Mental Health - Child Protection – Courts: You Need to Talk!

Our study of Minnesota child fatalities documented seven children who were killed by a mother who had chronic mental health crises, including repeated psychiatric hospitalizations.

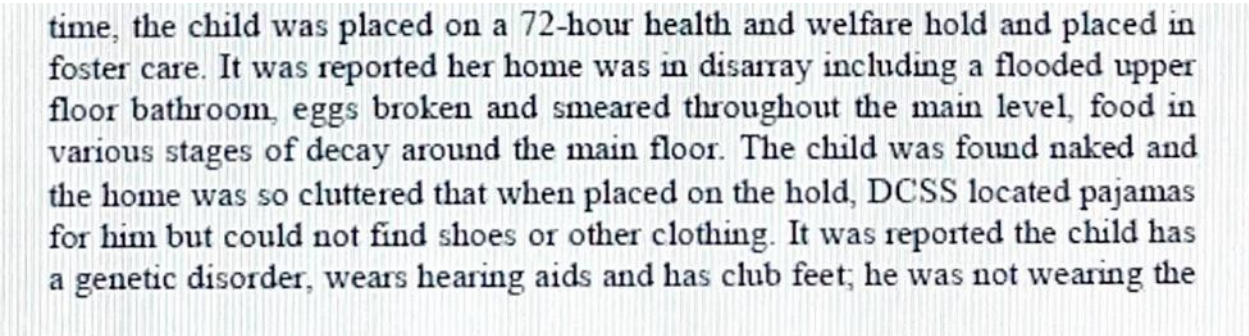
Six-year old Eli Hart's mother killed him with nine shotgun blasts shortly after he was returned home, and a few months after she was released from her second psychiatric inpatient stay. If the mental health facilities and child protection were in touch about the reunification it is not reflected in the court records. Additionally, role conflicts between Family and Juvenile Courts delayed hearings that would likely have given custody to Eli's father.

Mental health providers, child protection agencies, and district courts should develop communication protocols so children aren't reunified with parents who have serious mental health diagnoses without a solid safety plan and careful monitoring by mental health professionals, and those communications should be documented.

Narrative for podcast on mental health ebrief for 12-17-22

The case of Eli Hart illustrates issues that came out in a number of cases where the person who killed the child was the mother. Of the 88 cases in our current study of child protection counties in Minnesota, 24 of the killings were done by the bio mother, and of those seven or 29% were related to Serious and Persistent Mental Health, or SPMI issues.

In the case of Eli Hart's mother, she had been hospitalized twice in situations where she was actively hallucinating both times she was reunified with her then five-year-old son. The first time she was committed Eli


time, the child was placed on a 72-hour health and welfare hold and placed in foster care. It was reported her home was in disarray including a flooded upper floor bathroom, eggs broken and smeared throughout the main level, food in various stages of decay around the main floor. The child was found naked and the home was so cluttered that when placed on the hold, DCSS located pajamas for him but could not find shoes or other clothing. It was reported the child has a genetic disorder, wears hearing aids and has club feet; he was not wearing the

hearing aids. The social worker persuaded the mother to open a Family Assessment case and agreed to return Eli home.

During this period Eli's mother obtained a series of Orders for Protection (OFP) making what later were determined to be false accusations against Eli's father. According to the social work reports Eli's supervised visits with his father were very positive and he thrived in his care of his father and that of his fiancé. However the Family Court declined to consider his petition for custody until the Juvenile Court case was resolved. The role of the Juvenile Court was to determine whether the mother was able to take care of the Eli. As our child welfare experts have told us, Juvenile Court does not have the authority to determine custody issues so they

couldn't decide that the father was a better placement. They are only able to decide if the mother was a safe place for Eli to be, and the default is that it has to be considered safe unless it can be proven otherwise. At times Eli's mother followed her case plan, at other times she did not. Eventually the social worker advised the court that her home was not an unsafe place for Eli to be. However the Guardian *ad litem* disagreed, which is not common. In the end the Guardian *ad litem* went along with the social work and Eli was returned home a few months after his mother was released from the hospital. Had the Family Court been able to move ahead with the custody question and transfer custody to the father Eli's life might have been saved.

It seems self-evident that if a child is being reunified with a mother who has ongoing major mental health issues, the mental health provider should have a discharge plan that takes into account the mother's likely ability to be a parent to a five or six-year-old child, especially one who has special needs. This should go hand-in-hand with child protection having a solid safety plan, which would include child protection maintaining regular contact with the mother, facilitating more frequent visits with the father since he appeared to have a positive effect on Eli's behavior and happiness, having the mental health agency monitor the mother's mental health on an ongoing basis, and that both entities should be in continuous communication. To be fair it is possible that some of this was going on. In my experience hospital social workers do discharge planning routinely and perhaps some efforts were made to coordinate with child protection. But in reality and our review of the 88 fatalities since 2015 we rarely if ever saw in the court records documenting how a safety plan was implemented, and documentation of mental health services is limited to dates of inpatient placement and whether generally the parent was following through on appointments with a mental health provider in the community. So even if this kind of communication were going on, which seems unlikely in the fatality cases we reviewed, there is at a minimum a need to have a protocol that this be documented in the case plan.

Another aspect of this case involves local law enforcement. When Eli was killed, his mother was found driving the car with one tire being only on the rim. When she was stopped she had blood on her and there was blood all over the backseat. However the police let her go. A few minutes later they discovered what was left of Eli's body in the trunk. That scenario in itself is a head scratcher and while it wouldn't have helped Eli had the police been more thorough before they let the mother go, it is consistent with a lack of urgency in cases involving children.

Issues around the role of law enforcement do have a bearing on another case that you will be able to read in our upcoming report on child fatalities, that of Tayvion Davis. His mother abused Tayvion and his siblings to the level of torture from 2006 until a year and a half after his death in 2018. Beginning with when the mother was convicted of malicious punishment of the child 2006, all of the children were beaten, at times the mother would hold their hands down and hit them away repeatedly with a hammer, the children ran away repeatedly, most of them were was sexually abused, and finally Tayvion was deliberately left in a garage overnight subzero temperatures and froze to death. The police did not treat the garage as a potential crime scene with the result that valuable evidence was lost. The abuse continued until nearly a year and a half with several additional reports to child protection during that period of time. Also during this time the Juvenile Court judge denied the county worker's request that the other siblings be

removed from the home. About 18 months after Tayvion was killed the mother reported one of the children missing to the police. It turned out that several children had left because of a beating with a hammer. The police found the mother delusional and removed the children. At that point the children disclosed what had happened to Tayvion. Once again, appropriate attention to the mother's mental health issues and communication between local child protection and mental health professionals might have ended years of torture much sooner. In addition, if the police had preserved evidence and the caseworkers had interviewed the children separately immediately after Tayvion's murder, they would've discovered much earlier that the mother had frozen him to death and avoided additional trauma to the siblings.

The case of Melody Vang is similar. Melody was killed early in 2021 shortly after being returned from foster care. Her parents bound her and put her in a closet, a classic element of torture, and beat her to death within days of reunification. Again the mother had ongoing significant mental health issues documented in the case record, and she was ruled incompetent to stand trial for Melody's murder. But the coordination between mental health providers and child protection either was missing or it wasn't reflected in the record.

These and many other cases in our study have multiple examples where the either was a clear lack of coordination among mental health providers, child protection, the courts, and local law enforcement, or if it did occur it wasn't documented.

As I have said many times in our blogs and other articles, the idea of working across silos is easy to say and hard to do. Every field of human services has its own legal parameters, reporting requirements, research-based best practices, and other structures that provide some accountability and standardization but also make it difficult first of all just to find time to reach across to people in related sectors, and frequently creates positive barriers to doing this. Confidentiality requirements are one common example of that but there are others, such as the fact that data that essentially is looking at the same information is structured or defined slightly differently from sector to sector so it is difficult to exchange, or requires special training or an undue amount of explanation.

That said, it is routine for a mental health facility or any hospital for that matter to do a discharge plan that takes into account the family situation of the person being discharged. I am not an expert in this area, but it would seem that mental health providers should be routinely checking with child protection when discharging mothers of small children when they continue to have significant mental health challenges. And again it is possible that is going on. But it does seem that if that were the case it would show up at least occasionally in the child protection court records. Conversely, if one of the reasons that a child is put on a 72 hour hold and placed in foster care is that the mother is presenting as delusional, and hallucinating, and is committed to an institution,, it would seem like the child protection would be reaching out to mental health caseworkers to coordinate their activities. Court records frequently referred to details such as the period of time when a mother was placed in inpatient care, and whether or not they were following through on their therapy in the community, but rarely if ever document any coordinated case planning with the other entity.

So the takeaways from these cases for me are first that County child protection agencies and local mental health providers, including inpatient institutions, need to reach out to one another and develop standard operating procedures for situations in which a patient is being discharged to a home where they will be expected to parent children, especially younger children. Similarly, mental health providers who are seeing patients in the community need to have standards for communicating with child protection if there is risk to the child. I don't have experience in the nuances regarding the intersection of client confidentiality and the role of the mental health provider as a mandated reporter. So that would have to be sorted out. But in cases where children are at risk, it seems to me that the priority needs to be the child not provider/client confidentiality.

In addition, caseworkers need to document these interactions with mental health providers in their CHIPS petitions and reports to the courts so it can be seen whether they are doing what they are supposed to. And in general, there needs to be much better documentation in the court records of whether safety plans were actually functioning as planned. While we understand from conversations with social workers and managers that safety plans are generally taken seriously and that there are efforts to implement them. But in the fatality cases that we saw in the study it was often evident that safety plan was only on paper and not really being monitored.

Regarding the overlap between child protection and local law enforcement, there are other cases in our fatality report that provide better examples of where those relationships need to be worked on. So that is probably the subject for another podcast. Of the cases we have talked about here however, that of Tayvion Davis suggests that the default policy should be to consider every child fatality suspicious unless there is very clear evidence to the contrary, and that local law enforcement should exercise due diligence by interviewing those involved and gathering physical evidence to investigate the death.

This will be our last blog and podcast for the year 2022. We will be taking a break over the next two weeks for the holidays and look forward to seeing you again in 2023!

Rich Gehrman

Executive Director, Safe Passage for Children of Minnesota

12/16/22