

Presenters: Female Narrator; Tom Oates, Child Welfare Information Gateway; Kathi Wells, Kempe Center for the Prevention and Treatment of Child Abuse and Neglect

[00:00:00]: Music Introduction

**FEMALE NARRATOR** [00:00:03]: This is the Child Welfare Information Gateway Podcast, a place for those who care about strengthening families and protecting children. You'll hear about the innovations, emerging trends and success stories across child welfare direct from those striving to make a difference. This is your place for new ideas and information to support your work to improve the lives of children, youth, and families.

**TOM OATES** [00:00:33]: The coronavirus pandemic could be the event with the greatest impact to the planet for the arguably past 70 years. With all the events that made up the story of a tumultuous 2020, the way our day-to-day lives changed because of the pandemic - that's the lead. It caused us to question; question our methods, question our leaders, question ourselves. From this, we've adapted to new ways of working, interacting, and sharing information. And of course, child welfare was no different. Welcome into the Child Welfare Information Gateway podcast. I'm Tom Oates and happy you are here with us. We are continuing and really, wrapping up our series on What Did Child Welfare Learn from 2020. Now, check out our other episodes in this series that explored how caseworkers worked to manage their own energy against the elevated levels of anxiety and stress, and the movement to remake child welfare into an anti-racist, equitable and more just system.

[00:01:36]: Now, this episode dives into the changes the field has taken, and is taking, to not only support, but participate in, our communities' public health. The pandemic made us think about our own health and safety and that of the children and families involved in the child welfare system. But along with that, the general shift toward prevention and supporting families is bringing child welfare together with other social service disciplines. And all of this is to work upstream in a public health approach. Now, 2020 saw the field – sometimes out of necessity – adopt new tools and practices, and expand its partnerships to increase information sharing and learning and to help navigate and adapt to our new environment.

[00:02:21]: Now, to talk about this intersection of child welfare and public health, we talked with Dr. Kathi Wells, the Executive Director of the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect – and yes, she's a doctor. She's a practicing pediatrician. So, we discuss how the child welfare field initially reacted to the pandemic, the connections being developed to bring multiple disciplines to the table (or 'virtual table' in today's environment), and the shift in being public about mistakes and how that leads to greater improvements in service delivery, and the value of approaching child welfare as a teammate with other human services to improve the well-being and social determinants of health for our communities. Now, I doubt there's many people who would want to experience 2020 all over again, but there were some things the previous year taught us and forced us to implement that we can take away as actual improvements. Okay, reviewing what child welfare learned from 2020, with an eye toward service delivery as an element of public health with Dr. Kathi Wells, here on the Child Welfare Information Gateway podcast.

[00:03:31]: Dr. Kathi Wells, thanks so much for taking the time and joining us here on the Child Welfare Information Gateway podcast.

**KATHI WELLS** [00:03:38]: Thank you for having me, it's truly a pleasure, I appreciate it.

**TOM OATES** [00:03:41]: And I think this is really unique, in terms of looking back in 2020 in terms of what did the field learn and approaching child welfare in terms of a public health approach. I'm really, really glad that we have you on specifically, because as we take a look from the child welfare lens, yes, you come to us as Executive Director of the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, but let's also not forget that you are also the section head for child abuse and the associate professor of pediatrics at the University of Colorado School of Medicine. And, so, you have this connection, also with the Children's Hospital of Colorado, so this wonderful intersection in looking at how the field has reacted to 2020, but the shift toward public health. And, so let me start by kind of going back to - I guess, when we talk about 2020 - where it all began. And so, the pandemic first hit and states and locations were implementing the shut down or the stay-at-home orders, what did you see when we look back at how the child welfare field initially reacted to those stay-at-home orders?

**KATHI WELLS** [00:04:52]: Yeah. You know, it was, what I saw is a lot of great conversations and reaching out and recognizing that in many ways, I guess being in a pandemic - I think probably the first one any of us have been in, luckily - it means there's no great, easy answers. And so, I really, one of the things that I saw was pretty quickly, people were reaching out to one another in innovative ways. In Colorado, the director of child welfare started hosting these town halls for anybody within the child welfare system that wanted to participate at any level, right - supervisor, all the way down to the front-line staff. And, we began to have conversations that spanned healthcare and the courts and child welfare and placement agencies and folks that were really having to tackle difficult questions, not just about the daily work but, and how families and kids were affected, but also how that affected the workforce. And, you know, so, I think really how do we as a healthcare system try to bring at least the information we were getting - we were daily briefed and sometimes multiple times a day - as a healthcare person, right, trying to figure out how we made sure our healthcare settings were responding the right way. But then, we had opportunities to have those pretty immediate conversations with child welfare and courts and other systems that were trying to make really important decisions for kids and families during this difficult time, as well.

**TOM OATES** [00:06:21]: When you think back to all of those questions that kind, you know, flooded out from every part of this system and the systems that are connected to this system, what do you recall as maybe those main unanswered questions that really folks were struggling with?

**KATHI WELLS** [00:06:37]: Yeah. I think one was safety, right. So, worker safety and working differently. Right, so what does that look like when a worker is not able to assess a child or a family in the same way, right. Not in person, maybe virtually. And, what does it mean for that worker going home to their own family and what risks might they be bringing home and what stresses. You know, I have such tremendous respect for my child welfare colleagues, you know, how hard the work is anyway and then having to try to do it almost with one or two hands tied behind your back just seemed really limiting. There are a lot of questions around, you know, decreased calls to the hotlines, right, so fewer reports and what did that mean. And, you know, I think we still don't fully understand, but there was a lot of, you know, conversations that spanned - oh my goodness, these children are in homes where maybe they're not safe and nobody sees them, they're not being seen by the traditional reporters all the way to well, maybe families are doing better than we would've expected or maybe things get reported that

maybe are more along the lines of a family that doesn't have resources, poverty that maybe really shouldn't rise to the level of child welfare.

[00:07:53]: So, those were, you know, some of the questions that were coming up. I think the other one was a lot of questions around placement, visitation. And so, professional visitation, professional interactions in terms of assessing child safety, but also reports and caseworkers were having to make decisions about being able to have contact with family members. And, when we put children in places, whether it's a residential treatment location, you know, setting or whether it's a foster or a kin setting, having a location that's safe. And so, there are a lot of questions about just the actual work, about placement and safety and where kids are if they're not in a safe place and then just personal safety of workers. So, just, this whole new level of fear and I think difficulty for the work being done every day. Going home to their own families - am I bringing something home?

**TOM OATES** [00:08:49]: Despite the fear and despite the additional constraints, however, the work still had to go, you know, the work must go on, right? And yet, we're also dealing with a field that many times is dealing with limited resources, so folks are forced to be resourceful. So, in that resourceful theme, where did you see - at least from your vantage point - the actions that agencies were taking to kind of work around all those constraints and still try to connect with families as best they could?

**KATHI WELLS** [00:09:20]: Yeah. Creative things around, you know, getting families access to the internet that wouldn't have access. So, they could now actually participate in a court hearing. Kids, so they could participate in things like school, obviously has been an issue. But also, other things, you know, we, you know, because I was in these daily briefings at a hospital level, you know, we heard about things like getting access to testing. We began to ask questions - well what about a child that needs to go into an out of home placement for a host of reasons. Maybe their parents are both ill and not able to care for them or their single parent. Maybe there is a safety concern, maybe there's been a violent incident at home. And how do we know that child is not bringing something to a placement, right, so placements became a concern. And, you know, we did sort of assemble the right people and started asking the right questions and when we brought these questions to the medical community, they said well, yeah, we got to find a way to test them, the child or maybe even caseworkers in certain circumstances like we would our healthcare professionals. Because, they're having to perform duties that in many ways are very similar to what healthcare workers are doing.

[00:10:28]: So, I think really it shined a light on caseworkers as being really essential workers and having to do it with, like you said, limited resources and where can we really leverage those partnerships to get them access to whatever we possibly could - like testing, like safety, personal protective equipment. That was another thing that was talked about a lot was not having access to PPE and, you know, what were, you know, we had access to some of the best infectious disease specialists in our field and so tapping their brains around what should we be recommending for Department of Human Services Agencies for their caseworkers in terms of what they should be donning and not donning, right, as we say in the medical parlance, you know, masking, clothing, you know, what makes sense, given their contact so that they can feel as safe as possible based on the information that was literally churning out daily.

**TOM OATES** [00:11:25]: And with all of that then there was this idea of you're still trying to create contact, how do you do it safely. And so, if there's one theme that we saw across - and not only child welfare, I mean, as you're talking about the daily briefings, I'm not sure many of them were done in a single room around one table. We were talking as you and I are talking from about 2,000 miles away,

we're looking at each other through a computer screen and you mentioned the idea of getting access to the internet, getting access to remote meetings for courts or for visits. And so, we're finding ourselves now in this world of connecting remotely, right, and so, that looks like something that as much as it was a theme and seen and embraced across 2020, we're still gonna be looking at that as a tool as we move forward. So, I'd like your take both from, from really the healthcare and the caseworker kind of perspective on this idea of connecting remotely - and there have gotta be pros and there have gotta be cons not only for the staff, but also for the families involved, as well. I know it's a big topic because now everything quote unquote is remote, but in terms of administering services and the health involved, give me a sense of the pros and cons when you think about okay, service delivery remotely in child welfare.

**KATHI WELLS** [00:12:50]: Yeah. Well, I'm gonna speak first to the professional benefit in terms of we were able to assemble people and connect people that might have not been able to connect in the same way. And, I mean by that I might be able to call our infectious disease specialist and have them jump on a quick meeting with the child welfare director or someone like that. So, there was some interesting twists that way, right. It might have been harder to get those folks together. But, in terms of service delivery, you know, you're right, I mean, there's some aspects both in the healthcare world and in child welfare world where there are advantages, right. So, we could see kids, you know, we could provide a telehealth visit - Children's Hospital Colorado did just this incredible job of ramping up telehealth very quickly. And so, there were able to be health visits in a safe way and seeing kids.

[00:13:42]: Same thing with child welfare or court hearings or visitations; that you could actually access people maybe a little bit - as long as they had access to the internet, a little bit easier than if they had to hop three buses and try to get into a hearing or meet with a caseworker. So, there were definitely, you know - and I think some of that, you know, may take with us, right, the advantages of connecting that way, the advantages of following up on a patient when we don't necessarily. My first visit with my new primary care provider was virtual. And, you know, it afforded me an opportunity to see my doctor even though we were in a lock down. On the flip side, of course, is the inability to see not only just relationship, right, I think we could connect in ways that we haven't before but it's always better when there was a relationship first, right, there's a trust relationship. And then, what you can see, right. So, we see each other in a box, so a square box. And, we even have fancy things like virtual backgrounds that can hide things behind us.

[00:14:50]: And yet, that's only a very small lens of what's going on in that world and you know, I've had even educators and other health professionals tell me of things that they've seen, even talking about their own kids in classrooms, things that they've seen in the background that was very telling as to what their environment was and they would've never realized that. Of course, for caseworkers that are often going into the home and experiencing that - different from a teacher, different than a doctor would - it also limits their ability to see what that environment looks like. And I think that creates a lot of angst for those providers, knowing that they're limited in that way. So, there's definitely, you know, two sides to that in terms of being able to access and being able to maybe connect with someone quicker without having the challenges they might face in terms of transportation, but the downside of limited in what you can see and experience and smell and hear about what's going on in that world.

**TOM OATES** [00:15:53]: Yeah, I've used the term window shopping a lot - in I can see more, but again, I'm only limited to almost a two-dimensional interaction with folks. And it's, it does, it provides more options but even within those options, you are - and to kind of twist the phrase a little bit - you're stuck in a box, right, in terms of what you have and I think that's a big, kind of struggle point to where child welfare once you can really get to a point to where I can interact with people face to face that potential

meetings can still go through - let's say you mentioned a court hearing - well, now somebody doesn't have to take a full day off work and they don't have to worry about parking or the weather if they're traveling. And so, you've got those options, yet if I need to see the environment, I may still have to, you know, go back to quote unquote the way things were. I want to shift gears a little bit because as I mentioned at the beginning, your unique crossroads in terms of, you know, being a pediatrician and yet this deep involvement in child welfare. And, I touched a little bit on kind of just a few bullet points on your deep resume, but I'd love for you to give us a sense and take a step back and walk me through your background and how this connecting between child welfare and healthcare came to be, you know, how did Dr. Wells end up in this crossroads here?

**KATHI WELLS** [00:17:26]: Yeah. You know, I'd say it's two large things. One is when I was a young general pediatrician in a small community, I encountered women that were struggling with substance use disorder, particularly methamphetamine use, and they had new babies and learned pretty quickly the complexity of such situations. And, felt very strongly that we addressed these settings much better when we worked collaboratively as multiple disciplines. And so, as a healthcare practitioner, starting to think about what might be the kinds of things that we could think about, not just for the baby that I was seeing and what was needing to happen in terms of a child welfare response - safety, you know, permanency and well-being - but also thinking about how do we prevent this. How do we, if we know that someone is struggling with substance use disorder that if they have children they may touch the child welfare system, couldn't we do something on the front-end, before that happened?

[00:18:30]: So then, I did my fellowship in child abuse pediatrics and I spent 15 years in a really unique setting. It was a medical community based within a child welfare facility. So, much like a child advocacy center, but this was a really interesting model in Denver and, you know, we had a really interesting structure where law enforcement, child welfare agency and the hospital system for a pretty large area were one, right. So, we didn't have multiple different law enforcement jurisdictions, multiple different counties and it really gave me a front row view of the places where I could see that our healthcare system could be a better partner and share some responsibility. Because, things that we were doing - particularly when you think about public health, which is sort of a population-based health, thinking about the kinds of things we do in public health, preventing diseases, right, preventing circumstances that place people for long-term health ramifications. Understanding what we know about adverse child experiences and the risk for health, long-term health impact of when kids experience abuse or neglect as a child, for the rest of their life they may have impact.

[00:19:52]: So, it just, it's, so that was one thing, knowing that data around ACES. But then also seeing the places where we in healthcare knew how to engage in a trusted relationship with a family where there might be something that I recommend that I might have there may be a caseworker that's down the hall that's just recommended the very same thing and often a family may engage, may feel more a trusting relationship with the healthcare provider than child welfare. And, you know, I saw that pain in our child welfare system when they experienced this because I knew they wanted to do things to help support families and hold them up and lift them up and make places safe for children and not be involved if they could help it, but yet, often times it was met with much more resistance when recommendations came that way.

[00:20:45]: So, it became clear to me that the more we could partner, the more we could partner in gathering important information and discerning complex health information, but also suggesting early interventions and resources that may be healthcare related, may be connecting someone in a warm connection with resources, right. We do this in medicine, you know, in a pediatric clinic, if I know a

family is struggling with food insecurity, I'm gonna make a referral to a program to help them with that. That family might receive that referral a little differently when it comes from a healthcare person. So, we instituted a couple of things, right. So, screening for kids that were needing placement or at risk of placement, medical screening and then often, we would hear other needs. The family that might be there because of investigation would be pretty angry. We sat and talked about their frustration around toileting issues or their frustrations about a developmental challenge or things that we are pretty used to dealing with.

[00:21:46]: Then, and secondly, we started the nurse home visiting program, a family wellness program that would be a nurse, a public health-based nurse that would engage with the family that was referred that may not even meet criteria for investigation, but everybody was pretty worried about. So, I just think there's a lot of ways that we could partner and I think it's so ironic that we're in the middle of a global pandemic, a public health crisis and yet we're having these opportunities to think creatively and differently about the work we do and our shared goals, which are healthy and happy families and safe kids.

**TOM OATES** [00:22:24]: I'm curious to go deeper into that public health approach, which really - and you mentioned - its multiple disciplines coming together and is a great example of that partnership where it's healthcare, it's even law enforcement, it's child welfare. But it all comes together to really work - as you mentioned - work upstream. When you do have, you know, all of those disciplines at, well I guess it would be at the virtual table now, what should child welfare agencies be prepared to bring. How would they, how are they best positioned to contribute to kind of that multidisciplinary approach? Because it's not just, you know, public health is not just child welfare, but a positive public health approach would affect, you know, multiple areas, including child welfare. So, when you've got those disciplines coming together, what should child welfare view as their ability to contribute?

**KATHI WELLS** [00:23:22]: Yeah. That's a great question because, you know, I think one of our challenges, right, is that particularly child welfare tends to be a system that may move between times when there is a high profile, difficult situation and suddenly, someone's lost their job and it's a very sensationalized situation all the way to moving towards a more supportive approach, and things tend to move back and forth. And, I think to be really thoughtful about how this is done in terms of there's only so many resources and I would be the first to advocate for more resources to support the work of child welfare, because we can't ask more and more and more when there isn't enough resources. And, when you already have systems in place like public health that is taking the population health approach to how do we address the needs of individuals, that is healthcare in some sense, but that is, that's a larger umbrella, right, that's food insecurity, that's safety, that's permanency, you know, that's a roof over your head, that's poverty, you know issues related that can stem from poverty. When that's already happening, one of the things that I think child welfare brings that healthcare systems can't always address is safety and that question of, you know, if you look at the data, you know, five kids dying every day of abuse and neglect and yet that number hasn't changed a lot.

[00:24:49]: We have made inroads in physical abuse and sexual abuse, then we have a large group that's neglect, right. And so, how do we start to think about not a one size fits all model, but bringing data, bringing a scientific and epidemiological approach to the work that we collectively do so that, you know, when a person is referred to a public health clinic for a problem, there's a lot of surveillance that happens, right, so that problem is addressed, there's a treatment, there's an intervention put in place and then we surveil it and we see what happens in the long term. And, I think the more we continue to explore those opportunities which are happening and there's more and more conversations, I think we'll

have a real ability to understand what interventions work, what does work mean, what does that mean in terms of outcomes and how do we put limited resources into the things we tend to know work better. So, we talk about evidence-based but part of that is just surveilling and understanding the intervention and looking at long-term impact.

[00:25:51]: So, I think bringing that lens and making sure that we are thinking that way requires trust, sharing information. Which is, you know, healthcare system is a great example, right, I mean, I think people in child welfare probably have heard, oh I can't share that, it's HIPAA, a lot, right, they're pretty used to hearing that, right. And yet, until we can get to a place where we can really share information in a meaningful way that protects confidentiality, protects that privacy that is really critical, I think that that will be some opportunities to really understand cross sectional impacts. And, I think one of the things that child welfare will be bringing is saying, alright, where are things best suited in partnership, relationship in that more public health lens and we don't have to take that burden. And then, what things really should child welfare be more engaged in, particularly around things like safety. So, I think it's the partnership, I think it's the trusted sharing relationship that I think is really critical to be able to say limited resources, one agency can't do everything. How do we lean into our partners that do parts of that well and share the burden a little bit?

**TOM OATES** [00:27:11]: Yeah, and you brought up data which is something that child welfare is collecting a lot of and uses to help, you know, justify change or positive interventions that work versus interventions that may need a little more study. And, one of the things as we go back to this overarching theme of what did child welfare learn from 2020, the data also backs up this overarching need for a more just and a more equitable child welfare system. And some of your stories of a family listening, maybe taking the advice of a doctor or a clinician over something from child welfare, points to how the system may be viewed from the families that the system is intended to serve. So, switching this overarching approach to maybe less reactive and more proactive, working upstream to become a little bit more equitable, more just, working to bring families together, more supportive - as you mentioned - of families is another approach in terms of this, you know, an upstream, a public health approach of ideally not being there, you know, when the police would be called, but ideally being there, you know, days, months, weeks earlier to provide the supports so that incidence or call never needs to happen.

[00:28:34]: And, I'm curious - because now I'm gonna ask you to maybe take the child welfare hat off and put the medical hat back on - of the overarching change to a more equitable and socially just system. How does that impact a family, how does that impact a child or a parent in terms of those social determinants of health for a family that we know can, you know, reduce the impacts down the road? I'm just curious for when the change needs to be made at an agency and they have to go up to leadership - is there a case to be made that this is just plain healthier?

**KATHI WELLS** [00:29:12]: Absolutely. And, I think, you know, we know that in medicine, right? We've had to take a hard look in healthcare, too, about those disparities that, honestly, still in some ways occur. And, so we know that when families or kids can have access to the kinds of resources, the basic kinds of resources that they need, their health will be better in the long-term and their ability to learn and their ability grow and their ability to be a contributing part of society is critically, you know, tied to those things. And so, thinking about what kinds of things can be put into place to help them be successful in those ways so that we know down the road they'll have less risk for healthcare impacts.

[00:29:57]: You know, healthcare's an interesting system, too, right because people have called it healthcare for a long time but in many ways, a lot of folks would argue its illness care and that we only

fairly recently started to really focus on where we put our resources into maintaining health, rather than treating illness. And so, it's a really interesting parallel of saying we can, you know - not that treating illness is not important, and of course I would never advocate we close down the clinics that treat illness, on the other hand, the more resources we can put on the front-end to prevent that illness from beginning at all, we're going to not only save money, but we're going to have a healthier society.

**TOM OATES** [00:30:40]: You know, you talked about - and again, going back to the public health approach and getting the multiple disciplines together - we had talked before we started recording and you had mentioned the idea of the virtual village. And, as much as you talked about getting the agencies and those disciplines together to treat a family, I'm curious not when it comes to just the overarching information sharing, the big partnerships where multiple disciplines within one big societal system - could you give me a deeper sense of what goes into a virtual village, the example that you were sharing with me earlier?

**KATHI WELLS** [00:31:20]: Yeah, you know, after when COVID began to happen, we really started to talk about ways that, you know, we know we were having these individual connections kind of real-time, connecting - as I said - our infectious disease specialists with someone from child welfare trying to get the latest information. And, it occurred to us - especially since we're in a virtual space - might it be easier to bring some of those folks together. So, you know, in the conversation, how can we have someone who brings the lens of what the different systems, not just healthcare, but you know - the court systems perspective, a family voice - these other perspectives in a way that really could better inform the work that we're doing. And so, you know, we began to select topics. You know, one of those for example - what's really happening out there? Is child abuse increasing, is it hidden, is it just, you know. And, trying to bring the folks that were looking at those numbers and trying to understand what they meant into a virtual room together to have a conversation and learn.

[00:32:21]: And, you know, what was really fascinating to me is that, you know, I might be asking let's say, you know, because it's the hat I often wear as a medical person who is really busy and is, you know, on these calls back-to-back for infectious disease and yet, their ability to sort of get information to a whole other audience that really needed the information they had to share, you could see their sense of satisfaction in being able to be a part of that team. And so, you know, I think sometimes our systems are built where we resist that cross-system collaboration - like I said, for good reasons around confidentiality - but I think the more we can break down those barriers, the more we realize that we have so much to share that's valuable and the virtual village is one of the places to do that. We started out with just someone presenting some information and then opening it up to facilitated dialogue and really rich conversations came out of that. And, a lot of it really then did start to focus on equity and fairness and justice and what does that mean and allowing people to think a little differently about the work that they are so committed to doing.

**TOM OATES** [00:33:32]: Yeah, that's a common theme over so many different issues and innovations and topics we address here on the Child Welfare Information Gateway podcast. And so, anybody who has listened when we talk about cross-system collaborations, it's a question that I often ask and so, I'll ask it to you from your perspective. When it comes to that collaboration and making sure that sticks and works and is fruitful, what are the must haves, you know, what are the keys to success in order to, you know, not only get everybody at the table once, but to keep them at the table and make sure that those relationships bear fruit and we see positive outcomes?

**KATHI WELLS** [00:34:11]: Yeah. Trust. I think genuine authenticity of really getting to know one another and knowing that why someone's there, that they're there because of a common goal. For us a lot of it was like, if we can all agree that our common goal is making the world a better place for kids and families and, I think that helps. Humility. You know, you mentioned at the beginning, I'm a physician and yet I have learned so much from folks from all different walks of life. Professionals, but also families, right, that we serve. And, I think being able to acknowledge that there's a lot we don't know but that we are stronger together. And, I think the last thing is, is this sense that it's not a sign of, you know, we don't have to come to the table with all the answers. In fact, maybe the pandemic - as hard as this has been for so many people, and I do not mean in any ways to minimize that - but there have been some things I think that have come out of it that have been helpful. And, I think one of them is that nobody has all the answers, right? And so that sense of humility that says we can all learn and grow from one another and hold each other up in that process.

**KATHI WELLS** [00:35:41]: You know, one of the things about child abuse work that's been interesting to me is I've gotten to work with child welfare daily, law enforcement, sometimes the court system, educators often, healthcare. And, what's really been interesting to me is that for many of us doing this work, it's probably not the most glamorous way I could be a doctor or, you know, a social worker could be, you know, do their work or a cop, even. But we tend to I think band together around this really deep-seated desire to help kids and families. And, so I think maybe the last thing is giving each other some grace. And, that means that there are times when someone might approach something in a certain way and it might be easy to judge what they, the reason that they're saying what they're saying or they're believing, but if we give each other a little bit of grace and try to be more curious and listen and understand where they're coming from, I think that really creates the space that we can do some pretty incredible things together.

**TOM OATES** [00:36:45]: Based on this approach and it's not just in Colorado, we're seeing this shift toward the public health approach, we've been seeing for years the focus on collaborating within your partners, be they public, private, philanthropic partners within somebody's community - I'm curious from your vantage point where the new and future professionals coming into the child welfare field, what are the opportunities that they have now to help shift that system forward, to help move things, to help make and remaking the system, if you will.

**KATHI WELLS** [00:37:26]: You know, I think one of the big areas is learning together, right. So, those places where, you know, when I've seen this work really well is when someone was really comfortable calling me up, you know, as a physician and asking a question. And so, really laying down some of those divisions and barriers, I think is one place. I think the other place where there's opportunities, medicine did years ago and it used to be if a medical mistake was made, it wasn't necessarily something that was talked about or researched or understood, it was often something that was kind of hidden. And, that's changed completely. And, now in medicine, we have this whole approach that it doesn't matter whether you're the person sweeping the floors, if what you're seeing and hearing is not right and you question it, you're allowed to question the surgeon in the room, right. In fact, you're not just allowed, you're expected to. And, when mistakes occur - because we're all human - when something doesn't go the way we expected is rather than trying to find someone who is responsible, it's really that sense of curiosity, but what we can learn and what we can do better. And so, those are a couple of things that I hope will be our fields moving forward is continuing to find that sense of how can we always learn from what happened and do better, rather than trying to hold someone accountable. I think that's horrible for sustainability in the field - I don't know how someone stays in a job when they're fearful that if they make a mistake it may cost them everything. And, you know, I think medicine is finally getting that a

little bit better, right, and feeling supported. That if I make a mistake, I'm not gonna be thrown under the bus. And so, I think those two things - feeling more collaborative, more connected, being able to reach out to our colleagues that know a lot about something that we may not know as much about and feel okay to do that and then be okay to be human and to do the best we can every day.

**TOM OATES** [00:39:27]: You said it - when everybody comes to the table, you don't have to have all the answers. And, when you don't have the answer, it's probably a smart thing to do to ask around. And, having those relationships, having that trust it's a growth mindset of I'm here also to not only help others but I'm also here to learn and maybe to learn to help others better and kind of pick up along the way and kind of that shared knowledge management across your partners, across your field, across the disciplines kind of puts us in a position to walk in with that attitude for those new and future professionals to kind of try to make sure you're always appreciating in value. Dr. Wells, so imagine the future for me, for child welfare over the next - especially after, you know, we're putting 2020 behind us and what we've learned - so over the next five years, even to the next decade what does the future look like in your mind?

**KATHI WELLS** [00:40:29]: You know, I see, you know, it's interesting, we've talked a lot about public health and if you've seen a picture of public health, right, it's really evolved and now we're looking at public health also on disease and violence prevention that goes beyond the traditional things that public health started around. You know, things like pandemics, right? And, environmental and those kinds of things. So, I think for me the more that we, that child welfare will feel comfortable sharing the burden a little bit and engaging with other systems because that multidisciplinary way of saying, you know, the more we learn, the more we realize we don't know and the more we can reach out to other agencies. So, I think the future is more collaborative partnerships that really come to each other with a sense of curiosity and shared mission. And, I do think families and kids will be better because of it.

**TOM OATES** [00:41:28]: For those communities that maybe aren't at that stage yet, what's your advice on that first step for them to get there?

**KATHI WELLS** [00:41:34]: Have coffee together, have a virtual meeting, I guess, that's the today. I mean, I just do think its relationship and, you know, I tell our trainees, our medical students, our residents if you're gonna go to a small community, sit down and meet your local child welfare person. Sit down and meet some of those folks, become a part of the community child protection team. Sit on and volunteer your time. Because I think it's through those relationships we realize we're not all that different and sometimes you know, a caseworker calling up a doctor feels really scary or calling up, you know an administrator at a school or something and the reality is when we all sit down and get to know each one another, we're all not that different. So, I think it's just about finding ways to build those relationships in a way of curiosity, in a way of sharing where we would like to go together.

**TOM OATES** [00:42:24]: And as you mentioned before, learning from each other and then, you know, growing with each other. Dr. Kathi Wells, I couldn't thank you enough for spending your time, your energy and just sharing your experiences and your thoughts with us as we kind of, you know, put the close on 2020 and move forward and try to build off that. So, thank you so much, again for your time with us here and being part of the Child Welfare Information Gateway podcast.

**KATHI WELLS** [00:42:54]: Thank you so much for having me. Let's look forward to a brighter 2021.

[00:43:01]: Some more information about these shifts in service delivery that I want to point you to are posted on this episode's web page. Just head on over to [Childwelfare.gov](https://www.childwelfare.gov) and search podcast. We'll link you to a page on the Children's Bureau's website with a collection of resources surrounding child welfare and COVID-19, including ensuring that critical court hearings continue, child welfare worker safety is also addressed, and applying virtual and telework tools for virtual visitation. We'll also point you to a collection of resources regarding the framework for prevention of child maltreatment, including primary - more of a universal - prevention, secondary prevention for those at higher risk, and tertiary prevention targeted toward families in which maltreatment has already occurred. You can also find all the other episodes in this series looking at What Did Child Welfare Learn from 2020, that's over at [childwelfare.gov](https://www.childwelfare.gov). We'll also connect you to links to the Kempe Center, where you can find their resource center which has some specific sections around child welfare & COVID-19, along with Virtual working and virtual learning.

[00:44:06]: A reminder, though, to visit Child Welfare Information Gateway at [Childwelfare.gov](https://www.childwelfare.gov) for your informational needs surrounding laws & policies, publications and resources, training, there's data and contact information there, or you can search the nation's largest library dedicated solely to child welfare. My thanks again to Dr. Kathi Wells from the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, along with the University of Colorado School of Medicine and Children's Hospital Colorado. Great to have her and that conversation looking at that intersection between child welfare and public health. And of course, my thanks to you for joining us here on the Child Welfare Information Gateway podcast. You can find us on Apple Podcasts, Google Podcasts, Spotify, Stitcher and Sound Cloud. But for now, thanks again for being a part of this community. I'm Tom Oates. Have a great day!

**FEMALE NARRATOR** [00:45:03]: Thanks for joining us for this edition of the Child Welfare Information Gateway podcast. Child Welfare Information Gateway is available at [childwelfare.gov](https://www.childwelfare.gov) and is a service of the Children's Bureau, U.S. Department of Health and Human Services Administration for Children and Families. The views and opinions expressed on this podcast do not necessarily reflect on those of Information Gateway, or the Children's Bureau.