Integrating Knowledge of the Child Welfare System into Medical Education: Preparing Future Physicians to Serve Vulnerable Populations

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BACKGROUND

Medicine and social systems interact frequently, and can be siloed yet demonstrative in patient outcomes. The child welfare system is an important example of this dynamic, which is not often discussed in medical school and can be complicated by delicate local and national politics. Within Rhode Island, Black children are 2.3 times more likely to be investigated by the Department of Children, Youth, and Families (DCYF) with Latino children following closely behind with a 1.9 times higher likelihood comparatively to their White counterparts.[1] The highest rates of investigation were in Woonsocket, Central Falls, Pawtucket and Providence, cities with some of the lowest average incomes in the state, as well as some of the highest numbers of Black and Brown families.[2] It is not a coincidence that historically marginalized populations are disproportionately affected by the child welfare system. In Rhode Island, 80% of DCYF investigations are for neglect, a broad categorization that includes "a failure to provide for basic needs."[2] This intersects with topics such as substance use disorder, which continues to persist given the nation's continued prescription drug and opioid epidemic. Birthing parents who use substances have historically had their children removed from their care, denying important opportunities to bond with their children with acts such as skin-to-skin contact. The Substance Exposed Newborn program was then established at the Rhode Island Department of Health to address this problem by managing the plan of safe care which documents and offers referrals that address the bio-psychosocial needs of the infant and birthing parent to avoid separating families.

Scholars have argued that investigating child neglect – particularly in a country with increasing cuts to social safety nets – is a method of criminalizing poverty, putting poor children at greater risk of being removed from their homes.[3] As future physicians, it is important that medical students not only understand this country's history of separating families of color, but also how to provide support and resources to these families and work against systemic oppression in the present day.

GAPS IN MEDICAL EDUCATION

Medical professionals frequently interface with child welfare agencies when identifying and reporting suspected cases of child abuse and/or neglect; however, this critical topic is underrepresented in medical education. One study found that in a population of 179 medical students, 77.7% demonstrated a low knowledge of child abuse/neglect diagnosis.[4] The study authors pointed out that inadequate medical school education can lead to a gap in future medical doctor knowledge. This educational deficiency can leave doctors unable to effectively fulfill their responsibility to protect children and to reflect on systemic contributors such as lack of financial resources, dwindling community support, linguistic barriers, and other social factors which could be mitigated by providing connection to social support systems locally or nationally.

Medical students may learn the legal requirements of mandatory reporting, but are rarely taught about the intricacies of the child welfare system, including how cases are investigated, the types of support available for families, and how to work collaboratively with social workers and other professionals involved in child welfare. Thus, despite the critical role physicians play in child protection, early medical education that could provide exposure and knowledge falls short in preparing students for their future responsibilities.[5] This gap continues far past the classroom as well, as a 2004 study found that 92% of residents surveyed felt they needed further training in child protection, including 85% of graduating residents of that year.[6] Furthermore, other research has found that healthcare providers reported receiving very little formal training in child maltreatment unless they specialized in child abuse pediatrics, with one sharing that, "during training in medical school in general pediatrics, [child maltreatment is] a very small part of the core curriculum, but everyone has some degree of exposure."[7] These findings highlight a national issue in medical education, one that must be addressed to ensure future physicians are prepared to support families in the most productive way possible with multiple social supports, necessitating only rare involvement with the child welfare system.

DCYF EDUCATIONAL PANEL AT BROWN UNIVERSITY

In the hopes of bridging this gap in knowledge, we organized an education panel discussion as part of our Warren Alpert Medical School Master's course in Population and Clinical Medicine. The aim of this opportunity was to educate medical students on the importance of understanding DCYF investigative practices and their impact on the community. This panel consisted of a family physician, a peer recovery specialist, a DCYF administrator, and two individuals with prior experience of DCYF involvement. A survey assessing the following domains were provided to students: satisfaction with the panel (e.g., areas done well and areas to improve in); prior exposure to DCYF; confidence in their understanding of DCYF policies and investigative

Table 1. Survey Responses (N=11)

Variable		N	%
Prior Exposure to DCYF	Yes	6	54.5%
	No	5	45.5%
Do you believe your medical school education has made you feel confident in understanding DCYF and their investigation process?	Strongly Disagree Disagree Neither Agree nor Disagree Agree Strongly Agree	5 4 1 1 0	45.5% 36.4% 9.1% 9.1% 0%
Do you think this panel and associated readings should be made a required portion of medical school?	Strongly Disagree Disagree Neither Agree nor Disagree Agree Strongly Agree	0 0 0 4 7	0% 0% 0% 36.4% 63.6%

processes via their medical school education thus far; and desirability to integrate readings and this panel into future medical school curricula. Eleven attendees responded to the survey with the results provided in **Table 1**. One participant stated, "This was the best panel I have ever attended at the medical school. I learned so much about DCYF and left with a whole new understanding of the system, how it operates, and how I can counsel my patients on interacting with them…I would strongly suggest adding this to the doctoring curriculum – I know it would be incredibly impactful."

These findings underscore a significant shortcoming in medical education. As future physicians, medical students must be equipped with a foundational knowledge of DCYF, and similar child welfare agencies to adequately serve children and families in distress. Without this knowledge, physicians may find themselves ill-prepared to navigate the complexities of child abuse cases, potentially overlooking warning signs or failing to provide appropriate support to families in crisis without consideration of other social services available to families.

RECOMMENDATIONS FOR MEDICAL EDUCATION

Given the importance of understanding child welfare systems, it is clear that more comprehensive training on these topics should be integrated into medical curricula. This could take the form of dedicated lectures, workshops, and panel discussions. Involving people with lived experience from both sides of the system can be instrumental, and also forwards partnerships in the community. Medical schools should also consider incorporating case studies and simulations that allow students to practice identifying signs of abuse, when to report cases to child protective services, when to direct to social support networks, and working with multidisciplinary teams to assist children and families before the child welfare system needs to be involved.

In addition, medical students should be encouraged to engage with child welfare systems during their clinical rotations, allowing them to understand first-hand what the process entails and potential avenues of redirection before calling. To this end, they can develop a deeper understanding of the challenges and complexities of child welfare cases as well as the role that physicians play in protecting vulnerable children. Not every situation needs to be reported, and instead by partnering with social workers and other community organizations, involving a family with the child welfare system can be avoided.

In conclusion, integrating knowledge of DCYF into medical education is not just a matter of fulfilling legal requirements – it is about equipping future physicians with the tools they need to provide comprehensive, compassionate, and socially minded care to some of the most vulnerable members of society. It is also about strengthening the relationships and mutual understanding between social systems and medicine, for the betterment and justice of the community as a whole. Our survey results and broader research underscore the need for medical schools to prioritize this area of education. By making these changes, we can ensure that future physicians are not only prepared to diagnose and treat illness, but also advocate for the safety and well-being of children and families in crisis. ❖

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Disclosures

None