Child Maltreatment: The Role of a Dental Professional

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Note to Pennsylvania Dental Professionals: This course is not approved for Pennsylvania's Department of Public Welfare Act 31. ***Click here*** for a list of Act 31 Child Abuse Recognition and Reporting CE providers.

Warning: This course contains content that some may find disturbing.

Conflict of Interest Disclosure Statement

- Dr. Wright reports no conflicts of interest associated with this course. He has no relevant financial relationships to disclose.
- Jennifer Johnson reports no conflicts of interest associated with this course. She has no relevant financial relationships to disclose.
- Dr. Jeanette MacLean reports no conflicts of interest associated with this course. She has no relevant financial relationships to disclose.

Dental Students: This is part 2 of a 2-part continuing education series. "*Domestic Violence, Intimate Partner Violence, and Elder Abuse: Know the Basics*" is the first course. For students taking these courses, both courses should be completed. As healthcare providers, you are obligated to understand these topics and report, as appropriate.

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Overview

This continuing education course will provide information on child maltreatment and outline the responsibilities of dental professionals in the recognition, reporting, and treatment of such cases. For students taking these courses, both courses should be completed. As healthcare providers, you are obligated to understand these topics and report, as appropriate.

Learning Objectives

Upon completion of this course, the dental professional should be able to:

- Identify the possible signs and symptoms of child maltreatment as they might present in the context of dental health care.
- Develop strategies for gathering facts from the child if appropriate.
- Recognize legal obligations of dental professionals to document and report suspected child maltreatment.
- Identify the treatment that dentists should provide to children believed to be the victims of maltreatment.
- Recognize ways the dental profession can help reduce child maltreatment.

Introduction

Child maltreatment is a widespread problem that touches all ethnic, cultural, and socioeconomic segments of our society. The United States Department of Health & Human Services reports that in 2020, there were 618,000 (rounded) substantiated victims of child abuse and neglect, including 1,713 child fatalities. Because many incidents of child maltreatment go unreported, the number of children subjected to abuse and neglect is believed to be far greater. Health professionals are legally mandated to report suspected cases of child maltreatment to the proper authorities consistent with the laws of the jurisdiction in which they practice. Since craniofacial, head, face, and neck injuries often occur in child abuse cases, dentists may be the first health professionals to see an abused child. Therefore, it is important for dental professionals to be able to identify possible maltreatment and comply with legal obligations for documenting and reporting those situations.

Defining the Problem: Child Maltreatment

In 2020, 3.145 million children received child protection services either through investigation or alternative response according to statistics gathered annually by the United States Department of Health & Human Services, Administration for Children and Families (hereinafter DHHS Study).[1] This represents a decrease in the number of children for whom a child protection investigation or alternative response was initiated compared to data from 2016-2019; however, this decrease in the number of children who were provided child protection services may well be the result of lack of access rather than lack of need. Children were homebound in 2020 due to the COVID 19 pandemic. Teachers and other mandated reporters did not have as much in-person contact with them, allowing indicators of abuse or neglect to go unnoticed.

For the purposes of the DHHS Study, evaluators collected data on neglect, physical abuse, sexual abuse, and sex trafficking from investigations in all 50 states, the District of Columbia, and Puerto Rico. The study found

that an estimated 618,000 children were substantiated victims of maltreatment in 2020. Of these victims, approximately 76.1% were neglected, 16.5% were physically abused, 9.4% were sexually abused, and 0.2% were sex trafficked with some overlap occurring. Another 6% fell into the other category (e.g., threatened abuse, lack of supervision). The incidence of substantiated maltreatment of boys was slightly higher than the incidence of maltreatment of girls.[1]

Of the total number of substantiated maltreatment victims, approximately 1,713 children died in 2020. Of the children who died, 73.7% suffered neglect and 42.6% suffered physical abuse alone or in combination with other maltreatment. The rate of fatality was higher for boys at 60% than for girls at 40%.

Child maltreatment occurs in all ethnic, cultural, and socioeconomic segments of American society. The DHHS Study identified several caregiver risk factors for the perpetration of child maltreatment: Alcohol Abuse, Domestic Violence, Drug Abuse, Financial Problem, Inadequate Housing, Public Assistance, and Any Caregiver Disability.[1] The two risk factors resulting in the largest percentages of victims were domestic violence and drug abuse. Approximately 90.6% of child victims were maltreated by one or both parents. Slightly more than 14% of victims were maltreated by someone other than the child's parent; and of that nonparent group, the largest categories were relatives (5.4%) and unmarried partners of a parent (3.3.%). There is overlap in some of these categories.

This course utilizes a broader definition of maltreatment than the DHHS Study. Child maltreatment as set out in the Child Abuse Prevention and Treatment Act of 1974 includes the following: "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm".[2] Because states have different statutory definitions for physical abuse, sexual abuse, emotional or psychological abuse, and neglect, it is important for practitioners to know their states' specific statutes.

All states, the District of Columbia, and the territories have laws that mandate reporting of various types of maltreatment.[3] Reporting was limited to physical abuse in the early 1970s, but in the early 1980s, reporting was expanded to include sexual abuse.[4] When psychological or emotional maltreatment was recognized as a residual effect of neglect and also as a separate form of abuse, the reporting of neglect and psychological/emotional abuse was added to mandatory reporting statutes.[5]

The Dentist's Role in Intervention

According to the American Dental Association's (ADA) Principles of Ethics and Code of Conduct, dentists shall be obliged to become familiar with the signs of abuse and neglect and to report suspected cases to the proper authorities, consistent with state laws. In all 50 states, health care providers (including dentists) are mandated to report suspected cases of abuse and neglect to social services or law enforcement agencies. In order to properly comply with the legal mandate for all health professionals to report suspected cases of child maltreatment, dentists must be cognizant of their responsibilities as outlined by the American Dental Association (ADA).[6]

These responsibilities include:

1. To observe and examine any suspicious evidence that can be ascertained in the office.
2. To record, per legal and court rules, any evidence that may be helpful in the case, including physical evidence and any comments from questioning or interviews.
3. To treat any dental or orofacial injuries within the treatment expertise of the dentist, referring more extensive treatment needs to a hospital or dental/medical specialist.
4. To establish/maintain a professional therapeutic relationship with the family.
5. To become familiar with the perioral signs of child abuse and neglect and to report suspected cases to the proper authorities consistent with state law.

What Presenting Problems Suggest Possible Child Maltreatment?

Craniofacial, head, face, and neck injuries occur in more than half of child abuse cases.[7] Oral trauma, caries, gingivitis and other oral health problems are more prevalent

in maltreated children than in the general pediatric population. A dental professional must therefore be able to identify and address physical and behavioral manifestations that suggest possible abuse and/or neglect. The following is an outline of possible signs and symptoms of physical abuse, sexual abuse, psychological/emotional abuse, and neglect.

Physical Abuse

Physical abuse may result in numerous types of injuries including contusions, ecchymosis, abrasions, lacerations, fractures, burns, bites, hematomas, retinal hemorrhaging, and dental trauma. Head and orofacial injuries for which dentists should be alert include:

- **Head Injuries**[8-10]
  - Scalp and hair – subdural hematomas (cause more serious injuries and deaths than any other form of abuse), traumatic alopecia, subgaleal hematomas, and bruises behind the ears
  - Eyes – retinal hemorrhage, ptosis, and periorbital bruising
  - Ears – bruising of the auricle and tympanic membrane damage
  - Nose – nasal fractures or an injury resulting in clotted nostrils

The oral cavity is thought to be a central focus for physical abuse because of its significance in communication and nutrition. Injuries to the mouth can be inflicted with utensils and bottles from forced feedings. Hands, fingers, scalding liquids, or caustic substances may also be used to cause harm. The following are some examples of orofacial abuse that may be observed.

- **Orofacial Injuries**[9,11,12]
  - Lips – lacerations, burns, abrasions, or bruising
  - Mouth – labial or lingual frenum tears (characteristic of more severely abused children), burns, ecchymosis or lacerations of the gingiva, tongue, palate, or floor of the mouth
  - Maxilla or mandible – past or present fractures to facial bones, condyles, ramus, or symphysis of mandible. Malocclusion or temporomandibular joint limitations may be a result of this type of injury
  - Teeth – pulpal necrosis, fractured, displaced, or avulsed teeth

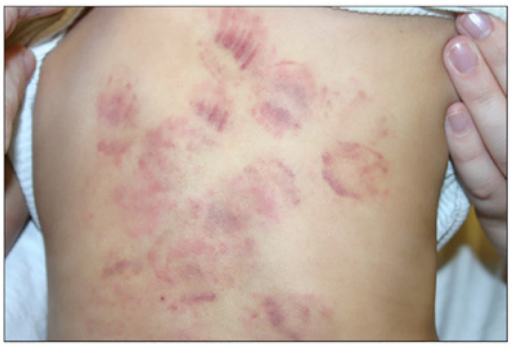

Figure 1. Child-on-child attack with possible multiple bitemarks sustained at a day care facility.

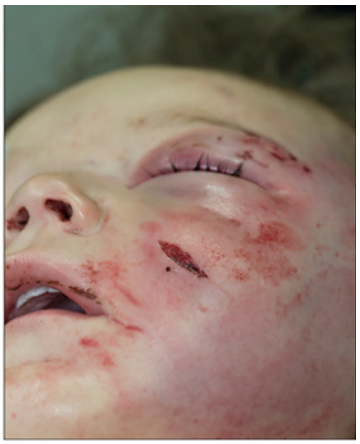

Figure 2. Facial injuries of child abuse victim. These images represent classic signs of abuse that should be explored, documented, and reported to child protective services.

- **Bite marks**
  - Many times misdiagnosed as simple childhood bruises but often associated with physical or sexual abuse
  - Typically in an elliptical, horseshoe, or ovoid pattern
  - A central area of hemorrhage, may be found between markings of the upper and lower dental arches, suggesting physical or sexual abuse
  - Animal bites tend to tear flesh, whereas human bites compress tissue
  - Although marks may occur anywhere on a child's body, the most common sites are the cheeks, back, sides, arms, buttocks, and genitalia
  - In addition to making a mandated report in a case where bite marks are indicative

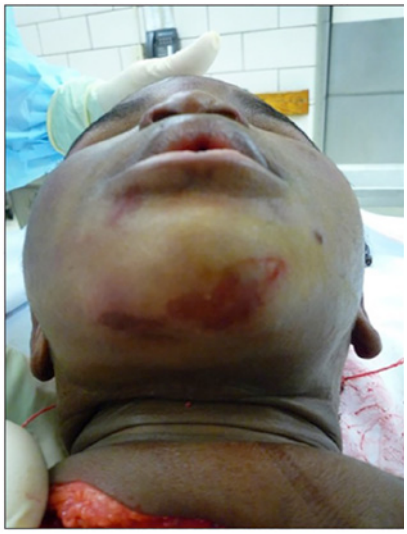

Figure 3A. Child abuse homicide victim with facial, oral and peri-oral injuries.

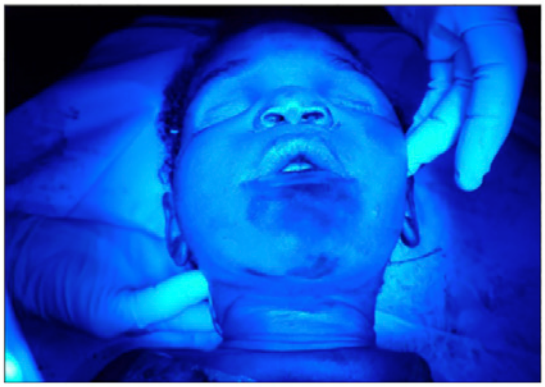

Figure 3B. Same victim in Figure 3A with injuries photographed using 425nm blue light narrow band illumination highlighting the extent of the massive bruising the child sustained before dying.

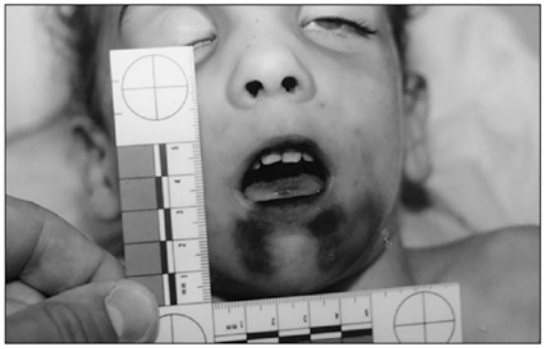

Figure 4. Child abuse homicide victim with burns on the chin and other facial injuries.

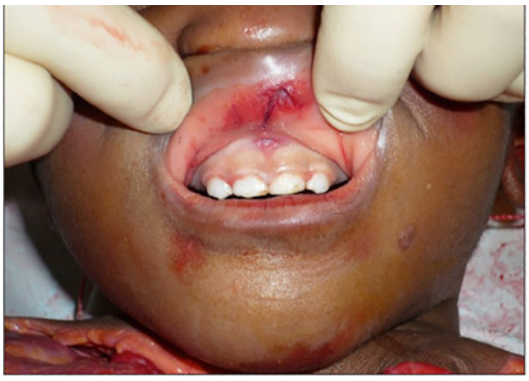

Figure 5A. Torn labial frenum on a child abuse homicide victim.

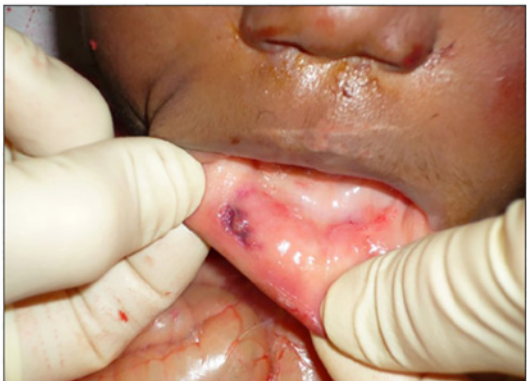

Figure 5B. Torn labial frenum on a child abuse homicide victim.

of abuse, the general dentist should include a recommendation for further evaluation by a forensic pathologist or odontologist.[13,14]

Sexual Abuse

The following orofacial manifestations are often signs of **sexual abuse** and should always be reported to law enforcement and/or child protection with recommended follow-up medical testing and treatment as part of the treatment plan:[11,15,16]

- **Gonorrhea** While rare, it is the most commonly sexually transmitted disease in sexually abused children. May appear symptomatically on lips, tongue, palate, face, and especially pharynx in forms ranging from erythema to ulcerations and from vesiculopustular to pseudomembranous lesions; oral and perioral gonorrhea in prepubertal children is pathognomonic of sexual abuse.[16]

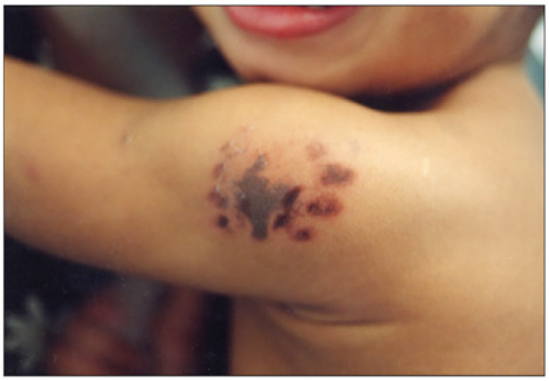

Figure 6. Child-on-child attack at a day care leaving possible pediatric bitemark on victim.

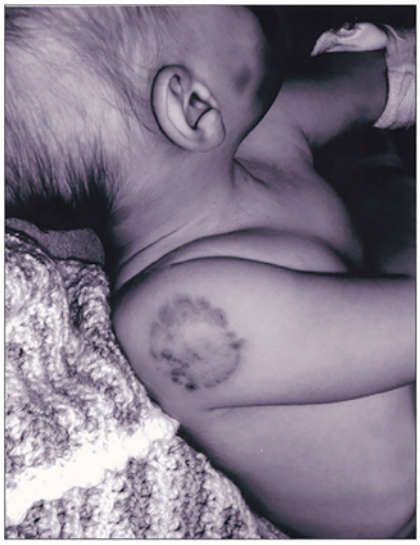

Figure 7. Child abuse victim with fracture left arm, facial injuries and a patterned injury on the right shoulder. This child survived the attack.

- **Condylomata Acuminata (veneral warts)** - Appear as single or multiple raised, pedunculated, cauliflower-like lesions. In addition to the oral cavity, lesions may also be found on the anal or genital areas.
- **Syphilis** – Manifests as a papule on the lip or dermis at the site of inoculation; the papule ulcerates to form the classic chancre in primary syphilis and a maculopapular rash in secondary syphilis.
- **Herpes simplex virus, Type 2 (HSV-2)** – Herpes simplex virus, Type 2 (genital herpes), presents as an oral or perioral, painful, reddened area with a grape-like cluster of vesicles (blisters) that rupture to form lesions or sores. Can also be transmitted vertically from mother to infant during birth, or horizontally through nonsexual contact from a child or caregiver's hand to the genitals or mouth.[17,18]
- **Unexplained erythema, ecchymosis and/or petechiae** – Such trauma at the junction of the hard and soft palate may indicate forced oral sex.

Psychological/Emotional Abuse

A dental professional, including any members of the dental staff, may observe other concerning signs and symptoms in the waiting area or during the exam itself. Depending on their severity, these signs and symptoms might not suggest maltreatment standing alone, but when observed in combination or with any of the signs of physical abuse, sexual abuse or neglect as outlined above, indicate possible maltreatment.

- **Concerning signs and symptoms exhibited by the child:**[19,20]
  - Extreme lack of self-esteem
  - Significant, unexplained delays in development
  - Inappropriate or underdeveloped social skills and poor personal boundaries
  - Inability to regulate mood and/or behavior, manifesting extremes
  - Pronounced nervous or repetitive behavior such as sucking and rocking or self-inflicted injuries such as lip or cheek biting
  - Change in the child's mood, demeanor or routine from the last visit
    - Acting out behavior
    - Fears, anxiety or distress
    - Regressive behavior
    - Sexualized behavior
  - Atypical interaction between the child and caregiver
  - Failure to make eye contact when discussing suspected abuse or neglect
  - Severe symptoms of self-destructive behavior – self-harming, suicide attempts, engaging in drug or alcohol abuse
  - Statements by the child disclosing abuse or neglect
- **Concerning signs and symptoms exhibited by the caregiver/s:**
  - Lack of supervision in waiting area

- Extreme discipline, including hitting, slapping, yelling, berating
- Disinterest in the child's dental needs and recommendations for treatment
- Disinterest in the child in general

Neglect

Neglect is often misunderstood and misdiagnosed. Cavities, periodontal disease, and other oral conditions are commonly associated with inadequate attention to nutrition and dental hygiene and can be signs of neglect. These conditions are not benign; they can lead to pain, infection, loss of function and other health conditions, which can negatively affect normal growth and development of a child.[7]

Dentists must distinguish, however, between caregivers who cannot provide adequate care for their children and caregivers who will not. Dental neglect is defined by the American Academy of Pediatric Dentistry as the "willful failure of parent or guardian, despite adequate access to care, to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infections."[21] Before making a report of maltreatment to child protection, a dentist should determine whether the caregiver understands the explanation and implications of the dental issue and, despite having the resources to address the condition, fails to do so. When the failure to provide adequate dental care is based on financial or transportation barriers, a different type of intervention should be considered. If parents fail to obtain therapy after barriers to care have been addressed, the case should be reported to the appropriate child protective services agency as concerning for dental neglect.

1. Indicators of **dental neglect**[9,22] include:
   - Multiple, untreated caries easily detectable by a lay person
   - Untreated pain, infection, bleeding, or trauma affecting the orofacial region
   - History of lack of continuity of care in the presence of identified dental pathology
   - Failure on the part of the caregiver to provide information concerning the child's history or demonstrated disinterest in the child's presenting issues and the dentist's treatment recommendations

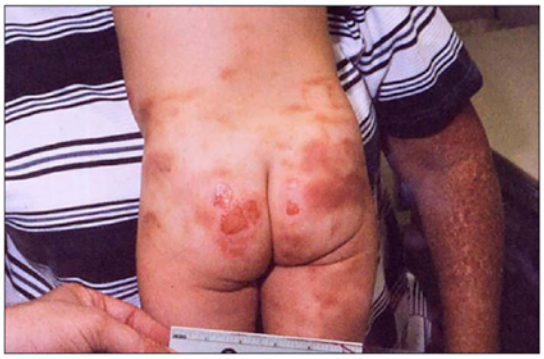

Figure 8. Severe case of diaper rash from caregiver neglect of the child.

2. Indicators of **general neglect**[23,24] include:
   - Constant food seeking behavior by the child indicating extreme hunger
   - Unexplained fatigue or listlessness
   - Unattended medical needs
   - Poor personal hygiene, extremely dirty or unbathed, severe diaper rash
   - Inappropriate or inadequate clothing for the weather conditions
   - Poor school attendance or school performance

Assessment and Documentation

Assessment

In assessing situations of suspected maltreatment, the dental professional needs to examine and consider the presenting problem or injury in light of the surrounding circumstances based on the child's age and history.[7]

- A key indicator of abuse or neglect is a significant discrepancy between the history given for the presenting problem/injury and the clinical findings. In addition to the signs and symptoms outlined above, the dental professional should monitor for multiple injuries over time or injuries in different stages of healing.
- If you as a dental professional, suspect maltreatment based on physical injuries and/or other concerning signs or symptoms as outlined above, the child should be given an opportunity to provide information outside the hearing of the parent or caregiver.16

Caution is advised, however, when seeking information from the child. Detailed interviews of the child should be left to child protection, law enforcement, and/or a forensic specialist. When talking with the child, the **dental professional's job is to collect only those minimal facts sufficient to making an adequate mandated report** as follows:[25]

- Ask the child what happened and who was involved, utilizing open-ended questions in a non-threatening way; listen to the child's response without interrupting; give the child your undivided attention
- Ask follow-up questions only as necessary to find out what happened and who was involved and then stop asking questions
- Consider the child's development; use age appropriate language
- Use the child's words; do not substitute adult words, thinking you know what the child means; clarify without suggesting your own words or explanations
- Remain neutral; your response could have a lasting impact on the child's further ability/desire to disclose abusive situations; do not make promises to the child
- Examples of possible open-ended inquiry:
  - Child presents with two broken teeth and bruises about the face: "*I see you have two broken teeth, tell me about what happened.*" After child has explained what happened, ask who else was there and who did what to whom.
  - Child presents with labial or lingual frenum tears: "*How did that happen?*"
  - Child presents with ulcers, lesions, blisters that suggest a sexually transmitted disease: "*Tell me about these blisters,*" and "*Who knows about the blisters?*"
  - Six-year-old child presents with a red mark on the child's neck that looks like a "hickey:" "*Tell me about that red mark.*" Suppose child says that Ricky likes to play a sucking game: "*Tell me about the sucking game,*" and "Who is Ricky," *Tell me about Ricky.*"
  - Eight-year-old child presents with multiple cavities, terrible breath, gingivitis, sores in the mouth that are indicative of poor dental hygiene rather than sexually transmitted disease. Additionally, your receptionist told you that the child has been begging for snacks, hitting younger siblings, and ripping pages out of the magazines while the caregiver talked on the phone and did not interact with the child or the younger siblings. You can and should try to assess child's general care as well as the child's dental care, using an open invitation "*Tell me about…*" For example, "*Tell me about brushing teeth*" or "*Tell me about the food you eat.*"
- When the dental exam is completed, reassure the child by thanking him/her for talking to you; ask if the child has any concerns, and as appropriate, ask what the child does if the child is scared or needs help.[16]
- Do not ask the child to repeat any disclosures to others in your office or share the child's disclosures with others, including the caregiver.
- The caregiver may have already given a reason/history for obvious injuries before the examination. If this reason/history is not consistent with your observations and/or the child's information, you should document the facts that were presented to you, using the caregiver's own words and the child's own words. You should not confront the caregiver.[16] If the caregiver has not given a reason/history before the examination and/or the presenting problem is ambiguous (for example, a bite mark on the cheek that child would not explain), a brief inquiry into the problematic finding can be sought from the caregiver, but a detailed interrogation should not be undertaken by the dental professional.
- Assess the need for medical attention and assess the immediate risk of harm to the child.

Documentation

Document only what you know based on what you saw and heard. You are not responsible for "proving" the case.[25]

- Document everything you observed, including a detailed description of the injury.
- Document everything the child said, using the child's own words.
- Document everything the caregiver said, using the caregiver's own words.
- Document what you saw and heard, NOT

your assumptions or conclusions about what you saw and heard. The only opinions you should include in your records are those relevant to the dental examination and treatment. For example, after fully describing a suspicious chancre, it is appropriate and necessary to include your professional conclusion as to whether the chancre is consistent with primary syphilis. You should also include recommendations for further treatment.

- Document any diagnosis and treatment recommendations, including photographs and radiographs, where appropriate.

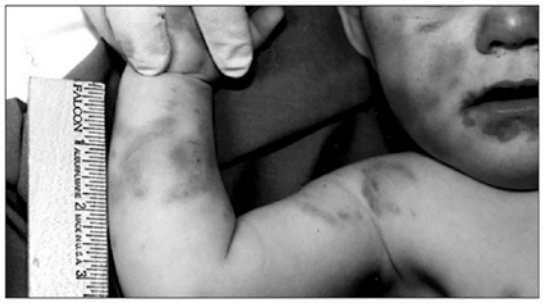

Figure 9. Multiple injuries on child abuse victim. The injuries on the face would be readily seen by a dental health care professional. Closer examination of the child may have noted the injuries on the arm and axilla.

Reporting

If you have reason to believe a child has been abused or neglected, you are legally obligated to report your concern to your local child protection agency and/or local law enforcement. As health care professionals, dentists and their staff are mandated reporters. All states have some type of mandatory reporting statute. In some states, reporting laws only apply to professionals, but in other states, reporting laws apply universally to anyone who suspects child maltreatment, including professionals.[4]

1. States have different requirements regarding procedures, forms, and timing for making reports of suspected child maltreatment; consequently, all dentists should be familiar with their own state's statutes on mandatory reporting; however, in general:[5,25,26]
   - The duty to report is activated by "reasonable cause to suspect" or reasonable cause to believe" that a child has been maltreated.
   - If there is reasonable cause to believe the child is at imminent risk of harm, call 911 for emergency law enforcement assistance.
   - In all other cases, the verbal report should be made within 24 hours to maximize the ability of child protection and law enforcement to investigate and keep the child safe (state statutes may differ on the timing requirements).
   - A written report documenting the assessment and treatment recommendations should be made within 48-72 hours (state statutes may differ on the timing requirements).
   - The identity of the reporter is confidential; however, mandated reporters should be aware that they could be subpoenaed to testify about their observations if the case goes to trial, but not the fact that they made a report.
   - A person who makes a good faith report is immune from criminal and/or civil liability.
   - The report triggers an investigation; it does not mean that the child will be taken out of the home immediately. Any out-of-home placement and/or services offered to the family will depend on the outcome of the investigation.
   - Failure to make a mandated report can have implications for professional licensure.
   - Failure to make a mandated report can be a criminal offense.
2. The initial verbal report to authorities should include the following information:[25,26]
   - The nature and extent of the suspected maltreatment, including all relevant details from your examination, observations, and any conversations with the child and the caregiver.
   - Identifying information for the child and the person believed to be responsible for the maltreatment if that information is available to you, including birth dates and addresses available to you.
   - What the child said, using the child's actual words.
   - What the caregiver said, if anything.
   - An explanation of any actions taken or recommendations regarding treatment.
   - The reporter's name and address if required by the state in which the report is made.

3. The dental professional should **not** do the following:

- Do not inform the caregiver that a mandated report is being made.[16] If the caregiver is the perpetrator, advance notice gives him/her a chance to pressure the child into denying or recanting the maltreatment or to further harm the child. It also allows time for that individual to contaminate or destroy potential evidence. If the caregiver is not the perpetrator, he/she may still be complicit in the maltreatment. It is not uncommon for a non-abusing caregiver to be motivated to protect the suspected perpetrator for financial or other emotional reasons.
- Do not delegate the reporting responsibility to a designated person within your health care system in lieu of making the report to the proper authorities yourself.[27] You may be tempted to delegate or even directed to delegate if you work for a larger dental or health care system rather than being self-employed. Keep in mind that you are the individual professional who can be held criminally responsible if the designated person within the health care organization does not make the mandated report.

Treatment for Orofacial or Dental Trauma

1. If the injury or presenting problem is limited to the mouth, and if the dentist feels competent to treat the case, treatment should be initiated. More extensive trauma such as fractures, lacerations, or serious injuries to the head, body, or extremities should be referred to the appropriate medical/dental specialists.
2. If the dentist reasonably believes that the child is at imminent risk of harm due to the injuries already sustained or the potential for further serious injury, the dentist should call 911 and request police assistance, and if needed, emergency medical assistance while the child is still in the office. Note: Dental professionals do not have the authority to detain children; only law enforcement officers have that authority.

What can Dental Professionals do to Reduce Child Maltreatment?

Despite growing public exposure and concern over child maltreatment and the existence of mandatory reporting laws, underreporting continues to be an issue for health care providers, including dentists.[4,16] Dental professionals may be reluctant to report for many reasons, including lack of knowledge and training about their obligations, fear of being wrong, negative reactions by the caregivers, and concern about being drawn into an investigation and court proceeding. In response, some dental schools are providing more comprehensive training on identification of child maltreatment and mandatory reporting.[16] On-line courses such as this one help achieve the same goal: **Awareness**.

The fact that you are taking this course shows that you take your obligations seriously. Keep in mind that you may or may not be the first or only person to report a concern about a particular child. Your report might be one of several reports about the same child and could provide an important piece to the puzzle of what is happening to that child. Do not underestimate your role as a dental professional in the reduction and/or reoccurrence of child maltreatment.

What are some specific things that a dental professional can do to reduce the incidence and/or reoccurrence of child maltreatment?

1. Follow legal mandates:
   - Dentists should follow their jurisdiction's statutory mandate to report suspected child maltreatment to child protection and/or law enforcement.
   - Dentists should make sure every member of the dental office team is trained and aware of the signs and symptoms of child maltreatment and committed to recognizing and reporting suspected abuse and neglect.
2. Attend to the needs of child patients, including educational, financial, and transportation.

- Dentists can and should be a major force in the secondary and tertiary prevention of dental neglect through the effective education of parents and children who are at risk.
- In situations where a determination of dental neglect of a child has already been made by social services, dentists can offer to educate caregivers on the importance of good oral hygiene and routine dental care individually or by presenting this information to groups of caregivers through agencies providing parenting education.
- If financial or transportation obstacles exist, dentists should assist by providing information to parents about government-sponsored dental care facilities or dental clinics specifically established to provide care gratis or based on a sliding fee scale. Clinics that offer extended hours for low-income families who don't have dental coverage and can't take time off from work during regular business hours to bring children for dental care may be an additional option.

3. Increase educational opportunities for dentists, dental students, and dental staff on the issues of identifying child maltreatment, documenting, reporting, and treatment.
   - Increase exposure of dental students to the issue of child maltreatment in their undergraduate dental curricula.
   - Mandate dentists to submit proof of completion for a continuing education course on the topics of recognizing signs and symptoms of child maltreatment, documentation and reporting obligations to their respective licensing boards.

Conclusion

Through early detection and reporting, dentists have the opportunity to reduce the incidences of maltreatment of children. Detecting and reporting suspected cases of abuse is not intended to punish the caregivers; rather, it is necessary to provide for the safety and health of children. To provide that important safety net, dentists must be trained to identify abuse and neglect, collect and document sufficient facts to make a mandatory report, and treat child victims.

Course Test Preview

To receive Continuing Education credit for this course, you must complete the online test. Please go to: *www.dentalcare.com/en-us/ce-courses/ce599/test*

1. **Over 3 million children received child protection investigative or alternative response services in the United States in 2020 according to the U.S. Department of Health & Human Services.**
   A. True
   B. False

2. **According to the U.S. Department of Health & Human Services, approximately how many children were substantiated victims of child maltreatment in the United States in 2020?**
   A. 3.145 million
   B. 520,000
   C. 618,000
   D. 850,000

3. **Child abuse and neglect is _____.**
   A. only found in low-income families
   B. found more often in rural communities
   C. less prevalent in the United States than in the rest of the world
   D. found in all cultural, ethnic, and socioeconomic segments of American society

4. **The incidence of child maltreatment of girls is much higher than the incidence of maltreatment of boys?**
   A. True
   B. False

5. **Which two caregiver risk factors for maltreatment identified in the 2020 DHHS study resulted in the highest percentages of child victims?**
   A. Caregiver disability, drug abuse
   B. Disabilities of child, inadequate housing
   C. Financial problems, alcohol abuse
   D. Domestic violence in the home, drug abuse

6. **It is unlikely that a dental professional will see indicia of maltreatment during a routine dental examination of a child because craniofacial, head, face and neck injuries occur in less than half of child abuse cases.**
   A. True
   B. False

7. **Oral trauma, caries, gingivitis, and other oral health problems are more prevalent in maltreated children than in the general pediatric population.**
   A. True
   B. False

8. Which of the following statements is true regarding the reporting of child abuse and neglect?

A. Only nurses and physicians must report child abuse and neglect.
B. All health professionals are legally mandated to report suspected cases of child maltreatment consistent with state laws, including dentists, dental assistants, and dental hygienists.
C. Pediatric dentists and pediatric oral surgeons are the only members of the dental profession who must report child abuse and neglect.
D. Dental hygienists are not required to report suspected cases of child maltreatment.

9. All of the following roles and responsibilities are included in the American Dental Association's Principles of Ethics and Code of Conduct, EXCEPT one, which is the exception?

A. To record any evidence that may assist in the legal proceedings of a child maltreatment case
B. To be aware of the signs and symptoms of child abuse and neglect
C. To treat all injuries exhibited by a child suspected to have been physically abused
D. To establish/maintain a professional therapeutic relationship with the family

10. Injury to the eyes of a child who has been physically abused is indicated by all of the following factors EXCEPT ONE. Which is NOT a specific indication of an injury to the eyes of a physically abused child?

A. Retinal hemorrhage
B. Ptosis
C. Traumatic alopecia
D. Periorbital bruising

11. Which of the following is characteristic of more severely abused children?

A. Labial or lingual frenum tears
B. Cavities
C. Bad breath
D. Bruised cheek

12. Bite marks are usually associated with what types of abuse?

A. General neglect
B. Physical and sexual
C. Neglect and physical
D. Emotional and dental neglect

13. All of the following are strong indicators of a dentally neglected child EXCEPT one, which is the exception?

A. Multiple, untreated caries
B. Untreated pain
C. Untreated infection
D. Child is very talkative

14. All of the following orofacial manifestations are specific indicators of sexual abuse EXCEPT one, which is the exception?

A. Classic chancre of primary syphilis
B. Herpes simplex virus, Type 2
C. Erythema, ecchymosis and/or petechia of palate
D. Head trauma as indicated by bruises to the forehead and mouth

15. If you have observed ulcerations that you suspect are gonorrhea, you should do the following?

A. Ask the parent to make a follow-up dental appointment in a week to check on the child to make sure it clears up
B. Note the observation in the child's file but nothing further
C. Report your observations and concerns to child protection
D. Confront the parent

16. If a verbal child presents with ulcers, lesions, or blisters that suggest a sexually transmitted disease, an appropriate approach by the dental professional is to ask the child, "Tell me about these blisters," and "Who knows about the blisters?"

A. True
B. False

17. When a dental professional believes that a child is the victim of maltreatment, the dental professional should do the following things EXCEPT one, which is the exception?

A. Consider the child's development and history
B. Ask the child about who and what happened, using open ended inquiry and the child's terminology
C. Remain neutral
D. Interrogate the child and get as many details of the abuse as possible

18. Which best describes what you should include in documenting suspected child maltreatment?

A. Names, addresses and dates of birth; what you observed; what the parties said; diagnosis and treatment
B. Analysis of your state's mandatory reporting statute, your observations, what the parties said, diagnosis and treatment recommendations
C. Caregiver's dental history, the weather that day, your observations, the family's payment history
D. Your opinion of child protection investigations, detailed description of the dental injury, your opinion of the family in general, the family's socioeconomic status

19. If you have worked in one state as a dental professional and you move to another state, you can assume the mandatory reporting requirements are the same.

A. True
B. False

20. The duty to report is based on which of the following?

A. The family's payment history
B. Facts that support a reasonable cause to suspect maltreatment
C. Multiple cavities
D. A gut feeling

21. A dental professional should always inform the caregivers before making a maltreatment report regarding their child.

A. True
B. False

22. After a dentist makes a maltreatment report, which of the following is true?

A. The child protection investigator will identify the dentist as the reporter to the family.
B. The child will always be taken from the home.
C. It is the responsibility of child protection and/or law enforcement to investigate.
D. The dentist can be held civilly liable.

23. A dentist should never call 911 even if the dentist reasonably believes the child is in imminent danger.

A. True
B. False

24. Failure to make a report when there is reasonable cause to suspect child maltreatment could result in criminal charges.

A. True
B. False

25. Dentists can assist in the prevention and reoccurrence of child maltreatment by making sure their dental office team is aware of the signs of child abuse, counseling parents on good oral hygiene and routine dental care, and reporting suspected cases of child maltreatment to the proper authorities.

A. True
B. False

References

1. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020.
2. Child Abuse Prevention and Treatment Act of 1974 (CAPTA), Public Law 100-294.
3. Walsh WA, Jones LM. A statewide study of the public's knowledge of child abuse reporting laws. Crimes Against Children Research Center. University of New Hampshire. 2015 Sep.
4. Vandervort FE. Mandated Reporting of Child Maltreatment: Developments. APSAC Alert. 2012 Fall;3(4).
5. U.S. Department of Health and Human Services. Children's Bureau. Mandatory reporters of child abuse and neglect. Child Welfare Information Gateway. Washington, DC. 2019 Apr.
6. ADA. The ADA Principles of Ethics and Code of Conduct.
7. Fisher-Owens SA, Lukefahr JL, Tate AR. Oral and Dental Aspects of Child Abuse and Neglect. Pediatr Dent. 2017 Jul 15;39(4):278-283.
8. Macintyre DR, Jones GM, Pinckney RC. The role of the dental practitioner in the management of non-accidental injury to children. Br Dent J. 1986 Aug 9;161(3):108-10. doi: 10.1038/sj.bdj.4805898.
9. Davis GR, Domoto PK, Levy RL. The dentist's role in child abuse and neglect. Issues, identification, and management. ASDC J Dent Child. 1979 May-Jun;46(3):185-92.
10. Hamilton J. Child abuse: the dentist's responsibility. CDS Rev. 1990 Oct;83(9):18-23.
11. Schmidt BD. Physical abuse: specifics of clinical diagnosis. Pediatr Dent. 1986 May;8(1 Spec No):83-7.
12. American Academy of Pediatrics Committee on Early Childhood, Adoption, and Dependent Care: Oral and dental aspects of child abuse and neglect. Pediatrics. 1986 Sep;78(3):537-9.
13. Bernat J. Dental trauma and bite mark evaluation. Child abuse: a medical reference, 2nd Ed. Stephen Ludwig (Ed). New York, NY Churchill Livingstone. 1992. 175-190.
14. Stechey F. Bite marks and cans—child abuse and neglect syndrome. Ont Dent. 1991 Jan-Feb;68(1):19-20.
15. Dorion RB. Bite mark evidence. J Can Dent Assoc. 1982 Dec;48(12):795-8.
16. Ivanoff CS, Hottel TL. Comprehensive training in suspected child abuse and neglect for dental students: a hybrid curriculum. J Dent Educ. 2013 Jun;77(6):695-705.
17. Stevens-Simon C, Nelligan D, Breese P, Jenny C, Douglas JM Jr. The prevalence of genital human papillomavirus infections in abused and nonabused preadolescent girls. Pediatrics 2000;106(4):645-649. 29.
18. Bussen S, Sutterlin U, Schmidt U, Bussen D. Anogenital warts in childhood – always a marker for sexual abuse? Geburtshilfe Frauenheilkd 2012;72(1):43-48.
19. Casamassimo PS. Child sexual abuse and the pediatric dentist. Pediatr Dent. 1986 May;8(1 Spec No):102-6.
20. Allen DM, Tarnowski KJ. Depressive characteristics of physically abused children. J Abnorm Child Psychol. 1989 Feb;17(1):1-11. doi: 10.1007/bf00910766.
21. American Academy of Pediatric Dentistry. Definition of dental neglect.
22. Vadiakas G, Roberts MW, Dilley DC. Child abuse and neglect: ethical and legal issues for dentistry. J Mass Dent Soc. 1991 Winter;40(1):13-5.
23. Erickson EL, McEvoy AW, Colucci ND. Child abuse & neglect: a guidebook for educators & community leaders. Holmes Beach, FL. Learning Publications. 1984.
24. Goldman RL, Gargiulo RM. Children at risk : an interdisciplinary approach to child abuse and neglect. Austin, TX. Pro-Ed. 1990.
25. Lukas Miller A. Presentation: Collecting Minimal Facts - Responding to Suspicions or Disclosures of Abuse. CornerHouse. 2019.
26. CornerHouse. Reporting Abuse. Accessed August 19, 2020.
27. Lukas Miller A. Presentation: What Every Mandated Reporter Should Know. CornerHouse. 2014.

Additional Resources

- No Additional Resources Available.

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