are overloaded on their clinic days.

They sit around for a very long time and have about a three minute interview and are asked to come back on the following Wednesday. This goes on for seven to eight months, and they get annoyed.

I do know that in one particular institution, I am thinking of, hostility has been shown frequently because of the delay and of the too many return visits. A two-hour wait for a five-minute interview is discouraging to anyone.

Dr. Jordan: This isn't the way we do it. Rarely would one wait an hour, except maybe for an MD in our clinic. Occasionally that happens. Never are they seen for only five minutes. Usually it is an hour.

Dr. Adelson: How many months does your average evaluation take?

Dr. Jordan: Once it is started, what would you say, Miss Foley?

Miss Foley: There is quite a bit of variability according to the problem. For example, just last week, we had a conference on a youngster whose workup was begun the end of December. That child moved through rather quickly. So much concerns the child, his problems, and family attitudes.

As we said earlier, sometimes we deliberately take as long as six months, but we don't have parents reacting hostilely towards our appointments.

We spend a lot of time with them. We provide available resources for them along the way.

Dr. Adelson: This seems to be in conflict with what we just heard.

Dr. Jordan: I am talking about families coming in with hostility. They are already rejecting the child, and they are real unhappy about the whole situation. They try to manipulate us and make us do what they want.

Dr. Adelson: This won't come up with dentistry.

Dr. Cohen: Dr. Jordan, I know what you are talking about. I don't think this problem is one that can be solved. I think we, as professional people, do the best we can.

If you have hostile parents they may not bring the child to you after you have told them and made your evaluation, whether it be a neurological evaluation or psychologic or psychiatric or dental evaluation. We can't send out to bring the child in.
DR. JORDAN: But would some of these dentists who see these children, understand and be understanding enough with a hostile parent who was trying to tell him what to do?

DR. POIACK: They are so glad to see us there is no hostility.

DR. COHEN: I think people are reluctant to pay for medical and dental bills, and then there is a tremendous amount of hostility. So you have it with normal people.

DR. ADELSON: There must be a differentiation between a medical evaluation and a dental evaluation in this particular instance.

When hostility is shown by a parent at an evaluation center, it means that they have had some inkling of what they are going to be told. I am not sure it is hostility, so much as it is a defense mechanism. They don't want to be told that. They want to be told what they want to hear.

But when a parent brings a child to see the dentist, this is one of the easiest areas to avoid unless the child is in pain. So that, generally, you will find if a parent brings a child into a dental facility for treatment, you will not find hostility.

MISS FOLEY: You are all in a specific position to help them, and this makes a tremendous amount of difference. Parents come to us feeling very hostile towards professional people because of past experiences. But when they find out this is a place that is concerned, that wants to help, we see a whole change in their attitude.

But I think you are all in a wonderful position, because you can relieve the pain, fill the carious teeth, and make life so much more pleasant for the child and the family.

MR. HORMUTH: Except, I think, the point Dr. Jordan is trying to make, maybe there are too many people in private practice with the kind of attitude and approach you have mentioned around the table here.

I think if you will recall back in 1949 and 1950, when Brooklyn Jewish and Flower Fifth were set up, outside of your (Dr. Adelson's) program at Flower Fifth, I can recall a private list of maybe six or seven dentists in the whole City of New York who were prepared to take on these retarded children.

I think maybe these parents do come to these clinics with a great deal of hostility.

We don't have very many clinics available. There are only 138 in the whole country. These are seeing about two percent of the retarded children. The number of dentists that are willing to deal with these parents who have a certain amount of hostility, I think, are rather few.

About three years ago, we had at one point considered the possibility of a pamphlet addressed to the parents that would essentially cover some of the things you have considered under family responsibility. As we began to talk to some of the dentists, they felt that maybe this wasn't the time to do this. Primarily, because they didn't feel there were enough dentists in private practice in the community to really provide this kind of care. And what we were afraid of is giving the parents a pamphlet which they would use to beat the dentist over the head with and maybe not enough men were ready to follow through on it.
DR. ADELSON: If the question was phrased, does the dental profession see hostility on the part of the parent, I would say, yes; no question about it. But the question was phrased, do we?

No. All we see is the feeling of overwhelming relief that they have found the facility for the individual. But I have no doubt that there are many practitioners who are faced with tremendous hostility because they will reject the child for treatment. No doubt.

DR. MINK: I think there are a number of dentists who probably help create this hostility. Because when I was up in Minneapolis with our new interns and a private patient would be referred in, when bounced around a little bit, they had some hostility towards dentistry.

The new intern not properly broken would see a backlog of caries, built up over a number of years, and would immediately jump on the parent for not taking care of the child's mouth. When, maybe, they had been trying to get somebody for the last three years to do it, and they have thus created a hostility, which takes a lot of patience to overcome.

Those of us sitting around this table are not a fair example of the average dentist seeing handicapped children. Maybe they got someone into the office and the man didn't know they were retarded. They made a routine appointment and they come to the office and the guy won't do anything.

DR. POLLACK: In my office, the parent fills out a medical resume for the child. There is one question, is the child mentally retarded? And it goes down the list. But we don't ask them this over the phone.

DR. MINK: I have seen Mongoloids where the local physician never told the parents.

DR. ADELSON: I think this is true, also, on the national level. I know if you ask, is your child handicapped, on a piece of paper, and what is the handicap, cerebral palsey is far more acceptable than mental retardation. I think this is not a sign of ignorance. There are certain tendencies in most areas to avoid a "stigma".

DR. MINK: We get back into another subject, back into community responsibility.

Some schools take these children into school, and the teachers haven't enough courage to kick them out when they find out they are retarded. If they kick them out, they make the pupil aware.

Some of these children will stay in school two or three years before somebody bothers to tell them they are retarded. And they are even promoted. When they are sixteen they can kick them out. This is a unique problem, of course. But I can speak on this for two states.

DR. MILLER: One of the big problems facing program people today is the question of what dental services should be provided mentally retarded children.

Does anyone want to talk to this point? How much dental service should be provided retarded children?

DR. POLLACK: Total.

DR. ADELSON: All that is possible, of course.

DR. ROSENSTEIN: All the home care instruction possible, not only given once but repeated and repeated and repeated, with the parent receiving instruction as well as the child. I know that it is just not complete dental care and they need the preventive work more. We know that if you follow the
idea, we found out in that survey that I spoke about earlier, where we found the handicapped child had a lower filled factor, but the D and M is greater, it means more missing teeth. When he gets to be a young adult, we have added dental crippling to his other crippling conditions, and with these patients, dental restorative work is additionally more difficult. So that it is essential that we see these children as early as possible and institute preventive care as early as possible. We must prevent tooth-loss.

DR. ADELSON: I would put additional emphasis on orthodontic and periodontal services for the same reason.

I would add emphasis to the total area of care, but I would emphasize orthodontic and periodontal service to prevent loss of teeth.

DR. MESSORE: A recall system, whether they need anything or not, should be set up.

DR. ROSENSTEIN: The recall for the handicapped is more necessary than it is for the normal child. They may not yet be able to do as thorough a home care job, even with the brushing, and I think we try to recall ours at 3 1/2 to 4 months intervals.

DR. LAW: What do you do for them then?

DR. ROSENSTEIN: Prophylaxis, cleaning, additional caries taken care of, and we repeat again home care instruction. Repetition is a big part of it.

DR. LAW: Awhile ago you were concerned with getting these children cared for. You were concerned about the numbers of them. You were worrying about putting out pamphlets because you were going to overwhelm the dental profession. Now you are going to give them all comprehensive dental care?

DR. ADELSON: Then let us talk about what should be done, not what is done.

Ideally, thorough comprehensive dental care.

DR. MILLER: With frequent recall.

DR. ROSENSTEIN: It is much simpler if we can see the child earlier.

DR. POLLACK: From a practical standpoint, the greatest benefit in the health of the community in terms of its resources can be gained in preventive dental practice as compared with the cost of neglect.

MR. HORMUTH: Could you define for me what you mean by early preventive care? Does all early preventive care need to be handled by a dentist?

DR. POLLACK: Not all of it. Preventive dental care today includes nutrition, education, topical fluoridation, X-ray.

DR. MILLER: Someone has defined dental services to include preventive, diagnostic, therapy, and follow-up services that are made available on a one-to-one basis -- (patient-dentist).

This is the concept of dental care. Preventive is just redundant actually. Dental care includes preventive services.

MR. HORMUTH: Would you spell out what some of these items are. Might it not be part of existing programs to stimulate some of this through other personnel?

DR. MILLER: We will spell out the services, Rudy, but these will come later, if you will permit.

DR. MINK: Back to Dr. Law's question, what you are saying, if we have X number of hours to treat X number of patients, we can't proceed to have comprehensive care for all of them. What do we do?
DR. LAW: That is what I am asking, what are you really going to do for these patients?

DR. MILLER: Let us talk about the concept of treatability of these patients. We have heard talk back and forth. Some children are said to be fully treatable and some partially treatable.

Does anyone want to talk about treatability of patients? Is there such a thing as partially treatable and fully treatable?

DR. COHEN: All mentally retarded patients are treatable either in the office or in the hospital. If you cannot treat him awake, he can be put to sleep.

DR. ADELSON: I will say, as regards manageability, all retarded patients are manageable one way or the other, but treatability, no.

DR. COHEN: All mentally retarded patients, as far as I know, are treatable.

DR. SAUNDERS: We can treat every patient who comes in one way or the other, or we can manage every patient that comes in.

We have these pathological diseases which have in their syndrome functions mental retardation, and I have a lovely list of them.

Let us take one. For instance, the uncontrollable hydrocephalic. I think in many ways, except for relief of pain and discomfort, that we are maybe beating our heads against the wall. I think on some of these children you would be subjecting these children to a definite medical risk for us to go in and institute complete treatment.

DR. MILLER: In other words, every patient who presents himself to a private office can be managed by a dentist if he puts himself out to do this. Or there are means available whereby a dentist can see that care is provided. If he doesn't want to do it himself, he should refer him, perhaps, to a specialist. Is this correct?

DR. COHEN: He can relieve that patient of pain, and relieve the patient of the pathology that exists in his mouth.

DR. MILLER: The dentist has a responsibility here, because all of these children are treatable and manageable?

DR. COHEN: Right.

DR. ADELSON: I would like to know what classification of retardation do you use? Because I have heard four different classifications around this table of mental retardation.

DR. MILLER: Mr. Hormuth, would you care to answer this one?

DR. ADELSON: Do you use the AAMD classification?

MR. HORMUTH: This is what we are asking the clinics to report on, the AAMD classification.

DR. ADELSON: I know there is a problem in this. Frequently, at this table, I will interpret a particular classification one way and someone may interpret it another way, and so forth. I think it is important for us to define terms and understand what we are talking about. Because we are talking about manageability and treatability. This is where it enters into.

DR. SAUNDERS: You can't always put manageability and treatability into levels of IQ or mental age.

DR. ADELSON: I made that statement but at the same time we have to know what groups we are talking about.
DR. SAUNDERS: The children taken to the office are ambulatory. That would be the educable and some of the treatable. Whether we get into the severely handicapped, I don't know.

DR. ROSENSTEIN: More of those are likely to be institutionalized, and this is not the group being considered.

MISS FOLEY: But we have got in Memphis alone 300 youngsters waiting to go into the institution. Some of whom have been waiting three or four years. So I think these too are problems in the community.

DR. MILLER: Another question which faces people in programs was brought up by Dr. Law and repeated by Dr. Mink. It is the one about the prudent use of restricted sums of money that might be available for dental care.

With the same amount of available funds, does one attempt to provide restricted services to a large number of retarded children, or complete treatment to a small selected group of the same?

DR. ADELSON: It seems to me that our first and foremost concern is with pain and, therefore, my own feeling, depending upon the amount of money -- would be to eliminate the pain and the pathological conditions which would lead to the deterioration of the general behaviour and health of the patient.

DR. MINK: I have heard the expression used by one of our faculty -- I may be misquoting him -- that in one of the states where he used to be, that they had a priority, that they were allowed to fill permanent teeth. In other words, they could only use amalgam, and so forth, for permanent teeth only.

In other words, the object was to save permanent teeth. This would be eliminating pain. This was one method of treating to accomplish the most with the least. I don't know if this was ever followed up. This would be an interesting thing to try sometime and would break all of my principles.

But I thought of this out in the Eastern part of Kentucky, some of those counties don't even have a dentist.

So if they did want to give dental care, to go out there and take the students, and treat one segment with complete care that is not retarded, and another segment with temporaries and primaries, and then when they are sixteen, see who has the most permanent teeth.

DR. ADELSON: This is the same problem as education. You want to give one child or a small group of children a terrific education or diffuse it out. Which are you going to do?

DR. MINK: It breaks all my principles to even think along those lines.

DR. LAW: I bet they would be just as well off.

DR. MINK: I am afraid that is what I would find.

DR. MILLER: A lot of program people operate with a restricted amount of money, and they have the problem of what to do with this money. Should they provide more service, complete service for a small restricted selected group of children, or spread it thin, taking as many as come?

DR. ADELSON: You must do the latter because the moment you admit to a certain amount of selectivity you run into a fantastic amount of problems. How do you select your cases to provide for complete treatment? You must diffuse it out on an emergency level, first, and then proceed to Dr. Mink's suggestion.
DR. MINK: I don't want to be quoted as trying to support this. This is a hypothesis.

DR. MESSORE: I don't think you have to be worried about being overwhelmed with numbers of cases. When we get to that stage, I too will be worried about it.

I think right now, in the next two or three years, we should stick to complete dentistry.

DR. ADELSON: Are there institutions providing dental services with restricted funds unable to supply complete services to their patients?

DR. LAW: Every hospital in the country, practically.

DR. SELTINGSLOH: In regard to something mentioned there, there is a tendency to increase the volume of patients in institutions without increasing dental services. When there was a ratio of small population to a small dental staff, they were able to have a comprehensive program. Then, as you increased them, in some cases trebled your population to your dental staff, you invariably ended up with this thinning out.

You have to neglect your deciduous teeth to maintain full, long range coverage. You have to go to your permanent teeth care, and you are forced into these things. You have no alternative because your budget is limited.

DR. MILLER: But it would be ideal if total care could be provided for all.

DR. SELTINGSLOH: Well, we tend to look at the practical. The ideal would be fine.

DR. SAUNDERS: What we try to do in our State Hospital, one, we always provide for the relief of pain, but two, we go through the student levels and, therefore, the dormitory levels and take the ones first on a vocational rehabilitation program, the ones that have the greatest chance of going back into society, and make sure they have no handicaps in going back into society. Slowly work down on a recall situation.

We have started out on an IQ of 70. Now we are down on an IQ of 30. This includes hydrocephalics, microcephalics, and associated pathological disease processes.

But you have to be there for the relief of pain. I think there is so much pain that is going to occur and, as far as I am concerned, that even necessary dentistry includes restoration for the primary teeth.

DR. MILLER: I think we have spoken enough on this point. I would like to move on into priorities of care and standards of care. Any program for promoting and maintaining dental health should provide for complete fulfillment of certain pedodontic standards.

In 1945, the American Society of Dentistry for Children developed a set of oral services for children that would meet the minimum requirements for growth, development and health.
This is a list of services that the profession has in mind in assisting the individual to achieve a satisfactory state of comfort, function and appearance.

I have here this list of standards of dental care for children adopted by the American Society of Dentistry for Children, 1945. I would like to pass these out.

STANDARDS OF DENTAL CARE FOR CHILDREN
Adopted by
American Society of Dentistry for Children
1945

1. Periodic examinations, including x-ray diagnosis
2. Dental prophylaxes
3. Restoration of carious teeth with silver amalgam or silicate fillings, or with metal castings if necessary
4. Pulp treatments, including cappings, partial or total pulpectomies when indicated
5. Anesthesia, when necessary for the control of pain
6. Preventive orthodontic appliances to maintain space and to prevent mal-occlusion
7. Prosthetic appliances, when needed to replace missing teeth and to restore function and satisfy esthetics
8. Treatment of periodontal disease and mouth infections
9. Extraction of hopelessly diseased, impacted or supernumerary teeth
10. Surgical procedures when necessary for the health of the child
11. Patient and parent education to encourage the application of scientific knowledge for the prevention of disease and the promotion of health

This list of standards for oral health services for children applies to children in general and is not pointed towards the mentally retarded child, per se. It is very possible that there are several omissions. This has nothing to do with priorities, and I think we might take some time and consider this list and see if any are omitted, what should be added to this list and, perhaps, relate this list in the order of priorities for mentally retarded children.

Does anyone recognize what is omitted from this list?

DR. POLLACK: Dental prophylaxis and fluoridation.

DR. ROSENSTEIN: The concept of instruction in home care procedures, would that be included in number eleven? I think it deserves a mention by itself to be more specific.

DR. MILLER: How about special needs? The mentally retarded children have special needs and they are not covered here.

DR. COHEN: For the mentally retarded child the home care program is extremely important, because it necessitates the involvement of the parent or the guardian, because many of these children can't do it themselves, and they have to be educated to do it for the child. So this should receive priority.
DR. MINK: I think number five probably could be broadened somewhat for the care of the retarded children to include in very general terms sedation and general anesthesia.

DR. BUGG: The institution of appropriate techniques for the management of these children, including sedation.

DR. ROSENSTEIN: I think it is where mental retardation becomes complicated with emotional disturbance. But otherwise I have found a lot of ten, nine, twelve year old retarded children who are in the trainable area to be perfectly cooperative and willing to have dentistry done without sedation.

DR. MINK: I totally agree on that. We used to have trouble finding cases to do under general anesthesia, but if we talk about recommendations for the retarded child and somebody sees this list and is using this list as a guide, and we specifically omit the use of sedation in those cases where it is necessary or the use of general anesthesia where it is necessary, that this, in a sense, is saying that this is never needed.

There are some of us here that probably use more than we need to; and probably some of us here that probably don't use it as much as we need to.

DR. MILLER: Do you think we ought to include it as a separate item?

DR. COHEN: No. I think in No. 5 you can say, anesthesia may be necessary for the control of pain as well as general anesthesia for mouth rehabilitation where indicated.

DR. MINK: We use the word pre-medication incorrectly. We use it only in sedation. It could be prophylactic.

DR. OBERMAN: Institution of appropriate technique for the management of these children, including anesthesia and sedation.

DR. MILLER: I might also, while we are at it, pass out another list of essential dental services for children which was prepared by Dr. Gerry of the National Institute of Child Health and Human Development. (enclosure)

DR. ADELSON: Is there anything on fractured teeth in that?

DR. MILLER: Let me pass this out to you and then you might be able to relate one against the other, and we can come up then with a list of priorities and order of services, if you will.

DR. POLLACK: I bring this up and just make this as a suggestion. It might not be germane to this list. But in the dental treatment of these children, more so than others, we need a more thorough social and psychometric examination. But this might not fit in standards of care for mentally retarded children. But in preparation for this care. We need this information. We need a thorough medical examination, psychometric and social.

DR. MILLER: This might be added to the order of priorities as an adjunct to general care.

DR. ROSENSTEIN: It is a requirement, and it is right up at the top.

DR. ADELSON: This question of traumatic injury is an important one, not only from the standpoint of treatment, but also from the standpoint of number 11. In educating the parent to be as careful with regard to fractured teeth, etc., and also from the standpoint of various appliances where the dental profession could suggest methods whereby children may be made less accident prone. I think this is a very important feature.

DR. POLLACK: That is a good family duty, accident prevention.

DR. MILLER: Are there any other additions?
DR. MINK: I would also like to see these injuries as a separate item.
DR. MILLER: Let us add it. Maybe it would be wise to list those fourteen
in simplified terms on the blackboard, and then let us consider them and try
to arrange them in an order of importance or list of priorities which may be
used as a guide in selecting how much and what services will be rendered and
provided for retarded children.
What do you want to list first?
DR. POLLACK: Did we agree about the suggestion of medical evaluation to
be in this? I think that should come first.
DR. MILLER: We could make a point that it is essential that the dentist
receive a complete medical workup and social background of the patient before
undertaking dental treatment.
This is a necessary adjunct to treatment and care. If services are to be
provided, what is the order in which they should be provided?
DR. SAUNDERS: I just had one question which sort of came to my mind.
Should we actually put down a list of "priorities of dental care", in that I
feel like we may get into this type of situation where we can't do all of this.
We just do number 1.
DR. MILLER: This is the point. We are not necessarily saying which of
these things should be done, but this is a list in order of importance. In
the event funds are not available to permit all of these services, we could
have a cut-off point. But certainly these are essential.
DR. SAUNDERS: But what is essential for one child may be completely not
essential for the others.
DR. MILLER: I don't think anyone will disagree with the need for re-
lieving pain when pain exists.
DR. MINK: You are in a sense dictating. People have referred to this
study in Minnesota as a standard.
If you list these as priorities, you are creating a standard. But if he
says, you do this instead of this, somebody is going to tell you, you can't
do this because that is not high up on priorities.
DR. POLLACK: I would list them in order of care. You know what you do
when you see a patient the first time. What do you do? You find out if he has
pain and you relieve it.
DR. MILLER: Change the wording and instead of calling it priority of
care, let us list the order of care.
DR. POLLACK: True. The first thing you are going to do as an adjunct is
get the medical and social history, and the second thing is relieve pain.
DR. MILLER: Education should permeate everyone of these orders of care.
You cannot relegate education to any one particular place. It applies across
the board.
Emergency care and education; examination and education; everyone of
these standards could have education tacked onto it.
DR. ADEISON: This is a specific program for the management of a re-
tarded child. If it is a facility to deal with retards in a community, then
actually number 1, education of the parent, should be carried out by that
facility regardless of individual care. Do you understand what I am trying to
say? It depends on just what these will be used for.
DR. MINK: This is what we have been saying all afternoon. We have to educate them before we tell them what they need.

DR. ADELSON: That's right. We would then cut down on the need for dental care. That is ordinarily the function of the facility, to educate.

DR. POLLACK: Then Dr. Miller is talking about the education of specific services rendered.

DR. MILLER: We are talking about dental care rendered by a private practitioner, and listing them right now. In a clinical program, would this differ?

DR. ADELSON: No, but the program, itself, is an additional function, I feel, when dealing with handicapped, providing additional information to parents on a generalized standpoint, not only on a specific one by an individual practitioner. That is why I didn't know where these rules apply.

DR. MILLER: These are standards of care we are talking about on a one-to-one relationship, patient to dentist.

DR. POLLACK: I think there is an appropriate distinction, educational program over and above the procedures rendered, which is the general education of the parent.

DR. ROSENSTEIN: I wonder if you are thinking of what I said before, which is the specific instruction for home care procedures which normally would fit when you are making your examination and diagnosis, when you give your prophylaxis.

DR. POLLACK: Then the specific additional program in terms of each service rendered goes along with it. We are really combining here standards and procedures.

DR. MILLER: That's right. We are taking these standards and trying to arrange them in an order of care.

DR. POLLACK: All you have to do is put three as including X-rays instead of periodic examinations.

DR. LAW: What is the matter with periodic?

DR. POLLACK: Because periodic examinations refer to standards of care, rather than order.

DR. SAUNDERS: I think we are getting into a mess on this situation, because I think everything depends on the child.

We are trying to fit the mentally retarded children into a category of suggested order of dental services or suggested priority of dental services. I think the child, himself, or the parents, themselves, are going to make our order. I think we should make a list of dental services which should be performed for the mentally retarded children, and the dental services necessary for the mentally retarded children, but I don't think we should have an order of dental services. I am definitely against it.

DR. MINK: Dr. Saunders' suggestion has a lot of merit because you may not do this in order of treatment.

DR. POLLACK: Fundamental to the success of any therapeutic measure is an orderly approach to the problem. This does not mean that everybody is going to fit in with the order. But you have got to have an orderly approach.

It doesn't mean that if you can't do a periodic examination, or it doesn't mean if you can't take X-rays, you shouldn't do a prophylaxis. There has to be some order of approach.
DR. MILLER: I think you will all be satisfied if we put it in some sort of order, and then modify the order in accordance with the statement Dr. Pollack just made.

DR. ROSENSTEIN: A child should have the benefit of a diagnosis. Once you eliminate the emergency cases and your general concept of the education of the parents, and again we are talking about ambulatory children, the child deserves a diagnosis.

DR. MINK: Nobody is disagreeing with you at all. It is just a matter that sometimes you can't always do everything that first time around.

DR. SAUNDERS: But, by putting down these recommendations in order, we will be coming back and people will be passing out these things for years, saying, this is the order in which these people should be treated because this Committee said so.

DR. POLLACK: You can say, this is the order if the child is amenable.

DR. MILLER: What would you recommend, Dr. Saunders?

DR. SAUNDERS: I would say this is a beautiful situation which says essential dental services for children should be listed and not even put in numerical order so there won't be any problem at all.

DR. MILLER: I want you to repeat what you said before.

DR. SAUNDERS: That the child, himself, in the situation he comes into your office should be the one to determine the order of care and the services to be provided. But as an objective, all services should be provided.

DR. MILLER: And here is the list of services?

DR. SAUNDERS: Right.

DR. MILLER: How do you feel about this?

DR. ROSENSTEIN: I think we should have a logical start, and the logical start is the examination and diagnosis. If there is an emergency situation, you don't naturally go ahead with a diagnosis until you relieve the patient. And following such, a mouth should be cleaned up, every mouth.

DR. SAUNDERS: I think we are making suggestions to intelligent professional men who have this in their mind in the first place. I think the thing we wish to emphasize to these intelligent professional men is that all these services are necessary and essential for the mentally retarded child, and they should leave out no services.

DR. ROSENSTEIN: We are hoping to get these to dentists who we have been told all day are turning these children away and shouldn't we give them guides?

DR. SAUNDERS: We shouldn't tell the dentists how to practice his individual dentistry.

DR. ADELSON: Isn't there some order of priority needed in those institutions which have restricted funds? Isn't that behind what you had asked for?

DR. MILLER: Right.

DR. ADELSON: If you are asking for that specifically, let us then take that up after all the essential services are finished and put aside. Let us give you an order that you can provide your facilities which have restricted funds.

DR. OBERMAN: It seems to me, Tennessee has going here the largest program I know of. I think you already mentioned it, but would you reiterate how you approached this problem?
DR. WILLIAMS: This is primarily left up, in Dr. Saunders' philosophy, to the individual treating dentist. We don't have any list we supply to the men.

DR. ROSENSTEIN: The more I keep looking in Dr. Saunders' Philosophy, to any list we supply to the men, at that, I go along with Dr. Saunders' recommendation that we put that down under essential dental services for the child, because the more we add to this, the more confusing it is going to be to the dentist.

DR. ADELSON: This is a list to go to dentists where you apparently think or believe that there is a problem in certain particular areas or facilities whereby there are only restricted funds. You wish to know the order of priority, so that the funds can be used to the best ability. This is a separate question from the essential dental services for mentally retarded children.

DR. SAUNDERS: May I say again, any time you allow a State Legislature to get hold of a list of essential dental services in order of priority, where they can say, we will take care of priority one for all patients and not priority two, we have created again another monster.

I think every concept we should have and put out is for essential and complete dental care on all levels for all patients.

Any time we drop down to a priority system, any time we drop down to anything but total care, I will assure you partial care exists, and we are trying to upgrade our standards and not downgrade our standards.

DR. MILLER: You would prefer to say a list of maximum standards rather than minimum standards?

DR. SAUNDERS: Correct.

DR. LAW: I am interested in setting up a small institution with high comprehensive care. This is almost what we have now in the total dental profession. We are taking care of a small part of the public much less than 40% and giving them relatively good care, and the rest of the population has gone to hell.

DR. MESSORE: It is up to the rest of the population to come. It isn't that we are not giving it to them.

DR. LAW: I am not arguing why. I am telling you the facts of the things you already know.

DR. MESSORE: You might as well give them everything if there is only a few coming.

DR. POLLACK: I think that we are wearing two hats sitting here, and practically all of us are doing it.

Because many of us are private-patient-orientated. In terms of our private patients and in thinking about them, we think in terms of total dental care in an orderly manner.

As custodians of public funds is the way we are thinking today under the Children's Bureau. Then we have to establish because of the insufficiency of these funds a priority of care. So although on a private patient basis we might not like this idea, when we deal with public funds we have to accept it.

DR. MILLER: I would rather have your point of view as private practitioners, because these guides will have to be acceptable to private practitioners. But as Dr. Saunders pointed out, this is something we have to know, so we will talk about it a little.

DR. POLLACK: Our order of service is first come, first served, total care, with exception of emergency. That is it, and that is the end, and
any man who does less than that to a private patient is violating his contractual relationship.

DR. MILLER: How about payment for care?

DR. POLLACK: I think that is the trouble we are having in discussing this. We all know with limited funds you have to have a priority.

DR. MINK: There are an awful lot of children in this country getting far from ideal care in private offices.

DR. MILLER: What can we say about quality of care?

DR. ADEISON: I don't think we should say anything. I think it is up to the State Boards and local societies.

DR. SAUNDERS: I think it should be stated that sometimes because of the difficulties in management of these children that dentists take short cuts. Let us say anything but complete dentistry ought not be attempted because of the problems you are going to have to do over again. Because of this, the best we can do is necessary. I found so many times because a dentist thinks a child is defective, he will put in a defective restoration.

DR. ADEISON: I don't think we can set ourselves up as judges of our profession on quality of work. This is not what any individual or group of practitioners are set up for.

DR. MILLER: There may be certain basic fundamentals which in themselves make for quality service, such as training and experience. We are not talking about somebody going in and looking in a mouth and saying, there is an overhang in this amalgam and, perhaps, it can be finished better.

Quality of care can go beyond this. If a man has ample training, if he is a pediatrician and has broad qualifications--these are measures of quality.

DR. POLLACK: Quality of care is important and I will tell you why. The standard of care to which the community holds specialists is greater than that which the community holds for the general practitioners. In view of the complicated nature of treatment of mentally retarded, do you have an added burden to use someone who maintains greater standard of care as demanded by the community? In other words, do you have an added moral responsibility to seek specialty services for these children in view of the complicated nature of the dental care? I don't know.

A general practitioner could take care of all patients. Does he have an added responsibility in sending mentally retarded children to a pediatrician in view of the fact that this child might require dental anesthesia for everything he needs; and assuming that the specialist can do it better than the general practitioner?

Does the private practitioner have an added responsibility along these lines as long as the community has determined that the standard of care is greater for the specialist?

DR. MILLER: I think we have made certain statements applicable to the private practitioner, but I think we can also go a step further and admit that perhaps a program person who is connected with an institution or with a clinic program supported by public funds which may be limited, might set up certain priorities among essential dental services. So that he can supply basic essential services or render care to a number of children for whom he may be responsible.

Is this acceptable?
DR. LAW: Whatever order you put these down in is going to assume some order of priorities. When you publish them without making priorities, I will buy that.

But I think it is going to be accepted as somewhat of a priority on that basis. I would agree to see some of this order go out, for example, that you do prosthetic appliances before you treat periodontal disease of these children. I don't think you should.

Don't label them priorities, label them dental care services. But even the fact that they are in an order or list gives them certain priorities. So I would rearrange them without numbering them or calling them priorities.

DR. SELLINGSLOH: I would tend to say total dental care services, and I am applying it now to institutional work. It would be applicable to private practice too. We simply tend to try to establish in institutional services three or four categories, all on equal terminology.

One would be emergency care. The other one would be diagnosis. Another one would be corrective treatment. Another one would be probably examination, preventive treatment, not to give priority to any one. Any service that is offered would fit under any one of these. No order, but tend to imply that a good total dental care service would incorporate these phases.

DR. MILLER: Would incorporate preventive, diagnostic, remedial, corrective services, and follow-up care.

(Whereupon the hearing adjourned until Tuesday morning, March 9, 1965.)

On March 9, 1965, at 9:00 o'clock A.M., the meeting resumed pursuant to adjournment, when and where the following was had:

DR. MILLER: To sum up, I think we established yesterday that this business of dental health or dental care for mentally retarded children is the responsibility not so much of the individual, who usually cannot provide for himself in this case, it certainly is a parent responsibility. It also is a community responsibility.

Before a community responsibility, it is a responsibility of all the people in the community and especially towards the mentally retarded as a group. The community has the responsibility for health education.

Certainly if prevention and care cannot be provided by the family, the community should take some leadership in establishing a program or in promoting a program to provide care for the mentally retarded child.

The parents' responsibility as was pointed out yesterday, in the case of the mentally retarded children depends so much on the fact that he needs guidance.

He has to be told what to do and what channels to follow; in arranging for care for his child.

We decided also yesterday that dental care should include all those diagnostic, remedial, educational and preventive and follow-up services which can be provided by a dentist for the child.

We decided yesterday that in professional dental care by a private practitioner that there should be no order of priority, but rather services should
be left to the judgment of the practicing dentist, and also to the demands of the individual case as to what course of action to follow in rendering care. Also, we mentioned the fact that all children, mentally retarded as well as others, are fully treatable and manageable.

Now, are there any additions or corrections to the statements that I made so far?

DR. ADELSON: Just an addition. Under Community Development of Financing to Indigent Patients, the 2nd one, and six down, "Seek out available funds to finance care programs for indigent retarded children."

DR. MILLER: Would you go along with a statement that if this is the only program or facility available for the retarded child, the community should set up a sliding fee scale?

DR. ADELSON: I go along with that.

DR. MILLER: And the community project could extend then to others besides the indigent except that they would have to make arrangements for care?

DR. ADELSON: I have no objections to anyone being treated at a particular facility, but I do feel the people who can afford should pay, and a sliding scale would certainly be agreeable.

DR. MILLER: This conforms to the philosophy of private health care. I might say that in public health, the care component of the public health program should provide for those who have no other means of getting it. So there is nothing that we are advocating which is not a part of a basic public health program.

DR. ADELSON: However, I would like to see a statement that only where there is no facility that funds can be appropriated for a facility and that there be no interference with private practice.

DR. ROSENSTEIN: It is very likely in the small community with one dentist who doesn't take these particular difficult cases. The community may be so small that it may have no facility either. So that there needs to be maybe a consideration for an intermediate level of personnel, and very often it might be the pedodontist. It may be in the next big town or the next city.

So that the dentist will know that he can't handle this child, but the man who is specializing in pedodontics might be sufficiently trained to accept him as a patient, and it still keeps it at the proper level of private practice in the hands of people trained to take care of the handicapped.

DR. MCKNIGHT: Are there any programs available now, mainly by State Health Departments? I believe Missouri has one. I am not familiar with all of them by any means. Which would provide dental care for handicapped children?

DR. MILLER: There are many programs for normal children in existence in this country. Mobile units are used in some places. Fixed installations are used in some states, but there is no care available for certain special classes in many areas of the country.

DR. MCKNIGHT: I have reference to your dentists who might not wish to accept patients of this type. To me, the most feasible thing is a state program, something along these lines.

DR. LAW: I am sure these will vary from state to state. I believe the Connecticut State Health Department pays $50.00 towards the cost of operating room and anesthesia for an overnight stay in the hospital for a child. This
cannot be used to pay a fee to the dentist. It is strictly for hospitalization for the child that needs general anesthetic.

The dentist either contributes his time or they find other sources of funds to pay him in the community. It varies in the local communities just how they apply this. For one patient in the community, it might be much more economical, as far as everybody is concerned, to take the patient to a center, rather than try to bring the unit out to him.

This is something which has to be worked out by the community. We don't propose to tell them how to work their own problems. Each state program will vary, and I am sure the communities have their own ideas about what they want to do about it.

MR. HORNUTH: I don't know whether this situation here is similar to basic pediatric care in some areas. I wonder whether by adding the phrase "for the indigent" here, whether this might create problems when you begin to move into training programs in terms of, say, post-graduate training, and this kind of thing, where the teaching staff essentially is being paid for and where you really cannot charge twice for a service and where, for purposes of training, you may well want to have it broader than just an indigent population in order to teach or train.

Would this kind of addition hamper a program such as that? I know when you get involved with medical schools in terms of post-graduate training, most of those projects have set criteria for the kind of patients that they see and don't charge. It gets pretty involved and complicated.

DR. MILLER: In other words, they are interested more in teaching material and material for teaching purposes.

DR. SAUNDERS: They have a sliding fee scale and this type of thing, but if a certain type of teaching case comes along, then if the professor or head of the department says this is a teaching case and we should see this child here because of its value to the students, then the indigency clause is usually written out for these patients. I know this is the way it works in our out-patient center.

DR. ADELMAN: If we are working with the population figures as presented by Dr. Miller, I don't think we will have any problem whatsoever from the standpoint of enough patients for teaching facilities. I think it is a little different from pediatric studies where they may be looking for anomalies, for the rare cases, and so forth. You are not dealing here with a situation such as that.

DR. MILLER: Let us get on with this discussion this morning. What are the reasons that are proposed for the present state of dental neglect among the mentally retarded? It lays the blame squarely at the doorstep of the dental profession.

Among other things, the dentist generally is charged with pulling in the welcome mat for this group of patients, in order to discourage parents from bringing their retarded children in for treatment.

Now, if this is the case, we are definitely concerned because the American Dental Association states in its policies that care should be available to all, regardless of income or geographic location.

What then, precisely, should be the responsibilities of dentists toward the mentally retarded child?
DR. SAUNDERS: I think again you have to go back to the fact that you have to consider children first. The welcome mat is pulled in for any child. There are some dentists again that training or anything else is not going to help. Because of certain mental quirks, they do not desire or wish to do it. If a man sits there and says, I don't know how to handle this thing. I haven't handled a child under 12 years of age in 20 years, and I don't wish to see children at all. He recognizes this fact and recognizes his own inability. I don't think you can blame him or crucify him. He is looking at this thing very rationally.

DR. ADELSON: It is true that the welcome mat is pulled in for children. But I think if we look back over the history of children's dentistry, the attitude of the profession towards accepting children, we have seen a tremendous change in the past fifteen years. Fewer welcome mats are being pulled in and it is because of the education of the profession on all levels. I think the same thing will hold true on this level when it comes to the mentally retarded.

We educate the profession not to be frightened. It is true we will find a certain number of men who prefer not to handle children, as we find a certain number of men who will not handle men or women or old people, but I think this will change with education of the profession. There is no doubt about it.

DR. MILLER: But what should be the responsibility of the profession in the matter of rendering care, in general, to all patients?

DR. ADELSON: I don't think anyone is going to disagree with you on this level, plus to the best of his ability.

DR. MINK: I think that there is a different basis with dentistry being as elective as it is. Naturally a man who practices couldn't take every indigent patient in the community and still maintain his own living. But he can take them and eliminate infection and pain which is his obligation. But when it came to elective procedures, talking about the non-paying patient, now, I think we have a question as to whether he should go ahead.

DR. MILLER: Do you think the question of inability to pay, for instance, is one of the reasons that the mentally retarded child is not accepted in the private office? I don't think we are talking about the same thing.

DR. MINK: I think it is fair on the part of the dentist and his personnel not being sure on how to handle this patient and rather than getting involved in a situation in which they can't do anything, they completely avoid it by not seeing the children.

I think this is true with pre-school children whether they are retarded or not. I think it is a matter of fear of handling a situation and not being sure of being able to follow through. This is what education does. It overcomes this fear.

DR. ROSENSTEIN: I agree with you. A great deal of the lack of care, I wouldn't say all of it, is due to this, but a great deal is due to an insecurity or a lack of knowledge about the conditions that the child has, and it points up the need for training. But the training shouldn't be in dental procedures, because they have studied their dentistry and they know their
dentistry. So this needs to be additional training so that the dentist learns more about the conditions that the child has, so that he can understand the child.

Once this is done, once there is this understanding, many more of these children will be accepted. I think the type of result that comes from this additional training was demonstrated in the Fergus Falls area, because they held institutes for physicians and dentists and held local meetings for the dentists, told them about the characteristics of these children -- the dentist doesn't have to be the teacher. It could be the pediatrician, a psychologist can give them behavior aspects of these children -- they understand them better and will be more readily acceptable.

DR. SELLINGSLOH: I think the responsibility of the dentists could be shown in a case I became acquainted with not too long ago, where one of the mentally retarded children was allowed to go on furlough, to a small community with one or two private practitioners there. Shortly after he arrived there, and with more than half of the furlough still allowable, the patient had a toothache. The parent took the patient to a private practitioner.

There were fears of the dentist in undertaking this situation. But the responsibility of that dentist was carried out when he simply referred the patient back to the institution for care.

Then we maintain an image of dentistry that is acceptable both to the private dentist and to the people of the community. So that if they don't wish to participate in the care, then it should be their responsibility to seek out knowledge of who to refer them to. So there would be action, rather than just get on a merry-go-round and go from dentist to dentist and finding disappointment.

DR. SAUNDERS: It is very interesting to me when I examine the children in our institution, when I see just how many of them, especially from the higher socio-economic level, have outstanding dental care. In fact, I feel like most retarded children of the higher socio-economic groups in our state school have received dentist-care.

It is very surprising that most of these children have seen only about four different men. There are four men that have done all the dentist-work on probably these 200 retarded children.

DR. MILLER: Can we say, then, the practicing dentist is morally obligated to accept all patients presented to him, and either render care to that patient or else arrange for care for that patient, if he is incapable, or if he is unwilling to handle that patient by himself? But he should make some disposition of the case, rather than just turn it out.

Now, we know that in dealing with retarded children a dentist may find himself in several different relationships: He may accept the patient as a private patient in his own office. He may accept the patient on referral from a community program and handle him in his private office. He may participate in a clinical program, on a part-time basis. He may even participate in a community program on a full-time status.

Should there be any difference in the relation between dentist and the patient in these different situations?

DR. ADELSON: I can see no difference at all.
DR. MILLER: Are the responsibilities the same, regardless of what situation he works in?
DR. ADEISON: The situation is exactly the same.
DR. MILLER: How about the relationship of the dentist to the child's physician or to a physician who might be familiar with the case? What, exactly, should the relationship be between the two?
DR. ADEISON: There has to be consultation with the physician prior to treatment. There is no question about that with the retarded child.
DR. OBERMAN: Would the dentist want any additional information?
DR. ADEISON: No question about it; he must have it.
DR. ROSENSTEIN: Even though we agreed that there is no need for this being a priority, a complete medical-social history is required; otherwise, how does the dentist know what condition this child has, unless he gets an abstract of the medical history.
DR. MILLER: Before any treatment is undertaken, it is most important then to get a complete history, a medical evaluation of the child.
DR. COHEN: It is a medical and family history, an interview with the mother, of the problems she has with the child at home. Both things are important.
DR. MILLER: There should be this relationship with the parent who brings the child to the dentist?
DR. COHEN: There certainly should before any treatment is instituted for any form of handicapped condition. There should be a briefing or an interview with the parents so that the dentist gets an understanding of what the family problem is, the parents' attitude toward the child, the behaviour of the child at home. This is very important, plus the medical consultation. Then the dentist has a full picture of the whole problem.
DR. MILLER: Does the parent have a part to play in establishing rapport between the dentist and the patient in this particular case?
DR. COHEN: Absolutely.
DR. MILLER: More so than with normal children?
DR. COHEN: That's right.
DR. MILLER: Do you think parents, perhaps, should be present in the operating room?
DR. COHEN: This varies from case to case. Sometimes it is all right and sometimes it isn't. But I think that there should be some orientation with parent and dentist right from the beginning.
DR. ROSENSTEIN: I go along with what Dr. Cohen says. One of the things that the dentist needs to get from the parent is just what the child is capable of doing at home and what he can do by himself. And it is through information like this that the dentist can begin to assess the child's potential for cooperation in the chair. Can he sit quietly in the chair; can he fold his arms, and so on?
As far as cooperation from the parent, we found very often in severely handicapped children, where there has been other therapy, the family has learned the concept of discipline.
In these instances, the family is sufficiently objectively minded to assist the dentist. In the majority of instances, the parent or grandparent of
the severely retarded, or otherwise handicapped, child is a help to the dentist in the office.

DR. ADELSON: I think it is an important point to bring out the fact that a medical consultation, should be held prior to the orientation of the parent. Because very frequently we get a distorted viewpoint of the child's capabilities and potential.

It is wise for us first to get the correct and objective picture from the family physician. Then listen to the mother.

I don't think we ought to go into actual techniques there, because, first of all, there is disagreement in certain areas of children's dentistry as to whether parents be in the room or out of the room.

Certainly, with the retarded children, I don't think we could have any set rules. In addition to which, I think the temperament and personality of the dentist is involved quite a bit.

DR. COHEN: I think there is one other aspect that is very important, and that is the psychological aspect of the parent-dentist relationship. I think this is an opportunity for the dentist to share with the parent all of the problems that this parent has had with the child through the years.

DR. MINK: Another important aspect of this parent interview, it gives the parent confidence in the dentist, that he knows what he is doing, which is of the utmost importance. Because if they don't have confidence in an individual, they are going to be insecure in letting him treat their child.

DR. MILLER: Dr. Adelson brought out that we shouldn't go too deeply into technique. We don't want to be telling the dentist how to handle the child, but we must remember that we are looking to you people whom we consider experts in this area to lay down certain guide lines for the average general practitioner who has been fearful about taking these children.

I think we can take a few liberties and, perhaps, go a little bit into technique and outline some of the steps that a dentist could or should take in order to overcome or dispel fear on the part of the patient.

DR. ADELSON: Mr. Chairman, if you are planning on getting more dentists to treat retarded children, the only way is by having short-training institutes on the local level.

The only way that we can do it, as far as I can see, is to first eliminate the fear and, secondly, bring them to the brief lectures and institutes which you would have in different parts of the country.

But the more and more we go into techniques, I am afraid, you are going to have difficulties, because you are not giving them enough, and a little knowledge is going to be dangerous. We are liable to lose these practitioners whom you may bring in by oversimplifying the situation.

DR. MILLER: I don't believe we are looking for an order of steps that a practitioner can follow in handling all retarded children. But, certainly, there are certain things which he has to know, which he can utilize to overcome fear on the part of the patient.

He should be familiar with such things as premedication, and I wonder how many dentists who practice need some additional training in dental medicine.

He should be made aware, I think, of the fact that with proper pre-medication he can manage and treat just about everyone who walks in.
DR. ADELSON: There is disagreement even on this point. I heard gentlemen sitting around this table who feel premedication is totally unnecessary, that with a knowledge of the child and pedodontics, you don't need it.

DR. ROSENSTEIN: I wonder if we are all agreed that the first thing needed by the dentists is additional knowledge about the significance and meaning and all other aspects about mental retardation. This is the basic need, so that he can understand the conditions in the child.

DR. POLLACK: I think the fundamental recommendation to the practitioner at the local level is to seek out and participate in training programs that might be available, or are available for the management of mentally retarded children. This is his responsibility.

DR. SAUNDERS: I think you could say it is the responsibility of organized society and also the dental schools to provide such training.

DR. ROSENSTEIN: The example Dr. Saunders quoted certainly indicates in the State of Texas somebody took the bull by the horns, and so you had courses presented down there.

You mentioned four dentists. Are they all dentists who had short courses?

DR. SAUNDERS: The courses we have had so far have been lip-service. In other words, lecture and discussions. Almost every man of the forty-some people we have had so far has requested more practical experience.

DR. COHEN: I think the dental schools are lagging in this area. I think the majority of dental schools are not giving formal courses or short courses. I know I participate in one and have for the past ten years in Pennsylvania. The first year, we gave a full course. Now it has dwindled to once a year.

You find, even if the schools do participate, you only have a limited number of practitioners who avail themselves of this sort of course.

DR. MINK: I think that dental schools, perhaps in many cases, are doing more harm than good in this area. I can speak from one example.

When I was at Indiana, the dental students would rotate through a clinic for a day or a couple of days of a semester. If they happened to be there on a day when you had some really severely handicapped children, this was their only exposure. And then they would leave this environment with the idea this is the typical picture of the handicapped child.

I followed this up by interviewing many of the students, by asking them, what in your mind is a typically retarded child. I almost got the classic picture of a severely involved, severely hypertonic patient, or something like that. When they graduate and leave that school, they have the feeling that this is the typically retarded child.

We have seen the Fergus Falls study and other areas.

We could use the practical psychology that we treat normal children with, that we can succeed without pre-medicine and without general anesthesia. The vast majority of these do not need these. When we give these courses, we should select retarded patients to make sure we have the mildly involved, cooperative retarded. Just like when we assign students, we don't give the new students the most difficult problems. We try to give him a patient with which he can do a job.

I think very strongly the dental schools don't give an adequate back-

ground. They give exposure and lip-service to this. They need an adequate course with proper background taught by professional men that know the answers.
and not by dentists to whom perhaps this sounds good, so he talks about it. And then they need to treat retarded patients in their regular dental clinic environment and not in a hospital set-up or the set-up where you make a big deal out of treating handicapped children, like this is a specialty area in itself.

I feel if we could instill in dental students that, in order to treat them, they have got to get their hands in their mouths. But this one day or two days exposure, I think, can do more harm than good in dental school.

DR. ADELSON: I agree with regard to undergraduate dental schools, but I would not apply the same attitude to graduate students who have been in practice. However, this is a nationwide problem, apparently, in the fact that there aren't enough men to accept these things, and the problem could be broken down into two basic parts: The problem at present and the problem we are going to have in the future.

The problem we are going to have in the future lies with the dental schools. This probably can be solved by having as part of the pedodontic graduate program a portion of the curriculum assigned to the dental care of the handicapped. But we still have a problem in many areas of the country, how do you get the rural practitioner, who may be one of two practicing in the community, to treat the retarded children. The only way we can do that is to try and interest them and stimulate them by short courses given on a local level.

That is the only way you can do it. You are not going to bring them into a training school; you are not going to refer the child 400 miles away to a specialist or institution. We do not have dental schools in every community in the country.

DR. MINK: I don't disagree with your philosophy there at all. So how do we take care of the children in rural areas?

DR. ROSENSTEIN: I haven't attended these courses, but I have looked at them. Many of these short one-week courses are hospital orientated and pre-medication orientated, and they talk about the difficult child; they talk about the exception rather than the rule. And the man goes away from there, and many times he goes away with the idea, my God, if that is what I have to do, I am going to stay further away than I did before.

DR. MINK: I think the courses are enough, but the problem is in how the courses are given. We gave these twice when I was in Indiana, and we would select men whom we knew saw children. This was sponsored by the State Health Department.

Then we would use these men for referrals. We already knew one that saw children to start with. Because you pretty well know the men in your area.

Secondly, we invited them in and they took this week's course. We actually paid their transportation. Then we used these men for referral purposes when we would get a retarded child from that area. It was harder for them to slough off when they knew who was sending the patient. It worked quite effectively, not 100%, but practically 100%.

So I think the short courses for the practicing dentist is about the only way.

DR. MILLER: You are saying, also, that professional dental care for the vast majority of mentally retarded is not very much different than it is for normal children.
DR. MINK: I think with local anesthetic, rubber dam and mouth prop that we can treat the vast majority of these people.

In fact, we had trouble in Indiana with finding cases to use premedication and general anesthesia for our teaching program for post-graduate students in pedodontics.

DR. MCKNIGHT: I have talked with some of the gentlemen in the room on this same subject, and I couldn't agree more strongly with them.

We treated children who ranged from the very mild to the very serious. We have had made available certain money which would provide hospitalization for those children in the very severe group.

These children are usually treated at one of the places that we staff, Crippled Children's Hospital.

I forget exactly how long this particular little sum of money has been available, but three years or something. In the time that it has been available, we have not used all of this money to hospitalize children. Most of these kids are treated in a dental chair just as we would treat any other child.

We use the same techniques in treating that you use with any kid that comes to your office. The same psychology, the same understanding, the same interest in the patient.

I feel very strongly and agree with Dr. Mink wholeheartedly that there are those who give anyone a lot of trouble, but let us don't make too big a deal out of treating most of these kids.

DR. MINK: In these training courses, the short one-week courses or whatever you want to call them, I think it is imperative that the dentist and his assistant together should attend these courses. Because I think in treating a retarded or any difficult child, it is almost impossible without the aid of a good assistant. The assistant is as much a part of this dental team treatment as is the dentist, himself.

The assistant can attend these courses and become knowledgeable in the area. The dentist's assistant is going to be of great benefit to this dentist in treating.

DR. ADELSON: On the question of general anesthesia and drugs, from the standpoint of manageability, I agree with Dr. Mink and Dr. McKnight.

We are speaking of the use of drugs on a routine basis, now, or of the use of general anesthesia on a routine basis, and continually putting the child under general anesthesia, continually sedating the child. I think we should break away from this concept. It is highly important to remember that there are times, that premedication may be of assistance to break through the initial fear problem, to establish rapport, and then it is totally unnecessary to use drugs again.

I think the same thing can be applied to general anesthesia. Let us say that we have a child who is in pain with highly rampant caries. Here we have the situation that the breaking through to establish rapport is interfered with to a great extent because of the pain.

In this case, a one-time general anesthetic, never to be used again in routine therapy and routine treatment, is highly recommended, so far as I am concerned.
So let us get away from the concept of using a particular technique routinely on these children for management. There comes a time when general anesthetic is necessary, not only from the management standpoint, but predominantly in order to restore the mouth very rapidly. Then routine therapy be used.

DR. ROSENSTEIN: I am very pleased to hear this unanimity of opinion, because there is involved here something that is basic.

It relates to principles in pedodontics, developing the patient rapport, and how they are conformed to. I am glad to see confirmed certain principles.

First, whoever is going to handle or work with these mentally retarded children or otherwise handicapped children must have a knowledge of the handicapping conditions and the behavioral aspects of the conditions. This is repeating what I said before.

Once he has this knowledge and understanding, the dentist can apply basic principles of pedodontics. And with the observations of the operation of an active clinical program, we evolved a third principle, that the children will benefit greatly from this type of approach, because they grow with it. I believe that every handicapped child should be screened this way, and if he is amenable to this type of treatment, that is fine.

If he cannot be managed adequately and successfully, then there are other procedures available, as Dr. Adelson has mentioned.

DR. MILLER: How do you feel, Dr. Messore, about what has been said here about the use of general anesthesia?

DR. MESSORE: We try to wean them as soon as we can. We have to start some of them, as Dr. Adelson mentioned, where you can't do it another way.

I'd like to know. Is there an abundance or lack, of pedodontists? I don't mean those that call themselves one.

If there is such a lag toward normal children there really should be a greater lag toward the abnormal children. If we cannot get practitioners interested in normal children, you are going to find a greater percentage that won't be interested in the abnormal child.

As to premedication, we try to wean them from that, too. We sometimes start with stronger and then go down to weaker sedation.

As to anesthesia, there are different types of anesthesia. We try to get away from too strong an anesthesia. We have medical men doing that.

I think that we should wean these children from heavy pre-operative sedations and general anesthesia. They can be handled. Our goal, is to get these children ready for a private office. This general anesthesia thing can be overdone.

DR. POLLACK: I am concerned with some things that Dr. Messore said. I think with the growing manpower shortage facing us, I think we ought to concentrate on interesting general practitioners in this area. I don't know if the top age isn't too high, but the Children's Bureau goes up to twenty-one.

DR. MINK: I think you find with the vast majority of pedodontists, the cut-off age will be fourteen.

DR. POLLACK: Any statistics given have to be adjusted as to the locale. But with our increased methods of transportation and communication, locale isn't as important as it was many years ago.
We have patients who travel 20 miles for one visit to a dentist. So locale isn't important as it was before.

About fifteen, twenty years ago, the ratio was fifty-eight dentists to one hundred thousand. Now it is forty-six per one hundred thousand.

Even with the increase in dental schools and increase in student "chair days," it is going to get worse. We are not able to maintain the ratio even with only forty percent of the population seeing patients on a regular basis.

We expect by 1980 that forty percent will grow to sixty percent.

DR. POLLACK: The average income for dentists has gone up from $10,000.00 to $15,000.00. The average work-week is less now than it was fifteen years ago, and we expect it will get less as time goes on. You are going to put out propaganda now which you want to create a greater demand for dental service. You can't even meet what you have got now. So you have got to solve this thing in several ways.

One of them is to interest more general practitioners in this field. The second is better education programs in terms of preventive dentistry.

I am concerned about the fact that we ought to get more general practitioners interested in the care of these handicapped children.

DR. COHEN: I think if you are realistic about what is happening in dentistry at this particular time in the history of our country, you just have to look at our economy.

If you are involved in teaching in the way I have been for a very long time, you take a look at your dental graduates. They are attracted to the more glamorous and more lucrative aspects of dentistry, no matter what you say.

Dr. Messore said we need more pedodontists. We have so little time in our programs in pedodontics in most of our universities. Dr. Mink is doing it a much better way. I think he will probably end up with much more young men interested.

When you add the glamour of plates and dentures, it just doesn't work out well. We are not attracting the numbers of young men that we should into children's dentistry. I think the older men are lost. I don't think we can do much with this group. Dental education has to take stock of what they have been doing. What is important in dentistry? They ought to work on this aspect of it.

Play down the plates and the dentures and play up the most important aspects of dentistry -- children's dentistry -- because if you did this and you had a good preventive program, you would eliminate most of the things we are involved with.

DR. MILLER: Concentrate on conservation of teeth?

DR. COHEN: That is correct.

DR. MINK: I heard some of the old doctors in pedodontics talking about fifteen or twenty years ago that Dr. Adelson related to. That pedodontics was not even a course in dental schools fifteen or twenty years ago. Now it is a required course. We all know there are some dentists who shouldn't see kids, and a lot of them don't. A lot of them see kids, and we ought to make them sign things that they will never see a child; but I think eventually, maybe in our lifetime, that the handicapped in this group is going to be part of dentistry.
I am sure that geriatric dentistry is having the same problems we have here with the retarded handicapped children.

DR. OBERMAN: Pediatrics is going through this same business right now. I don't know whether it would be appropriate, perhaps it wouldn't, for this group to spend a little time to suggest how they would like to stimulate interest.

DR. MINK: Along the same lines, one of my staff is on the Licensing Committee that recently submitted a recommendation to the Pediatrics Departments trying to find out how much dentistry is really being taught to the pediatrician and in pediatric programs, because we may have a dentist who will treat the child but the pediatrician doesn't know enough about it and he says, no, you can't do anything. Don't go ahead.

I think it is a two-way problem. The pediatrician needs to understand what can be done for these children as well as the dentist.

DR. ROSENSTEIN: Pediatricians are going through a change, but their change is entirely different from ours. The pediatrician nowadays is concerned with immunizing well children and this constitutes the major part of the problem, and he is concerned with emotional problems.

We are in a very precarious position. Dental disease is as prevalent as it ever was before, and we are not getting the manpower to take care of this dental disease.

We are not interesting our young men who graduate. Because I see the boys who get out and ask for letters of recommendation. Pedodontics is still on the bottom of the pile.

DR. SHERMAN: I am extremely sorry I didn't get to hear the discussion yesterday, because it seems like it was certainly very stimulating. But hearing the discussion this morning, as I see it, there is a two-fold job ahead of us.

One is in dental education. We have got to do a better job with the limited amount of time, with our undergraduate students. In other words, we have got to raise a new breed.

Secondarily, we must stimulate the so-called younger men that are already out in practice.

We have got to stimulate the undergraduate students in some way. The profession, altogether, must face this problem and get our men interested, not just the specialist in dentistry for children but the men who are in general practice. We have got to have him meet this problem.

DR. SELLINGSLOH: I am in agreement with Dr. Sherman on this situation. You have given a real good approach to the early years, up to 18, 19 years of age. But we run across a lot of the severely retarded that are living a longer span of life, and we need maintenance beyond that 18, 19 years. It has to go beyond the specialty then and you have to appeal to the general practitioner on this for continued maintenance over a period of time.

DR. SAUNDERS: Bringing up money, some of the reluctance of people to treat the retarded and handicapped basically is because they feel like it is going to be charitable service and not be as financially rewarding as other service. This may be a reason for non-treatment of the handicapped in their office.
DR. ADELSON: I think it is a factor but in a reverse way. I think you could possibly use the financial aspect to interest more, but I don't think it is the financial aspect that keeps them uninterested.

DR. MCKNIGHT: On the contrary, I think that this might well be a problem. Most of the men who limit themselves to children -- are interested in them, or I doubt that they would have entered the specialty.

However, aside from his interest in children there is still a financial aspect. Unfortunately, I think that in some cases this would be a factor. I feel that too frequently we might find men -- who would refuse a child treatment because it might take more of his time, when he would not be able to put in $1,000.00 worth of crown or bridge.

DR. POLLACK: We have agreed that the average practitioner who is untrained in this, who is faced with this child for the first time, turns him away before anything like time or money consideration comes into it. He turns him away because he just doesn't know what to do with the child.

Now, I admit to you that after this man knows what to do and begins to handling them, a secondary factor might be financial. I think a reluctance on the part of the professional to take care of this child is because of the lack of knowledge in these areas and, I think, secondly, money may be a factor.

DR. MCKNIGHT: Let me, in a sense, reverse my position. I think you are right. That they are afraid of them first, but secondly, they are interested in knowing what is it going to pay.

DR. ROSENSTEIN: There are two different levels of reaction of people. One, the undergraduate students who are just beginning to be exposed to pedodontics. This is probably the result of the increased sympathy for the retarded and cerebral palsey and other handicapped children that the general public is being exposed to. They are developing an increased sympathy because of TV programs and radio appeals and mail appeals and newspaper articles, and so forth. And I think most of these fellows were all aware of a professional moral obligation, and their reaction was that, well, I have to take care of the retarded child of the families in my area, and I want to learn as much about it as possible.

I think this is not limited to the four counties in the Fergus Falls region. I am sure there must be dentists in the other parts of the country who feel the same way, just like everybody here is dedicated to this. So what this points out is the need for more knowledge.

DR. POLLACK: I agree with Dr. Rosenstein 100%. Because of the emotional appeal of the handicapped, I think we have a ready manpower source at local levels to take care of these children. Our job is to get the training and information to these men.

DR. MILLER: I think we have arrived at some agreement on a few basic points. Dr. Law has these things written down for us. Would you mind repeating them, Dr. Law?

DR. LAW: I got the feeling, really, this morning for the first time that the group was unanimous in their opinion. That the general practitioner does have a place in this field. That they can take care of the great majority of these children. That we are going to need education at the undergraduate level primarily, and this is the history of all things.
Pedodontics started out as a post-graduate thing and got no place until it really achieved stature in schools as an undergraduate course. I think this is true of the handicapped children. It has to be done; we all seem to agree on this.

At the same time, I think most of you felt that post-graduate education should be made available to the practicing dentists.

There is terrific competence and knowledge spread around the table here to do all of this teaching at the undergraduate level through our facilities available for it in the various institutions, and there is competent teaching personnel at all of these institutions, and that really we are not in as bad shape as we may have thought we were yesterday.

Yesterday, the thing seemed to be all on the institutional level. I never got the feeling that you really had accepted the private practitioner as a co-worker in this field. I feel you do accept him and you feel there is a very definite place for him. With some relatively small degree of training, the average dentist can take care of the majority of these patients in his own office.

DR. MILLER: This leads to another question, now. You say the general practitioner has a place in this. Precisely, how far can we expect the general practitioner to go in his private office in handling these patients?

DR. POLLACK: As far as his training and equipment will permit.

DR. MINK: I think we are getting pretty individual here. I think certain individual general practitioners could be just as capable and good and do as much in their office as any well-trained pedodontist if he had the background for it and the knowledge. Others will do a limited amount and will refer more difficult ones out much sooner, perhaps. There are two things you are actually saying.

One, are you talking about how much he can do in his office, or how much can he do in his office and from there go to a hospital environment? On something like this, I think the whole problem really is dependent upon the general practitioner just like anything in dentistry is, if it is really going to get done, because the specialists are for the difficult.

Most pedodontists up my way, this is my opinion, probably 50% are treating many, many children who are good kids that don't need that much, but they are better with children and parents take them there. But they are not treating the real difficult problems which specialists should be capable of treating.

DR. ROSENSTEIN: Dr. McKnight reminded me just a moment ago about a recommendation I made yesterday, that a good core of interested general practitioners will be found in the roster of the American Society of Dentistry for Children.

We know that this group of dentists are interested in dentistry for children and learning about it and getting the "Journal of Dentistry for Children," and reading articles on it. So if a core of general practitioners is needed, this would be a good one, and it has got a membership of appreciable size.

DR. ADEISON: There are two points that I have been thinking about. I think we are underestimating the appeal that the care of the handicapped has
for many general practitioners. I think it is easy to enlist the aid of general practitioners. I think there is a certain hero role assigned in a smaller community to the dentist who takes care of handicapped children. I think that this is known by dental practitioners.

That should in any rural area the local component society have a meeting and the question be asked, how many of you men would like to give a half-day of your week to the treating of handicapped children, we are setting up a course here for you, I think that there will be a tremendous response in this area.

I am not saying that you will keep all of them interested, but I think that there are many men throughout this country whom we can enlist in this, and I don't think that the manpower shortage applies when it comes to this particular problem here.

So I think we are overestimating our problems in getting the aid of general practitioners, particularly in areas where you are going to need them.

Secondly, the thing that bothers me was the point that the pedodontists generally turns over a patient at a certain age. I don't think it should be true in the case of retardation.

I think that in this particular case there should not be a turning away of the patient at a certain age in the area of the handicapped.

DR. POLLACK: I disagree. One of the reasons why pedodontists should turn patients away after a certain age is because the patient moves into an adult-type dental problem which requires adult-type solutions.

Then what you have to do is train your pedodontist in certain other areas in which he might be deficient in meeting adult problems like bridge-work and prosthetics.

DR. ADELSON: I believe they have originally been trained in this area.

DR. POLLACK: But they have the right to be called specialists because they have received additional training in certain other areas, and have agreed to restrict their practice. This is part of the arrangement that was made with the dental profession and with the American Dental Association.

DR. MILLER: Dr. Adelson is saying that the chronological age of a patient in the case of mental retardation should not be the criterion for pedodontic care.

DR. POLLACK: But his dental age and dental needs do not stay static with his chronological age.

DR. SELLINGSLOH: I would like to suggest this. What we are trying to say by keeping it with the initial contact at the early age would be regarding covering the maintenance program after eighteen years of age. He could simply refer him to the proper practitioner that would take care of surgery, crown and bridge, the prosthetics, etc. but he would have contact with this patient continually, rather than cutting out.

DR. SAUNDERS: Speaking as a pedodontist, our office is not arranged for or do we have the equipment for taking an impression for gold work or for prosthetics. We don't do this type of work.

I haven't done a prosthesis of any kind for an adult for six years. I feel like if I started to attempt this type of thing I would be depriving the person of the best possible care. I don't feel that the pedodontist should
just keep this person forever. I feel that there are some very adequate gen-
eral practitioners. I don't say I am agreeing with Dr. Pollack, but I feel like
these people should be referred out to the general practitioner who is knowl-
edgeable of their problems. There are certain things for a pedodontist and
there are certain things that a pedodontist should not do.

DR. MINK: Dentistry for the handicapped at dental schools is taught by
pedodontists, which is wrong. I feel again back in the dental school level we
should involve people in the operative department and people in the pedodontal
department and people in prosthetics, and so forth. This isn't easy.

In our new school we tried to do this once and sent out a copy to the
whole faculty, and the whole response we got was from the pedodontist depart-
ment. The rest of them have to be educated in the schools to take care of this
responsibility.

I am in pedodontics for a reason, and when they get to be a certain size,
this is it, and I am not going to hang on to a lot of older patients for
years and years. I will be honest about that.

I think most pedodontists feel the same way. You might keep them older
than nineteen, but you are not going to take them on when they get to be fifty
and sixty years old. I think we need education of other people who are teaching
our students to be general dentists and showing an interest, and not just
pedodontists.

DR. ADELSON: But we originally spoke of two approaches. One was within
the dental schools assigning the role to the pedodontic department; the sec-
ond was going out and enlisting the aid of the general practitioner. One is a
present problem and one a future problem.

If we are looking to the future, the thought had occurred to me that
ultimately our pedodontists are going to be responsible, as we had originally
talked treating these patients.

DR. ROSENSTEIN: Pedodontist divisions and departments are including the
older patients in their handicapped patients program.

The extent to which we include older patients in our handicapped patients
clinic is one half-day. Our fellows get the training and are taking care of
these older patients.

I made the point that it is so essential that we get the children as
early as possible yesterday. It is so because the neglect, the dental
crippling that took place in so many of these older handicapped people's
mouths was so outstanding that the direction we have got to stress is getting
the handicapped child as early as possible, so that we can prevent this dental
crippling. It would be wonderful if we could eliminate the problem of the ex-
tensive restorations for the older handicapped patient.

DR. LAW: This would be sort of ideal for the unhandicapped person, too.
It doesn't occur there to get them this early. Look into the mouths of any
large group. They are not much better off than the handicapped.

DR. ROSENSTEIN: For the ambulatory handicapped group that will seek
treatment and be accepted there is already an inculcation of some sort of
discipline in their training, in their sheltered workshop or whatever, and the
dental home care instruction, has to be added to the discipline.

DR. POLLACK: I agree with Dr. Mink about the school trend in the special
care clinics for the handicapped is definitely out of pedodontics. The move-
ment is toward the general practitioner.
DR. ADELSON: If that is true, then the point I brought up doesn't exist. It was the future I was thinking about.

DR. SELLINGSLOH: That is what I'm talking about. Pedodontics plays a major role and will continue to play a major role in this, but they will not be the only ones playing the role.

DR. MCKNIGHT: This might be kind of a simple statement. What we are trying to do here is to set up something to help these kids, and we are pointing toward other meetings. If we are doing this, if we are trying to look at our immediate need, then could we focus attention just for a minute on this.

This care is going to come largely from our general practitioners. We can eliminate a certain percentage because many of the general practitioners will not accept any children. I go back again to Dr. Rosenstein's statement, that we concentrate on a group such as American Society of Dentistry for Children. Can we get these men? Can we get down to brass tacks and lay out some plans to interest these men in taking the handicapped child? Maybe this is entirely out of order, but it seems to me that this is the crux of our situation. We have an immediate problem which needs solution as quickly as we can get it.

We cannot possibly meet the need with our specialists or any other such group. We have to go back to these men who are interested in and willing to accept children.

We have to teach them the techniques which might be necessary to handle a special group of handicapped. To me, this is the crux of our problem.

DR. MILLER: We will give you an opportunity during the last half hour of this session to make certain suggestions and recommendations to the Bureau. We would like to know what you people think the contribution of the Children's Bureau might be in order to help solve some of the problem that is facing us. We are very much open to suggestions. A point was made before, and I think we might stress it, that the auxiliary people in a dental office do have a part to play in the care and management of the retarded child.

Could we elaborate a little bit on this point?

DR. MINK: I feel that a well-trained assistant who feels comfortable in working with retarded children is a tremendous asset to the dentist. I feel that many times the dentist may come to the training session and he, himself, will not take back the same knowledge he learned there to help her.

If she could sit in on some of these sessions, this would be beneficial to him in the care of the patient, because in many offices, she is the first one to contact the child. I feel that even the severely retarded children have feelings, and they can sense insecurity; and if there is any insecurity anywhere in the chain, this may create a management problem that, otherwise, in the trained office would not be there. Ideally I feel the dentist as well as the assistant and office personnel would benefit from these training programs.

For example, if it is as Dr. Saunders mentioned, the men wanted more practice where they actually worked on the patient, this would be the ideal to bring this assistant along and actually help him in such an environment to treat the patient so that she gets exposure, too.

I say, again, I feel with an interested educated dentist and a trained sympathetic assistant and a local anesthesia, a rubber dam and a mouth prop, in some cases where they have lack of concentration, that you could treat
these children in the average dental office without any special equipment and without any special approach other than the same approach you use toward any difficult child.

Now, again, I feel premedication is of the utmost importance. There are those children with whom you have to use premedication. A pre-operative setup is of the utmost value. Again, you have to use it, and the dentist has to see you use it other than just talking about it. Again, this goes back to school and these courses. I think a small majority will disagree, but general anesthesia is a must.

As both of these men said, most patients never have to have a general anesthetic more than one time. Some few do. A lot more design special chairs. You see this in the literature. There are certain cases where this is important.

As soon as you tell the general practitioner in dentistry he has to buy a whole bunch of equipment to treat this rare child, because it is rare, they are not going to have a whole lot of these children. He shies away.

You tell him he can treat these children the same as he does the rest of his children. He can't see it.

Maybe I am simplifying it. I don't think it is a big deal. I don't think it is some big specialty that we have to set ourselves up as super-specialists or something like that.

DR. SELLINGSLOH: There are other things to come up where you get into facilities on these auxiliary personnel in cases where there are areas of severely retarded and even in the mild or moderate retarded.

We have found through experience that in the cities that have licensed dental hygienist, that they help tremendously in the preventive program and, yet, in their education, they have had no exposure to retardation.

In cases where you have to use your assistants in programs, it has benefited the program tremendously to include them in any future training sessions. It orientated them to the type of patient, and it produced a great deal of help to the program.

DR. MINK: Can I make one comment on the dental hygiene role?

When I was in Indiana, the dental hygienists, because they seem to have more time than dental students, spent a great deal of time working with the handicapped children, much more than the dental student. They were tremendous in working with these kids. They could get radiograms and work up some of these kids.

I think the dental students could have done the same things if they had the time. But hygienists were a real asset in this area.

DR. ADELSON: I am bothered by something. I am bothered by an oversimplification. It may be due to the fact that possibly I, at Flower, have seen different patients than you gentlemen have. Maybe because of the large population in New York City, more of the severely handicapped, more of the hyper-active severely handicapped children are seen there than they are in other locales.

DR. MINK: Of the thousands of children that I have examined, I would hesitate very strongly to say that the great majority can be handled in an office under exactly the same conditions as non-handicapped children are handled. There is a large number of children that I have seen, I know, at
this particular evaluation center who cannot be treated that way. I am not
saying general anesthesia is the answer, but let us not over-simplify this.

DR. MILLER: I think somewhere along the line the analogy has been made
to the concept of the team approach to this entire problem.

We heard something about this yesterday from Dr. Jordan, and his group.
Certainly the concept of the team approach is nothing new to dentistry
because we have been conducting and participating in programs for children
with clefts.

May we suggest now in the handling and managing of the handicapped child
that there is a place for a team effort. This concept that you brought out is
very interesting, the need for training, not a man in pedodontics or in care
for handicapped children, but rather the training of a team or a group which
works together in handling this child. That they should be trained as a unit,
rather than an individual person. This is an interesting concept, as far as
we are concerned.

DR. MINK: What I said is that if we are going to have the post-graduate
courses to practicing general practitioners, that there would be value in
bringing their office personnel along to take this course along with them.
Not just a course for dental assistants in the care of handicapped, but along
with them.

DR. ADELSON: I think this would be excellent. I would be concerned if
there were a rigid rule that the entire team must be educated in these pro-
grams. This is what I would be against. I would say, wherever possible,
definitely bring in the auxiliary help.

DR. MILLER: Would you recommend pilot training programs in this direc-
tion?

DR. POLLACK: I would most definitely.

DR. COHEN: You are referring to a graduate dentist.

DR. MILLER: Yes.

DR. OBERMAN: There is a parallel. I don't know how parallel it is. At
Cornell, for instance, for some years, they are taking teams of physicians
and nurses who are interested in the premature child, taking them as a team.
There is a difference between the two, but for a period of time they work
together in the care of the premature. It has worked out well.

DR. COHEN: This also could be worked out in the dental school where
you have a training program for dental assistants.

We have one, too, where the girls are integrated with the dental stu-
dents, and the dental students utilize not only dental assistants, but at
Forsythe we use hygienists where they have practical training in the clinic.
So it can be worked out in this area, too.

DR. SAUNDERS: I, myself, try and take my office girls to any type of
conference or meeting or seminar where they are welcome, but I run into
problems in the fact that they are not as easily able to leave their families
and take off.

DR. OBERMAN: I was wondering if this would take into consideration the
development of the university affiliated centers for training in mental re-
tardation.

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The program is to include representatives from pediatrics, psychology, social work, just anything you can think of, associated with many of the medical schools. Dental components certainly have been talked about.

These centers are predicated on the basis that they will be used for training. They will be used for the training of many, many disciplines, and this seems to be a place that dentistry should like to explore.

They are developing rather rapidly in the medical schools. I am sure many of these medical schools have dental schools associated with them.

DR. MILLER: I think we made clear some time during this conference that there is need for the dentist to assume some leadership and to identify himself with ongoing community programs for he has a contribution in providing care to the retarded child or the handicapped child. This might be an area where this could apply very, very logically.

MR. HORLUTH: Well, I would also hope, based on these discussions, that this group in some future meeting would provide us with guide lines in relation to what kind of course content ought to go into these university affiliated centers, as they are being built and approved, in relation to dental training -- training of dentists and associated personnel.

There have been three of these projects approved, thus far.

Basically, we see these centers as providing the bulk of the training in relation to a variety of professional disciplines for serving the retarded.

So that I think, based on the discussion here, we can get some guide lines.

DR. MILLER: At a future meeting and, perhaps, we can get some information along these lines much sooner than this.

I would like to ask you, when you return home to think a little bit along these lines, and perhaps jot some ideas on paper and submit what you think should be included in the way of facilities and resources in these centers.

DR. POLLACK: Do you think it would be inappropriate for me to discuss something on the matter?

Johns Hopkins received one of these three. We received $3,500,000.00 for the construction of one of the centers. Included in this center is space for a dental unit in terms of treating and orientation.

Arrangements have just been completed between the University and the Maryland School of Dentistry and the Johns Hopkins Hospital for this training facility at the Johns Hopkins to be made available to the students of the University of Maryland Dental School.

It is our plan to rotate our students through this institution, and to use the institution as a possible pool of patients for observation of dental treatment procedures.

These plans are in the early stages, but they progressed far enough for us to be able to count on the availability of this center for our training program at the dental school both on the undergraduate, post-graduate and graduate level.

MR. HORLUTH: I think our concern is in relation to staffing of these facilities once they are constructed. It seems to me in terms of the proposals coming in, we would need some kind of guide and directions from a group like this as to what kind of people ought to be paid for in terms of staff positions in this kind of a setup.
If you are going to have someone who is going to be in charge of training as a part of the staff of the overall center, what kind of person ought this to be?

DR. ADELSON: This problem of staffing, (again this may be a local problem), is a big problem.

I believe the only way it could be solved is by using university or dental school faculty. Because I think there is a problem in staffing any clinic outside of the dental school, no matter what it is for. It certainly is a problem staffing them with adequately trained practitioners.

If we are going to be practical, I think that the only way you will be able to do it is by having a very close link with the university dental faculty. Otherwise, you will staff it with untrained men.

DR. MILLER: How about the policy of training people who are willing to go into the teaching profession? This is also a problem area.

DR. OBERMAN: Isn't it a problem of raising money?

DR. ADELSON: Putting it bluntly, yes.

DR. OBERMAN: Are you implying we need to take a closer look at graduate fellowships, so that two years from now you will have some personnel to move into these slots?

DR. ADELSON: This would be a very wise idea.

DR. MILLER: I might say, the Children's Bureau is very much interested in the matter of fellowships.

I think we have reached the point now where we have just about exhausted you, gentlemen.

We would entertain from you, gentlemen, a series of recommendations or suggestions whereby we can improve the situation in general by way of providing dental care, or making it available, or interesting the profession in providing dental care for the mentally retarded child. So we are now open for your suggestions and recommendations at this point.

DR. POLLACK: That the Children's Bureau take a more active role in the education of dentists on the local level so that the dentists on the local level can provide dental services for the mentally retarded. I think we have already said all that.

DR. OBERMAN: Is there a need for support of pilot programs to study certain aspects of dentistry?

DR. COHEN: I think so. I think there is a need for a demonstration pilot study, preferably in areas that are going to have a complete setup similar to the one at Johns Hopkins. I think this makes sense.

Where you have all of the available services working toward a common goal, I mean a complete diagnostic and treatment of the abnormal child. There is one other suggestion I would like to make. That the Children's Bureau sponsor a regional study on the dental problems that exist in non-institutionalized mentally sub-normal patients.

DR. MILLER: I think this suggestion was made yesterday as a motion. This one is well taken, and we have this under consideration now. But we are not going to restrict it to the non-institutionalized. We would like to apply this in all areas of retardation, and relate it to socio-economic factors.

DR. COHEN: You are going to include institutionalized and non-institutionalized populations?
DR. MILLER: Yes.
DR. ADELSON: I would like a survey be made of existing facilities throughout the country.

DR. MILLER: It just so happens that a questionnaire on this was prepared originally. I alluded to it yesterday. This questionnaire was prepared for distribution to those clinic programs that are supported by Children's Bureau funds to yield information on existing dental programs. I don't want to put words in the mouth of the Committee, but it might be easier for this Committee to gather this information for us or to make the recommendation.

DR. ADELSON: Would there be any objection to sending out on the part of, let us say, this group to every dental school in the United States a questionnaire as to whether they are paid to provide any type of dental service?

DR. MILLER: How about including clinic programs?
DR. ADELSON: That's right, and clinic programs. Because I am not sure that one hundred and thirty two represents the correct figures. One Hundred and thirty two may represent only those that you know.

MR. HORMUTH: One hundred and thirty two represents only the specialized clinical services for the retardation. These are in terms of clinical programs with medical direction which provides special services for retardation. This does not include large numbers of programs as a part of an emphasis on cerebral palsy, neurological disorders, which also see retardation.

DR. ADELSON: This was the point I was getting at. If there are other clinical programs going on for other handicaps where there is overlapping, the questionnaire can specify care of the dentally treated retarded.

This could provide us with a comprehensive survey of what facilities there are, and should we do anything with the facilities or should the Bureau do anything.

DR. MILLER: Can this be done in the name of the Committee?
DR. POLLACK: I get two distinct impressions here. One impression is that this Committee was called together for one single meeting, to accomplish one single purpose in reference to a future meeting, and as soon as we walk out of here at 12:00 o'clock, this Committee ends.

Then, on the other hand, I hear reference to this Committee acting in some purely advisory capacity, as if it is going to be a continuing thing.

DR. MILLER: This Committee was set up originally as an ad hoc Committee for this particular purpose, to establish guide lines for consideration by a larger regional meeting.

Could not this Committee make the recommendation that information be obtained in connection with this next big regional meeting to assist its participants in analyzing the problem, in considering the problem?

DR. POLLACK: Doesn't this Committee end and its duties end forever?
DR. MILLER: This Committee will end as a Committee at 12:00 o'clock today. We may see fit to call some of you people together at other times on other problems or as other areas present themselves for consideration.

DR. MINK: Would it be out of line for this Committee to recommend to the appropriate group, whichever it is, perhaps the American Association of Dental Schools or something like this, consideration be given for the
incorporation of an undergraduate course along the lines of dental care for retarded or handicapped, as a recommendation from this Committee?

This would require, perhaps, some meetings, but do you feel strongly enough this should be incorporated in the teaching curriculum, and that this Committee make that recommendation?

DR. POLLACK: We can make that recommendation to the regional meeting.

DR. OBERMAN: We went through this with reference to pediatrics, and we almost got our heads eaten off. This was for pediatric professionals, and they said, we knew all about mentally retarded children. You are not going to tell us what we should put in our curriculum. The answer is, we didn't.

We enticed them to the meeting, anyway, and they learned an awful lot. I think there are various ways to do it.

DR. MINK: There is a meeting coming up in Detroit, (Proctor & Gamble is sponsoring it), for a member from each pediatric department. But a similar type thing geared for graduate pediatric programs for people involved in teaching undergraduate programs is considering the problem.

One, should this be incorporated in an undergraduate program?

Two, if it should, what type recommendation could be made?

I feel that too many times somebody else is telling us what to do without giving us an opportunity to sit down as a group of teachers and plan something.

Dr. Adelson and I were talking about the ADA telling us what to do in our amount of time in the graduate programs, where we are convinced time is not important. What is being taught is important.

True, there is so much difference in graduate programs. Some get a lot of handicapped, some get none. Should we work on this?

If the American Board of Pediatrics Meeting stated a section of our work is going to be related to handicapped children, you bet your life they would start teaching it in these graduate areas. But somebody has got to work on it.

DR. MILLER: While we are talking about need for information on disease prevalence and dental problems, and resources available throughout the country for rendering dental care for mentally retarded children, I would like to ask you here who have identified yourself with short-term training courses for dentists, whether you would first document your experiences, and then we would like to get some report on your experience in working with practicing dentists.

DR. ADELSON: Are you talking about those who experienced the short courses in the field of retardation?

DR. MILLER: Yes.

DR. ROSENSTEIN: Could you include courses in the field of handicapped, including mental retardation?

DR. MILLER: Yes. We would like to get any of this information that people have prepared and used. Anything that might be applicable to the problem.

We are also interested in developing projects for mentally retarded children, in training, management and care of the retarded child.

DR. MINK: You would like us, as a follow-up to this meeting, if we had outlines, submit this to you, and a statement of our feelings as to how the course went and what we would be doing if we did it again?
DR. ROSENSTEIN: Are we going to receive copies of what has been transcribed?

DR. MILLER: We will see you get copies, yes. These will be edited copies, if that meets with your approval, rather than having every word that has been transcribed duplicated.

Did someone recommend that we obtain information on what is happening in the programs throughout the country in dentistry for mentally retarded children as it relates to programs for retardation in general, in the name of this Committee?

How would the administration of this be handled if this Committee is going to be discharged?

MR. HORMUTH: I think one of the problems in terms of the Children's Bureau doing it, if we utilize the same format with more than ten agencies it needs to go through Bureau of the Budget clearance. We need to get all kinds of clearance on it in order to use the same form in more than ten different places. This gets kind of complicated.

It would be much simpler if the Committee or School of Dentistry did this rather than have the Government Agency do it. I don't know whether you could do this if you discharged the Committee.

DR. OBERMAN: This could be on the basis of a grant.

DR. ROSENSTEIN: Could an alternative be, and I think there is one that would obviate the need to go to the Budget Department, to take a sampling of ten. That is your limit. That would well be a cross-section of the different areas, the different regions of the country.

MRS. SCHIFFER: I am a little unclear about what the survey would be. We first talked about what the mental retardation clinics do with regard to dental care.

Then, secondly, the suggestion was made that it should be broader than that, that there are other clinics and facilities that treat mental retardation.

But, thirdly, it seems to me now what is being talked about is a survey of dental training in general education.

DR. MILLER: I think we are talking about a broad identification of all resources that are available throughout the country which would include manpower, facilities, training, and resources available.

DR. ADELSON: I would like to know every functioning dental service for handicapped in the broad sense of the term, handicapped rather than retarded, because of the fact that many of them are mentally retarded patients, yet do not identify them primarily as such. They may be CP Centers such as Roosevelt, Long Island, who are treating a high percentage of retarded individuals. They may be in various areas of the country that we do not know of yet, which can be utilized.

DR. MILLER: This is a tremendous undertaking.

DR. SAUNDERS: Just sitting here, I can think of ten centers where dental treatment could be found in Dallas County alone that could take care of the handicapped.

DR. ADELSON: If there are these many centers, first, we must find out, which are the centers and locations that are needed, or can be utilized to service the retarded population.
DR. MINK: It seems to me this is a necessary element to this whole business. We decided we are going to find out what they need. Now we ought to find out what is being done.

DR. MILLER: I think this can be handled without too much difficulty if we work through State Dental Directors. If we work through the Dental Division in each state, we can request from each State Dental Director identification of these facilities which exist within his state for handling handicapped children.

So I don't think this is too difficult an undertaking. We need somebody to coordinate such effort. We can probably work this problem out some way or other.

DR. POLIAK: I would like to strongly suggest that when this questionnaire, or whatever is going to be done, is sent out, that it be determined what level of care is provided for these children.

I have seen too many of these things. I was associated with a center before I came here. They said, yes, we provide dental treatment. But really they didn't. So I would suggest, also, evaluation of the level of dental care they receive.

DR. ADELSON: May I suggest with reference to that, that I am not sure that we are interested in the level of dental care, so much as we are interested in the type of facilities, the equipment they have, and what staff they have. The ultimate purpose here is to utilize the facility, not to keep going with what they are doing. I think the one hundred and thirty-two are doing what you want, apparently.

DR. POLIAK: The question you are suggesting might give a better picture. I don't care how you do it, but not just the simple, do you provide dental care or don't you.

DR. MILLER: We feel rather confident we could get some meaningful information. It would be no problem to develop a questionnaire to send out. Are there any other points to be made?

DR. MESSORE: I think it is very essential clinics and centers, directly and indirectly, be connected with the general hospital, because I have observed over the years how many times it becomes so important.

DR. MILLER: That these clinics be identified with the general hospital?

DR. MESSORE: Either as an integral part or indirectly connected, which, in my mind is more important than they be connected with a dental school. In taking care of these children, if we didn't have direct connection with a hospital we would be in a terrible fix.

DR. ADELSON: I have been trying the last day and a half to take off my blinders which everyone wears. Dr. Mink is, firstly, affiliated with a dental school. Dr. Messore with a general hospital. I keep trying to put my mind in the position of what happens in the rural areas where this may be a tremendous problem in getting the services. Transportation, and so forth, is a problem, and yet the only center you may have may be a small parent-group-sponsored facility, where there may be one or two dental chairs with possibly no volunteers or one volunteer or two volunteers.

This is the reason why I thought of the questionnaire, to find out in those rural areas, those widely separated areas, what can be utilized in the future for retarded children.
Do they got a certain nucleus now of men who have some experience in
dealing with the handcapped?

DR. COHEN: Dr. Miller, you made much of asking the Departments of Public
Health to give an estimate of what was going on in their particular state re-
garding dental services for the mentally retarded.

Might I, also, suggest that you include in that the Departments of Mental
Health, and then you would get a picture of the institutionalized patients and
the dental care that they receive.

DR. ADELSON: A correct picture. I think we have to very strongly put a
sharp cleavage between institutionalized patients and non-institutionalized
patients. I think this is a state problem with the dental care of retarded
children within the institutions. I think that most of the discussion here
in the day and a half has dealt with the non-institutional.

DR. COHEN: It is still a dental problem.

DR. ADELSON: It is a tremendous problem, but I don't think we have
enough time to go into this area at this point, and certainly not in the last
thirty-five minutes.

DR. COHEN: Dr. Miller, I thought, said he was interested in the insti-
tutionalized and non-institutionalized.

DR. MILLER: We have to be.

DR. COHEN: I am just making the suggestion to get some data.

DR. MILLER: There are certain difficulties involved along the line.

There is departmentalization of different activities within the state admin-
istrations. Institutions in certain states are controlled and supervised by
Department of Health, and in other states, Department of Hospitals, and in
other states in another Department. There are problems involved in this, but
we will try to get all the information we can.

MR. HORMUTH: I wonder if, in talking about these various pieces of in-
formation, what we are getting down to is a multifaceted kind of questionnaire
which will go out to different components, and then somebody needs to put
this together. I could very well see the possibility of a questionnaire going
out through NARC, through the local units raising questions from their point
of view as a local parent group, what kind of dental care are they able to
obtain.

Is this, from their point of view, as parents and as a local organiza-
tion, adequate? Where do they get this from?

I doubt whether some of the dental directors in State Health Departments
could provide this kind of insight, but I could see where this would be real
valuable, if it could be collected, and be next to the kind of information
that you might get from Dental Directors, and alongside information you get
from clinics, and alongside information you get from dental schools.

So it seems to me you are talking about a number of different sources
you are trying to reach and it almost looks like there are a number of dif-
ferent kinds of approaches.

DR. ADELSON: But that is the only way we would be able to get a clear
picture.

DR. MILLER: I think this could be done. We have to realize there are
different sources of information and a questionnaire can be developed appli-
cable to that particular agency or group of agencies.

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The questionnaire, for instance, that might be sent out to the State Association for Retarded Children would necessarily differ from the one we sent to the Dental Director in the state or to an institution, but we probably could undertake some such thing or have somebody do it for us.

DR. SELTINGSLOH: I think this would be a very good idea. I think we should conduct, perhaps, a private study in this particular area. If you are going to have this next Conference in the Southeastern region, I think we should accumulate all the information that we can on what facilities exist, what is being done for the mentally retarded, and I think this might be an undertaking for the coordinator of a future conference.

DR. ADELSON: As a point of information, Dr. Miller, your Regional Conference will take up six states in the Southeast. What segments of the dental population will be present at that Regional Conference? Who will that be?

Dr. MILLER: They will be people from dental public health, people from institutions of higher learning, (dental schools), people from private practice with an interest in the mentally retarded, representatives from the Committee or Council on Dental Health or the Committee for Handicapped Children in State Dental Societies, etc. Now, if there is nothing else to be brought up to this Committee, I would like to express my thanks and discharge the Committee.

(Whereupon, the meeting adjourned.)