MSW Child Welfare Faculty Attitudes, Perceptions, and Knowledge of Pediatric Dental Neglect

Journal:	Professional Development: The International Journal of Continuing Social Work Education
Article Title:	*MSW Child Welfare Faculty Attitudes, Perceptions, and Knowledge of Pediatric Dental Neglect*
Author(s):	*Goldman, Discepolo, Pollack, Robins, Vyshedsky, and Auerbach*
Volume and Issue Number:	*Vol.27 No.1*
Manuscript ID:	*271032*
Page Number:	*32*
Year:	*2024*

Professional Development: The International Journal of Continuing Social Work Education is published two times a year (Spring and Winter) by the Center for Social and Behavioral Research at 1923 San Jacinto, D3500 Austin, TX 78712. Our website at www.profdevjournal.org contains additional information regarding submission of publications and subscriptions.

ISSN: 1097-4911

URL: www.profdevjournal.org **Email: www.profdevjournal.org/contact**

MSW Child Welfare Faculty Attitudes, Perceptions, and Knowledge of Pediatric Dental Neglect

Goldman, Discepolo, Pollack, Robins, Vyshedsky, and Auerbach

Abstract

This study aimed to examine the attitudes, perceptions, and knowledge of educators teaching Master of Social Work child welfare courses toward pediatric dental neglect. The study employed a quantitative cross-sectional descriptive design with four open-ended questions. While all participants generally noted the child maltreatment vignettes as serious and as constituting child maltreatment, dental neglect was seen as significantly less serious and less distinctly a form of child maltreatment.

Background

An Introduction to Dental Neglect

The American Academy of Pediatric Dentistry defines dental neglect as "willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection" (AAPD, 2022, p.16). There is no precise definition as to how many teeth, and the extent to which the teeth are affected by dental caries, qualifies as dental neglect (Hartung et al., 2019). Efforts to create standardized measurement tools are forthcoming. Oral manifestations include visually untreated cavities that can be detected by a lay person or nondental health professional (Ramazani, 2014). Children who suffer from dental neglect may experience pain, issues with eating, infection, loss of function and sleep, poor appearance, low weight, poor school performance, low self-esteem, and poor quality of life (Ramazani, 2014). These factors can thereby lead to poor nutrition, suboptimal learning outcomes, and subnormal growth and development (Costacurta et al., 2015**).**

Social determinants of health can be a contributing factor to untreated dental caries. Family socioeconomic status is a well-documented factor affecting oral health (Ramazani, 2014). The CDC (2021) states that children from low-income households and children of racial minority background have untreated caries in their primary teeth at much higher rates. These populations are also more likely to interact with the child welfare system (Laskey et al., 2012; Cénat et al., 2021). Therefore, to avoid potentially perpetuating discriminatory trends in child welfare referrals, it is crucial to evaluate the social factors that may contribute to a child's oral health status to identify true cases of dental neglect versus cases that result from barriers to care. It is also important to consider eligibility for Medicaid services does not directly translate to obtaining care. Only one in five children who are covered by Medicaid services receive preventive oral health care, even though they are eligible (Mouradian et al., 2000).

Despite its potentially detrimental health consequences, dental neglect is rarely an isolated issue that leads to its own child protection referral (Bradbury-Jones et al., 2013). Only a minute number of states have instituted mandated dental screening laws for school entry, amongst which the criteria and guidelines vary significantly (Fleming, 2019). Between 2008-2019, three states (South Carolina, Utah, and West Virginia) passed dental screening laws, bringing the number of states with such laws as of 2019 to 14, plus the District of Columbia, with efforts in two more states (Connecticut and Massachusetts) under process. A majority of states do not have any dental screening laws, and even states which have adopted mandated dental screening laws have reported difficulty in enforcing these laws.

Incorporating Dental Neglect into Child Welfare Curricula

While child welfare training exists in social work programs, the extent to which dental neglect is incorporated into the curriculum remains unclear. Title IV-E partnerships between social work educational institutions and state public child welfare agencies seek to improve the skill level of the workforce and allow for the retention of child welfare workers (Deglau et al., 2018). As part of the Social Security Act, Title IV-E provides federal funding to facilitate programming for children in the child welfare system (Newell & Bounds, 2020). The two components of Title IV-E agency/university partnerships are the place-

Katheryn Goldman, DMD, MPH, Ph.D, is Adjunct Instructor of Social Work at Wurzweiler
Keri Discepolo, DDS, MPH, is the Chair of the Department of Pediatric Dentistry at Boston University
Christine Vyshedsky, Ph.D, LCSW, is an Assistant Projessor at Wurzweiler School of Social Work
Paris Robins, BSW, MSW, Ph.D, is an Adjunct Lecturer at Yeshiva University
Charles Auerbach, Ph.D, is a Professor and Chair of Research at Wurzweiler School of Social Work
Daniel Pollack, MSW, JD, is a professor at Yeshiva University

ment of students into public child welfare agencies as their capstone field education experience and professional development, continuing education, and training of current child welfare workers (Newell & Bounds, 2020). Bertram et al. (2020) note that specifically denoted child welfare field instructors invest more time into this type of traineeship than they would in a more typical MSW field placement. Therefore, one might expect detailed child welfare training in these programs. Title IV-E agency/university partnerships, as well as child welfare educational courses in the MSW curriculum, provide foundational knowledge through which students can identify and analyze cases of child abuse and neglect.

Sobeck et al. (2022) indicate that field education is also a significant component of the social work curriculum that can provide students with real job exposure to the field of child welfare. Students can intern at public and private agencies and gain exposure to differences in worksite protocols, policies, programming, worker competency and evaluations, and the macro-micro continuum of service delivery. These experiences prepare students for clinical experience in child welfare and may present a strong opportunity to prepare students to evaluate and identify dental neglect, amongst other forms of child maltreatment, in a supervised setting. Both didactic and field placement educational programs at the MSW level in child welfare provide a starting point to understand the extent to which social workers are exposed to foundational knowledge and training surrounding identifying and managing cases of pediatric dental neglect. However, little is currently known about the extent to which dental neglect is incorporated into child welfare curricula in social work programs.

Methodology

Research Design

The study employed a descriptive design using a cross-sectional and purposive sampling strategy. A web-based quantitative survey with four open-response questions was sent to Master of Social Work faculty who teach child welfare. Prior to dissemination to faculty, the survey tool was evaluated by a child welfare expert to identify changes required to assist with the validity of the survey tool.

Data and Subjects

First, the research study obtained IRB approval. Prior to survey dissemination amongst the target demographic, a key informant who works in the field of child welfare and child welfare education made modifications to the survey to help achieve content validity. Content validity pertains to whether the survey tool covers all the content in the underlying construct (Fitzpatrick,1983). Master of Social Work programs were identified using the Council on Social Work Education website. Master of Social Work programs were selected due to students' likely subsequent attainment of licensure and participation in the workforce in the capacity of a social worker, thereby increasing the need for a strong foundational child welfare knowledge. Only fully accredited programs in the United States were considered for this study. Faculty who taught child welfare at the MSW level were identified via the program website or an identified institutional or child welfare faculty member. Only faculty who were currently on staff at the time of data collection were contacted to participate.

Measures

The survey was divided into four discrete sections. The first section provided five case vignettes modified from the CARIS Child Abuse Report Intention Scale. The survey was intended for nurses as an assessment of child welfare decision-making. A portion of the scale was modified with direct permission from the author for its use in this dissertation (Feng & Levine, 2005). The vignettes included cases of supervisory neglect, medical neglect, physical abuse, and sexual abuse. The dental neglect vignette was created de-novo as the CARIS vignettes did not include a case of dental neglect. After each vignette, the respondent was asked to rate the seriousness of the case on a scale of 1–10, with one being not at all serious and 10 being the most serious. The respondent was then asked the extent to which the case represents abuse/neglect on a scale of 1–10 with 1 being not and 10 being definitely yes. The final question asked for a decision on how to proceed with the case, the first option being a family assessment typically utilized for lower risk cases and one where blame was not asserted and the second being an investigative report, which would require the future need for substantiation (Child Welfare Information Gateway, 2020). Comparison of the responses between all the child maltreatment vignettes was utilized to analyze variability in responses and perspectives between dental neglect as a form of child maltreatment and

other forms of child maltreatment.

Subsequently, section two evaluated the respondents' knowledge, comfort in identifying, and comfort in managing cases of dental neglect. Knowledge of dental neglect was considered a moderating variable as it was hypothesized to moderate the relationship between the independent and dependent variables. The section also evaluated questions related to perceived level of importance of dental neglect. The third and fourth sections asked for demographic information of the individual participant and the institution.

In addition, there were open-response variables that were incorporated in the survey. Two of these questions evaluated why or why not an individual may be comfortable identifying/ managing cases of dental neglect. The remaining two response questions evaluated why the participant made the decision to pursue an investigative versus a family assessment response for dental neglect and medical neglect. This information helped to identify patterns in decision-making surrounding dental neglect and allowed for comparison to medical neglect.

Results

A total of 86 participants responded to the survey. Surveys were filtered for analysis based on respondents who answered questions past consent. This left 65 respondents who answered a portion of the survey with data appropriate for analysis. Sixty-two respondents completed at least one vignette. This was acceptable as HLM will work with incomplete data (raters) within clusters.

Quantitative Results

Descriptive Statistics

The sample reflected overall national demographic trends in social work professionals being predominantly white (67.39%) and female (81.6%; Salsberg et al., 2020). The second largest racial demographic group includes individuals who identified as Black or African American (26.09%). Only a small number of participants (6.1%) identified as being Hispanic, Latino, or Asian (2.17%) or Native Hawaiian or Other Pacific Island (4.35%). The mean age, years of work experience in child welfare, and years of teaching in child welfare of the participants exhibited large standard deviations, indicating a widespread in these variables. Most participants maintained an MSW degree (55.1%) and were full-time faculty (77.1%). About 68% of the respondents had experience supervising child welfare staff, and most of the participants taught child welfare in both a didactic and field instruction format (47.9%).

Most participants belonged to institutions that participated in a Title IV-E partnership (80.4%). Most participants also worked in institutions with greater than 15,000 students (53.1%), were found in urban settings (63.27%), and worked at public institutions (83.7%). Moreover, most of the programs were in the West (37.5%), followed by the South (25%), Midwest (22.9%), and Northeast (14.6%). Of the programs, 51.1% offered a child welfare concentration, and only 27.7% had an affiliated dental school.

The majority of MSW faculty respondents (64%) were not familiar with the AAPD definition of dental neglect. Most participants stated that they were sometimes (39.6%) or often (33.3%) comfortable managing, and sometimes (44.9%) or often (34.7%) comfortable identifying, cases of dental neglect. Most faculty believed that they did not have educational and clinical training to teach about dental neglect; however, many found it very relevant to the child welfare curriculum. Additionally, 87.8% expressed a willingness to receive additional training on dental neglect. Participants noted no (68%) or insufficient (26%) educational training, as well as no (80%) or insufficient (16%) clinical training, on dental neglect. The average cases of dental neglect managed by participants was 3.9; however, the standard deviation (7.7) noted a spread in the data. Many participants (46.9%) somewhat agreed that it was difficult to identify dental neglect in clinical practice. Participants also acknowledged that dental neglect is discussed very little (43.75%) in their child welfare curriculum.

Hierarchical Linear Modeling

As demonstrated in Table 1 (appendix), dental neglect had the lowest mean score on a scale of 1 –10 for the vignette being identified as child maltreatment. Dental neglect also had the highest standard deviation in rating scores, demonstrating a wider spread of scoring. Sexual abuse, followed by physical abuse, had the highest mean scores of identifications of the vignette as child maltreatment. Sexual abuse, followed by physical abuse, had the lowest standard deviations, demonstrating more uniformity in scoring amongst participants.

The HLM model supported the descriptive

data in Table 1. As demonstrated in Table 2 (appendix), when asked to score the vignette as to how much the situation constitutes neglect in the fixed portion of the model, dental neglect had the significantly greatest decrease in identification score compared to physical abuse, followed by medical neglect and then supervisory neglect. Sexual abuse had the smallest decrease in identification score when compared to physical abuse. The random effects parameters demonstrate variation from one participant to another in the ratings of identification of child abuse and neglect. The model demonstrates that there is the most agreement between participants when comparing identification scores of physical abuse to sexual abuse and the least agreement between participants comparing identification score of physical abuse to dental neglect.

As demonstrated in Table 3 (appendix), dental neglect had the lowest mean score on a scale of 1 –10 for seriousness of the events in the vignette, followed by medical neglect. Dental neglect also had the highest standard deviation in rating score, demonstrating a wider spread of scoring. Sexual abuse, followed by physical abuse, had the highest mean scores of seriousness and the lowest standard deviations respectively, identifying more uniformity in scoring. Like the findings for the dependent variable identification, the HLM model supports the data in Table 3. As shown in Table 4 (appendix), when asked to score the seriousness of the events in the vignette in the fixed portion of the model, dental neglect had the greatest decrease in seriousness score compared to physical abuse followed by medical and then supervisory neglect. There was no significant difference between the seriousness score of physical abuse and sexual abuse. The random effects parameters demonstrate that there is the most agreement between participants when comparing seriousness scores of physical abuse to sexual abuse and the least agreement between participants comparing seriousness scores of physical abuse to dental neglect.

The descriptive data of action taken in Table 5 was also supported by the data in the HLM model. As shown in Table 6 (appendix), which reports odds ratios for the dependent variable action, when controlling for experience as a child welfare supervisor, gender, years educating in child welfare, and frequency of dental neglect in the curriculum, the odds of investigation response of supervisory neglect decreased significantly by 55%, and for medical neglect and dental neglect decreased significantly by 98% compared to physical abuse. The odds of investigation of sexual abuse compared to physical abuse was not significantly different. Those individuals without supervisory experience had significantly higher odds of choosing an investigation response in the vignettes (234% increase). Females had significantly higher odds (597% increase) of choosing an investigation response in the vignettes. For every one-year increase in education experience in child welfare, the odds of choosing an investigative response in the vignettes increased by 9%. Finally, for every one unit increase in frequency of including dental neglect in the child welfare curriculum the odds of an investigation response in the vignettes decreased by 44%. Perceived level of importance did not affect perceived severity or classification of dental neglect. However, the frequency of dental neglect in the child welfare curriculum did affect the proposed action taken in the child welfare vignettes.

Qualitative Data

Four open-response questions were asked to obtain qualitative data. The first two open-response questions requested a rationale for why the participant chose the action response, the investigative or family assessment, for the medical and dental neglect vignettes. The remaining two open-response questions requested rationale for perceived comfort management and identification of cases of dental neglect. It must be noted that several participants responded that they did not have a choice between the two plans of action in their state.

Medical Neglect Action Rationale

Investigation Response

A common theme amongst participants who chose an investigative response was that the situation of medical neglect was an imminent health threat with potentially serious medical consequences, thereby implying a safety concern for the child. Participants also noted the young age of the child, which added to the child's vulnerability in the situation. Additionally, parental fitness was also questioned, noting that the parents were either unable or unwilling to obtain medical care for the child. Finally, participants also noted that the parents directly ignored a physician's directive of medical advice to obtain more advanced care for their child.

Family Assessment

Participants who chose family assessment primarily noted a lack of information on social barriers or health literacy barriers that may have caused the family to not present to the hospital. It was also noted that the parents sought assistance from the pediatrician, indicating concern for the child's well-being. Others questioned the amount of time that had elapsed between the initial pediatrician encounter and the lack of follow-up to the hospital, stating that there was inadequate information to determine whether enough time had passed for the directive to be considered ignored. Many individuals noted the role of the social worker to be facilitative and supportive toward the families, implying that the family assessment response was the preferred method to engage with the family to manifest a lasting long-term outcome.

Dental Neglect Action Rationale

Investigation Response

Like medical neglect, a common theme amongst participants who chose investigative response was that the situation of dental neglect was an imminent health threat with potentially serious medical consequences. Participants also noted that the child suffered actively from pain. Several participants who chose an investigation response identified that the family had already been engaged in obtaining resources and eliminating barriers to care and that the parents were made aware of the severity of the child's oral health condition. One participant also suggested the potential for child removal.

Family Assessment

Several participants who chose the family assessment response questioned the presence of unaddressed or unknown social or cultural barriers. Participants also noted a possibility of parental misunderstanding or lack of understanding of the severity of the child's oral health condition. A few participants believed that the child's condition was not life-threatening, or the health threat was of unknown risk. It was also noted that the family sought medical services albeit emergency care. While one participant did consider the concept of willful neglect, it was in the context of having to be deciphered from environmental factors, such as poverty and barriers to care that might impact the ability of the family to follow through with appointments. Finally, a common theme as found in the medical neglect vignette was that the family assessment approach was the preferred method to engage with the family to obtain long-term change. Moreover, one respondent stated that substantiating child abuse did not ensure family compliance.

Comfort Identifying and Managing Dental Neglect

Individuals purporting higher levels of comfort managing cases of dental neglect pointed to previous exposure or significant experience in the child welfare workforce. Having the ability to consult with a dental professional was also reported to provide greater comfort in managing cases of dental neglect. Participants who never managed a case in practice or reported no training on the subject felt less comfortable managing cases of dental neglect. Additionally, a few participants reported it to be out of their scope of care. Other participants also pointed to situational factors, such as a lack of resources for families to obtain dental care, which made them feel less comfortable managing these cases.

Specifically, in terms of identifying cases of dental neglect, several participants noted that state definitions of neglect are not necessarily congruent with the AAPD definition, and dental neglect is not necessarily operationalized.

Discussion

While the quantitative data reflected similar action trends for both medical neglect and dental neglect, the medical neglect vignette was written more vaguely as it did not address the family's social barriers. Therefore, it can be said that the vagueness in the medical vignette could more readily account for the variability in qualitative rationales for the action of medical neglect. The dental neglect vignette, however, addressed the unknown social, educational, and financial factors of the scenario. The dental neglect vignette stated that the child was in significant pain and suffered from an infection associated with untreated dental caries. Reasonable accommodations had been made for the family to attend appointments, which addressed transportation and financial barriers. The vignette also stated that the family was informed of and understood the severity of the child's oral health condition. Many participants distinctly noted these findings in their rationale, including the current active serious harm to the

child's health due to untreated dental caries. However, regardless of these factors being directly addressed in the vignette, many participants still provided rationale pointing to a concern for unaddressed social and cultural barriers to obtaining care, a need to continue to educate the family due to a lack of understanding, and the child's oral health status being of nonurgent or of unknown risk.

It is interesting to note this phenomenon of the continuation to seek social barriers and deficits in familial understanding as an explanation for the family's behavior for those who chose the family assessment response, even after these factors were addressed in the dental neglect vignette. This phenomenon may also be due to the perceived notion of lack of a potential for serious harm relating to untreated dental caries. The quantitative data supported the qualitative data, depicting that dental neglect is seen as less serious and less distinctly a form of child maltreatment. Based upon the information given in the vignette of pain and infection secondary to untreated dental caries, denoting the child's oral health risk as unknown or not of imminent risk is possibly suggestive of a lack of understanding of the severity of the systemic health consequences of untreated dental infection and dental caries large enough to cause a child significant pain. The consequences of untreated dental infection and severe untreated dental caries can be life-threatening and in serious cases result in death.

Irrespective of the action chosen, the variability in rationale toward the dental neglect vignette demonstrated a lack of uniformity in the way in which dental neglect is conceptualized by MSW child welfare educators. The spectrum of responses varied from child removal to solely helping the family recognize the needs of the child. The quantitative data also reflected this trend, since there was the least agreement among participants when comparing physical abuse to dental neglect in both seriousness and identification with respect to other forms of child maltreatment. The mean scores of identifications and seriousness were also the lowest for dental neglect with the greatest standard deviations.

In terms of action taken, dental neglect had the highest percentage of family assessment responses followed by medical neglect and then supervisory neglect. The generalized trend in the sample toward family assessment response for all forms of child neglect must also be considered. In the qualitative data, participants noted choosing family assessment as a means of developing a better rapport with families as well as better long-term and lasting changes for the families. Research conducted in Ohio that piloted the alternative response (family assessment) in the state found that the safety of the child was not lessened or compromised by the introduction of the alternative response/family assessment approach (Kaplan & Rohm, 2010). The pilot found that when the families had greater satisfaction with the treatment by their worker, a significant increase in services related to poverty, counseling, mental health services, and satisfaction of families was observed (Kaplan & Rohm, 2010). Therefore, family assessment may be the preferred, and is arguably the most reasonably appropriate, means of addressing the underlying social barriers that result in child neglect. However, the question of whether family assessment is still the appropriate response when services have been attempted to be addressed remains unanswered as in the case of the dental neglect vignette.

Conclusion

Implications for Social Education

The MSW curriculum provides foundational knowledge for the social work profession. Any professional interacting with children, including social workers, must be well-versed in the signs of child maltreatment, which includes dental neglect. By ensuring that MSW child welfare educators are prepared to educate social workers entering the profession, the new professionals would be equipped with the appropriate tools to identify signs of dental neglect in practice.

Implications for Social Policy and Practice

While oral health is an integral part of greater physical health, dental care itself is treated disparately by the greater healthcare system within the United States. Medical and dental training are completed, for the most part, independently of one another. Policy and practice surrounding dental neglect must acknowledge this dichotomy. As discussed in the study problem, while it is normalized to require vaccination and physicals for school entry, mandating dental screenings is less uniformly enforced and practiced. This means that children may more readily fall through the cracks in obtaining dental care.

It is also imperative to note that dental care is often practiced outside of a hospital setting in

private offices and is more susceptible to barriers to access to care, including insurance acceptance, transportation, and social familial factors. For this reason, identifying dental neglect in practice relies heavily on the ability to obtain a historical understanding of the child's dental health, which can help guide social work decision-making in practice. Increasing interdisciplinary care between the social work and dental professions can help to mitigate barriers that may be associated with a family's inability to follow through with dental care for the child and result in an inappropriate referral to child protection services.

Limitations

This study has several limitations. Primarily, when disseminating a voluntary survey, participants are a self-selecting population, and therefore are subject to response bias. Secondly, while the chosen sampling strategy was necessary to reach the target population, it also limited the generalizability and potential representativeness of the sample population as it made use of a non-random sampling method. Furthermore, while all the eligible schools were contacted to participate, generalizability was not likely. Thirdly, the research did not consider the individual participants' perceptions, experiences of, and attitudes towards dentistry in general. The participant's ideas and values about dentistry may have impacted the way that the participant rated the dental neglect vignette. Finally, none of the vignettes indicated the race of the child as it was desired for the comparison between types of child abuse and neglect to occur within relative isolation. Jones (2015) found that when controlling for poverty and other risk factors, African American, Native American, and Multiracial children were less likely to be assigned to family assessment responses compared to Caucasian children for some years in the time frame of the conducted study. As the vignettes in the current survey did not address the race of the child, it cannot be stated how race may have potentially impacted the action taken by faculty members.

References

Bertram, R., Collins, C., & Elsen, M. (2020). University partnership in child welfare workforce preparation and program implementation. Journal of Family Social Work, 23(2), 151–163.

Bradbury-Jones, C., Innes, N., Evans, D., Ballantyne, F., & Taylor, J. (2013). Dental neglect as a marker of broader neglect: A qualitative investigation of public health nurses' assessments of oral health in preschool children. *BMC Public Health*, *13*(1), 1–12.

Cénat, J. M., McIntee, S. E., Mukunzi, J. N., & Noorishad, PG. (2021). Overrepresentation of black children in the child welfare system: A systematic review to understand and better act. Children and Youth Services Review, 120, 105714.

Centers for Disease Control and Prevention. (2021). *Basics of Oral Health*. Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html

Child Welfare Information Gateway. (2020). *Differential response: A primer for child welfare professionals.* U.S. Department of Health and Human Services, Children's Bureau.

Costacurta, M., Benavoli, D., Arcudi, G., & Docimo, R. (2015). Oral and dental signs of child abuse and neglect. *ORAL & Implantology*, *8* (2–3), 68.

Deglau, E., Akincigil, A., Ray, A., & Bauwens, J. (2018). What's in an MSW? Graduate education for public child welfare workers, intention, engagement, and work environment. *Journal of Public Child Welfare*, *12*(3), 238–263.

Feng, J. Y., & Levine, M. (2005). Factors associated with nurses' intention to report child abuse: A national survey of Taiwanese nurses. *Child Abuse & Neglect*, *29*(7), 783–795

Fitzpatrick, A. R. (1983). The meaning of content validity. *Applied Psychological Measurement*, *7*(1), 3–13.Hartung, B., Schaper, J., Fischer, K., & Ritz-Timme, S. (2019). Care for children with dental neglect: Identification of problems and approaches to solving them. *International Journal of Legal Medicine*, *133*(2), 641–650.

Jones, A. S. (2015). Implementation of differential response: A racial equity analysis. *Child Abuse & Neglect*, *39*, 73–85.

Kaplan, C., & Rohm, A. (2010). Ohio alternative response pilot project: Final report of the AIM team. Retrieved from https://www.supremecourt.ohio.gov/docs/Boards/familyCourts/ARPilot/ExecutiveSummary.pdf

Laskey, A. L., Stump, T. E., Perkins, S. M., Zimet, G. D., Sherman, S. J., & Downs, S. M. (2012). Influence of race and socioeconomic status on the diagnosis of child abuse: A randomized study. *The Journal of Pediatrics*, *160*(6), 1003–1008.

Mouradian, W. E., Wehr, E., & Crall, J. J. (2000). Disparities in children's oral health and access to dental care. *JAMA*, *284*(20), 2625–2631.

Newell, J. M., & Bounds, C. W. (2020). University agency partnerships: A title IV-E training initiative on ethics and child welfare practice. *Field Educator*, *10*(2), 1–9.

Ramazani N. Child dental neglect: A short review. Int. J. High Risk Behav. Addict. 2014;3:e21861. doi: 10.5812/ijhrba.21861.

Salsberg, E., Quigley, L., Richwine, C., Silwa, S., Acquaviva, K., & Wyche, K. (2020). *The social work profession: Findings from three years of surveys of new social workers.* The Council on Social Work Education. https://www.socialworkers.org/LinkClick.aspx?fileticket=1_j2EXVNspY%3D&portalid=0

Sobeck, J., Boraggina-Ballard, L., Najor-Durack, A., Lashore, T., & Olivera, A. (2022). High impact practices in graduate education: Preparing social work students for careers in child welfare. Journal of Social Work Education, 1–16 .

Appendix

Table 1

Average Score of Dependent Variable Identifications Across Vignettes

	Mean	*SD*	*N*
Supervisory Neglect	9.2	1.7	62
Medical Neglect	8.7	1.5	58
Dental Neglect	7.9	1.8	53
Physical Abuse	9.4	1.4	55
Sexual Abuse	9.9	0.6	54
Total	9.0	1.6	282

Table 2 *Dependent Variable Identification HLM*

Type of Abuse / Neglect	*Coefficient*	*CI*		*p*
Supervisory Neglect	-0.6821684	-1.098492	-.2658447	0.001
Medical Neglect	-1.148996	-1.540312	-.7576795	0.000
Dental Neglect	-1.909381	-2.393758	-1.425005	0.000
Sexual Abuse	-0.4145839	-0.7987279	-0.03044	0.034
Cons	9.855512	9.686565	10.02446	0.000

Random-effects Parameters	*Estimates*
Supervisory Neglect	1.484974
Medical Neglect	1.320995
Dental Neglect	1.645039
Sexual Abuse	1.255069
Cons	0.371454

Observations 282

Table 3
Average Score of Dependent Variable Seriousness Across Vignettes

	Mean	*SD*	*N*
Supervisory Neglect	9.3	1.2	62
Medical Neglect	8.9	1.2	59
Dental Neglect	8.0	1.5	54
Physical Abuse	9.8	0.6	55
Sexual Abuse	9.9	0.44	55
Total	9.1	1.3	285

Table 4 *Dependent Variable Seriousness HLM*

Type of Abuse /Neglect	*Coefficient*	*CI*	*p*
Supervisory Neglect	-.5272842	-.8236733 -.230895	0.000
Medical Neglect	-.9666714	-1.281773 .65156955	0.000
Dental Neglect	-1.824478	-2.212914 -1.436042	0.000
Sexual Abuse	-.0545455	-.2202693 .1111784	0.519
Cons	9.859838	9.742132 9.977544	0.000
Random-effects Parameters	*Estimates*		
Supervisory Neglect	1.101133		
Medical Neglect	1.153298		
Dental Neglect	1.393914		
Sexual Abuse	.3325817		
Observations 285			

Table 5
Comparison of Dependent Variable Action Taken in Vignettes

Vignette	*Family Assessment*	*Investigation*
Supervisory Neglect	23 (37%)	39 (63%)
Medical Neglect	30 (51%)	29 (49%)
Dental Neglect	33 (61%)	21 (39%)
Physical Abuse	6 (11%)	48 (89%)
Sexual Abuse	3 (6%)	51 (94%)
Total	95 (34%)	188 (66%)

Table 6
Dependent Variable Action HLM

Type of Abuse / Neglect	*OR*	*CI*	*p*
Experience as Child Welfare Supervisor (No)	3.340411	1.277828 8.732277	0.014
Gender (Female)	6.974192	1.999541 24.32527	0.002
Frequency of Dental Neglect in Curriculum	.5601354	.3280753 .9563403	0.034
Years Educating in Child Welfare	1.089666	1.024329 1.159171	0.006
Supervisory Neglect	.045032	.0070308 .2884278	0.001
Medical Neglect	.0244146	.0033303 .178984	0.000
Dental Neglect	.0244005	.0033257 .1790272	0.000
Sexual Abuse	.5318408	.100273. 2.820846	0.458
Cons	7.187348	.7165899 72.08862	0.094
var(cons)	.3305332	.0007036 155.2738	

Observations 221