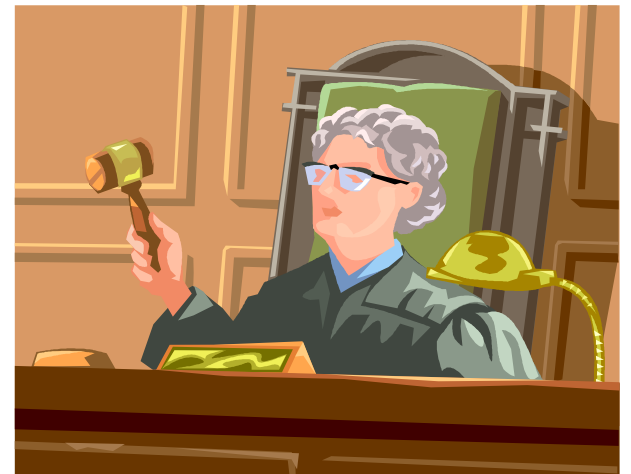


Parenting in Dependency Court

Judge Cindy S. Lederman
Presiding Judge of the Miami-Dade Juvenile Court

**NRC/IOM Committee on Depression, Parenting
Practices and the Healthy Development of Children**

The Beckman Center at the National Academies
Irvine, California
April 14, 2008





a mother's love



is



only



known

LUCKY

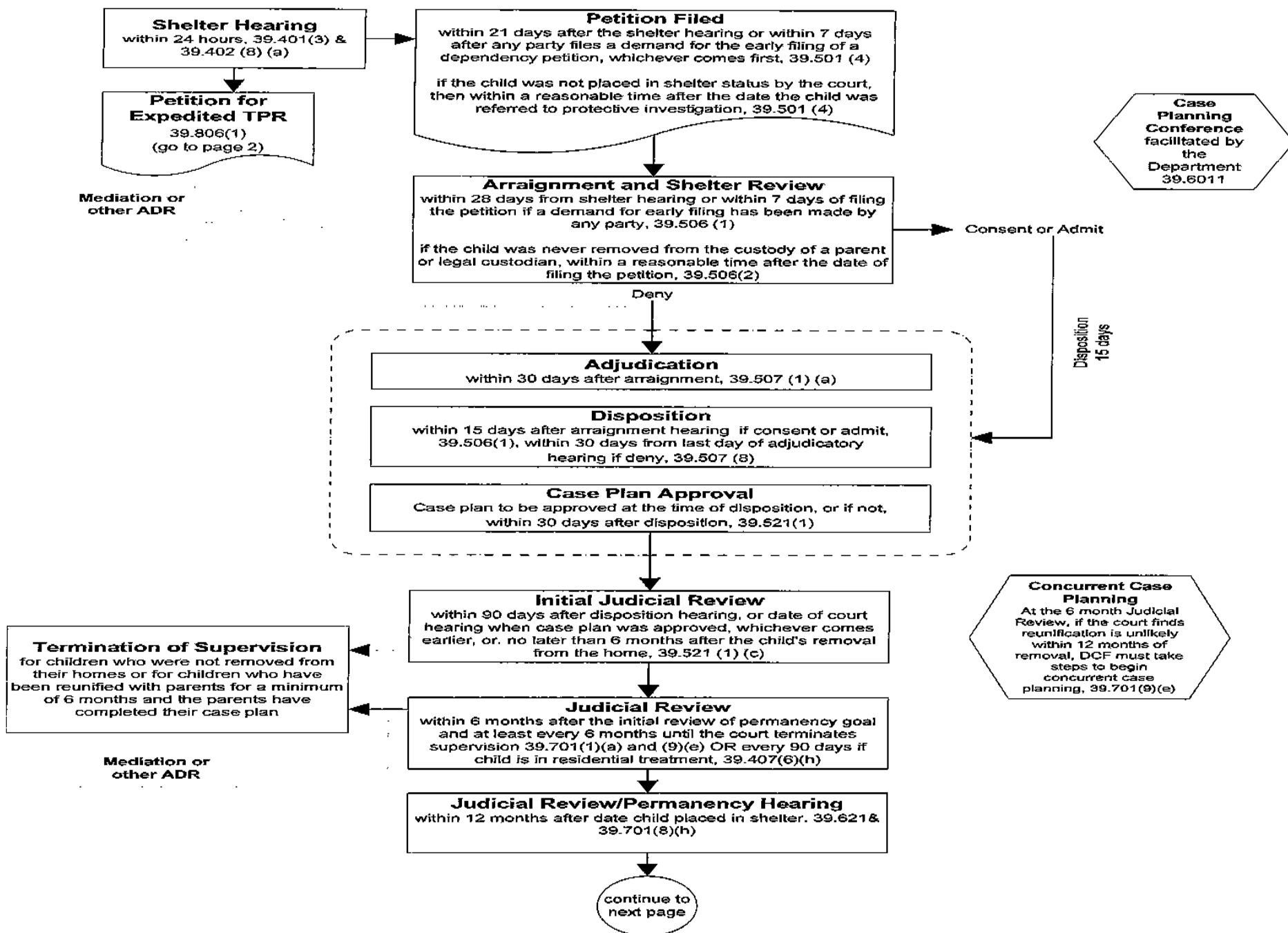


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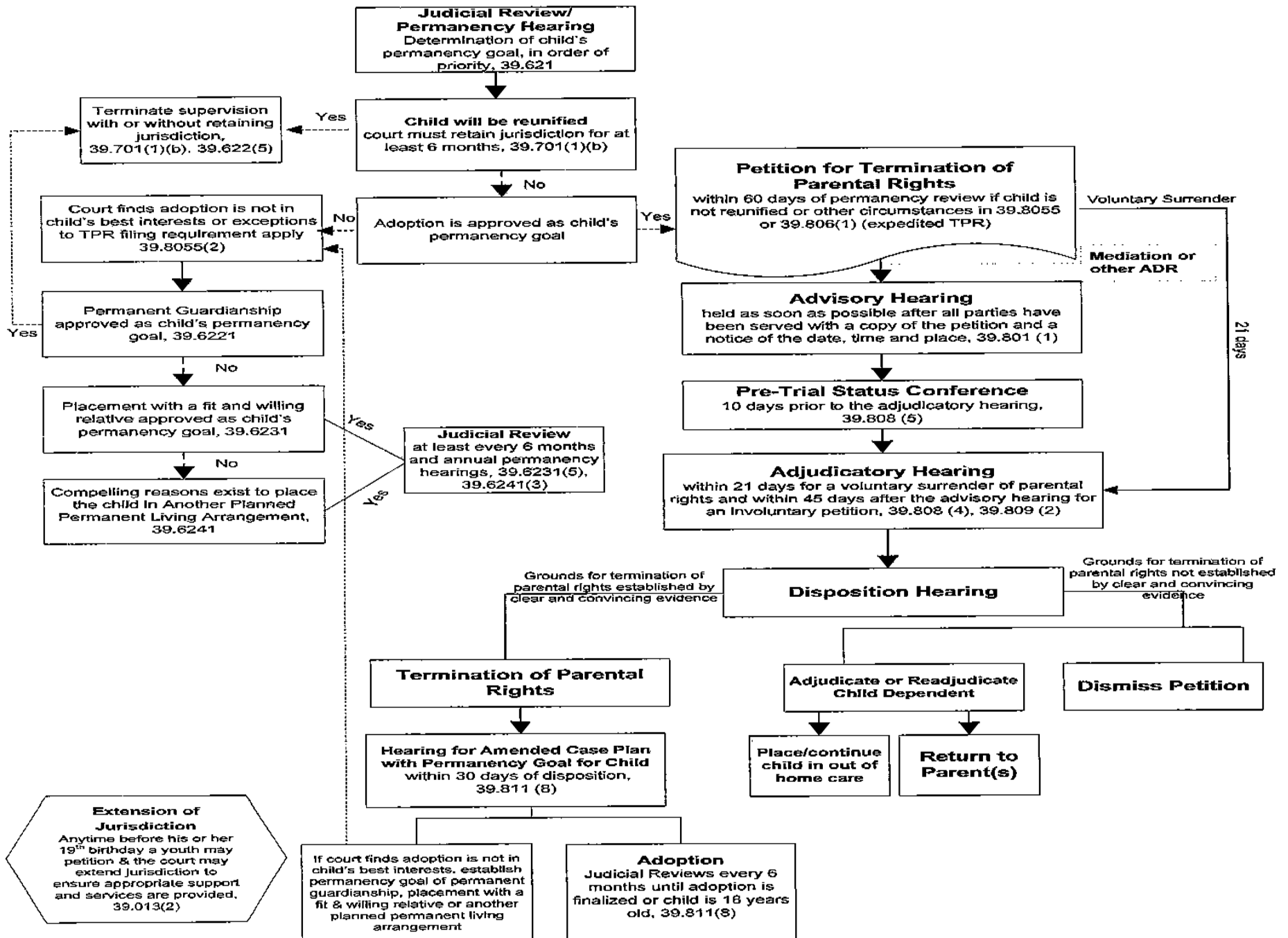
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Dependency Case Management Flowchart

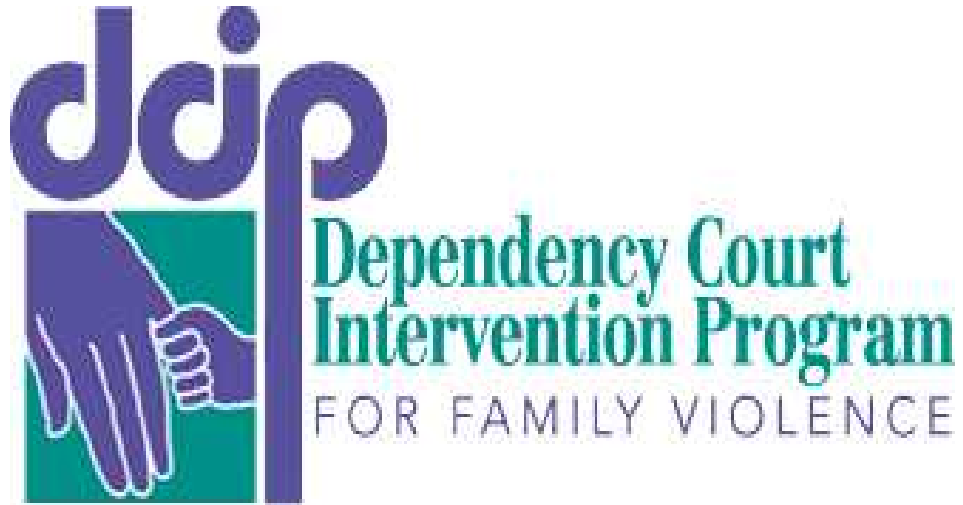


Dependency Case Management Flowchart (continued)



Miami-Dade and Monroe County Child Welfare Population

Race	#	%
Black non-Hispanic	2575	59%
Hispanic	1265	29%
White non-Hispanic	471	11%
American Indian	3	0%
Oriental/Asian	6	0%
Other	41	1%
Total	4361	100%



Infant and Young Children's
Mental Health Pilot
Project
Miami-Dade County Juvenile
Court

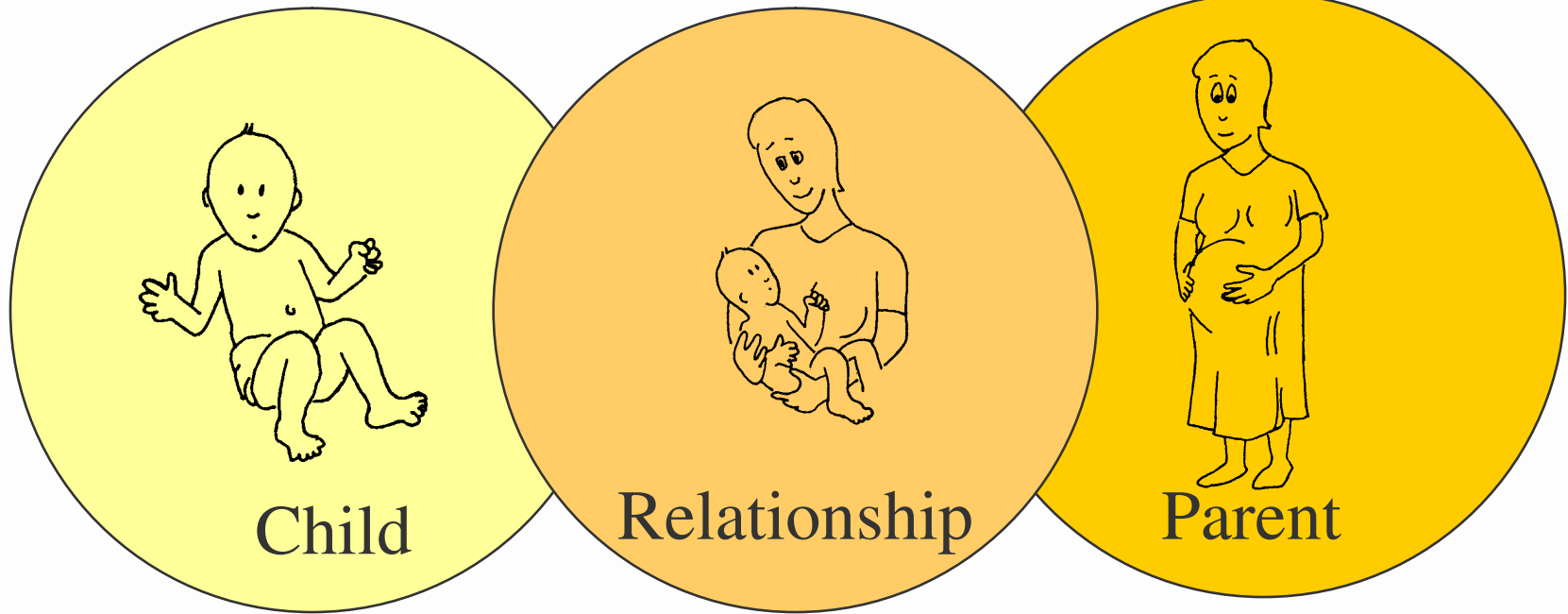
Miami Safe Start Initiative



*A Model Community Response for
Young Children Exposed to Violence*



Child-Parent Psychotherapy



Goals of Child-Parent Psychotherapy

- The infant was harmed in the relationship and must be “healed” in the relationship
- The therapeutic work incorporates a broad range of techniques to enhance the mother’s awareness and responsiveness to her child’s needs
- Emotional and behavioral problems in infancy and early childhood need to be addressed in the context of primary attachment relationships
- Promoting growth in the caregiver-child relationship supports healthy development of the child long after the intervention ends

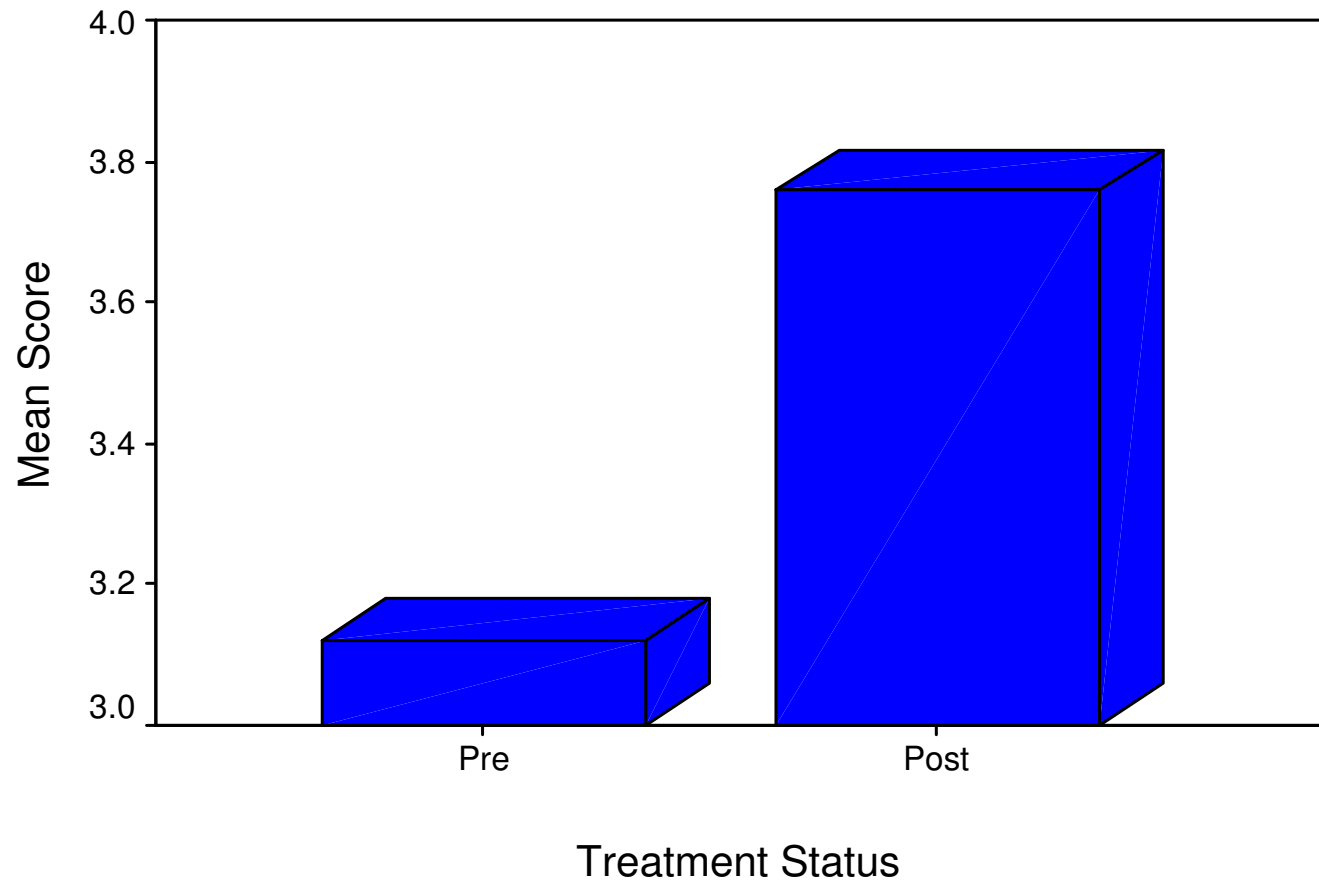
Therapist models appropriate parenting behavior

Promotes empathy
and restores trust
and reciprocity in the relationship

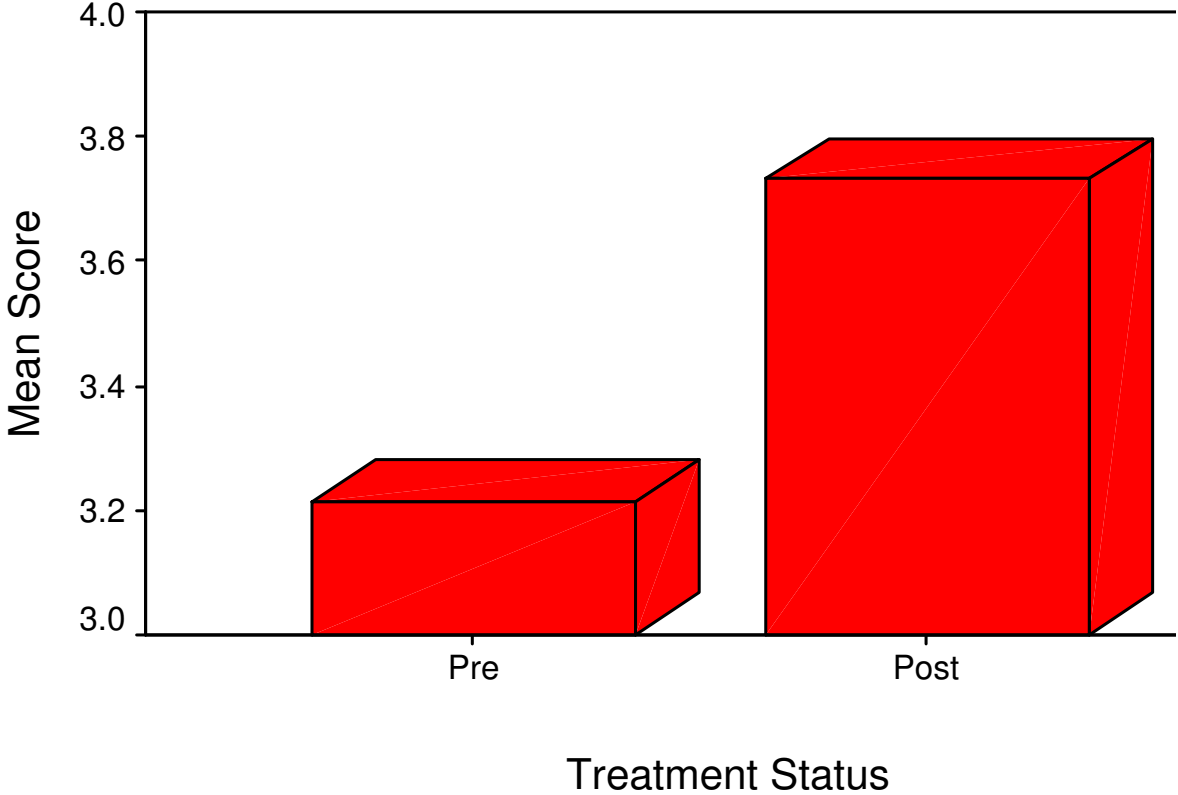
Examines underlying concerns from the mother's
own upbringing that may influence her interactions
with her child.

Promotes healthy parent baby interactions at the
inception of the formation of the relationship

Parental Behavioral Responsiveness by Treatment Status

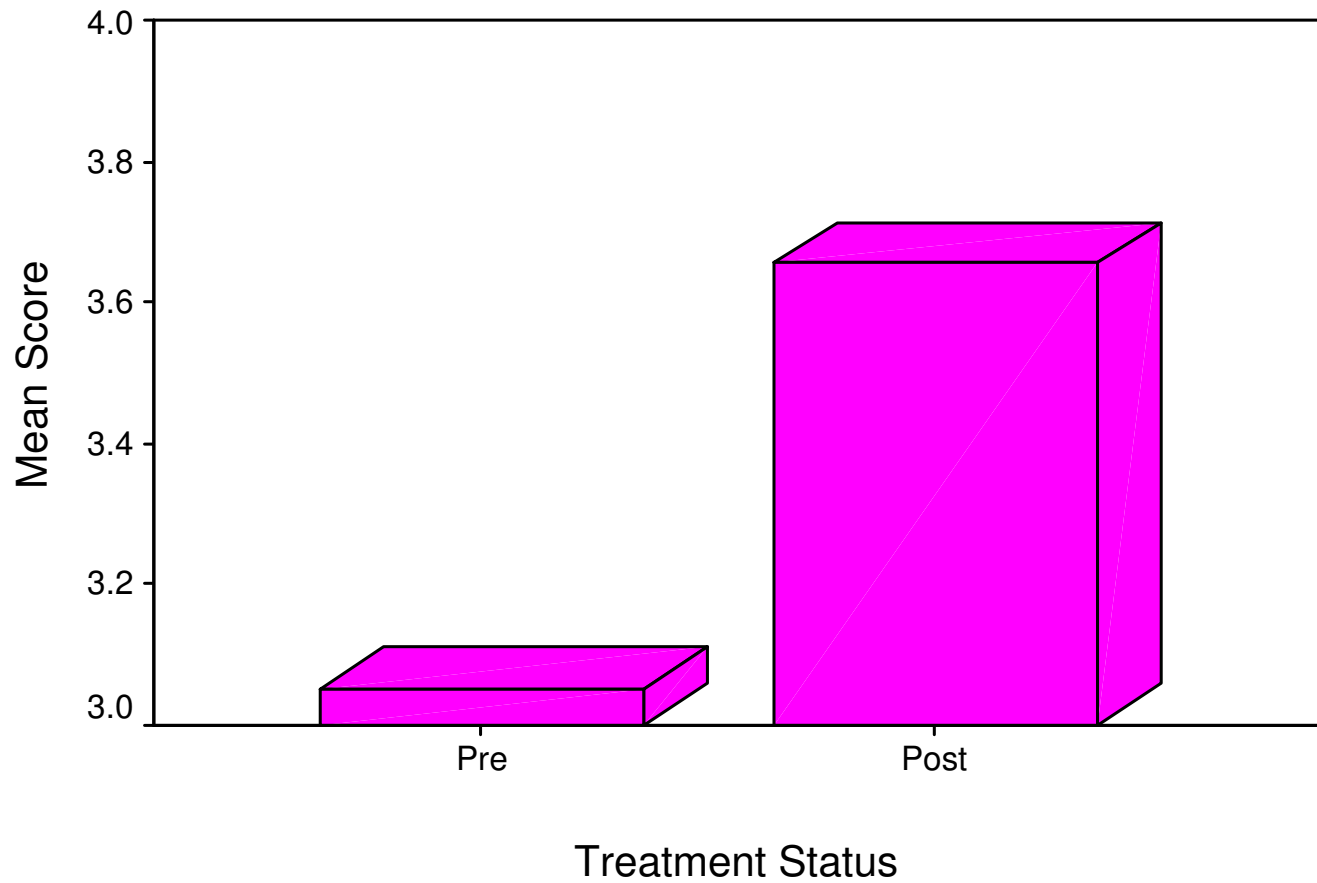


Parental Intrusiveness by Treatment Status

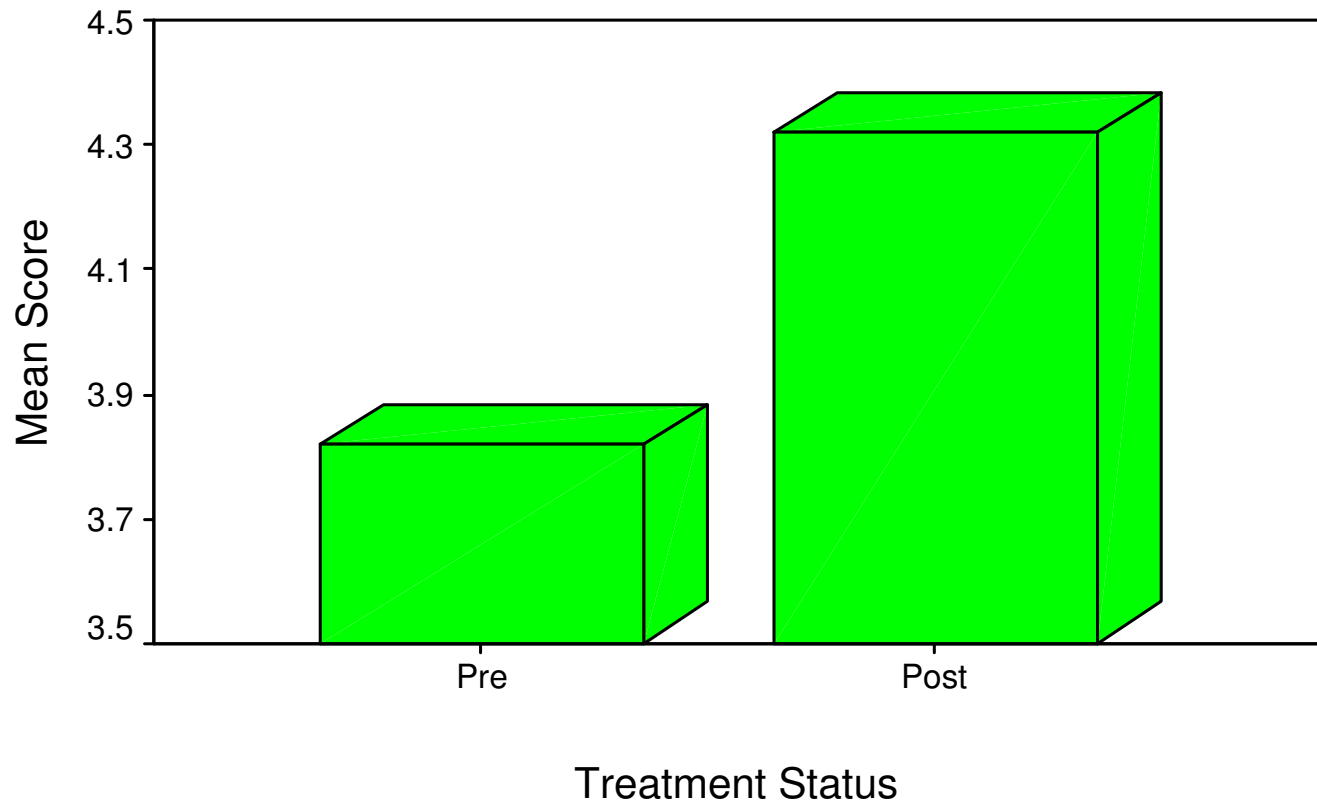


Note: Higher score = more optimal behavior

Parental Emotional Responsiveness by Treatment Status

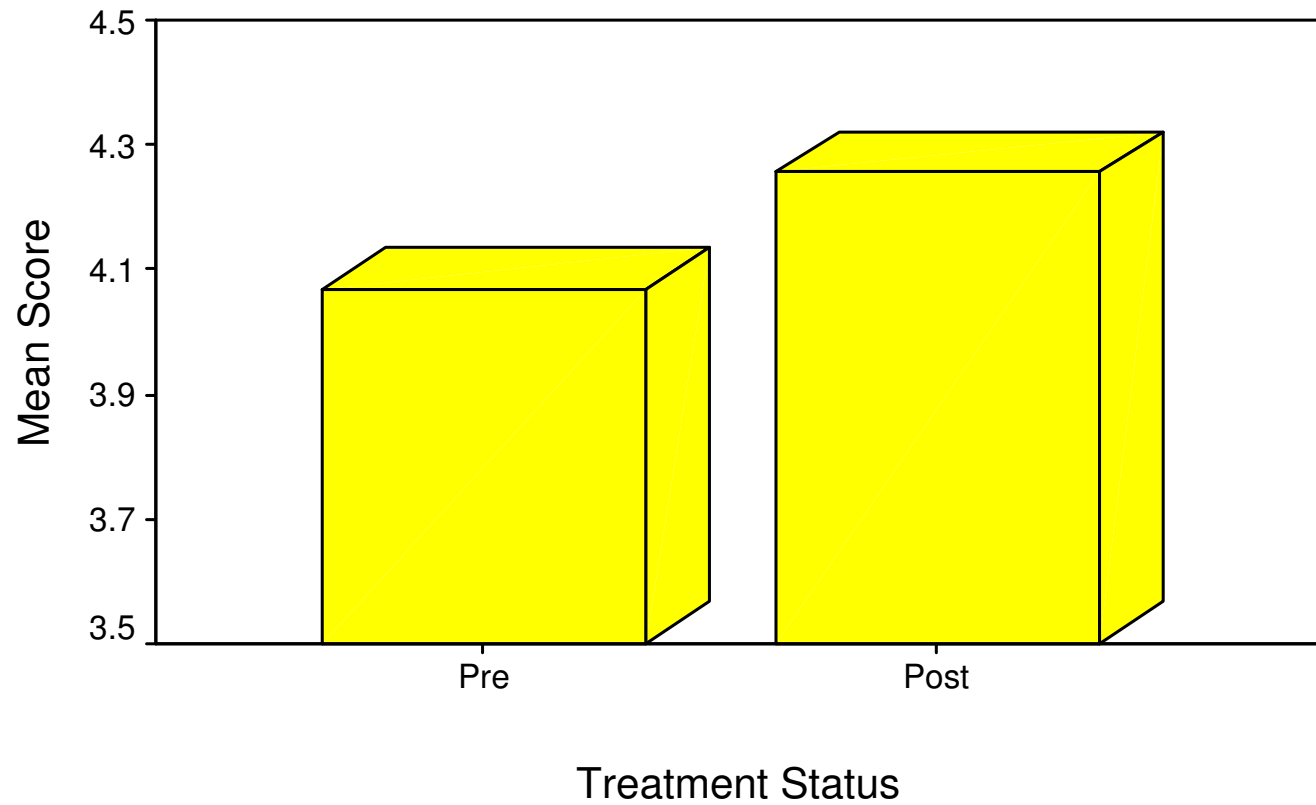


Parental Discipline by Treatment Status



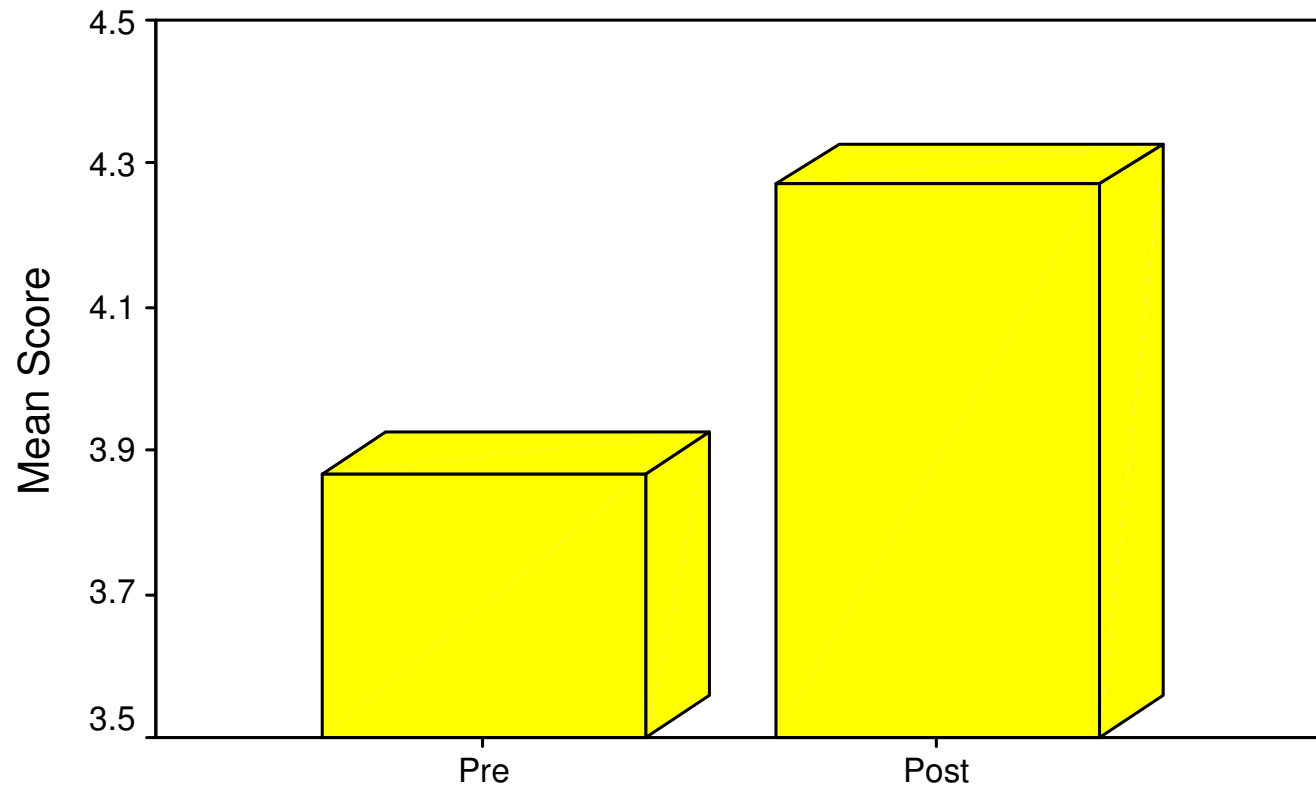
Note: Higher score = more optimal behavior

Parental Affect by Treatment Status



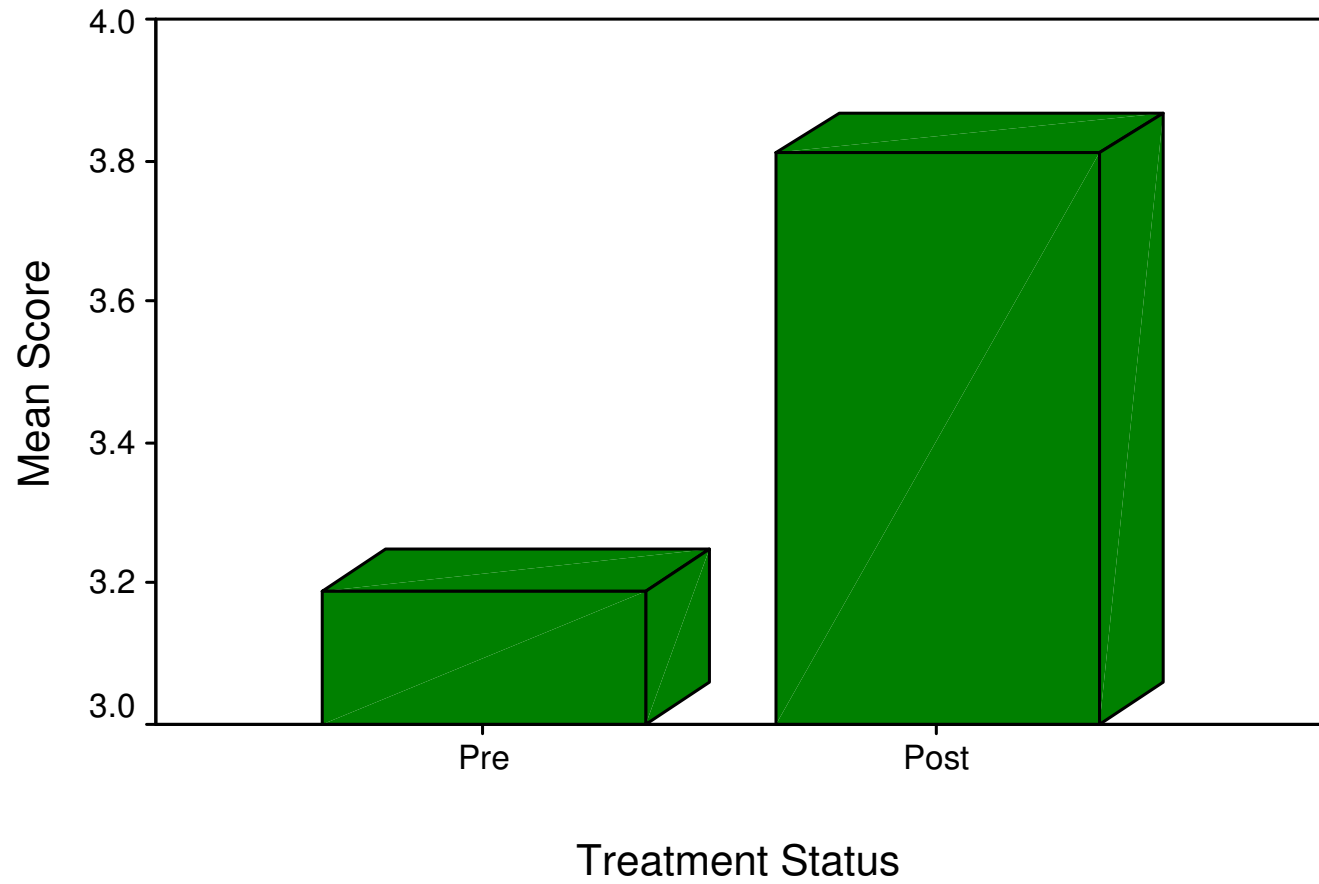
Note: Higher score = more positive and less negative affect

Child Affect by Treatment Status

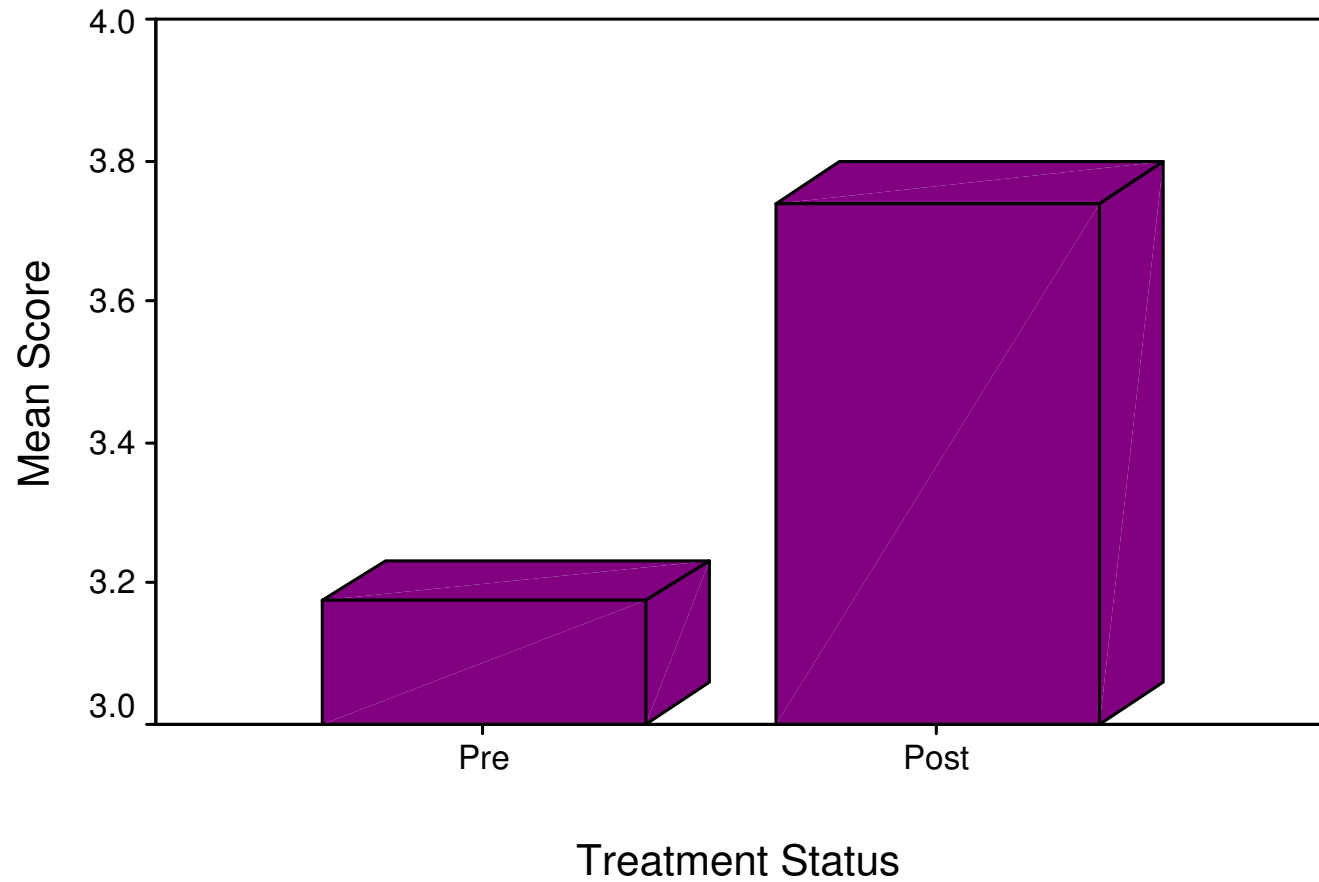


Note: Higher score = more positive and less negative affect

Child Enthusiasm by Treatment Status



Parental Responsiveness at Reunion by Treatment Status



Child Responsiveness at Reunion by Treatment Status

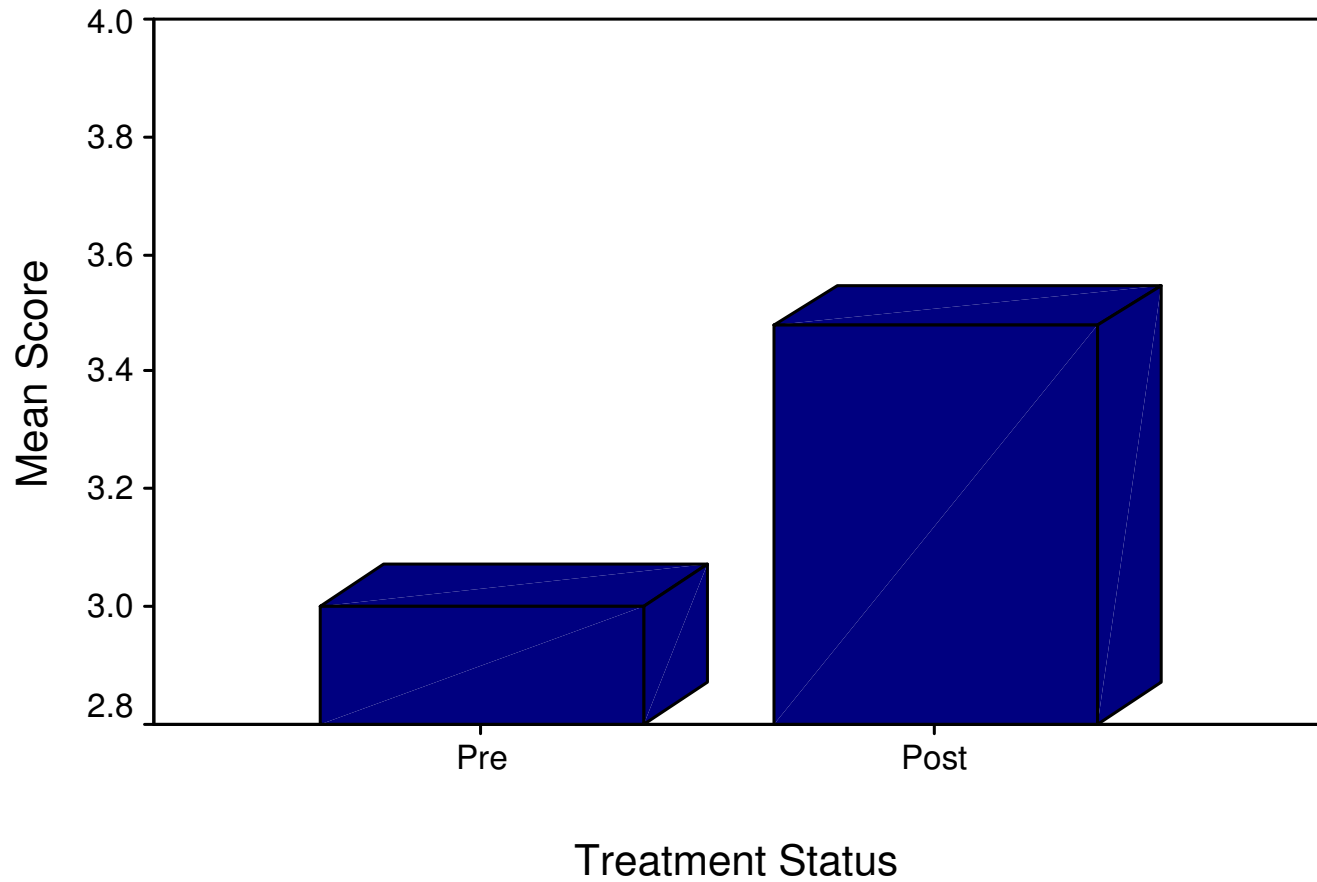


Table 4. Parent and Child Relationship Scale Results

Parent Subscales		Pre-Test Mean	Post-Test Mean	Significance
	Positive Affect	3.83	4.09	NS
	Withdrawn/Depressed	4.25	4.50	NS
	Irritability/Anger	4.58	4.75	NS
	Behavioral Responsiveness	3.50	4.17	P<.005
	Emotional Responsiveness	3.67	4.25	P<.05
Child Subscales				
	Positive Affect	2.75	4.17	P<.001
	Withdrawn/Depressed	3.67	4.83	P<.001
	Irritability/Anger	3.17	4.50	P<.005
	Noncompliance Towards Parental Instruction	3.25	4.25	P<.001
	Aggression Towards Parent	4.67	4.92	NS
	Enthusiasm Scale	3.08	4.33	P<.001
	Persistence	2.83	4.08	P<.002
Reunion Subscales				
	Parent's Emotional and Behavioral Responsiveness	2.80	2.90	NS
	Child's Emotional and Behavioral Responsiveness	2.30	2.70	P<.04

Note: The higher the number, the better the response for all scales.

Other Outcomes



- No further abuse or neglect
- Permanency rate of 100%
- Caretakers depression decreased from mild to minimal (BDI 14.85 to 10.88)
- **5 year follow up:** all Mothers reunified or have right to visitation with children. (Including one child who was adopted). 17 dyads were found

Model Parenting Programs

- Evidence based
- Pre test and post test
- Measured observations of parent with child at least twice during program
- Uniform detailed reports provided to the court with testing and observational scale included
- No more “Certificates of Completion”
- Data is trending towards increased stress at post assessment on the Parenting Stress Index (PSI)

Barriers to Implementation



- Very high risk population
- Funding: medicaid (especially without diagnosis)
- Engagement / case management is not reimbursed
- Institutional malaise
- Capacity
- Paucity of trained IMH clinicians
- Lack of monitoring and accountability
- Community providers' level of functioning
- Chasm between research and practice
- Non compliance rate is about 50%
- Leadership

