

Policy on Recognition and Management of Child Abuse and Neglect in a Dental Setting

Adopted

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Abbreviations

AAPD: American Academy of Pediatric Dentistry.

CAN: Child abuse and neglect.

CPS: Child Protection Services.

Majr: Medical subject headings major topic.

Tiab: Title and abstract.

** Used in the PubMed search to identify all terms that begin with this truncated base.*

Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes that, as mandated reporters, dentists play a critical role in identification and intervention of child abuse and neglect. The intent of this document is to review the oral health care professional's role in the recognition and management of child abuse and neglect and encourage further education regarding mandated reporting, social services, and child safety.

Methods

This policy is based on a review of current dental and medical literature pertaining to child abuse and neglect (CAN) utilizing a search of PubMed/MEDLINE. Search parameters include publications in the last 5 years in English using the terms: (*evidence based dentistry* [Majr] OR *pediatric dentistry* [Majr] OR *dental care for children* [Majr] OR *paediatric dentistry* [Tiab] OR *dental health services* [Majr] OR *dentistry* [Majr] OR *public health dentistry* [Majr] OR *community dentistry* [Majr] OR *oral health* [Majr]) AND (*pediatrics* [Majr] OR *physician's role* [Majr] OR *child abuse* [Majr] OR *decision making, shared* [Majr] OR *adolescent* [Majr] OR *child* [Majr]) AND (*child abuse, sexual* [Majr] OR *child neglect experience** OR *child maltreatment* [Tiab] OR *child neglect* [Tiab] OR *childhood abuse experience** OR *child physical abuse* [Tiab] OR *mandatory reporting* [Majr] OR *risk factors* [Majr] OR *practice patterns, physicians* [Majr] OR *child welfare* [Majr] OR *child advocacy* [Majr] OR *child protection** [Tiab] OR *physical abuse* [Tiab] OR *child protective services* [Majr] OR *violence* [Tiab] OR *child endangerment* [Tiab] OR *child exploitation* [Tiab] OR *non-accidental trauma* [Tiab] OR *non-accidental injur** OR *abusive head trauma* [Tiab] OR *trauma-informed care* [Tiab] OR *mandated report** OR *human traffick** OR *dental fracture** OR *mandibular fracture** OR *fictitious injur** OR *inflicted trauma* [Tiab] OR *social work* [Tiab] OR *social stress**). A total of 88 articles were identified and reviewed by title and abstract. When information from these articles did not appear sufficient or was inconclusive, policies were based on expert and consensus opinion by experienced researchers and clinicians.

Background

Child abuse and neglect (CAN) is a public health concern in the US. In the 2023 federal fiscal year, 52 states and territories reported 546,159 victims of CAN, equating to a rate of 7.4 victims per 1,000 children.¹ In addition to the acute dangers associated with physical harm or neglect, childhood maltreatment can lead to chronic problems in adolescents and young adulthood, including negative effects on mental health, cognition, and physical and sexual health as well as substance abuse.² Adult survivors of adverse childhood events such as sexual abuse have higher rates of dental fear³ (Bradbury-Jones 2021) and anxiety⁴ (Fredriksen 2019), which affect their likelihood of keeping and tolerating dental visits³ (Bradbury-Jones 2021).

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While each state may have its own definition of child abuse, the federal Child Abuse Prevention and Treatment Act (CAPTA) Reauthorization Act of 2010⁵ defined child abuse and neglect as “at a minimum, 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”. The AAPD’s definition of dental neglect includes the “willful failure of a parent or health care guardian to seek or follow through with medically-necessary care that would ensure a level of oral health essential for adequate function and freedom from pain and infection.”⁶ Though physical signs of abuse may be easier to identify during a clinical examination, determining presentations of dental neglect can be complicated by social factors and the unpredictable nature of dental caries in children. Factors that may be considered when determining neglect include access to dental care, parental oral health literacy, and financial stability. Communication with the child’s other health providers, caregivers, school administrators, or other involved parties may help clarify whether neglect is intentional or an unintentional byproduct of external circumstances.

Dentists and other oral health professionals are in a unique position to identify CAN. Greater than 50% of child abuse physical injuries occur in the orofacial region,⁷ with the lips being the most common oral site.⁸ As with other health providers, dentists are ethically⁹ and legally obligated to report suspicion for CAN to proper authorities, consistent with state laws. It is, therefore, critical that oral health professionals undergo the necessary training and develop skills to recognize and respond to signs of potential child maltreatment in the dental setting.

Currently, standards for dental education programs do not address child maltreatment.¹⁰ While every state designates dentists as mandated reporters, only 13% require childhood maltreatment reporter training for licensure.¹¹ Continuing education requirements for license renewal also varies by state, but they can help ensure dentists are equipped to aid those families in need of support or intervention. The Commission on Dental Accreditation’s standards for advanced pediatric dentistry education programs require didactic instruction on orofacial injury and emergency care to include the assessment, evaluation, management, and reporting of CAN and non-accidental trauma.¹² Continuing education on CAN for oral health care professionals is available through organized dentistry associations, academic institutions, and private education companies. Additionally, software applications offer training modules on identifying signs of child abuse, gathering histories, and determining presentations that may raise suspicion.

Systematic reviews and other studies have identified risk factors for child abuse, such as social stressors (eg, financial instability, housing insecurity, unemployment),^{13,14} parental experiences (eg, interpartner violence¹³⁻¹⁵), substance misuse¹⁴⁻¹⁶, mental health conditions^{14,15}, childcare demands (eg, families with higher numbers of minors^{14,15}), and children with special health care needs^{17,18}. These risk factors can be categorized at child, family, community, and societal levels.¹⁹ Identified factors are by no means prescriptive or suggestive of a direct causal relationship between social history and child maltreatment. Nonetheless, screening for social challenges and assessment of relational health, when paired with social supports and counseling resources, may help identify at-risk families and mitigate potentially harmful behaviors.^{19,20} History gathering can include questions regarding household resources, social supports, parent well-being, and parent-child relational well-being.²¹

During both planned and emergency dental visits, documentation²² of any physical injuries—including type (eg, abrasions, lacerations, contusions, fractures), character (eg, size, shape, color), and location²³—or pathologic lesions (eg, condyloma, petechiae) both intra- and extraorally is indicated.⁷ Inquiry regarding the etiology, timing, duration, and symptoms associated with a given finding can help determine the need for further investigation into physical and/or sexual abuse as a potential cause of injury. When possible, obtaining separate histories from the child and caregiver can be helpful in corroborating or disputing a disclosed cause of injury.^{24p165}

Photographs (with consent), disclosure of abuse in the child’s words, and treatment needed are key components of documentation. In the case of biting injuries, referral to a hospital for prompt bitemark analysis and DNA testing are indicated.²³ A forensic odontologist may be contacted if not part of the hospital team.²⁵ Referral to a hospital also is indicated for those with extensive physical injuries that require urgent evaluation for CAN or another etiology that may mimic child maltreatment in presentation. Immediate

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referral to a hospital or child protection clinic with protocols for a pediatric forensic evidence collection and acute sexual assault examination is indicated for a child who has confirmed or suspected recent (not to exceed the past 72-120 hours, depending on jurisdiction) sexual abuse. Reporting sexual abuse disclosed by a patient is indicated even when not considered acute. A sexual assault examination by a trained, skilled examiner is needed, though not considered urgent unless the child is experiencing symptoms.²⁶ When there is clear concern for the child's safety at the time of the dental visit, consultation with the proper authorities is warranted prior to dismissal of the child and the accompanying adult.

Timing of a mandated report can vary by state, with some requiring that concerns be reported within 24-28 hours following a suspicious encounter.²⁷ Timely reporting of concerns can aid in prompt investigation and interventions necessary to prevent further harm. Familiarity with local pediatric abuse teams can be helpful for those oral health professionals in need of guidance or support in such cases. Despite dentists being mandated to report CAN, nearly 30% of dentists do not report despite their suspicion.²⁸ Barriers for reporting CAN include fear of violence to the child and/or dental team²⁹, lack of certainty of the diagnosis^{30,31}, litigation fears³⁰, concern that child will not receive needed treatment, perceived shortcomings in Child Protective Services (CPS)³¹, and limited knowledge on how to report²³. Dentists are not required to have proof of abuse to report suspicious findings to Child Protective Services. They are immune from liability when reporting in good faith and may be at risk of penalty for not reporting.^{32,33}

Policy statement

The AAPD acknowledges the importance of recognizing and responding to signs of child maltreatment when they present in the dental setting. To better train oral health professionals to respond to cases of suspected abuse or neglect, the AAPD encourages

- identification of families at-risk for CAN and referral to counselors, physicians, and social services when needed.
- pediatric dentists to be familiar with a child abuse team available to consult and call them for guidance if there is an examination finding in question.
- required predoctoral, postgraduate, and continuing education on CAN by oral health professionals
- implementation of office-based protocols and staff training on the reporting, documentation, and communication surrounding cases of CAN.
- preservation of laws that include oral health professionals as mandated reporters of CAN.

The AAPD also joins the American Academy of Pediatrics' call for collaboration⁷ among pediatricians, oral health professionals, and other physicians to increase prevention, detection, and treatment of oral and dental aspects of abuse and neglect in children. Furthermore, the AAPD encourages public awareness campaigns on child abuse and neglect as well as awareness of child exploitation and other violent crimes against children in order to promote child safety.

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