Slide 1 - Welcome

Welcome to the training on Case Planning and Intervening for Permanence. Introduction to Mental Health: Developed and presented by the Indiana Child Welfare Education and Training Partnership.

Slide notes

Welcome to the training on Case Planning and Intervening for Permanence. Introduction to Mental Health: Developed and presented by the Indiana Child Welfare Education and Training Partnership.
Today, we will explore the categories of mental illness, treatment options, and the impact of mental illness on families. You will learn more about working directly with caregivers who experience mental illness as an experienced Family Case Manager.

At the end of this training, you will answer questions regarding two scenarios. The questions are located in the front of your Case Planning and Intervening Participant Manual. Locate your manual now, and find the scenario question pages for Joyce and Lisa.
According to the 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders (referred to as DSM-V), Mental Illness is defined as behavior that departs from some norm, is harmful to the individual or others (distress), and originates from some dysfunction within the individual.
As a Family Case Manager, you will likely work with clients who experience mental illness. While you must not act as a therapist or counselor, and you must not make a mental illness diagnosis, you will learn to recognize symptoms of mental illness in a client. You may then act as an advocate or facilitator for your client, assisting them in selecting interventions, understanding services, and encouraging them to participate in treatment. It is also the responsibility of the FCM to assess whether a mental illness affects one's ability to parent. Many people can effectively parent with a mental illness and do not require further intervention from the Department of Child Services.
As a Family Case Manager, you are able to request assistance from nurses, and services specialist who are also employees of DCS. You will notice references to nurses and clinical services specialists throughout this training, but first let’s find out what their role is within the Department of Child Services.
DCS Nurses

- Answer Medical Questions
- Consultation/Collaboration
- Review and Interpret Medical Records
- Participate in CFTMs, meetings, and family visits
- Provide Resources and Research
- Assist with CANS
- Assist with PEDS information

Slide notes

DCS Nurses are available to support and assist the Family Case Manager, as well as other DCS team members. DCS Nurses can answer medical questions, consult and collaborate with the team, review and interpret medical records, participate in Child and Family Team meetings, provide resource and research information to the team, and assist with CANS, and PEDS information. DCS nurses do not provide medical services, procedures, or approve medication.
DCS Clinical Services Specialists

- Consultation regarding:
  - safety/risk
  - placement
  - assessment and services
  - behavioral health
- Liaison between DCS and partners
- Education regarding mental health and best practice models

Slide notes

DCS Clinical Services Specialists are licensed, masters level clinicians and are available to support and assist the Family Case Manager, as well as other DCS team members. Clinical Services Specialists are available for consultation regarding safety and risk concerns, placement decisions, assessments and service planning, and complex behavioral health issues. Clinical Services Specialists are available to act as a liaison between DCS and the mental health, juvenile justice, education, and provider communities. They can also educate Family Case Managers and the Child and Family Team regarding mental health and best practice models.
Mental illnesses that are most likely to impact DCS case planning efforts, will generally fall into one of these categories. Personality Disorders, Psychotic Disorders, Mood Disorders, Anxiety Disorders, Cognitive Disorders, and Substance Abuse Disorders. Let’s take a closer look at each category and diagnosis that fit in each one.
Personality disorders are associated with ways of thinking and feeling about oneself, and others that significantly and adversely affect how an individual functions in many aspects of life. Symptoms are different depending on the type of personality disorder, but in general, people have difficulty relating to others and handling stress and/or have a self-image that differs from how others perceive them.

- Diagnoses include:
  - Antisocial Personality Disorder
  - Borderline Personality Disorder
  - Narcissistic Personality Disorder
  - Avoidant Personality Disorder
  - Dependent Personality Disorder

Personality disorders are associated with ways of thinking and feeling about oneself, and others that significantly and adversely affect how an individual functions in many aspects of life. Symptoms are different depending on the type of personality disorder, but in general, people have difficulty relating to others and handling stress and/or have a self-image that differs from how others perceive them. Personality related disorders include: Paranoid Personality Disorder, Antisocial Personality Disorder, Borderline Personality Disorder, Narcissistic Personality Disorder, Avoidant Personality Disorder, and Dependent Personality Disorder.
Slide notes

Disturbances of perception and thought process fall into a broad category of symptoms referred to as psychosis. The threshold for determining whether thought is impaired varies somewhat with the cultural context. In other words, one must consider the cultural norms for a person before determining if a thought process is disturbed. The most common groups of symptoms are hallucinations such as sounds, smell, tastes, tactile, and visuals. Psychotic symptoms are most characteristically associated with schizophrenia. Psychosis related diagnoses include hallucinations, paranoia, delusions, schizophrenia, and narcissism.
Disturbances of mood characteristically manifest as a sustained feeling of sadness or sustained elevation of mood. Along with the prevailing feelings of sadness or elation, disorders of mood are associated with symptoms that include disturbances in appetite, sleep patterns, energy level, concentration, and memory. Diagnoses of disturbances of mood include: Depression, Bipolar Disorder, Seasonal Affect Disorder, Manic/Depressive, Mania, and Suicidal Thoughts.
Anxiety is normally an important physiological response to dangerous situations that prepares one to evade, or confront a threat in their environment. Normal anxiety is critical to survival. An anxiety disorder may be said to exist if the anxiety experienced is disproportionate to the circumstance, is difficult for the individual to control, or interferes with normal functioning.

Anxiety related diagnoses include panic attacks, obsessive compulsive disorder, post traumatic stress disorder, social phobia, specific phobias, generalized anxiety, attachment disorder and separation anxiety disorder.
Cognitive Function refers to the general ability to organize, process, and recall information. The progressive deterioration of cognitive function is referred to as dementia. Disturbances of Cognition diagnoses include Alzheimer’s disease, Autism, and Dementia.
A substance use disorder describes a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress. A person with this disorder will often continue to use the substance despite consequences. Each specific substance is addressed as a separate use disorder (e.g., alcohol use disorder, stimulant use disorder, etc.), but nearly all substances are diagnosed based on the same overarching criteria. The Substance Abuse training will provide more detail on this type of disorder.
Match the following

**Column 1**
- Schizophrenia
- Dementia
- Depression
- Panic Attacks
- Alcohol Use Disorder
- Borderline Personality Disorder

**Column 2**
- A) Anxiety Disorders
- B) Psychotic Disorders
- C) Mood Disorders
- D) Cognitive Disorders
- E) Personality Disorders
- F) Substance Abuse Disorders

**Slide notes**
Match the Mental Illness Diagnosis on the left to the correct category on the right.
Some specific diagnoses are associated with higher risk of endangerment to children. They include Schizophrenia, Bipolar Disorder, Depression, Borderline Personality Disorder, Antisocial Personality Disorder, Post Traumatic Stress Disorder, and Munchausen Syndrome by proxy. We will look at each of these diagnoses individually, considering noticeable symptoms of each diagnosis, what an FCM might recognize in interactions with these clients, and how you as the FCM can work in conjunction with the DCS Nurse and Clinical Services Specialist to establish an effective case plan for caregivers with each diagnosis.
According to DSM, five symptoms of schizophrenia include hallucinations, delusions, disorganized speech, grossly disorganized behavior, and negative symptoms such as social withdrawal, poor social skills, lack of motivation, etc.
As an FCM, you may notice characteristics of Clients with schizophrenia that decrease their ability to care for children. These clients often have unstable living arrangements and are not able to provide consistent housing for children. They may become non-compliant with their medication schedule. Clients with schizophrenia may experience command hallucinations, which include thoughts of harming their children. Clients who are actively psychotic, experience symptoms that interfere with their ability to complete tasks such as parenting, maintaining employment, managing a household, etc. When interviewing clients with known or suspected schizophrenia, ask them if they have a support system, or someone who helps them care for the children; if they are currently involved in treatment, and if they have recently experienced any life stress events. Some individuals may have long spans of time where they are relatively symptom free, and a stressful event may trigger psychotic symptoms.
Case Plan Considerations:

- Need to assess the parent’s functional level – is he/she capable of parenting a child (even on medication)?
- Medication compliance is usually a necessary, but not sufficient, prerequisite for parenting
- Provide mental health/support services
- Antipsychotic medications are usually effective for hallucinations and delusions, but not negative symptoms
- Parents with paranoid schizophrenia are often the most difficult to work with and may pose the greatest risk to the children
- Make sure the children are safe – safety plan for psychotic episodes
- Try to create stability for children by involving other caretakers and informal supports

Slide notes
When creating a case plan with a caregiver who has schizophrenia, it is important to consider the safety of the children, the caregiver’s ability to parent the child, and the caregiver’s desire to seek and maintain treatment. You will likely involve the DCS Clinical Services Specialist and DCS Nurse in your region in the development of these case plans. Review the information on the slide and click next when you are ready to move on.
Another prevalent mental illness is bipolar disorder. The most common symptom of bipolar disorder is mania. A person experiencing mania may be extremely irritable, have racing thoughts, or be euphoric. Often times, persons appear to be under the influence of an illegal substance when they are actually expressing symptoms of bipolar disorder. Additional symptoms include sleep disturbance, impulsivity, depression, or paranoia.
Clients with bipolar disorder sometimes possess characteristics that inhibit their ability to care for children. As an FCM, you may work with a client who is experiencing a manic phase. During this time, individuals have increased potential to abuse substances and make poor decisions, which can affect their ability to care for children. Caregivers with bipolar disorder sometimes come into contact with DCS when they are not compliant with their medications. Sometimes they stop taking medication because they don’t feel like they need it, or because they enjoy the high of manic episodes. When interviewing clients with known or suspected bipolar disorder, ask them if they have a support system, or someone who helps them care for the children; if they are currently involved in treatment, and if they have thoughts of suicide. Understanding these things will help you assess the level of safety for children in the home, as well as the urgency to offer services to the caregiver.
Bipolar Disorder

Case Plan Considerations:

- First consideration needs to be safety and stability of the children. Caretakers with Bipolar Disorder often lead very chaotic lives.
- Medication compliance needs to be a priority. Mood stabilizers, atypical antipsychotics and seizure medications are often effective.
- Safety plan for manic and/or psychotic episodes that accompany Bipolar Disorder.
- Consider heightened potential for suicide.
- Children should not have to care for mentally ill parents.
- Try to create stability for children by involving other caretakers and informal supports.

Slide notes

When creating a case plan with a caregiver who has bipolar disorder, it is important to consider the safety of the children, the caregiver’s ability to parent the child, and the caregiver’s desire to seek and maintain treatment. You will likely involve the DCS Clinical Services Specialist and DCS Nurse in your region in the development of these case plans. Review the information on the slide and click next when you are ready to move on.
According to the Center for Disease Control, one in ten Americans experience depression on some level. As an FCM, you will likely work with clients who are experiencing depression. Symptoms include depressed mood, diminished interest or pleasure, weight loss or gain, disrupted sleep, fatigue, negative thoughts, difficulty concentrating, and recurrent thoughts or attempts of suicide.
When interviewing or working with a client experiencing depression, you might notice that they are not able to meet the physical or emotional needs of their children. They may express a feeling of hopelessness and become easily frustrated. Depressed clients may be self-medicating with illegal drugs. They may recall a pattern of depression in the caregivers they had as children. Just like the other mental illnesses we have discussed, ask these clients if they have a support system, or someone who helps them care for the children; if they are currently involved in treatment, and if they have thoughts of suicide. Understanding these things will help you assess the level of safety for children in the home, as well as the urgency to offer services to the caregiver.
When creating a case plan with a caregiver is depressed, it is important to consider the safety of the children, the caregiver's ability to parent the child, and the caregiver's desire to seek and maintain treatment. You will likely involve the DCS Clinical Services Specialist and DCS Nurse in your region in the development of these case plans. Review the information on the slide and click next when you are ready to move on.
Characteristics:

- Intense, unstable interpersonal relationships
- Irrational fear of abandonment or rejection
- Poor boundaries
- Episodes of inappropriate and intense anger
- Self-destructive behaviors (e.g., promiscuous sex, reckless spending, cutting)
- May include suicidal ideation, behavior or threats
- Manipulation
- Lack of guilt
- Disregard for themselves or others

Caregivers with Borderline or Antisocial Personality Disorder are particularly concerning. These individuals likely have a history of unstable relationships, irrational fears, poor boundaries, anger, self-destructive behaviors, including suicidal ideation. Characteristics of particular concern regarding those with antisocial personality disorder is their deceitful manipulation, lack of guilt, and reckless disregard for themselves or others.
When interviewing, or working with a client who has a personality disorder, you might notice impulsive and manipulative behaviors. Clients may try to manipulate one or more members of the team and cause disruption. It is important to set clear boundaries and follow through with actions. Medications do not typically address borderline pathology behaviors. FCMs should ask these clients about any history of domestic violence or substance abuse. Because individuals with personality disorders tend to act on impulse, physical violence toward children is a concern.
When creating a case plan with a caregiver who has a personality disorder, it is important to consider the safety of the children, the caregiver's ability to parent the child, and the caregiver's desire to seek and maintain treatment. You will likely involve the DCS Clinical Services Specialist and DCS Nurse in your region in the development of these case plans. Review the information on the slide and click next when you are ready to move on.
Post Traumatic Stress Disorder

**Characteristics:**
- Negative alterations in thoughts or moods
- Intrusive symptoms
- Avoidance
- Alterations in arousal
- Depression and anxiety
- Sleep disturbances
- Anger

**Slide notes**
Post Traumatic Stress Disorder, or PTSD, is caused by exposure to some traumatic event, or events that involved actual or threatened death or serious injury to a person. Characteristics of PTSD include negative thoughts or mood, intrusive symptoms, avoidance, alterations in arousal, depression and anxiety, sleep disturbances, and anger.
When interviewing or working with a client who has PTSD, you might notice that they don't want to talk about their trauma. These clients may appear dissociated from their family or children, which makes them unable to care for the children. You may also notice unintentional rage among these clients. It is important to find out if the children may be a trigger for PTSD. If so, the children are at a great risk of becoming a victim of violence. You also need to know if the client abuses any substances in order to self-medicate.
MSBP is defined by the American Professional Society on Abuse of Children as:

“A form of child abuse whereby the child is a victim of maltreatment in which an adult falsifies physical and/or psychological signs and symptoms in the child causing this child to be regarded as ill or impaired”
Munchausen Syndrome by Proxy

**Characteristics:**

- A child who presents with one or more medical problems that do not respond to treatment or that follow an unusual course that is persistent, puzzling and unexplainable
- Symptoms that do not make sense
- Repeated hospitalizations and extensive medical tests that fail to produce a diagnosis
- Physical or laboratory findings that are highly unusual or discrepant with the reported history or that are physically or clinically impossible
- Signs and symptoms that disappear when the perpetrator is removed from contact with the child
Munchausen Syndrome by Proxy

Characteristics (Cont.):

- A family history of similar sibling illness or unexplained sibling illness or death (e.g., SIDS)
- A history of unusual or numerous medical ailments that have not been substantiated and raise questions about the reporter’s veracity
- A parent with symptoms similar to her own child’s medical problems or illness history that itself is puzzling and unusual
- A caregiver who refuses to accept that the diagnosis is non-medical
- Symptoms or episodes of cyanosis, apnea, “near miss” SIDS, or seizures not witnessed by anyone else except the caregiver
- Transfers to other hospitals or discharges against medical advice
An FCM working with a caregiver suspected of having Munchausen Syndrome may notice that other adults within the family will cover for the caregiver, or deny that a problem exists. Munchausen Syndrome is not a condition that can be confirmed by an FCM. Hospitals are generally the most reliable report source in this instance, but this is a difficult diagnosis to confirm. FCMs should work with the DCS Nurse and Clinical Services Specialist if Munchausen Syndrome is suspected.
When creating a case plan with a caregiver who has Munchausen syndrome, it is important to consider the safety of the children, the caregiver’s ability to parent the child, and other available caregivers. You will likely involve the DCS Clinical Services Specialist and DCS Nurse in your region in the development of these case plans. Review the information on the slide and click next when you are ready to move on.
DCS Policy

- Voluntary
- Suspected abuse of illegal substances or alcohol
- Suspected mental incompetence
- DCS cannot require action
  - Seek Court Order
  - Seek to access mental health records in PI

Slide notes

DCS Policy 4.16 outlines the procedure to request medical or psychological testing for caregivers who may be experiencing mental illness. DCS may ask a parent, guardian, or custodian to voluntarily submit to medical or psychological tests and assessments, as well as drug screens or other substance abuse assessments, when allegations of abuse or neglect may be due to illegal substance use, alcohol abuse, or mental incompetence. DCS cannot require action on the part of the parent, guardian, or custodian. DCS can seek a court order if a mental health evaluation is necessary. DCS may also seek medical records by request of the court in a Preliminary Inquiry. You may view Policy four point sixteen by clicking on the yellow post-it note.
Mental illness is treatable. Most treatments fall under two general categories—psychosocial and pharmacological. The combination of the two, known as multimodal therapy, can sometimes be even more effective than each individually.
Psychotherapy is a learning process accomplished largely by the exchange of verbal communication. It is commonly called talk therapy. Pharmacological therapy is medication based. The past decade has seen an outpouring of new drugs introduced for the treatment of mental disorders.
Psychotherapy participants can vary in age from the very young to the very old. Problems can vary from mental health problems to disabling and catastrophic mental health disorders. Although people are often seen individually, psychotherapy can also be done with groups or families. Participants present their problems and work with a psychotherapist to develop more effective means of understanding and handling them. There are many approaches to psychotherapy, an individual and therapy may try several before finding one that works. The FCM should receive a copy of the Treatment Plan when therapy begins with a client.
Finding the right drug dosage, drug side effects, and client compliance with prescriptions are all key aspects to pharmacological therapy. The use of psychotropic drugs by children should be closely managed. DCS Nurses can review medication use.
The combination of psychotherapy, or talk therapy, and pharmacological therapy, or drug therapy is called Multi-modal Therapy.
Evidence Based Treatment:

Diagnoses most likely associated with serious impairment or endangerment of children.

- Practitioner combines:
  - Interventions
  - Clinical experience
  - Ethics
  - Client preferences
  - Culture

- Used to guide and inform the delivery of treatments and services

Match the following

**Column 1**
- Psychotherapy
- Pharmacological Therapy
- Multimodal Therapy
- Evidence Based Treatment

**Column 2**
A) Combination of talk therapy and drug therapy
B) Therapy based on verbal communication
C) Medication Based Therapy
D) Based on practices established through scientific research

**Slide notes**
Match the terms on the left with the correct definition on the right.
Barriers to treatment fall under several umbrella categories. They include demographic factors, patient attitudes toward a service system that often neglects the needs of racial and ethnic minorities, financial, and organizational factors.
Slide notes
Stigma surrounding mental illness contributes not just to people not getting treatment, but also is a barrier to them finding work, housing, and support. It reduces patients’ access to resources and opportunities and leads to low self-esteem, isolation, and hopelessness. Stigma is particularly intense in rural communities, where anonymity is difficult to maintain.
The cost of treatment is a prevalent deterrent to seeking care. This is true even among people with health insurance because of inferior coverage of mental health as compared with health care in general.
Common patient attitudes that deter people from seeking treatment are not having the time, fear of being hospitalized, thinking they can handle it alone, thinking that no one can help, and embarrassment.
Some people are concerned that DCS may get involved, or our involvement may increase if they seek mental health treatment.
Members of racial and ethnic minority groups often perceive that services offered by the existing system to not or will not meet their needs. For example, by failing to take into account their cultural or linguistic practices.
Slide 50 - Barriers to Treatment - 7

Slide notes

Cultural identity imparts distinct patterns of beliefs and practices that have implications for the willingness to seek, and the ability to respond to mental health services. These include coping styles and ties to family and community.
People in rural America encounter numerous barriers to the receipt of effective services. Some barriers are geographic, created by the problem of delivering services in less densely populated rural areas.
Mothers and fathers with mental illness experience all of the challenges of other adults attempting to balance their roles as workers, spouses, and parents in addition to mental health symptoms.

The symptoms of mental illness may inhibit the parents’ ability to maintain a good balance at home and may impair their parenting capacity.
Here are some examples of how mental illness may impact parenting capacity.

Parents who feel lethargic and listless may find it difficult to provide stimulation, motivation, and inspiration for their child. Anti-psychotic medications may increase lethargy and listlessness. A parent may stop taking their medication to have more energy. Some parents with schizophrenia may find it difficult to be emotionally and physically close to their child. Care may be unpredictable or inconsistent, leading to attachment and behavior issues. Children may face boundary and reality issues, because of the ways in which their parent’s functioning is affected. Parents symptoms may lead to physical harm of the child, sometimes as a result of hallucinations, suicidal thinking, or an inability to meet their needs. Hospitalization of a parent with mental illness disrupts the child’s life. Parents are fearful that children will be removed, and therefore are fearful of asking for help.

The severity of a parent’s mental illness and extent of the symptoms may be a more important predictor of parenting success than the diagnosis itself.
The impact of parental mental illness on family life and children's well-being can be significant. Children whose parents have a mental illness are at risk of developing social, emotional, and/or behavioral problems. The environment in which children grow affects their development and emotional well-being as much as their genetic makeup does.
When a parent in the family has a mental illness, the children face a number of challenges:

- Inappropriate levels of responsibility
- Blame leads to anger, anxiety, and guilt
- Isolation
- Risk of poor school performance, drug use, and poor social skills
- Developing mental health problems
In some cases, a caregiver’s mental illness combined with other factors may increase the risk of harm to a child. Examples include Mental Illness combined with a history of domestic violence, Combinations of depression, substance abuse, and personality disorder(s), All of a child’s caregivers (both parents or only parent) have mental illness, Family isolation or lack of support, Poor compliance with treatment and/or medication, Self-harming behavior and/or suicide attempts, Psychotic delusions involving the child, Intellectual challenges combined with mental illness.
Resiliency is directly proportionate to the number of risk and protective factors present within the family. The greater number of protective factors and smaller number of risk factors, the greater the likelihood of a child being resilient.
When a caregiver has a mental health concern, it is important that DCS is able to determine:

- Child Safety
- Protective Factors
- Services

Slide notes
When a caregiver has a mental health concern, it is important that DCS is able to determine if that concern poses a threat to the safety of the child, and if there are protective factors that might mitigate that safety threat or if there are services that could be put in place to help assure safety.
A mental illness does not automatically create a safety risk for a child. Put the person before the illness. Use phrases such as “a person with schizophrenia”. Never use negative terms such as crazy, psycho, or retarded.

The behaviors that may result from the mental illness have the potential to pose a safety risk.

It is important to assess both the safety risk and protective capacities of a family.

Given DCS’s value of Safely Home, Families First, we must also assess if services could be put in place to keep the child safe in the home.
As described earlier, Protective Factors are characteristics in families that, when present, increase safety, stability, and well-being of children and families. On the next slide, you will see examples of Protective Factors.
Here are some Protective Factors a family may possess. Understand that these are examples, this is not a complete list. Child has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger. Caregiver has the ability to access resources to provide necessary safety interventions. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, and the caregiver is willing to accept their assistance. At least one caregiver in the home is willing and able to take action to protect the child, including asking an offending caregiver to leave. Caregiver is willing to accept temporary interventions offered by DCS and other agencies. There is evidence of a healthy relationship between caregiver and child. Caregiver is aware of and committed to meeting the needs of the child.
In this training we have explored mental illness, treatment options for mental illness, and its impact on families. You should now understand more about risk factors and protective factors as well. Using this information, read the following scenarios and answer questions for each scenario in the front of your Case Planning and Intervening for Permanence Participant Manual. This will be the foundation for a discussion during Case Planning and Intervening for Permanence Class.
Joyce has been diagnosed with depression. She has been able to function effectively as a mother and business owner. Joyce is the parent of four young boys ranging in age from 2-10, all of whom she adopted about 2 years ago. Joyce’s adjustment to parenting 4 young rambunctious boys has been very trying at times. She has had to make numerous adjustments to her schedule in order to manage the new responsibilities of her growing and changing household. Initially, Joyce felt very comfortable in her ability to manage all the new found ‘family related tasks’ and continue to run her family business. Recently Joyce has found herself tired, withdrawn, stressed, and with decreased appetite. One evening while caring for her kids, Joyce became upset with one of her sons and hit him out of frustration. He went to school with a bruise and DCS was contacted. Joyce reported that she has been able to manage her depression with medication in the past effectively but has recently felt overwhelmed.

Slide notes
Read the scenario and answer the questions in your Case Planning and Intervening Participant manual. Once you have answered the questions, click next to see the second scenario.
Lisa-Borderline Personality Disorder

Lisa is a single mother of 2 and just recently gave birth to her 3rd child. Lisa did not receive pre-natal care during her pregnancy because she stated that she did not realize she was pregnant until a month ago. Lisa suffers from Borderline Personality Disorder (BPD). Lisa has a history of not taking her medication as prescribed and says she takes it when she ‘feels like it’. At times, Lisa becomes very angry and physically abusive. She has been involved with DCS in the past due to physical abuse of her older two children. She said she has to ‘whoop’ them because they think they are grown. Lisa has had several live-in boyfriends over the past few years, and each time someone moves in she tells the children they are getting married. Many of these men have been physically and verbally abusive to Lisa and the children. DCS was called during her inpatient stay after several visits with the hospital social worker. Lisa repeatedly cried during these visits, saying she doesn’t know where her boyfriend went and that she can’t have another baby.

Slide notes
Read the scenario and answer the questions in your Case Planning and Intervening Participant manual. Once you have answered the questions, click next to continue.
Thank you for taking the Case Planning and Intervening for Permanence: Introduction to Mental Health training.

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Designed by: Crystal Offutt

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