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CLINICAL RESEARCH:

Dental Care Delivery in a Social Assistance Center in Mexico: A 14-Month Case Series of Children and Adolescents in Foster Care

Atención dental durante 14 meses en un centro de asistencia social en México: serie de casos de niñas, niños y adolescentes en resguardo

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ABSTRACT: All children and adolescents have the right to receive a series of special protection and assistance measures from their respective countries. States must protect them from all forms of maltreatment, harm, neglect, or abuse. In cases that arise, the priorities must be the restoration of rights and residential care that provides comprehensive services including health. The paper reports a descriptive and retrospective study for a 14-month period conducted as a case series of 54 children and adolescents who received dental care in a Social Assistance Center in Mexico, where they were temporarily housed. Based on the initial clinical evaluations, it was identified that 100% of them had at least one untreated cavitated caries lesion, and 64.8% had apparently not received previous dental care. A total of 418 dental procedures were performed and 19 patients were discharged with completed treatment plans. There is a need to seek more collaborative approaches and to make positive contributions to improve the oral health of the pediatric population in situations of vulnerability and Foster Care.

KEYWORDS: Adolescents; Dental care; Foster children; Oral health; Social service.

RESUMEN: Todas las niñas, niños y adolescentes tienen el derecho de recibir una serie de medidas especiales de protección y asistencia por parte de sus respectivos países. Los Estados deben proteger a los menores contra toda forma de daño, maltrato, negligencia o abuso. Para los casos que se presenten, es prioritaria la restitución de derechos y el acogimiento residencial que brinden servicios integrales incluyendo la salud. El artículo reporta un estudio descriptivo y retrospectivo durante un periodo de 14 meses desarrollado como una serie de casos de 54 niñas, niños y adolescentes que recibieron atención dental en un Centro de Asistencia Social en México, donde estaban alojados temporalmente. A partir de

las evaluaciones clínicas iniciales, se identificó que el 100% de los pacientes presentaron al menos una lesión de caries cavitada sin atender, y que aparentemente el 64.8% no había recibido atención dental previa. Se realizaron un total de 418 procedimientos dentales y se dieron de alta a 19 pacientes con los planes de tratamiento terminados. Existe la necesidad de buscar enfoques más colaborativos y de lograr contribuciones positivas para mejorar la salud oral de la población pediátrica en situaciones de vulnerabilidad y resguardo.

PALABRAS CLAVE: Adolescentes; Atención dental; Niños en resguardo; Salud oral; Servicio social.

INTRODUCTION

All children and adolescents have the right to receive a series of special protection and assistance measures from their respective countries, with free access to education and health to develop fully and grow in a favorable environment (1). The best interests of children must be considered a priority, guaranteeing a dignified life and the highest possible level of well-being (2).

States must protect them from all forms of maltreatment, harm, neglect or abuse, and intervene in cases that arise, because these situations can have long-lasting negative effects on individual development. For this reason, these are referred to as Adverse Childhood Experiences (ACEs) (3,4).

To help restore the well-being, safety, stability and health of affected individuals, Child Welfare and Foster Care Systems internationally make great efforts with the service of multiple professionals who work hard to ensure optimal living standards for minors (5). To this end, a coordinated and comprehensive service is required to ensure that they receive the necessary benefits, in an environment that can provide special care in education, prevention and health (6). It is important that the multidisciplinary team also includes dentists who promote oral health and early identification of diseases (7).

In Mexico, the protection of the rights of children and adolescents is actively supported, especially for those living in situations of vulnerability. The objectives of the national Child Protection System include ensuring the restoration of rights and, if necessary, offering residential care in Social Assistance Centers (also known as “Casas Hogares” in Spanish), where alternative care, shelter and nutrition, comprehensive health, education, culture and sports, among others services, are provided (8).

The aim of this article is to describe a case series of 54 children and adolescents who received dental care in a Social Assistance Center in Mexico affiliated with the local Child Protection System, where they were temporarily housed for restoring their rights and well-being.

CASE REPORT

PATIENT INFORMATION

A descriptive and retrospective study for a 14-month period was conducted as a case series developed by the Department of Social Service and the Mobile Dental Unit of the School of Dentistry of La Salle Bajío University (León, Guanajuato, Mexico), in agreement with the local Child Protection System and a Social Assistance Center where children and adolescents were temporarily housed. The manuscript was approved by the School of Dentistry's Research Committee with the code 180825L18. The Center also approved to report the results of the dental care through an information letter signed by its Coordinator and stamped

by the institution. Also, this report followed the CARE Guidelines.

For this case series, there were included all children and adolescents who were temporarily housed in the Social Assistance Center between June 2022 and August 2023. The only exclusion criterion was any health condition or Special Health Care Need that hindered a safe delivery of dental care among the Mobile Dental Unit, such as Autism Spectrum Disorder or Cerebral Palsy.

For patient care, the confidentiality of each child and adolescent was maintained, respecting data and identity protection rules, as the minors were under guardianship. Individual clinical records were completed, including authorizations, health regulations, and informed consents for dental procedures and behavior management. These documents were signed by either the Coordinator or the Medical Doctor assigned to the Center, who acted as guardians for the children. In order to respect the privacy of every patient, no photographs were taken.

As part of the Social Service program, free dental screenings and treatments were provided by dental interns under the supervision of a Pediatric Dentist for a period of 14 months, when the Mobile Dental Unit made 40 visits to the institution beginning in June 2022 and ending in August 2023.

During that period, a total of 54 children and adolescents were treated: 36 females (66.7%) and 18 males (33.3%), with an average age of 13 years (range: 4-17 years). Regarding patient demographics, various educational levels were recorded. The most representative groups were primary education at 29.6% (n=16) and unknown education at 37.0% (n=20). The information is described in Table 1.

Table 1. Demographic data (sex and education) for 54 children and adolescents in a Social Assistance Center.

Educational Level	Female	Male	Total
Preschool	1	0	1 (1.9%)
Primary School	11	5	16 (29.6%)
Secondary School	8	3	11 (20.4%)
High School	5	1	6 (11.1%)
Unschooled/Unknown	11	9	20 (37.0%)
Total	36 (66.7%)	18 (33.3%)	54 (100%)

CLINICAL FINDINGS AND DIAGNOSTIC ASSESSMENT

Before dental intervention, an initial medical summary was collected for every patient, which included personal and family history, vital signs, and medical conditions.

The available medical information of the children and adolescents indicated that 26 (48.15%) had a systemic condition, while 24 (44.44%) were systemically healthy. The health status of the remaining four children and adolescents was unknown. The information is organized in Table 2.

Table 2. Available medical information for 54 children and adolescents in a Social Assistance Center.

Medical Condition	n	%
Present	26	48.2%
Systemically healthy	24	44.4%
Unknown	4	7.4%

The top 3 categories of medical conditions reported were: psychological/psychiatric/neurological disorders (including mild to moderate depressive episodes, attention deficit disorder and oppositional defiant disorder), metabolic conditions (including

diabetes and hypothyroidism), and other medical conditions (including allergies and asthma).

A dental chart was also completed for each case to record the patient's initial condition, and a treatment plan was established. The dmft/DMFT index and the methods described by the World Health Organization (WHO) in 2013 were used to diagnose dental caries (9). The dental interns performed the caries assessment, following the same specifications from the Department of Pediatric Dentistry of the School of Dentistry, as they learned when they were dental students. Also, the charts were reviewed by a Pediatric Dentist, who assisted in every visit to the Center.

Given the descriptive nature of the study, no inferential statistical analysis was performed. Thus, based on the dental assessment, it was observed that all patients (n=54, 100%) had at least one untreated cavitated caries lesion. In addition, 19 cases (35.2%) were identified with at least one previous dental restoration, and 15 cases (27.8%) had experienced the premature loss of at least one tooth. The data are described in Table 3.

Table 3. Dental assessment for 54 pediatric patients during a 14-month period.

Initial dental condition	n	%
d/D: At least 1 tooth with a cavitated lesion	54	100%
m/M: At least 1 lost tooth due to caries	15	27.8%
f/F: At least 1 filled or restored tooth	19	35.2%

THERAPEUTIC INTERVENTION

Daily care was provided by dental interns, who were recent graduates of Dentistry who were in their year of Professional Social Service, supervised by a Pediatric Dentist. Treatments were limited to the discipline of Pediatric Dentistry, including: diagnosis, prophylaxis, sealants, resins, glass ionomers, pulp treatments, and stainless-steel crowns for primary teeth and extractions. Dental needs that corresponded to another specialty (e.g., Orthodontics, Endodontics, Rehabilitation) were referred to the School of Dentistry for further treatment.

OUTCOMES AND FOLLOW-UP

For the 14-month period of care (June 2022 – August 2023), a total of 418 dental procedures were performed for 54 children and adolescents during 161 consultations, including: 54 diagnoses, 62 prophylaxis, 37 fluoride applications, 99 sealants, 83 resin restorations, 12 glass ionomer restorations, 13 adjustments of previous restorations, 14 extractions, 6 pulpotomies, 4 pulpectomies, and 9 stainless-steel crowns for primary teeth, in addition to 6 other unspecified treatments and 19 discharges.

Regarding treatment plan completion, 19 patients (35.2%) were discharged, and the remaining 35 (64.8%) were unable to complete their dental treatments for various reasons, including family reintegration, relocation to other Centers, school attendance during morning hours, among others. The information is organized in Table 4.

Table 4. Completed dental treatments for pediatric patients during a 14-month period.

Condition	n	%
Completed treatment (discharge)	19	35.2%
Unfinished treatment	35	64.8%

Although the initial intervention at the Social Assistance Center concluded in August 2023, follow-up visits with the Mobile Dental Unit were scheduled to continue the agreement between the institutions. During 2024, seven visits were made to the Center benefiting 23 children and adolescents with 38 consultations and 116 dental procedures. It is planned to maintain the collaboration and further serve the Center's pediatric population.

DISCUSSION

The aim of the article was to describe a case series of children and adolescents who received dental care over a 14-month period at a Social Assistance Center in Mexico, where they were temporarily housed. A total of 40 visits to the Center were carried out with a Mobile Dental Unit to serve 54 children and adolescents, with a total of 418 dental procedures and 19 discharges for completed treatments.

It is important to note that the pediatric population with a history of Adverse Childhood Experiences (ACEs) and in a situation of vulnerability, presents a high risk of developing systemic and oral diseases (10). As mentioned by the American Academy of Pediatrics (AAP), children in Foster Care are considered a population with Special Health Care Needs (SHCN), who require priority medical, psychological, and dental evaluations during the first 30 days from entry into the Child Protection System, as well as routine checkups to ensure optimal health status (5).

Some unfavorable conditions (such as maltreatment, violence, abuse, or neglect) lead children and adolescents to be removed from their families and relocated to Social Assistance Centers. The goal is to solve social and legal conditions so they can return to their families, with adoption remaining as one of the last options (11). Because the information is sensitive and confidential, the reasons for admission were not reported in this case series. Furthermore, adolescence in particular is characterized by a high risk of developing negative behaviors and situations such as alcohol and substance use, criminal activity, early pregnancy, among others (12). For this reason, this sensitive data was also omitted in the article.

To provide safe and quality dental care, it is important to know the medical history and health conditions of patients, and in this way be able to make adjustments in management and establish individual precautions for each minor (13). However, in some cases it is understandable that medical information is scarce or unknown to some minors in Foster Care, who for various reasons have not previously received health screenings (5). The medical and dental consultations in Foster Care may be the first that children and adolescents have received in their lives, due to various economic, social and cultural barriers (14).

Regarding the dental assessments performed in this case series, 100% (n=54) of the children and adolescents had caries, given that all patients presented at least one cavitated lesion. Furthermore, 27.8% (n=15) had at least one prematurely lost tooth, and 35.2% (n=19) had at least one tooth with some type of restoration. Based on these findings, it can be noted that the majority of children and adolescents (64.8%, n=35) had apparently not received previous dental care and had limited knowledge about oral hygiene. This underscores a significant challenge for the health sector in addressing interventions for this specific population (15).

Currently, very few scientific reports have been identified with dental interventions and caries rate analyses for minors in Child Protection Systems. For example, Valpreda *et al*. in Italy (16) reported 83.0% of children in Foster Care with caries lesions, while Morón *et al*. in the USA (17) reported 93.1% of adolescents in Foster Care to have caries in permanent dentition. Also, Solis-Riggioni *et al*. in Costa Rica (18) reported a caries prevalence of 96.4% for children and adolescents in shelter. Specifically in Mexico, there is a precedent of the report made by Camacho *et al*.(19) with a 90.7% of girls in an orphanage with dental caries.

It is important to consider that some adjustments are required during dental care for children and adolescents in Foster Care, such as avoiding voice control techniques and physical

restraints, in order to not create more negative experiences for patients and to offer them the most friendly and comfortable treatment possible (20). If any psychological or psychiatric condition resulting from adverse experiences had arisen that prevented conventional management or safe dental care, any patient of this case series would have had to be referred to the appropriate specialized service to avoid complications within the Mobile Dental Unit.

Regarding treatment completion, it is important to note that only 35.2% of patients (n=19) were discharged. This finding may be explained by the constant admission and leaving of children and adolescents at the Center, who are generally on a temporary basis and, for various reasons, may be reintegrated with their families or relocated to other Centers. Therefore, it is difficult to complete the proposed dental treatments for all patients. However, the maximum benefit for children and adolescents should be sought by identifying their unique and specific needs and offering them preventive and therapeutic services during the available time they stay at the Social Assistance Centers (14).

Some limitations encountered during the dental care included: limited scientific background about children and adolescents in sheltered conditions, incomplete medical records or missing relevant information, limited number of visits to the Center given its remoteness from the School of Dentistry, more complex dental needs that required specialized services not covered by the Mobile Dental Unit and lack of quantitative data (e.g., mean dmft/DMFT or stratification by age groups). Moreover, no inferential statistical analysis was performed, given the descriptive nature of the study. The main disadvantage encountered was that most patients could not receive full follow-up care due to the nature of the temporary accommodation. However, the relevance of this report lies in the contribution it makes to increasing the available scientific literature on dental care for children in Foster situations.

As perspectives for future interventions and studies, it is suggested to complement dental activities with preventive, social, and educational work, given that a temporary stay in Social Assistance Centers can be beneficial for children and particularly adolescents, to adopt favorable health habits that they can replicate in their independent lives (21). Furthermore, general awareness must be raised so that health professionals can make significant efforts to support children and adolescents in situations of vulnerability, particularly those under the care of Child Protection Systems. Also, the high prevalence of untreated caries (100%) deserves a deeper analysis, including assessment of potential social determinants and structural barriers to care.

Finally, the primary takeaway lesson from this case series is that minors in Foster Care are, in most cases, at a higher risk of developing oral diseases and lacking dental care. Therefore, a coordinated and multidisciplinary approach is required to address these problems.

CONCLUSION

The case series demonstrates the complexity of health and dental care within the Child Protection System and Social Assistance Centers, where children and adolescents are placed for indefinite periods of time.

There is a need to seek more collaborative approaches and to implement tailored strategies to address the diverse and individual needs of the pediatric population in situations of vulnerability, as well as the implications for Public Health policies or Institutional dental care models in Mexico, Latin America and around the globe. In particular, dental professionals can make a positive contribution to improve the oral health of minors in Foster Care,

to enhance their quality of life and to increase the available scientific knowledge.

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