Tonya DiMillo Consulting

– Raising standards, preserving potential for youth in Maine –

A Pediatric Approach to Improve Child Welfare Systems

Child safety and wellbeing is at the heart of all of my work. My professional experience spans well over twenty years working on behalf of youth involved in the child welfare and juvenile justice systems. My most recent tenure was as the Chair of the Board of Visitors, BOV, for Long Creek Youth Development Center, LCYDC. Reflecting on becoming a member of the oversight board reminded me of my own conviction, to never lose sight of the child.

Last year the state of Maine experienced twenty-nine preventable, horrific, child deaths and murders, all linked to child abuse and neglect and/or cases known to the child welfare authorities. Four children died in one-month alone. In all four cases a parent has been charged with their child's death. This tragic record has been unfolding for over five years now, eighty-one child deaths compared to forty-nine, only five years prior[1]. This is almost double, and the highest on record. Why are we failing to protect our children?

Cases:

All of these recent tragedies are in the wake of two egregious child murders in late 2017, and early 2018. Both cases reveal poor decision making and/or failure to recognize abuse. Numerous child welfare reports were voiced by neighbors, school officials, and even police leading up to the death of Marissa Kennedy. Marissa, a ten-year-old-child, died from battered child syndrome having suffered from prolonged and constant beatings. Both parents were convicted of her murder. Although a child welfare caseworker visited Marissa just prior to her death, there is no indication of further intervention, even as Marissa was reportedly unable to remain awake during the visit. [2]

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[1] Russel , Eric. "More Children's Deaths Reported to State in 2021 than in Any Other Year on Record ." *Portland Press Herald* , 2 Feb. 2022.

[2] Diamond , Bill. "Commentary Fixing Maine's Child Welfare System Requires a Hard Look at the Truth." *Portland Press Herald* , 3 Nov. 2021.

Kendell Chick, was also beaten regularly and may have survived if a child welfare caseworker had visited the home. Kendell, only four years old, was removed from her biological parents due to neglect and substance use, only to be placed with her paternal grandfather and step-grand-mother where she died a traumatic death. Kendell died from blunt force trauma, and old injuries plagued her innocent body. Her step-grand-mother was convicted of her murder. We learned child welfare closed the case shortly after placing her in this home[3].

Maine is not alone in its failures. While cases pile up in Maine, they are piling up in our neighboring states. New Hampshire and Massachusetts have literally lost a child. No one has seen Harmony Montgomery, a four-year-old child previously living in shelters with her biological mother due to substance use. Harmony was sent by the Massachusetts child welfare courts to live with her biological father, a known convicted violent criminal living in New Hampshire, in 2018. She has not been seen since 2019, even after multiple New Hampshire Police response to the father's home and reports of abuse to child welfare by family members.[4]

Sadly, in yet another high-profile case based in New Hampshire, authorities recently charged a biological mother with homicide, after finding her missing five-year-old son Elija Lewis in a shallow grave in Massachusetts. There were signs of fentanyl in his system and potential signs of torture.[5]

Failing:
We are failing because well intentioned people and systems lose sight, they lose focus of the very child they are charged to protect. No one agency is responsible for child safety, however, the Office of Child and Family Services, (OCFS), is the agency responsible for investigating and responding to child abuse and neglect. In the wake of such extraordinary tragic child death cases and child murders we are experiencing in Maine, OCFS, may have lost its focus.

Reports from the Child Ombudsman's Office, the office designated to investigate complaints of child welfare cases, raise concerns in critical moments of child safety assessments, highlighting the potential for system failure(s).[6] The Office of Child and Family Services, OCFS, responded

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[3] Diamond , Bill. "Commentary Fixing Maine's Child Welfare System Requires a Hard Look at the Truth." *Portland Press Herald* , 3 Nov. 2021

[4] Crimaldi , Laura, et al. "Prior to Harmony Montogmery's Disappearance, a Series of Police Visits and a Fathers History of Violence ." *The Boston Globe* , 12 Jan. 2022.

[5] Anderson, Travis, and Dugan Arnett. "Mother of Elijah Lewis NH Boy Found Dead in Mass." *The Boston Globe*, 18 Apr. 2022.

[6] Children's Ombudsman State of Maine. "Maine Child Welfare Ombudsman 19th Annual Report." Children's Ombudsman State of Maine, 2021. http://cwombudsman.org/.

by stating its priority to keep children in their homes, while also describing its own foster care system as unsafe.[7] However, we already see the grave outcome of such predetermination.

Does an inherent conflict exist in decision making during safety assessments, if the stated goal is to keep children home, versus understanding and responding to the safety needs of each child? If the priority is to keep children in their homes safe, then the Maine Department of Health and Human Services, DHHS, would invest heavily in prevention programming, ongoing research, and treatment. And, when a child must be removed from their home for their own safety and well-being, the DHHS, OCFS would also invest whole heartedly in these important care systems too.

National child welfare expert, Emily Douglass, points to a lack of training in safety assessments and a lack of capacity in child welfare workers to fully recognize the risk to a child. Voicing concern that a focus on family strengths alone can result in a child's death. Suggesting unsafe behaviors may be down-played by a child protective caseworker pressured to find family strengths.[8] Christine Alberi, the Maine child welfare ombudsman, echoed these concerns, stressing a lack of prioritization on the child's safety in moments of heightened risk[9]

Additional investigative reporting from the Office of Program Evaluation and Government Accountability, OPEGA, reported that child welfare federal standards are quite high[10]. So high in fact, that Maine along with our surrounding neighbor states do not meet these standards. Federal financial penalties for not meeting standards allows for only incremental change over time. This approach to improvements may slow down pressure to meet these high standards, in recognition of the complexity to change systems and the desire to fund child welfare systems.

In my experience, oversight can only be as effective as the system standards of care. So, if the issue is not the need for higher federal standards, we can surmise it's about the lack of effective oversight, and the task of implementing such high standards. The role of independent oversight is to provide an external lens for understanding, investigating, advising, and guiding toward best outcomes. Oversight provides an independent mechanism for accountability, support in identifying patterns, and providing systemic recommendations. It is a mechanism that allows for

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[7] Maine.gov, Maine Department of Health and Human Services, Office of Child and Family Service. "Response to the Maine Child Welfare Ombudsman's 2021 Annual Report." Maine.gov, December 2021. https://www.maine.gov/portal/index.html.

[8] Douglass , Emily. "Child Welfare Workers Need Better Training ." *Portland Press Herald* , 15 Nov. 2021.

[9] Walsh , B. (2021, September 26). Diagnosing child abuse requires collaboration and expert advice, child advocates say. *The Maine Monitor* .

[10] OPEGA Reports. "Information Brief Oversight of Child Protective Services." Maine State Legislature. Office of Program Evaluation and Government Accountability, January 2022. http://legislature.maine.gov/opega/opega-reports.

continuous improvement, while maintaining such quality standards. Effective oversight can provide support to OCFS efforts in prioritizing the safety and wellbeing of Maine's children. Our children are worthy of such scrutiny.

A second OPEGA report released shortly thereafter, on the complex process of child welfare/ child protective services, reflects the same concerns regarding safety in decision making, among other red flags[11]. Concerns remain of flawed child safety assessments and/or decision making at critical moments during the investigations. We learned of inadequate training. We learned of the internal decision-making process and an internal quality review process. We learned about of the use of multiple risk and safety assessment and decision-making tools utilized in every step of the child protective investigation. As evidenced by our grave child outcomes, these decision-making tools and limited internal processes may not be enough. If these tools guide training, case outcomes and determination, they must now be examined for reliability and appropriate measure, in the wake of such historic failures.

The OCFS is utilizing these decision-making tools designed in partnership with Evident Change. Evident Change is a justice-oriented, research and data driven, non-profit focused on systemic change in child welfare, juvenile justice and adult protective services[12]. This justice-oriented lens and approach toward these systemic reforms in child welfare is necessary for creating greater equity and fairness among other measures, however this cannot be the only lens.

As lawmakers in Maine struggle to understand child welfare issues, enact policy and practice change, there is potential to lose sight. In reform efforts, there is now an opportunity to understand the tragedy and process in each of these cases, what intervention/preventions may have changed the trajectory, and place focus back where it belongs, on the child. Child abuse and neglect is a public health issue, not solely a social and justice issue. The lens in public health expertise is missing.

Recent reporting on the current misuse of emergency rooms for youth in crisis, highlights the impact of years of good intentions and collective efforts to reduce and remove congregate care settings, effecting multi-systems, in favor of a shift toward home and community-based care. However, the home and community-based care interventions for youth and families has not risen to meet these critical care needs in placements and/or effective treatment[13]. The problem with this misplaced focus and unintended consequence, is that our children in crisis need safe and effective responses. However, our communities remain deplete of services, and full of disparity. Social justice cannot be achieved by keeping youth in their broken homes and communities.

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[11] OPEGA Reports. "Child Protective Services Investigations." Maine State Legislature. Office of Program Evaluation and Government Accountability, March 2022. http://legislature.maine.gov/opega/opega-reports.

[12] "Inform Systems. Transform Lives." *Home | Evident Change*, https://www.evidentchange.org/.

[13] Richtel, M. (2022, May 8). Hundreds of Suicidal Teen Sleep in Emergency Room. Every Night. *New York Times*.

Child welfare is not the only system failing. Juvenile justice administrators in Maine resign over growing concerns, upheaval, and riots by youth placed at LCYDC, even after years of reform efforts[14]. New Hampshire officials face increasing scrutiny, facing hundreds of allegations of blatant abuse and torture toward youth placed in the New Hampshire juvenile justice facility, spanning over decades[15]. Youth seeking to heal from their past, unsafe in the hands of those to care for them.

The same limited thinking in child welfare, impacts juvenile justice. In juvenile justice simple assessments for risk of reoffending/recidivism are utilized. Narrowing intervention to the child's behavior. Treating specific behaviors with predetermined programs, versus understanding and responding to the needs of the comprehensive needs of whole child care. These youth are often our most poor and therefore most vulnerable[16].

The Child Mind Institute, shares that 1 in 5 children are challenged by mental health or learning differences. Yet most communities lack information, and access to adequate care. The lag between the onset of symptoms and treatment is over eight years[17]. We know that poverty, mental- health, substance use, developmental needs of child, violence in home and/or violence in the community often go hand and hand with risk factors for child abuse, and juvenile delinquency[18].

If we understand that appropriate response and care systems are wildly unavailable, and/or ineffective in most communities, then a social justice approach to children in crisis will never be enough. It's sorely lacking. The integration of a public health approach, however, in addition to social justice measures can empower and raise our standards of care in both intervention and prevention systems. This can be done when we better understand the safety needs, strengths, and challenges for each child. The intervention, assessments, and prevention efforts would reflect this knowing. When you focus on the child, you inform all systems of care, biological, foster, community-based care, care systems and programming.

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[14] Byrne, Matt. "Report Says Crushing Boredom, Chronic Staff Shortages Drove Outbursts at Long Creek ." *Portland Press Herald* , 8 Dec. 2021.

[15] Arnett, Dugna, and Laura Crimaldi . "The State Was Suppose to Rehabilitate Them. Instead, Hundreds of Children Were All Allegedly Abused in NH ." *The Boston Globe* , 22 Apr. 2022.

[16] DiMillo, Tonya C., "Long Creek Youth Development Center Board of Visitors 2017/2018 Report" (2018). Corrections Documents. 39. http://digitalmaine.com/doc_docs/39

[17] https://childmind.org/child/mind

[18] Cdc.gov risk and protective factors

Focus:
We have people who want to keep children at home and we have the unfortunate experiences in this state with ongoing tragic and grave outcomes. Keeping children home and safe is a worthy and principled belief. The problem is it cannot always be realized.

If the focus in safety assessments prioritized the safety needs of each child, would any differences in philosophy ever matter? What would matter is establishing safety for each child first. In this way, all systems from biological family, kinship care, foster family, or community-based care would rise up and respond to meet the safety needs of each child versus any predetermined response from our care systems.

Focus on each individual child's needs will tell us what matters to their safety, well-being and development. Focusing on the child requires us as leaders to go inward, so we can learn how to respond effectively. If we choose to focus on each child needs, we will stop being distracted by politics, philosophical differences, and money. We will instead know how to prioritize safety for every child, in any care system, simply in asking and evaluating what they need. A full understanding will provide information to build comprehensive response systems to meet these needs, and reach best possible outcomes.

It is not enough to just end these senseless deaths. We must also work to respond to a child's well-being. Creating a team of experts ranging from pediatrics, neuro/brain and body, as well as youth champions and advocates, psycho-therapists, and coaches can provide a public health lens that is specific and supportive to each child's safety and care. This team will *see* the whole child, through appropriate assessment and evaluation to understand each child's strengths and needs. These experts are the resources that will keep children growing and thriving by establishing a system of oversight that is invested in the whole child, their ongoing safety, health and wellbeing. Justice can be achieved in child safety, when we see mainly through the eyes of a child versus any pre-determined outcomes.

Response:
In response to the child welfare crisis, there is much support for expanding the Child Ombudsman's office, however, this much needed investment may only in appearance be effective, since the independent office recommendations can be easily dismissed. We know this because of the evidence of the Ombudsman's continued warnings, ongoing child deaths and OCFS simple response. The recent resignations of two board members from the Ombudsman's office in protest of ongoing child welfare fatalities and ignored reports and warnings by OCFS, confirms this challenge[19].

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[19] Ohm, Rachel. "Two Members of Maine Child Welfare Board Resign, Citing Inaction by DHHS." *Portland Press Herald* , 20 July 2021.

The response to juvenile justice reform is based in efforts to close facilities to keep youth in their communities[20]. As we have learned, such deinstitutionalization efforts without meaningful, and comprehensive approaches in the community may create another crisis in homelessness, adult corrections involvement and premature deaths.

If we believe that youth should grow and develop to be who they are meant to be, we would prioritize their feeling safe during interventions and prevention efforts. Deeper understanding and response to safety needs for children and their families will support long term outcomes as well as immediate safety. Achieving greater balance for each child in safety and well-being must be reflected in child protective training, safety assessments design and delivery, and in how our supportive care systems respond to meet these needs. This is no small task, the additional support of expertise in child health care in oversight can support progress toward better outcomes and in meeting high standards.

In my opinion, the people missing from the table are the pediatric experts in whole child care. These resources hold the wisdom, received the training and have the years of experience that can support OCFS and all response systems, in establishing safety, health and well-being for each individual child. These experts are often far removed from the decision making, yet could be the most supportive.

Systems of care and institutions are mostly implemented by elected governing officials, which are often based in philosophical and fiduciary lens. These driving forces may seek a less adaptive approach to leading and more prescriptive approach, and based on electability. If the addition of pediatric expertise and youth champions can alleviate politics, it could offer approaches based solely in best interests of the child.

The Council:
A policy measure of creating an additional team or council can provide a compassionate space for accountability to such complex issues as child protection, juvenile justice, and other care systems. This collaborative council can review the various stakeholder reports, recommendations, differences, and study how to collectively reach appropriate standards of care for the best possible outcomes for our youth and their families.

Creating a team of experts ranging from pediatrics, neuro/brain and body, as well as youth champions, such as coaches will provide a lens that is specific and supportive to each child's safety and care. This team will see the whole child, and support their health and well-being. In this way, every family system- biological, kinship, foster or community-based care systems will know how to rise in response to each child, establishing safety by meeting their needs, ultimately supporting their growth and development. By targeting and focusing care and response efforts on the most in need and in crisis, we can support the whole.

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[20] Byrne , Matt. "Lawmakers Make Late Move to Close Long Creek Youth Development Center ." 21 Feb. 2022.

Identified issue:

The bottom line, algorithm is simple. If we seek to nurture a youth in crisis and in challenge toward healing, then we will raise our standards of care across the state of Maine, through the guidance and support of appropriate and independent oversight. Such oversight, must be inclusive of pediatric and adolescent expertise in brain and body development to provide a child health care lens, in collaboration with the collective advisory and oversight boards.

Current Oversight models:

Children's Cabinet: The Children's Cabinet is an important collaborative model to implement policy and practice, learn from the field and adjust as needed. Members are key decision makers, appointed by the elected administration. They carryout the mission of their agency, hold a fiduciary responsibility, and uphold the plans for the elected administration.

Juvenile Justice task force: The juvenile justice task force is acting in oversight capacity. The task force is co-chaired by the DOC Commissioner, advocates, and a state legislator. Recent task force reports suggest regional committees provide added oversight to community-based care programs[21].

The Maine Child Ombudsman office: Designated to assist in, resolving concerns and complaints, regarding Child Protection Services[22]. Limited scope to open cases in child welfare, versus welfare of children. Recent findings and reporting from office have been dismissed.

Legislative oversight: Joint Standing Committee on Health and Human Services or the Joint Standing Committee on Criminal Justice and Public Safety[23]. Ongoing public oversight.

Government Oversight Committee: Capacity to investigate, subpoena and hold session outside of legislative calendar. Not intended for long term oversight[24].

Policy effort:

Pediatric Oversight Council: The best model based on numerous iterations, pairs pediatric experts in brain, body and neuro health with youth champions, such as coaches, advocates, and psychotherapists in a compassionate space such as a council, to reconcile the past, reflect the present and guide the future. Such a council *informs* safe responses versus reviews of current standards of care in our care systems, to create consistent healthy outcomes for our youth.

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[21] https://mainejjtaskforce.org

[22] https://cwombudsman.org

[23] https://legislature.miane.gov

[24] https://legislature.maine.gov

Since this model appears to be the first of its kind at the state governing level, consideration of instituting as a task force can provide the expertise at a state advisory and governing level, and the time to discern its effectiveness. This is an extraordinary time, requiring extraordinary response and measure. This strategy can support reaching shared goals for youth to safely, grow and develop to be who they are meant to be, with minimal risk.

Potential impact:
Independent Pediatric Oversight Council:

- Informing safe responses, increasing accountability, providing transparency and creating mechanisms.
- Consistent healthy youth outcomes, and long-term outcomes.
- Public reporting, education and awareness.
- Raise standards of care in intervention, and prevention systems practice and policy approaches.
- Experts in the driver seat, market and politics removed from health policy lens.
- Collaborative, multi system impact and integration.
- Expert and research driven comprehensive evaluations of strengths and unmet needs for all youth.
- Identify compassionate and equal pathways forward in all systems of care: health and wellness, education, as well as juvenile justice, child welfare.
- Long term research collaboration, to develop effective intervention and intervention systems
- Inspire innovation to address social determinants and impact policy and practice.

The Academic Pediatric Association, APA, supports the assertion that the addition of pediatric expertise in oversight of policy and practice development and implementation is critical to improving health outcomes for all of our youth, especially our most vulnerable. The APA encourages collaborative community and/or neighborhood-based public health approaches, tackling poverty and enhancing peoples' lives[25]. We can then argue that such pediatric expertise is imperative at all levels, to inform and guide interventions from community based, to the state governing level, and the federal level.

The (APA), Task Force on Childhood Poverty, sheds light on such approaches. This multi-disciplined team with a public health framework formed to tackle this alarming, complex social issue and address the risks associated with childhood development. Seeking to form policy efforts in areas of clinical care, education, research, and evidence-based approaches to root out

[25] Jutte, Douglas P., et al. "Neighborhood Poverty and Child Health: Investing in Communities to Improve Childhood Opportunity and Well-Being." *Academic Pediatrics*, vol. 21, no. 8, 2021, https://doi.org/10.1016/j.acap.2021.04.027.

the injustice, and to prioritize the whole health of children[26]. Utilizing wisdom and expertise, ultimately removing politics from proposed policy and practice efforts. Providing a public health lens to improve and impact social justice.

Child abuse is a public health threat. It threatens the lives of children, it threatens their ability to grow and develop free from the effects of trauma. Why wouldn't we want to integrate this lens of pediatric experts in whole body care, to guide, research and determine standards? This is an extraordinary time, requiring extraordinary response and measure. We can learn more about the short-and-long term effects of trauma, appropriate care and treatment, mitigate harm and nurture children toward healing. In this way, we will never lose sight.

www.tonyadimillo.com | (207) 807.5947 | tonya@tonyadimillo.com
30 Fern Lane, Cumberland Foreside, ME 04110

[26] Schickedanz, Adam, et al. "Child Poverty and Health in the United States: Introduction and Executive Summary." *Academic Pediatrics*, vol. 21, no. 8, 2021, https://doi.org/10.1016/j.acap.2021.09.003.