



The Role of Dental Professionals in Child Protection: A Contemporary Evidence-Based Review

Michael B. Guess, DDS, MS, MA*, Audrey Zhou, MBS¹

***Correspondence to:** Michael B. Guess, DDS, MS, MA, US.

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ABSTRACT

Background: Dental professionals serve as critical frontline defenders in child protection, with 50-75% of child abuse cases involving injuries to the head, neck, and oral cavity. Despite mandatory reporting laws in all 50 states, dental professionals report suspected maltreatment at significantly lower rates than other healthcare providers.

Objective: This review synthesizes current evidence on dental professionals' roles in child protection and provides evidence-based recommendations for contemporary practice, including COVID-19 impacts and trauma-informed care approaches.

Methods: We conducted a comprehensive review of literature from 2010 to 2025 using PubMed, MEDLINE, and specialty databases. We included peer-reviewed studies, systematic reviews, and professional guidelines addressing child abuse identification, reporting barriers, training effectiveness, and implementation strategies.

Results: Recent New Zealand research reveals that 70% of dental professionals fear false reporting, while only 48% report familiarity with reporting processes. The COVID-19 pandemic reduced dental office visits by 33% overall and decreased children's dental visits by 27% in 2020 compared to 2019. Evidence demonstrates that targeted training programs significantly improve reporting likelihood, while trauma-informed care approaches enhance patient outcomes. Current research identifies 15 validated screening tools and establishes frameworks for multidisciplinary collaboration.

Conclusions: Dental professionals must adopt evidence-based approaches, including universal trauma-informed care, validated screening tools, and enhanced training programs. Integration of COVID-19-specific protocols and multidisciplinary partnerships will strengthen child protection outcomes.

Keywords: child abuse detection, dental professionals, mandated reporting, trauma-informed care, COVID-19 impact, screening tools.

Introduction

Child maltreatment affects millions of children annually, with dental professionals uniquely positioned to identify and respond to suspected abuse. The National Child Abuse and Neglect Data System reports that child protective services agencies received 4.4 million referrals involving approximately 7.9 million children in 2020. Yet, experts estimate that three in four cases go unreported (1). This underreporting represents a critical gap in child protection systems.

Dental professionals examine the head, neck, and oral cavity during routine visits, placing them strategically to identify physical signs of abuse that other healthcare providers might miss. Research consistently demonstrates that 50-75% of physically abused children sustain injuries to the head, face, neck, and mouth. Additionally, dental neglect represents the most prevalent form of child neglect, occurring across all demographic groups.

The COVID-19 pandemic significantly impacted child protection systems, with official reports declining 20-70% due to reduced contact between children and mandated reporters (3). Simultaneously, children experienced a 27% lower likelihood of dental visits in 2020 compared to 2019, potentially missing critical opportunities for abuse detection (4). These pandemic-related disruptions highlight the urgent need for enhanced vigilance and improved reporting protocols.

Recent advances in trauma-informed care recognize that approximately half of children and two-thirds of adults have experienced traumatic events (11). This evidence necessitates fundamental changes in how dental professionals approach patient care, moving beyond traditional clinical models to incorporate biopsychosocial perspectives that address trauma's impact on oral health and treatment experiences.

Current barriers to reporting persist despite legal mandates. New Zealand research reveals that 70% of dental professionals fear false reporting, while only 48% report familiarity with the reporting process (2). These findings underscore the critical need for evidence-based training programs and systematic approaches to child protection in dental settings.

This review synthesizes contemporary evidence on dental professionals' roles in child protection, examining identification strategies, documentation protocols, reporting barriers, and innovative approaches, including trauma-informed care and COVID-19 adaptations. We provide actionable recommendations based on current research to enhance child protection outcomes in dental practice.

Contemporary Evidence on Child Maltreatment

Current Prevalence and Demographics

Recent research provides an updated understanding of child maltreatment epidemiology. Studies indicate that

up to 16% of children experience physical abuse in high-income countries, while 10% of girls and 5% of boys experience sexual abuse (13). New Zealand longitudinal data spanning 17 years reveal that approximately 20% of children have statutory child protection reports, with approximately 10% substantiated.

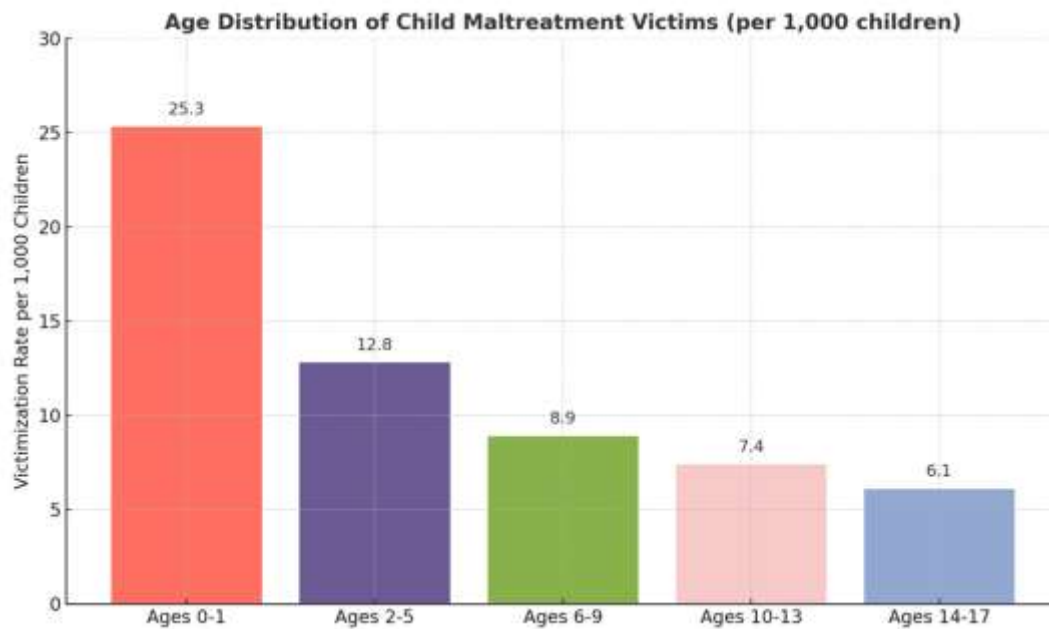
Table 1: Child Maltreatment by Type (2020 Data)

Type of Maltreatment	Percentage	Number of Cases
Neglect	61%	377,580
Physical Abuse	18%	111,240
Sexual Abuse	9%	55,620
Emotional Abuse	6%	37,080
Other	6%	37,080

Source: U.S. Department of Health and Human Services, *Child Maltreatment 2020*

Children under one year experience the highest maltreatment rates at 25.3 per 1,000 children, with rates declining as age increases. Racial and ethnic minority children face disproportionate risks, with African American children experiencing abuse at nearly twice the rate of white children. Children with disabilities demonstrate a 3.4 times higher likelihood of experiencing abuse or neglect compared to non-disabled peers.

Figure 1: Age Distribution of Child Maltreatment Victims

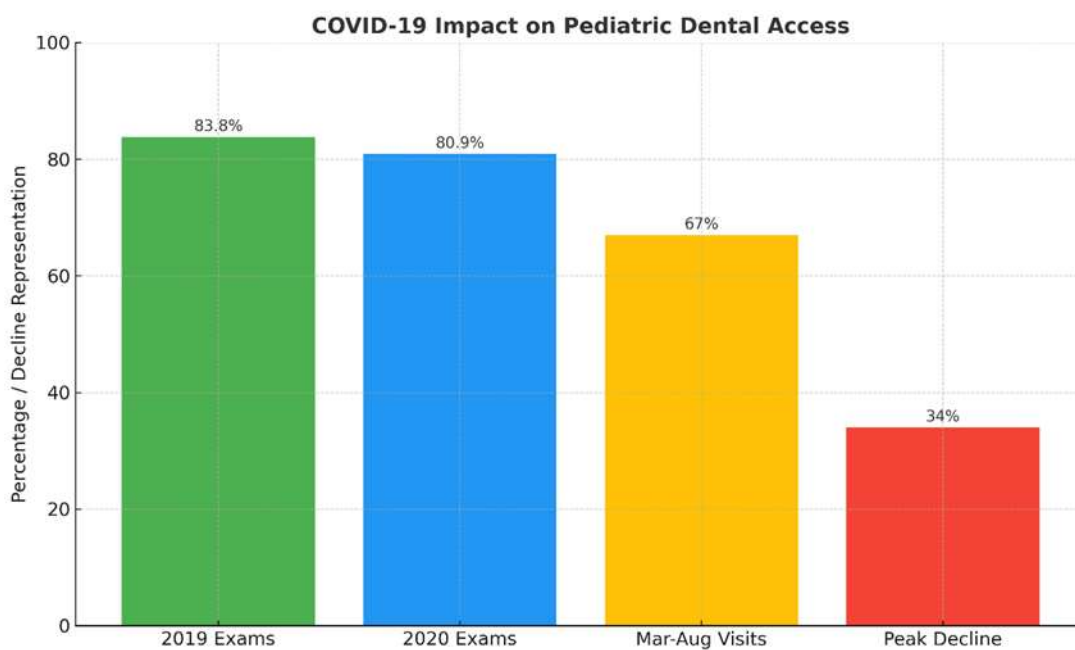


COVID-19 Pandemic Impact

The COVID-19 pandemic created unprecedented challenges for child protection systems. CDC surveillance data show that emergency department visits related to child abuse and neglect decreased in total numbers. Still, the percentage resulting in hospitalization increased, suggesting that cases reaching healthcare providers involved more severe injuries (3).

Despite the ongoing pandemic, official reports to child protection agencies declined across the United States by 20-70%, attributed to a decrease in in-person contact between children and mandated reporters (e.g., teachers, social workers, and physicians) (3).

Chart 1: COVID-19 Impact on Pediatric Dental Access



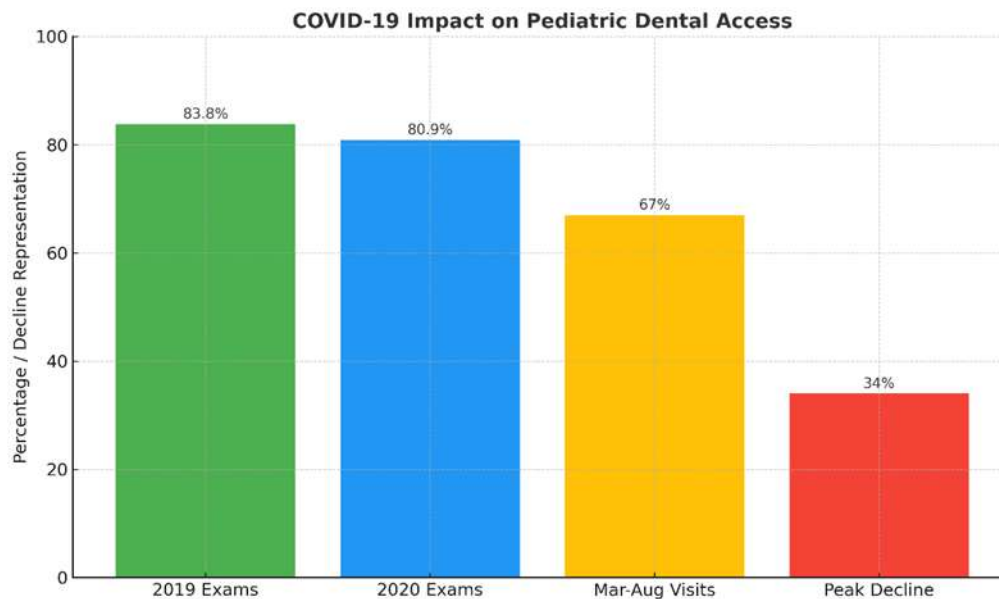
Sources: *CDC National Health Interview Survey* (6), *Kranz et al. 2021* (5)

The pandemic's impact on dental services proved particularly significant for child protection. Children experienced a 27% lower likelihood of dental visits in 2020 (odds ratio 0.73; 95% CI 0.65 to 0.82), with widespread declines in oral health status (4). Overall, dental office visits declined 33% from March through August 2020, with the most significant decline observed during the week of April 12, 2020, when there were 66% fewer weekly visits (5). CDC National Health Interview Survey data show that between 2019 and 2020, the percentage of children aged 1-17 years who had dental examinations or cleanings decreased from 83.8% to 80.9% (6).

Risk Factor Evolution

Contemporary research identifies evolving risk factors for child maltreatment. Traditional risk factors, including poverty (85% of cases), social isolation (70%), parental substance abuse (60%), domestic violence (55%), parental mental illness (40%), and previous CPS involvement (35%), remain significant. However, the pandemic introduced additional stressors, including job loss, housing instability, and prolonged social isolation, that amplified existing risks.

Table 2: Risk Factors by Prevalence

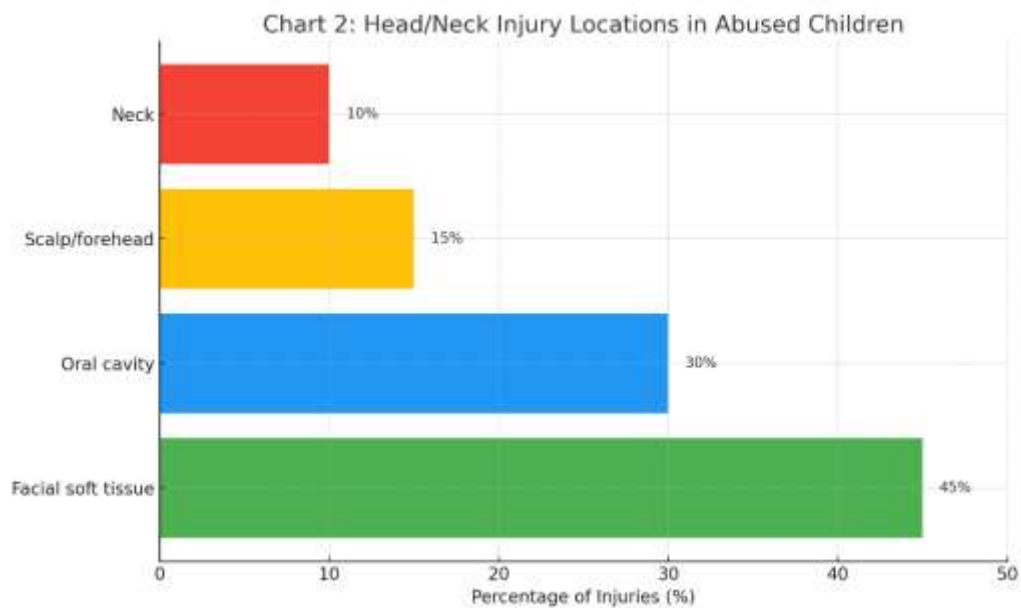


Studies document dramatic increases in alcohol and drug use during COVID-19, directly correlating with escalating abuse cases. Current continuing education programs emphasize that dental professionals must increase vigilance for these pandemic-specific risk factors while maintaining awareness of traditional indicators.

Evidence-Based Identification Strategies

Physical Indicators in the Orofacial Region

Dental professionals possess specialized training in head and neck anatomy that positions them uniquely to identify abuse-related injuries. Research establishes clear patterns distinguishing accidental from non-accidental trauma. Abuse-related facial injuries predominantly occur on soft tissue areas, including cheeks, ears, and neck, while accidental trauma typically affects bony prominences such as the forehead, nose, chin, and cheekbones.

Chart 2: Head/Neck Injury Locations in Abused Children

Critical oral cavity indicators requiring immediate assessment include:

- Torn labial or lingual frenula in non-ambulatory children
- Multiple dental fractures are inconsistent with the provided history
- Burns from hot liquids or objects affecting oral structures
- Bruises or lacerations inside the mouth without adequate explanation
- Missing teeth lacking appropriate developmental or trauma history

Contemporary clinical guides emphasize systematic evaluation of injury patterns, timing, and consistency with developmental capabilities (12). Practitioners must assess whether injury mechanisms described by caregivers align with observed patterns and the child's developmental abilities.

Bite Mark Recognition and Forensic Considerations

Human bite marks serve as pathognomonic indicators of abuse requiring immediate reporting and forensic consultation. Adult bite marks typically exceed 3 cm in diameter and display characteristic ridges and furrows. Recent forensic dentistry advances provide enhanced methods for bite mark documentation and analysis.

Current protocols require practitioners to immediately photograph bite marks using standardized techniques, including rulers for scale, multiple angles, and appropriate lighting. Digital photography offers advantages for secure storage and transmission, though practitioners must ensure HIPAA-compliant handling of sensitive images.

Behavioral and Psychological Indicators

Recent trauma research expands understanding of behavioral indicators beyond traditional presentations. Children with maltreatment histories often display complex behavioral patterns, including:

Age-Inappropriate Behaviors: Children may exhibit inappropriately adult-like behaviors (caring for siblings) or regressive behaviors (thumb-sucking in school-age children, loss of toilet training).

Trauma-Related Responses: Extreme fear disproportionate to dental procedures, unusual compliance to please adults, or dissociative behaviors during treatment may indicate trauma history.

Social and Emotional Indicators: Withdrawal from physical contact, hypervigilance, inappropriate sexual knowledge or behavior, and dramatic changes in academic performance warrant careful assessment.

Contemporary research emphasizes that these behavioral indicators require contextual interpretation rather than a standalone diagnosis. Dental professionals must document observations objectively while avoiding psychological interpretation beyond their scope of practice.

Caregiver Behavior Assessment

Studies identify specific caregiver behaviors that raise concern for potential abuse:

Inconsistent Histories: Parents providing changing explanations for injuries or stories inconsistent with observed trauma patterns require careful documentation.

Inappropriate Responses: Caregivers showing unusual lack of concern about significant injuries, blaming children for their injuries, or demonstrating excessive control during appointments may indicate problematic dynamics.

Controlling Behaviors: Insistence on remaining present for all procedures, answering all questions for children, or preventing child-provider communication may represent attempts to control narrative disclosure. Research emphasizes that these behaviors must be evaluated within cultural contexts and family dynamics rather than applied universally across all populations.

Trauma-Informed Care Implementation

Theoretical Framework and Evidence Base

Trauma-informed care represents a paradigm shift in healthcare delivery, recognizing trauma's widespread impact and integrating this knowledge into all aspects of service delivery. Recent studies demonstrate that approximately half of children and two-thirds of adults have experienced traumatic events, making trauma-informed approaches essential rather than optional (11).

Contemporary research provides comprehensive frameworks for dental practice transformation. This model emphasizes early detection, sensitivity training, and adherence to trauma-informed principles, including

safety, trustworthiness, peer support, collaboration, empowerment, and cultural humility.

Practical Implementation Strategies

Recent dental hospital research demonstrates effective trauma training implementation with measurable outcomes (10). Key components include:

Environmental Modifications: Creating physically and emotionally safe spaces through thoughtful office design, comfortable waiting areas, and clear communication about procedures.

Staff Training: Comprehensive education addressing trauma recognition, trauma-informed communication, and de-escalation techniques for triggered patients.

Procedural Adaptations: Implementing patient choice regarding positioning, pacing, and comfort measures during treatment and providing detailed explanations before procedures, and obtaining continuous consent.

Communication Strategies: Using trauma-informed language that validates experiences, avoids re-traumatization, and emphasizes patient autonomy and control.

Addressing Trauma in Pediatric Populations

Children with trauma histories require specialized approaches recognizing developmental considerations. Research indicates that dental settings may trigger trauma responses even when the original trauma occurred elsewhere. Effective strategies include:

Age-Appropriate Communication: Using language children understand while avoiding leading questions that might contaminate potential forensic interviews.

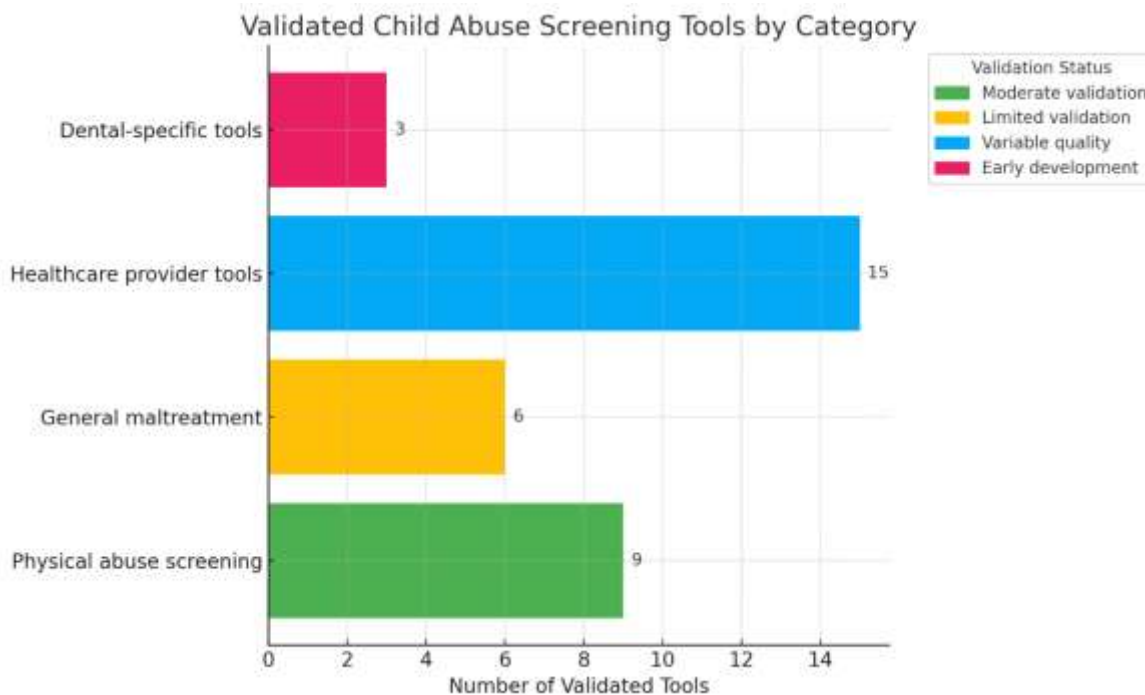
Caregiver Involvement: Balancing family involvement with child protection needs, especially when caregivers may be perpetrators.

Professional Boundaries: Maintaining appropriate therapeutic relationships while providing emotional support within the dental professional's scope of practice.

Contemporary Screening Tools and Assessment Methods

Validated Screening Instruments

Systematic reviews identify 15 assessment tools for child abuse screening used by healthcare providers, with nine specifically addressing physical abuse (7). However, research reveals significant gaps in tool validation and practical implementation guidance.

Table 3: Validated Child Abuse Screening Tools

Recent research provides culturally adaptable screening across diverse populations. These tools focus on core maltreatment indicators that researchers validated across multiple countries and cultural contexts.

Dental-specific screening tools developed using rigorous methodology offer practitioners objective assessment frameworks. These instruments help practitioners move beyond subjective impressions toward systematic evaluation of concerning presentations.

Technology Integration and Digital Solutions

Contemporary practices increasingly utilize electronic health records and digital documentation systems. Recent research demonstrates successful integration of universal screening protocols into electronic systems, improving detection rates and documentation quality.

Digital photography protocols for injury documentation require specific technical standards, including appropriate lighting, multiple angles, scale references, and secure storage systems. HIPAA compliance remains paramount when handling sensitive images of potential abuse.

Risk Assessment Algorithms

Emerging research develops algorithmic approaches to risk assessment, though human clinical judgment remains essential. Recent validation studies demonstrate successful application for specific injury patterns, though broader applications require additional research.

Practitioners must balance systematic screening approaches with clinical experience and cultural sensitivity. No screening tool replaces professional judgment, but validated instruments enhance objective assessment capabilities.

Documentation and Reporting Protocols

Evidence-Based Documentation Standards

Contemporary documentation requirements extend beyond traditional clinical notes to include forensic-quality recording that withstands legal scrutiny. Research demonstrates that high-quality documentation significantly improves prosecution outcomes and child protection effectiveness.

Documentation Requirements: Documentation must use specific anatomical terminology, precise measurements, and temporal indicators. For example, "purple discoloration measuring 3cm x 2cm on the left cheek, approximately 2-3 days old based on color progression" provides superior legal evidence compared to subjective descriptions.

Photographic Documentation Protocols: Current standards require multiple images, including general location views showing anatomical landmarks and close-up detail shots with measuring devices. Digital photography offers advantages for storage and transmission while requiring secure handling protocols.

Witness Documentation: All examinations and conversations require witness presence. This protects both patients and providers while ensuring accurate record-keeping of interactions and observations.

Updated Reporting Requirements and Timelines

Legal requirements vary by state but follow consistent patterns requiring immediate action for imminent danger and structured follow-up for non-emergency situations.

Table 4: Reporting Timeline Requirements by State Category

State Category	Initial Report	Written Follow-up	Documentation Retention
Category A (24 states)	Immediately	48 hours	Indefinite
Category B (18 states)	24 hours	72 hours	7 years minimum
Category C (8 states)	48 hours	5 days	10 years minimum

Current requirements typically mandate:

Immediate Oral Reports: Contact child protective services or law enforcement within 24 hours of identification, immediately for imminent danger situations.

Written Follow-up: Detailed written reports within 48-72 hours containing comprehensive information about

observations, conversations, and clinical findings.

Documentation Retention: Indefinite retention for most states, with a minimum of 7-10 years requirements for others.

Legal Protections and Professional Obligations

All states provide legal protection for good faith reporting, protecting healthcare providers from civil and criminal liability when reports are made with reasonable suspicion. Research demonstrates that fear of legal consequences represents an unfounded barrier, as no documented cases exist of providers facing legal action for appropriate reporting.

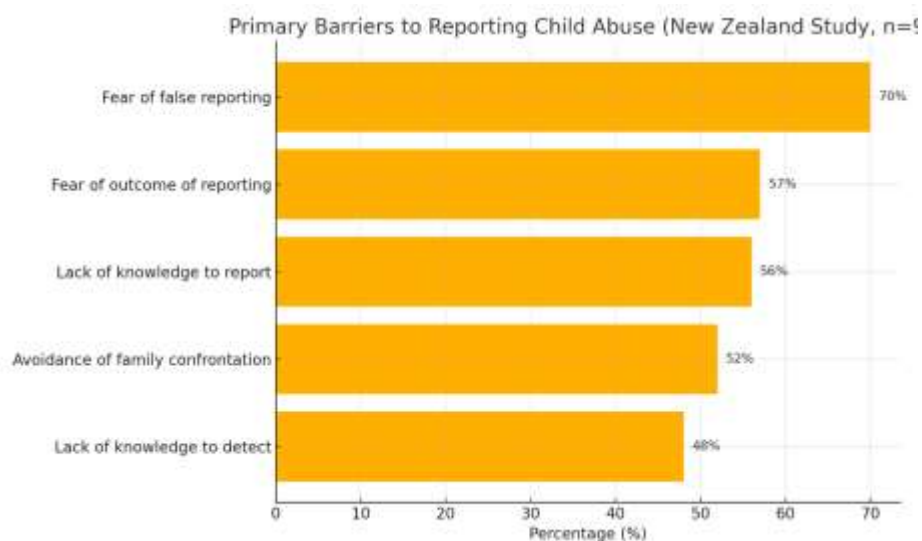
Professional obligations extend beyond legal requirements to ethical imperatives. Dental licensing boards increasingly emphasize child protection as a fundamental professional responsibility, with some states requiring specific training for license renewal.

Addressing Contemporary Barriers to Reporting

Knowledge and Training Gaps

Recent research identifies persistent knowledge deficits despite decades of awareness campaigns. New Zealand studies reveal that while 72% of dental professionals believe they can recognize signs of child abuse, only 48% report familiarity with reporting processes (2). During their professional careers, 62% had at least one suspected case, yet only 21% had ever reported their concerns.

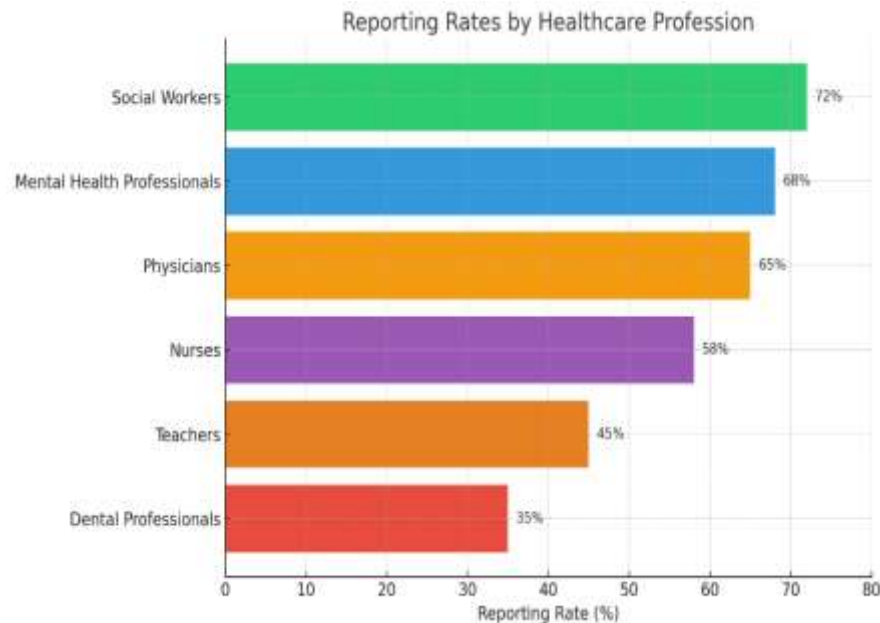
Chart 3: Barriers to Reporting Child Abuse Among Dental Professionals



Source: Han et al. 2022 (2)

Fear of false reporting (70%) represents the most significant barrier. In comparison, other concerns include fear of outcome of reporting (57%), lack of knowledge to report potential abuse (56%), avoidance of family confrontation (52%), and lack of expertise to detect potential child abuse (48%) (2).

Chart 4: Dental Professional Reporting Rates vs. Other Healthcare Providers



Effective training programs demonstrate measurable improvements in reporting likelihood. Research shows that targeted continuing education significantly increases dental hygienists' self-perceived likelihood to report suspected abuse, with effects lasting beyond immediate post-training periods (15).

Organizational and Systemic Barriers

Recent research emphasizes that training alone proves insufficient for sustained practice change (10). Successful implementation requires organizational support, including:

Policy Development: Clear office protocols addressing identification, documentation, and reporting procedures.

Ongoing Supervision: Regular case consultation and support for staff encountering difficult situations.

Multidisciplinary Partnerships: Established relationships with child protective services, law enforcement, and mental health professionals.

Quality Assurance: Regular review of cases and outcomes to improve system effectiveness.

Cultural and Communication Challenges

Contemporary practice serves increasingly diverse populations requiring culturally responsive approaches.

Research identifies specific challenges, including:

Language Barriers: Need for professional interpreters rather than family members when discussing sensitive topics.

Cultural Beliefs: Understanding diverse perspectives on discipline, family hierarchy, and healthcare authority that may influence reporting decisions.

Implicit Bias: Recognition of how provider assumptions about race, class, and family structure may influence abuse identification and reporting.

COVID-19 Adaptations and Future Preparedness

Pandemic-Specific Protocols

The COVID-19 pandemic created unprecedented challenges requiring adaptive responses. Current continuing education programs emphasize the need for heightened vigilance during public health emergencies when traditional reporting mechanisms experience disruption.

Enhanced Screening: Systematic assessment for pandemic-specific risk factors, including job loss, housing instability, substance abuse escalation, and social isolation.

Modified Service Delivery: Adaptation of trauma-informed care principles to accommodate infection control requirements while maintaining therapeutic relationships.

Technology Integration: Enhanced utilization of telehealth and digital communication methods while ensuring security and privacy protections.

Emergency Preparedness Planning

Research demonstrates the need for proactive planning for future public health emergencies. Effective preparedness includes:

Continuity Planning: Procedures for maintaining child protection protocols during service disruptions.

Communication Systems: Established methods for communicating with child protective services and law enforcement during emergencies.

Staff Training: Preparation for recognizing pandemic-specific risk factors and adapting screening approaches accordingly.

Implementation Strategies and Quality Improvement

Evidence-Based Training Programs

Successful training programs incorporate multiple elements based on contemporary adult learning research:

Multidisciplinary Approach: Integration of dental, mental health, and child protection expertise in educational design.

Case-Based Learning: Utilization of realistic scenarios allows practice of identification and reporting skills.

Ongoing Education: Regular updates addressing evolving research, legal requirements, and best practices.

Competency Assessment: Measurement of knowledge and skill acquisition rather than simple attendance requirements.

Practice Integration Strategies

Research demonstrates that successful implementation requires systematic practice integration:

Policy Development: Written protocols addressing all aspects of child protection from screening through follow-up.

Workflow Integration: Incorporation of screening and assessment into routine clinical procedures.

Technology Utilization: Implementation of electronic systems supporting documentation and reporting requirements.

Quality Monitoring: Regular review of identification rates, reporting patterns, and outcomes to guide continuous improvement.

Multidisciplinary Collaboration

Contemporary best practices emphasize team-based approaches extending beyond individual practitioner responsibility:

Child Advocacy Centers: Partnerships with specialized facilities providing coordinated services for abuse victims.

Mental Health Integration: Collaboration with trauma-informed mental health providers for comprehensive patient care.

Legal System Coordination: Understanding of legal processes and requirements for compelling testimony and evidence provision.

Community Partnerships: Relationships with schools, social services, and community organizations supporting comprehensive child protection.

Future Directions and Research Priorities

Technology and Innovation

Emerging technologies offer potential for enhanced child protection capabilities:

Artificial Intelligence: Development of screening algorithms supporting clinical decision-making while maintaining human oversight.

Digital Documentation: Advanced systems for secure storage, transmission, and analysis of sensitive

information.

Telehealth Integration: Expansion of remote screening and consultation capabilities while maintaining safety and privacy.

Research Gaps and Opportunities

Current evidence reveals significant gaps requiring future investigation:

Outcome Studies: Long-term research examining the effectiveness of various identification and intervention strategies.

Cultural Competency: Investigation of child protection approaches across diverse populations and communities.

Economic Analysis: Cost-effectiveness studies comparing prevention, early intervention, and post-abuse services.

International Perspectives: Cross-cultural studies of dental professional reporting practices and outcomes.

Educational and Professional Development

Evolving educational needs require innovative approaches:

Curriculum Integration: Systematic integration of child protection content throughout dental education rather than isolated courses.

Interprofessional Education: Collaborative training with other healthcare disciplines to improve coordination and communication.

Continuing Education Standards: Development of evidence-based requirements for ongoing professional development in child protection.

Conclusions and Recommendations

Dental professionals serve as critical frontline protectors for vulnerable children, with unique positioning to identify maltreatment that other healthcare providers might miss. Contemporary evidence demonstrates significant opportunities for improvement in identification, documentation, and reporting practices through evidence-based interventions.

Immediate Practice Recommendations

Implement Universal Trauma-Informed Care: Adopt trauma-informed principles in all patient interactions, recognizing that trauma affects approximately half of children and two-thirds of adults.

Utilize Validated Screening Tools: Implement systematic screening approaches using evidence-based

instruments rather than relying solely on clinical intuition.

Enhance Documentation Quality: Employ forensic-quality documentation standards with objective descriptions, precise measurements, and appropriate photographic evidence.

Strengthen Multidisciplinary Partnerships: Establish formal relationships with child protective services, law enforcement, and mental health professionals for coordinated response.

Update COVID-19 Protocols: Maintain heightened vigilance during public health emergencies when traditional reporting mechanisms experience disruption.

System-Level Improvements

Expand Training Programs: Implement evidence-based continuing education demonstrating measurable improvements in knowledge, attitudes, and reporting behaviors.

Integrate Technology Solutions: Utilize electronic health records and digital systems supporting systematic screening and secure documentation.

Develop Quality Assurance: Establish regular monitoring of identification rates, reporting patterns, and outcomes to guide continuous improvement.

Support Organizational Change: Provide policy development assistance, supervision, and ongoing support for practice transformation.

Research and Policy Priorities

Future efforts must address persistent gaps through targeted research and policy development. Priority areas include outcome studies examining the long-term effectiveness of various interventions, cultural competency research addressing diverse populations, and economic analyses comparing prevention versus intervention approaches.

Professional organizations, educational institutions, and regulatory bodies must collaborate to ensure that child protection becomes integral to dental practice rather than a peripheral responsibility. This includes curriculum integration, continuing education requirements, and professional accountability measures.

The COVID-19 pandemic highlighted vulnerabilities in child protection systems while demonstrating the dental profession's adaptability. Moving forward, practices must incorporate lessons learned while preparing for future challenges through enhanced training, improved systems, and strengthened partnerships.

Ultimately, protecting children from abuse and neglect represents both a legal obligation and a moral imperative for dental professionals. Contemporary evidence provides clear pathways for improvement through evidence-based practices, trauma-informed care, and systematic approaches to identification and reporting.

Implementation of these recommendations will strengthen child protection outcomes and fulfill the

profession's commitment to vulnerable populations.

THE ROLE OF THE DENTAL PROFESSIONAL IN CHILD PROTECTION

Identification • Documentation • Response

50-75%

of child abuse cases involve injuries to the head, neck, and oral cavity



RISK FACTORS

- Poverty
- Social isolation
- Parental substance abuse
- Parental mental illness

INDICATORS OF ABUSE

- Suspicious bruising
- Implausible injury explanation
- Behavioral changes
- Caregiver red flags

DOCUMENTATION & REPORTING

- Detailed injury description
- Photographic documentation
- Use of body diagrams
- Mandated reporting

BARRIERS TO REPORTING

- Limited training
- Fear of legal consequences
- Inadequate follow-up
- Concerns about misdiagnosis

Dental professionals can be crucial in recognizing and responding to child abuse while upholding ethical standards of patient care

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Medtronic