Background Paper 2

Child Neglect in Scotland: Rapid review of the literature on intervention

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Background

1. On 25 February 2016 the Cabinet Secretary for Education and Lifelong Learning, Angela Constance, made a statement to Parliament announcing a programme of action on child protection. Scottish Government committed to reviewing policy, practice, services and structures of the current child protection system to identify what works well and what could be improved. The focus of the Programme is on processes and systems which underpin child protection in Scotland and tackling child neglect was identified as a high priority.

2. As at 31 July 2015, 2,751 children were on the Child Protection Register: 39% had been the subject of emotional abuse and 37% had suffered from neglect. In addition, 'lack of parental care' is the most common reason for referral to the Scottish Children's Reporter Administration. A recent study by Dartington Social Research Unit (2016) reported that '*At least 1 in 5 children at any one time are 'in need', meaning that they have needs that may impair their future health or development' in Scotland*' (p.3) including parental attitudes permissive of antisocial behaviour and substance use, and poor family management. Part of Scottish Government's response to tackling neglect is to undertake a pilot programme of neglect improvement work in three local authority areas. The pilot aims to promote learning from different areas to improve how education, health and children's services work together to tackle neglect.

Context

3. Neglect is one of the most damaging childhood experiences and is associated with some of the poorest behavioural, emotional and cognitive outcomes. These affect life chances and contribute significantly to widening social, economic and health inequalities. Evidence suggests that one in ten children in the UK experience neglect and that it is the most prevalent form of child maltreatment. Current attempts to improve responses to neglected children are fragmented across training, development and research initiatives, none of which is sufficient in scope and scale to tackle a phenomenon that is complex, intractable, sprawling and entrenched. Child neglect is a major crisis that requires a comprehensive solution.

4. To experience neglect of developmental needs is one of the most profoundly damaging childhood experiences. There is now an overwhelming body of research that evidences just how harmful neglect can be to emotional, behavioural and cognitive development in the short and long term. Significant and sustained change is needed in the quality of care given to the child and the environment for children to experience positive outcomes as adults (Iwaniec, Sneddon and Allen 2003; Lutman and Farmer 2013).

5. The systems we have developed in the UK for the support and protection of children do not provide the most effective response to neglected children and are particularly poor at prevention of neglect in the first place and at responding early enough to prevent physical

and emotional damage. At the same time, there is a considerable body of evidence about what would be helpful to children and their parents: the problem lies with effective implementation of this evidence.

Rapid review of literature

6. The Centre for Child Wellbeing and Protection at the University of Stirling was commissioned by Scottish Government to undertake a rapid review of the literature in relation to programmes, approaches and interventions with children who may be experiencing neglect to inform the Child Protection Improvement Programme and the pilot programme of improvement work. The aim of this rapid review of the evidence was to identify the core and common elements and principles shown to be associated with effective practice with chronic neglect, including those incorporated within routine practice by a range of disciplines as well as those embedded within formal evidence-based programmes.

Aims and methods

7. This review aimed to bring together current literature on interventions with children and families who may have experienced neglect. This review did not include published material on the factors or characteristics of families where children experience neglect, but instead focused on evaluations of interventions or approaches with both children and families. It should be clear that due to tight timescales and limited resources this was not a full systematic review, but the approach did use the guidance on systematic review as a framework (Centre for Reviews and Dissemination (http://www.york.ac.uk/inst/crd/). Of course, such a review is limited by what interventions researchers evaluate. In particular the evidence base is limited by lack of research into the 'practice as usual' that characterises much of the routine multi-disciplinary intervention undertaken every day across Scotland.

8. Qualitative and quantitative studies were reviewed and included pre and post intervention studies, longitudinal follow-up, controlled studies, randomised controlled studies, single-case descriptions and evaluations of interventions without quantitative analysis. Background discussion papers and systematic literature were also included.

Search strategy

9. The following terms - *interventions* AND *approaches* AND *programmes*, *child** AND *neglect* – were used to explore all journals in the Wiley Online Journals Library and ScienceDirect Freedom collection, and the following databases:
    - SocINDEX with Full Text
    - ScienceDirect
    - Political Science Complete
    - Criminal Justice Abstracts with Full Text

- ERIC, Academic Search Index
- PsycInfo
- Business Source Complete
- CINAHL Complete

10. Articles from a range of disciplines were also searched: Applied Sciences; Health and Medicine; Life Sciences; Nursing and Allied Health; Political Science; Politics and Government; Psychology; Public Health; Social Sciences and Humanities; Social Work; and Sociology.

11. In total, 899 peer-reviewed articles were identified and screened. Articles were excluded if the focus was wider than neglect i.e. child maltreatment, if the focus was on the factors associated with neglect or if the focus was on the identification or signs of neglect. This initial screening for relevance resulted in 166 articles eligible for further screening.

12. The next stage of filtering considered the articles in more detail. A further 47 articles were excluded resulting in 119 articles to consider for data extraction. At this stage reviewers rated both methodological quality (1 *poor* – 3 *very good*) and the usefulness of the paper (1 *not at all* – 3 *very useful*) to the review question. A selection of articles was subject to review by two reviewers to ensure inter-rater reliability. Those articles which rated 1 for both were automatically excluded, however, articles that may have scored poor for methods, but high in relevance were included.

13. Forty-seven papers were included in the final review.

Limitations

14. The original aim of the review had been to include articles and papers which focused on neglect. The review was limited, however, as few studies or papers in relation to interventions have a specific focus on neglect. The decision was taken to include articles that discussed both child abuse and neglect, but distinguished between the two. Those which discussed neglect in the generic terms of *child maltreatment* or *abuse* were excluded. A second limitation was that much research and literature review focuses on the neglect of young children under the age of eight; there is little in the literature in relation to interventions with older children and young people (9-15). A third limitation is that some studies lacked adequate sample size and many studies of potentially promising prevention programmes lacked sufficient methodological rigor in terms of study design. A fourth limitation was that there were very few longitudinal studies to fully understand the effectiveness of an intervention over time.

15. Effective interventions in neglect face many challenges, not least because the nature of interventions and support will depend on how neglect is defined and understood (Daniel 2015; Hearn 2011). For example, if neglect is viewed as a symptom of structural inequalities and poverty, a case for adopting a public health approach to intervention can be made. If it is defined as an issue of poor parenting then the approach may focus on

parenting and home visitation programmes.

Included articles

16. Thirty-two articles were from North America and Canada, eight from the UK, and four from Europe and three Australia and New Zealand. Twenty-seven articles related to primary studies (level 1) and twenty articles were either reviews or discussion papers (level 2). In terms of methods and usefulness:

Primary studies

- 3 (methods), 3 (usefulness) 10 studies
- 3 (methods), 2 (usefulness) 8 studies
- 2 (methods), 3 (usefulness) 4 studies
- 2 (methods), 2 (usefulness) 5 studies

Guidance, review or discussion

- 3 (usefulness) 16 papers, reports or reviews
- 2 (usefulness) 4 papers, reports or reviews

Emerging themes

17. Child neglect is a societal problem requiring systemic intervention addressed through collaborative partnerships between statutory and non-statutory sectors and community members with attention to contextual factors, including poverty (Chambers and Potter 2008; Hearn 2011). It may be that society needs intervention at different levels: primary (or universal) prevention or public health approaches are designed to prevent behaviours before they occur. Such approaches focus on reducing risk factors and enhancing protective factors; secondary (or selected) prevention focus on the early detection and treatment of existing problems, often targeting groups or individuals identified as at-risk; and tertiary (or indicated) prevention approaches are designed to reduce the impact of existing problems (i.e., the re-occurrence of abusive behaviors). Thus, tertiary prevention programs focus on families in which abuse has already been identified (Hardiker 1991; Portwood 2006).

18. Several wide ranging factors are seen as potential contributors to child neglect, but only some may feature in a particular family at any one time (Garshater-Molko, Lutzker and Sherman 2002). In a recent article, Daniel (2013) neatly summarised the complex issues:

> '*The evidence points to the need to build comprehensive packages of support that are clear, focused and address the issues at each ecological level. In particular, there is evidence that the provision of direct support for children is of especial value. Intervention also has to include attention to the processes underlying service use and change, and it can hinge on the quality of the relationship between the practitioner and the parent and/or child. Authoritative intervention combines understanding of the factors affecting parents with realism about parental capacity and willingness to change based on close observation of*

> *evidence about the child's experience of care (Tuck, 2012). And, crucially, intervention to support neglected children has to be provided on a long-term, not episodic basis, but, again, we have known this for a long time*.'
> [Daniel 2015, p.10]

19. To understand how we might have a greater impact with children, young people and families living with neglect, the body of evidence is universal in identifying that attention needs to be given to individual family members in the context of their lived experiences in the home and within the wider community. This review does not provide answers, but does identify some common core principles grouped under the following emerging themes:

- Building blocks of an intervention
- Working with individual children, young people and families
- Interventions and programmes
- Working with communities
- Relationships

Building blocks of an intervention or service

20. The literature identifies several factors to consider when designing or beginning to work with families experiencing neglect.

21. **Clarifying the issues.** When formulating an appropriate intervention for neglectful families, it is important to distinguish between inadequate parenting as a result of a lack of parenting skills and inappropriate expectations of their children versus inadequate parenting as a result of clear social and environmental, or parental risk factors, for instance parental depression, anxiety, problematic substance use, financial difficulties, homelessness or mental health difficulties. It may be necessary to intervene first with these contextual problems as far as is achievable, before it is possible to embark meaningfully on tackling neglect (Barth 2009; Garshater-Molko, Lutzker and Sherman 2002; Glaser 2011).

22. **Individualised child-centred response.** Each family should be considered as unique (Gershater-Molko, Luztker and Sherman 2002; Glaser 2011). Different interventions will need to be considered once there is an understanding of the issues and the child's interaction with the caregiver. For example, Glaser (2011) describes parents who may be emotionally unavailable due to their own difficulties, parents who may exhibit hostility towards the child especially if the child also presents with behavioural problems, parents who have inappropriate, inconsistent or harsh expectations of the child, parents who use the child to fulfill their own needs and parents who fail to promote the child's health, educational and social development. Each requires skill and expertise by professionals, but may require different interventions or a combination of inputs by several agencies. Interventions should focus on building the strengths of the parent, as well as teaching new skills and should be culturally sensitive, whilst guarding against setting different standards

for children from minority ethnic groups (Gershater-Molko, Luztker and Sherman 2002).

23. **Engaging the family.** The research is clear of the need to engage effectively with families for interventions to have the greatest impact. Trust and respect are key components of effective engagement (Ingram et al. 2015; Pecora et al. 2012) with attention given to immediate needs and concrete services (Hearn 2011). Early engagement is critical to establishing a relationship, which can begin to address the family's issues (Ingram et al. 2015; Long et al. 2015). The actions of professionals at this early stage are critical for family engagement. In one local service in the District of Columbia, the first 48 hours after the referral focuses on resolving an immediate issue the family has struggled with. The belief is that this quick response demonstrates a worker's intent to help the family, builds trust and paves the way for further engagement (Ingram et al. 2015) and, no matter the circumstances, parents should be respected in their interaction with all professionals (Pecora et al. 2012).

24. **Creating a safe environment.** Creating a sense of safety for the child should be one of the first objectives of the intervention and is particularly important to focus for children experiencing neglect. In a more predictable environment, the child will be better able to develop adequate physiological monitoring and start learning from new experiences. This first phase of the intervention, to develop a safer environment at home, should be done in collaboration with those involved with the family. The safety of the living environment must be maintained throughout the interventions with the child and parent (Milot, St Laurent and Ethier 2016).

25. **Increasing parenting sensitivity.** Parents of neglected children have often been maltreated in their childhood (Milot et al., 2014) and the child's manifestations of stress might evoke in them powerful feelings that are related to their own past traumatic experiences. Some neglectful parents may require nurturing and parenting themselves by service providers (Gershater-Molko, Luztker and Sherman 2002) as past traumas are likely to interfere with their parental role; parents with unresolved traumas are more at risk of adopting atypical parental behaviours associated with increased risk for the child to develop a disorganised attachment, however, this should be approached with caution as some traumatised parents may be fragile and not yet ready to receive support (Milot. St Laurent and Ethier 2016).

26. **Comprehensive, multi-layered and flexible response.** Responses or interventions need to be comprehensive multidimensional and flexible and address how child neglect is experienced within a family while acknowledging how issues such as poverty and social isolation may be experienced differently (Barth 2009; Daniel 2015; Hearn 2011; Qualitieri and Robinson 2012). '*The current collection of interventions reflect attention "to pieces of the puzzle," when instead, the field should offer a comprehensive, flexible, and evidence-based approach*.' (Hearn 2011, p.721). This is echoed by Chambers and Potter (2008), who identify a need to think creatively about how to integrate services, rather than stack multiple interventions.

27. **Programme design features.** The literature identifies features of successful early intervention and prevention programmes: define clear objectives, monitor regularly, set clear achievable goal and modify the intervention based on the family's needs (Qualitieri and Robinson 2012).

28. **Addressing social supports and inclusion.** Responses should also identify both existing formal and informal supports and assist families with developing new supports to help sustain gains made during the intervention (Hearn 2011; Qualitieri and Robinson 2012). Interventions need to take account of the fact that neglectful parents may have poor social skills that make it difficult to maintain relationships (Gershater-Molko, Luztker and Sherman 2002). Behavioral interventions have been successful in teaching interactional and social skills (Erickson & Egeland, 1996). The use of modeling, practice, and feedback can significantly enhance social skills and result in a strengthened social network (Gaudin, 1993a).

Summary points: Building an intervention

- **I**t is important to distinguish between inadequate parenting as a result of a lack of parenting skills and inappropriate expectations of children versus inadequate parenting because of social and environmental, or parental risk factors.
- Each family should be considered as unique. Different interventions will need to be considered once there is an understanding of both the issues and the child's interaction with the caregiver.
- Effective engagement is essential for interventions to have the greatest impact. Early engagement is critical to establishing a relationship and the actions of professionals at this early stage are critical.
- Creating a sense of safety for the child is particularly important to focus on for children experiencing neglect.
- Increasing parenting sensitivity is important and **s**ome neglectful parents may require nurturing and parenting.
- Responses or interventions need to be comprehensive, multidimensional and flexible and address how child neglect is experienced within a family while acknowledging how wider issues such as poverty and social isolation may be experienced differently by families.
- Features of successful early intervention and prevention programmes include: clear objectives, regular monitoring, clear achievable goal and modifying the intervention based on family need.
- Addressing social supports and inclusion, and assisting families with developing new supports to help sustain gains made is important.

Working with individual children, young people and families

29. Before considering the range of interventions identified within the research, it is important to remember the children, young people and families at the heart of this.

30. A recent study by Lutman and Farmer (2013) followed-up 138 neglected children in England who had been looked after and reunified after two years and then again three years later. Significant predictors of a child's future wellbeing were persistent neglect and the presence of emotional and behavioural problems prior to the child returning home. After two years, half of the returns had broken down after two years, rising to almost two-thirds after five years. Rates of repeat neglect and abuse were also high: by the two-year follow-up, 59 per cent of the children had been abused or neglected after reunification and during the next three years, half of the children (48 per cent) with open cases had been abused or neglected. Fifty-seven per cent of the children had behaviour problems before reunification and their wellbeing was much poorer five years later than for the remainder.

31. In addition to the difficulties experienced by children before return, other factors associated with a child's poorer wellbeing at follow-up were no conditions having been set for parents, lack of clear focus on key problem areas, unplanned reunions including those caused by pressure from the child, continued and lack of specialist help for parents. Although these findings were in relation to children who had been looked after because of neglect, the changes required for both children and adults to impact on outcomes are nevertheless relevant for children who live at home.

32. Much less is known and understood about how neglect is experienced by older children and young people. A recent study (Raws 2016) reported that one in seven (15%) 14–15 year olds lived with adult caregivers who neglected them in one or more ways – they may have shown little or no interest in them, not offered warmth or encouragement, made no effort to monitor or protect them or failed to promote their health. Neglected young people reported low wellbeing and a higher propensity than their peers for behaving in ways that may jeopardise their health or their prospects. The author acknowledges that this finding may underestimate the scale of adolescent neglect as they are based solely on the reports of young people who were attending mainstream schools – and not those in specialist provision, those without a school place or missing from the system, or those in private schools.

33. It is unclear how much a lack of care and support may affect a young person as there is a sense that teenagers have their own natural resilience, and may be making lifestyle choices albeit that those choices may be considered risky. This study revealed that neglected teenagers tend to report doubts about their competence, have little faith that anyone cares about them, feel pessimistic about the future and are dissatisfied with their lives overall. These findings underline the need to take adolescent neglect seriously, because young people who experience it are also likely to suffer a pernicious undermining of their wellbeing regardless of whether they exhibit other negative behaviours.

34. The responses from young people in the study found that adolescents who were deprived were more likely to experience neglect, however, this finding related to how deprived the young people felt themselves in terms of possessions, experiences or resources rather than to household deprivation. This does not mean there is a causal relationship between poverty and neglect as some parents of teenagers may choose not to spend money on

goods and materials, but nor can poverty and the stresses it may bring combined with a failure to parent be ignored. The research also challenged notions of supervisory neglect for adolescents. A high level of supervision was found not to be linked to high wellbeing. This aspect of adolescents' lives – of control, rules, sanctions and curfews – is one where the parent-adolescent relationship may be tested, and where young people themselves will have expectations and a desire to see change as they mature and want to have a stake in negotiating.

35. The review identified one study which focused particularly on the behaviour patterns of neglectful mothers (Wilson, Kuebli and Hughes 2005). The study gathered information on 100 mothers for whom neglect had been substantiated and was the primary referral concern and cluster analysis was used to describe patterns of maternal behaviour. The mothers were rated with differences in maternal confidence, relatedness, impulse control, and willingness to engage verbally. The team anticipated that two clusters would emerge broadly one describing a relatively higher level of desirable maternal characteristics and another describing undesirable maternal characteristics, however, five clusters emerged with mothers exhibiting a range of characteristics, which has implications for the approach to interventions; For some, individual work focusing on emotional support and reassurance is more appropriate while others are motivated to obtain support and produce self-directed change when provided with the needed environmental resources. These mothers are more appropriate candidates for group-based interventions. Once the circumscribed issues are resolved it is suspected that these families will be relatively resilient and be able to maintain the positive growth experienced with intervention.

36. Neglectful mothers were also the focus of a study by Hildyeard and Woolfe (2007) to investigate the cognitive processes underlying neglectful parenting. Based on comparisons of neglectful and non-neglectful mothers on several childrearing tasks, neglectful mothers had significant problems in information processing concerning their child's emotions and behaviors; for example neglectful mothers did not always recognise the children's behaviour in ambiguous risk situations. These deficits, such as poor and inaccurate recognition of infant or child emotions, may interfere with neglectful mothers' ability to recognize infant signals of emotion and understand their behavior. Interventions aimed at improving parents' abilities to recognise emotions in infants' facial expressions may be an important part of treatment and prevention efforts.

37. A much less researched group is neglectful fathers One study (Scott and Stewart 2014) explored the dynamics of father-child interaction that may underlie fathers' risk for abuse and neglect. Data derived from structured interviews of 121 maltreating fathers were used to discern differential patterns of abuse-related problems in parenting. Five patterns of harmful parent-child interaction were explored: (1) emotional unavailability, unresponsiveness and neglect; (2) negative attributions and misattributions to the child, including hostility, denigration and rejection; (3) developmentally inappropriate or inconsistent interactions, including exposure to domestic violence; (4) failure to recognize or acknowledge the child's individuality and psychological boundary; and (5) failing to promote child's social adaptation.

38. The team found that for all patterns, except failing to promote children's social adaptation, problems were noted for at least half of the fathers, with particularly high rates in the areas of emotional connection and psychological boundaries. Analyses also revealed that maltreating fathers were most clearly differentiated by the degree of the severity of dysfunction (i.e., low, moderate, or high) in their relationships with their children. In combination, then, results support the need to consider both the severity of problems evidenced by fathers and the specific pattern of difficulties to be addressed.

39. Fathers in the 'severe' group had the greatest difficulties in all five dynamics examined and were the only fathers reported to have problems related to failures to promote children's social adaptation. Particularly notable about this group was their very low level of emotional availability to their children. A revealing finding was that the most nearly three-quarters of the fathers lacked an emotional connection to their children and described relationships characterized by emotional unavailability and unresponsiveness. The observed problems with responsiveness are in contrast to commonly held stereotypes that tend to emphasize fathers' rigidity and harshness. While not absent from descriptions, fathers' lack of responsiveness and emotional connection is not often identified as a risk factor in and of itself (Scott and Stewart 2014).

40. Such results have implications for intervention, pointing to the need to provide fathers with opportunities to build strong emotional connections with their children. Intervention needs to begin by increasing fathers' awareness of problems in emotional connection, which may need fathers to take responsibility for past harmful and abusive behaviours. Following such awareness, fathers may need to develop skills for responsive parenting in general, or may need support in more limited and specific areas (e.g., discussion of separation or case involvement).

Summary points: Children, young people and families

- Significant predictors of a child's future poor wellbeing was persistent neglect, the emotional and behavioural problems in the child not addressed, lack of clear focus on key problem areas and continued lack of specialist help for parents.
- Less is known and understood about how neglect is experienced by older children and young people. One in seven (15%) 14–15 year olds live with adult caregivers who neglected them in one or more ways and neglected teenagers tend to report doubts about their competence, have little faith that anyone cares, feel pessimistic about the future and are dissatisfied overall.
- How neglect manifests in maternal behaviour varies and is not simply a lack of 'good' maternal characteristics. This has implications for interventions to be most effective, for example, whilst some benefit from group based interventions others do not.
- Neglectful mothers do not always recognise the children's behaviour in ambiguous risk situations and may have poor and inaccurate recognition of infant or child emotions.
- Fathers, who abuse and neglect, range in the severity of dysfunction in their

relationships with their children. Fathers with the greatest of difficulties often show very low levels of emotional availability and connectedness to their children. Interventions need to begin by increasing fathers' awareness of problems in emotional connection.

Evidence-based interventions and programmes

41. A range of interventions and programmes have been subject to differing evaluations from randomised and non-randomised controlled trials through to case studies.

Childhood behaviour problems

42. Many meta-analyses and systematic reviews covering an evidence base of over 100 studies conclude that behavioural parent training is particularly effective in ameliorating childhood behaviour problems, with gains maintained at a 1-year follow up, particularly if periodic review sessions are offered (Carr 2014). Some programmes can be broadly characterised as behavioural parent training including Parent–child interaction therapy (PCIT), the Incredible Years parent training (IYPT) and Positive parenting program (Triple P)

43. A critical element of behavioural parent training is helping parents develop skills for increasing the frequency of children's prosocial behaviour (through attending, reinforcement and engaging in child-directed interactions) and reducing the frequency of antisocial behaviour (through ignoring, time-out, contingency contracts and engaging in parent directed interactions) (Forgatch and Paterson, 2010). Immediate feedback, video feedback and video modelling have been used in effective behavioural parent training programmes which allows parents to be directly coached by the therapist through a 'bug-in-the-ear', watching videotaped episodes of themselves using parenting skills with their own children or viewing video clips of actors illustrating successful and unsuccessful parenting skills (Carr 2012). However, as Carr identifies from a meta-analysis of thirty-one studies (Reyno and McGrath 2006 cited in Carr 2012) parents with limited social support, high levels of poverty-related stress, and mental health problems derive the least benefit from behavioural parent training.

44. Another application of technology is through the use of smart phones to deliver one module of a home-based intervention designed to minimise risk of unintended injury of under 5s. SafeCare is an evidence-based program of three skill-based modules that address risk factors for physical abuse and neglect: parent-child interactions, health care, and home safety. One study (Jabaley et al. 2011) focused only on the safety module of SafeCare. Training begins in the room with the greatest number of hazards. Following the initial assessment, the home visitor supports parents as they gradually take responsibility for securing rooms. The effectiveness of iPhone and video was examined using a multiple baseline design across in-home settings replicated across families. Home hazards were reduced dramatically across rooms and across participants. Face-to-face time of the home visitor was progressively reduced and replaced by video data collection. These data

suggest smartphones are promising for data collection and for augmenting face-to-face interactions. However, the authors note some limitations in use of technology [video material not always reliable; engagement may have been affected by novelty of access to iphone for participants].

45. **The Incredible Years Parent Training Program** has been implemented as a universal school-based prevention program. The programme is aimed at children aged 3 to 12 years, is founded on social learning theory and consists of at least 12 weekly, two-hour group sessions delivered by skilled practitioners. The program includes separate training programs, intervention manuals and DVDs for use by trained therapists, teachers and group leaders to promote children's social competence, emotional regulation and problem solving skills and reduce their behaviour problems. Parents learn child-directed skills (e.g., praise, description, reflection), effective discipline techniques (e.g., ignoring, Time-Out procedure), coping skills, and strategies to promote children's social skills through weekly 2-hour sessions (Baydar et al, 2003).

46. Numerous RCTs of the Incredible Years program have shown statistically significant reductions in child behaviour problems, improvements in parent-child relationships, reductions in harsh parenting, and improvements in prosocial behaviours. By providing dinners, child care, flexible hours, and make-up sessions, reasonable success was achieved at retaining low-income participants (Asawa, Hansen and Flood 2008). The Incredible Years program is in use in 17 countries worldwide including the UK.

47. **Positive parenting program (Triple P)** is a parenting and family support system designed to prevent – as well as treat – behavioural and emotional problems in children and teenagers. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential. It was developed by Matthew R. Sanders and colleagues at the University of Queensland in Australia and its five core principles of positive parenting are: (1) ensuring a safe, engaging environment, (2) promoting a positive learning environment, (3) using assertive discipline, (4) maintaining reasonable expectations, and (5) taking care of oneself as a parent. The emphasis is on parents learning how to apply these skills to different behavioural, emotional and developmental issues in children to more intense challenges.

48. The programme is delivered through five levels: Universal Triple P (Level 1) is a communications strategy designed to reach a broad cross section of the population with positive parenting information and messages. It is not a course or personal intervention delivered directly to parents; Selected Triple P (Level 2) is described as a "light touch" intervention providing brief one-time assistance to parents who are generally coping well but have one or two concerns with their child's behaviour or development. It is available for parents of children from birth to 12 years and for parents of teenagers; Primary Care Triple P (Level 3) is targeted counselling for parents of a child with mild to moderate behavioural difficulties. It is available for parents of children from birth to 12 years and for parents of teenagers. Level 3 interventions deal with a specific problem behaviour or

issue; Standard and Group Triple P (Level 4) is for parents of children with severe behavioural difficulties. It is available for parents of children from birth to 12 years and 12–16 years; and Enhanced Triple P (Level 5) is for parents whose family situation is complicated by problems such as partner conflict, stress or mental health issues. Pathways Triple P – for parents at risk of child maltreatment - covers anger management and other behavioural strategies to improve a parent's ability to cope with raising children.

49. The evidence base for Triple P is extensive and includes, to date, includes 43 controlled trials addressing efficacy, effectiveness, and dissemination, as well as 22 service-based field evaluations. Triple P has been evaluated as a universal, whole of population strategy and shown to strengthen parenting, increase family cohesion and reduce the prevalence of conduct problems in preschool-aged children from high-risk neighbourhoods, and to reduce coercive parenting practices through the implementation of multiple levels of Triple P (Sanders et al. 2008 cited in Prinz et al. 2009; Ting Wai Chu et al. 2015). One quasi-experimental study researched the preventive impact of Triple P on future child maltreatment at a population level using evidence-based parenting interventions in 18 counties in the US with families randomly assigned to Triple P or services as usual - approximately 85,000 families in any given year. Effects were assessed by comparing trends between the intervention and comparison counties of child maltreatment. There were fewer cases of abuse and neglect, fewer out-of-home placements, and fewer children with injuries requiring hospitalisation or emergency room treatment in the areas using Triple P at the time of the study and 24 months later. However, it would be important to determine whether these effects are maintained over time (Prinz et al. 2009 cited in Daro and Dodge 2009). Triple P is now used in 25 countries worldwide.

50. **Early Head Start** provides early, continuous, intensive, and comprehensive child development and family support services to low-income infants and toddlers and their families, and pregnant women and their families. It is designed to nurture healthy attachments between parent and child (and child and caregiver), emphasise a strengths-based, relationship-centered approach to services, and encompass the full range of a family's needs from pregnancy through a child's third birthday. Programme options are determined through the data collected from their community needs assessment and conversations with families and include centre-based services, home-based services, family child care services and a combination of some or all three.

51. A national randomised trial in the US found EHS to be effective in improving parent and child outcomes, but its effectiveness in reducing child maltreatment was not assessed. Results from a subsequent study, which focussed on the impact on child maltreatment and tracked children until the age of ten, indicated that children in EHS had significantly fewer child welfare encounters between the ages of five and nine years than did children in the control group, and that EHS slowed the rate of subsequent encounters. Additionally, compared to children in the control group, children in EHS were less likely to have a substantiated report of physical or sexual abuse, but more likely to have a substantiated report of neglect. This unexpected finding was thought to be due to

increased and longer-term contact with the family and increased visibility of the child (Green et al. 2014).

Problems in adolescence

52. Carr's review of the literature in relation to neglect (Carr 2014) reported that previous reviews had identified that young people with persistent antisocial behaviour fared better in family therapy compared with non-treatment control groups and somewhat better than treatment as usual or alternative treatments. These results showed that the average case treated with family therapy fared better than 76 per cent of untreated patients and 58 per cent of patients who engaged in alternative treatments.

53. Family-based treatments including functional family therapy, multisystemic therapy and treatment foster care were more effective than routine treatment. These family-based treatments significantly reduced the time the young person spent in institutions, the risk or re-arrest and recidivism 1–3 years following treatment.

54. **Functional family therapy** was developed initially by James Alexander at the University of Utah in 1972 and more recently by Tom Sexton at the University of Indiana (Wiggens 2012). It is a model of systemic family therapy held over a three month period for young people (10 – 18 years) with a strong history of offending (or violent, behavioural, school and conduct problems). Between eight and 30 one-hour sessions (average 12 sessions) are held over a three to six month period. It involves distinct stages of engagement where the emphasis is on forming a therapeutic alliance with family members, behaviour change, where the focus is on facilitating competent family problem-solving and generalization, where families learn to use new skills in a range of situations and to deal with setbacks. Whole family sessions are conducted on a weekly basis.

55. Functional family therapy has been the subject of one RCT (1973), a quasi-experimental efficacy study (1985), and a trial in 1988 and has been rolled out in 13 mental health organisations in New York (Wiggins, Austerberry and Ward 2012). All three trials showed reduced criminal offending and activity, and improved family communication in follow-up periods which ranged from six months to over two years (Carr 2014; Wiggins, Austerberry and Ward 2012). Functional family therapy has been implemented in Belgium, England, Netherlands, New Zealand, Norway and Sweden. Critical to its success was fidelity to the model and the solution focussed approach helped build trust between the FFT therapist, young person and family.

56. **Multisystemic therapy** was developed in the US by Scott Henggeler and Dr Charles Bordin. Multisystemic therapy combines intensive family and community based therapy with targeting young people aged 12-17 with serious conduct disorders and offending behaviour. Multisystemic therapy involves helping adolescents, families and involved professionals understand how adolescent conduct problems are maintained and aims to increase the skills of caregivers and parents to disrupt these patterns and change behaviours. Multisystemic therapy involves regular, frequent home-based family and

individual therapy sessions with additional sessions in school or community settings over 3 to 6 months. Therapists carry low caseloads of no more than five cases and provide 24-hour, 7-day availability for crisis management.

57. Reviews (Carr 2014; Wiggins, Austerberry and Ward 2012) have reported that rigorous RCTs in a range of countries, including England, and a meta-analysis of eleven studies found significant improvements in family relationships and a reduction in re-offending rates both in the short and long terms; effects which were maintained up to 4 years after treatment. The recent RCT in England found that families had thought that the interventions had come to an end too soon or abruptly and recommended that future implementation might consider a longer intervention for some young people or some follow-up sessions (Tighe et al 2012 in Wiggins, Austerberry and Ward 2012). Multisystemic therapy has been implemented in Australia, Canada, Denmark, Ireland, Netherlands, Norway, Sweden and the UK. Fidelity to the programme was key to outcomes identified.

58. **Multidimensional treatment foster care** was developed at the Oregon Social Learning Centre by Patricia Chamberlain and her team in 1983. Multidimensional treatment foster care combines procedures similar to multisystemic therapy, with specialist foster placement for young people who have engaged in serious, chronic anti-social behaviour, youth offending and conduct problems. The programme provides young people with a 'wrap-around' service of support which includes placement for six to nine months with specially trained foster parents, an individually tailored structured programme, weekly sessions with a behavioural therapist, support from an educational therapist and family therapy with the young person's birth family. Adolescents also engage in individual therapy, and wider systems consultations are carried out with the youngsters' teachers, probation officers and other involved professionals, to ensure all relevant members of youngsters' social systems are cooperating in ways that promote their improvement.

59. Multidimensional treatment foster care has been subject to a series of RCTs in the US, England and Sweden. The studies showed that this approach significantly reduced running away from placement as well as psychiatric distress and depression. Multidimensional treatment foster care has been implemented in Canada, Denmark, England, Ireland, Netherlands, New Zealand, Norway, Scotland and Sweden. Fidelity to the programme was again critical to successful implementation as well as strong leadership to both implement and sustain the programme, and recruitment and retention of foster carers (Carr 2014; Wiggins, Austerberry and Ward 2012).

Family Based or Parent Therapies

60. Systemic interventions are effective in a proportion of cases of child abuse and neglect. Systematic narrative reviews concur that for physical child abuse and neglect, effective therapy is family-based and structured. It extends over periods of at least 6 months and addresses specific problems in relevant subsystems, including children's post-traumatic

adjustment problems; parenting skills deficits and the overall supportiveness of the family and social network (Carr 2012).

61. **Parents under Pressure** was developed in Australia as an intensive, home-based intervention that draws on attachment theory with its emphasis on the central importance of a safe and nurturing relationship between children and their primary carer(s). The parent's capacity to provide consistent and appropriate parenting skills and be emotionally available to their children is dependent upon the parent's ability to understand and manage their own emotional state. The construct of mindfulness is utilised as a way of helping parents to understand and manage affect and to be fully present in the current moment with their child. Each of these capabilities is first assessed and a treatment plan is developed collaboratively with the family in which clear goals for change are agreed to. The programme consists of up to 20 weeks of in-home sessions (mean 10.5) of one to two hours where families work with the PuP therapist. The therapeutic process is assisted by the use of a parent workbook that invites the parent to engage in a process of self-reflection and personal goal setting around a series of modules.

62. In relation to the impact of this programme for families who may be experiencing abuse and neglect, Dalziel and colleagues (2015) reported on a recent trial of methadone-maintained parents randomised to the Parents under Pressure programme. At a six-month follow-up, the average rates of expected abuse and neglect had reduced by almost 17% compared with a slight increase of 3% in the comparison group Dalziel et al. 2015). Use of this programme in the UK has been supported by the NSPCC, which is working with the University of Warwick to evaluate its impact.

63. **Family Behaviour Therapy** approach was adapted for use in a trial with 72 mothers evidencing drug abuse or dependence and child neglect (Donohue et al. 2014). The mothers were randomly assigned to family behaviour therapy (FBT) or treatment as usual (TAU). Participants were assessed at baseline, 6 months, and at 10 months. The findings from the trial suggested that FBT might be beneficial in mothers who have been referred by child protection services for child neglect and drug abuse.

64. **Family Based Recovery** is an intensive, long-term clinical treatment program that provides substance abuse treatment, individual psychotherapy, parent-child relational support and developmental guidance, and comprehensive case management in the home and community. FBR clinicians are trained to provide all aspects of the model, which allows for the seamless integration of treatment components. Staff facilitate a weekly, two-hour group for parents and their children. Group attendance is another form of positive reinforcement, as clients may attend only when they have a negative urine toxicology screen and breathalyser result. The group provides a forum where parents experience peer support and discuss the successes and challenges of recovery or parenting. Staff work with families for up to one year and with no more than 12 families at one time.

65. Preliminary outcome data (Hanson et al 2015) suggests that in many cases FBR engages, stabilises, and effectively treats parents and promotes healthy parent-child attachment. The results indicate that relationship-focused substance abuse treatment in the home that prioritizes the parenting experience can benefit families and has the potential to improve future outcomes for the next generation. The service intensity and close collaboration between FBR and staff allows children to remain in the home although depending on the level of risk, staff may develop a safety plan that requires the parent to have 24-hour supervision with their child during the initial phase of treatment. Another key finding was that providing services in the home eliminated barriers to treatment and facilitated client engagement. It demonstrates a willingness to join with the family in its environment, while team members experience a client's daily life and gain deeper understanding of family functioning, values, and beliefs. Additionally, meeting several times a week promotes clients' recovery from their substance use disorder and sense of self-efficacy in parenting.

Intervention programmes and approaches

66. **Home visitation programmes** typically involve regular contact between a family and a home visitor and can address a variety of issues including parenting skills, education about child development, the parent-child relationship, safety in the home, mental health issues, economic problems, education and employment, adequate health care, and lack of social support. The intervention is usually delivered by trained professionals or para-professionals with limited caseloads, who provide education counselling, and support for families until the child starts nursery (or kindergarten) or reaches 5 years old. In addition, families are directed to wider services and social activities outside the home (Boulatoff and Jump 2007; Asawa, Hansen and Flood 2008). There are a variety of programmes in place worldwide and many are aimed at preventing child abuse and neglect. These include the Early Head Start Program (USA), Hawaii's Healthy Start Program (USA), Healthy Families America (USA).

67. Messages about the impact of home visitation programmes is mixed: RCTs and reviews have revealed significant differences in their impact. Across these programs, the most frequent positive outcomes included promoting healthy child development and school readiness, positive parenting practices, child and maternal health and decreased child abuse potential. Fewer programs documented evidence for reductions in child maltreatment (for most programs, this was not a strategic goal) (Asawa, Hansen and Flood 2008; Portwood 2006; Thompson 2015). Overall, these reviews suggest that early home visitation programmes are effective in reducing risk factors for child maltreatment, but whether they reduce direct measures is less clear-cut (Mikton and Butchart 2009). Unsuccessful programs tend to be implemented poorly with fewer weekly visits, lack intensity, are of short duration, and/or are insufficiently comprehensive (Portwood 2006).

68. Another study in Canada enrolled 163 families with a history of one index child being exposed to physical abuse or neglect in a randomised controlled trial to compare standard treatment (services from child protection agencies) with a programme of home visitation

by nurses in addition to standard treatment. At 3-years' follow-up, the recurrence of child physical abuse and neglect did not differ between groups. So, despite the positive results of home visitation by nurses as an early prevention strategy, this visit-based strategy did not seem to be effective in prevention of recidivism of physical abuse and neglect in families associated with the child protection system (MacMillan et al. 2005).

69. There are challenges to implementing such large-scale programmes: when programmes expand and are disseminated, the quality and scope of services may be affected and the original concept may be distorted. For some home visitation programs, several studies have revealed that families are receiving approximately half of the home visits they are scheduled to receive. This may be related to large caseloads, programme attrition, difficulty contacting the family, and characteristics of the visitor-family relationship (Asawa, Hansen and Flood 2008), large-scale programmes have shown limited commitment to research and program evaluation and there is a lack of controlled outcome research and that it is difficult to pinpoint an outcome to the home visitation programme as it is usually one of several supports and interventions for the family.

70. Among the factors that proved to be essential to the success of many home visitation programmes is the home visits and the relationship between parent and worker that had particular pertinence (Long et al. 2014). Gaining access to children, and relating effectively to them and their parents and carers in their homes, is a deeply complex practice. Parental engagement is a key issue for services working with families where children may be at risk of abuse or other significant welfare problems (Thompson 2015), but as has been discussed, engagement can be highly problematic. It is not uncommon for these parents to refuse admission to professionals on home visits, or, once in the home, to prevent professionals relating directly to the child (Long et al. 2014). The contact with families needs to be regular (weekly or fortnightly) and longer-term (one to two years and longer).

71. In their review of prevention programmes, MacMillan, MacMillan, Offord, Griffith and MacMillan (1994) concluded that programmes that included long-term home visitation (2 years or more) were more effective than programmes based solely on parental training or short-term home visitation. Since social isolation is one of the most frequently reported characteristics of maltreating families, the enhancement of social support is considered by many authors as an essential part of prevention strategies (Thompson 2015). The authors concluded that the most effective programmes for high-risk families were long-term, multidimensional and used an individual approach to address the problems of each member of the family. Findings such as this strike a chord with developments to health visiting in Scotland with the new Universal Health Visiting Pathway. The expectation of this new Health Visiting Pathway is that because of effective relationship building (underpinned by appropriately delivered training and ongoing Health Visitor assessment), the family remains at the centre of each home visit. Acknowledging that Health Visiting remains a specialist role that pivotally continues to involve ongoing assessment and professional judgement, the Health Visiting Pathway clearly emphasises the unique opportunity afforded by home visiting and its enhancement of the Health Visitor's key role

in assessing the wider context of family and community life and circumstances (Scottish Government 2015).

72. The **Nurse Family Partnership (US)** and **Family Nurse Partnership (UK)** is a voluntary home visiting programme for first time young mothers, aged 19 years or under. A specially trained family nurse visits the young mother regularly, from the early stages of pregnancy until their child is two. The FNP programme aims to enable young women to: have a healthy pregnancy; improve their child's health and development; and plan their own futures and achieve their aspirations.

73. Several reviews single the Nurse Family Partnership in the USA as the only home visiting programme whose effectiveness has been unambiguously demonstrated. A randomized controlled trial showed a 48% reduction in actual child abuse at 15-year follow-up (Carr 2014). In 2009, the Family Nurse Partnership was introduced in England and subject to an RCT. Between June 2009 and June 2010, 1,618 young mothers were recruited from 18 sites across England. Of these, 50% were allocated to receive FNP support and 50% to receive usual care. Data was collected at intake, during the pregnancy an when the child was six, 12, 18 and 24 months old. The FNP programme appeared to improve early child development, particularly early language development at 24 months and may also help protect children from serious injury, abuse and neglect through early identification of safeguarding risks.

74. The study did help to highlight the high levels of vulnerability amongst first time teenage mothers and their children suggesting the case for additional support for this group remains strong. However, FNP did not have an impact across four outcome areas: pre-natal tobacco use, birth weight, subsequent pregnancy by 24 months, attendance at Accident and Emergency, and hospital admissions in first two years of life. However, some have suggested that the level of support offered to first-time mothers in the UK is greater than support for mothers in the US (Robling et al. 2016). In Scotland, the new Universal Health Visiting Pathway has built on the lessons learned from interventions such as Family Nurse Partnership (FNP).

75. **Strengthening Families Initiative** is designed to reduce child abuse by enhancing the capacity of child care centres and early intervention programmes to offer families the support they need to avoid contact with the child welfare system. Strengthening Families also seeks to affect parent behaviour by using an existing service delivery system. Specifically, SFI uses focused assessments, technical assistance, and collaborative ventures to enhance the capacity of child care centres to promote five core protective factors among their program participants - parental resilience, social connections, knowledge of parenting and child development, critical support in times of need, and social and emotional competence of children. SFI is presented as problem solving rather than problem identification. At the time of publication, Daro and Dodge (2009) acknowledge that while anecdotal evidence support all of these assumptions, the ability of the SFI to achieve normative change within local child care and early care networks and

to reduce maltreatment rates remained untested. There were no published reports of program efficacy using a rigorous design and no known trials under way.

76. **Parent education programmes** are usually centre-based and delivered in groups and aim to prevent child maltreatment by improving parents' child-rearing skills, increasing parental knowledge of child development, and encouraging positive child management strategies. Seven of the 26 reviews summed up evidence relevant to this type of intervention from a total of 46 individual publications on outcome evaluation studies and from several other reviews. Two of the meta-analyses reported small and medium effect sizes for parent education programmes on the basis of both risk factors and direct measures of child maltreatment. Other reviews concluded, however, that while the evidence shows improvements in risk factors for child maltreatment, evidence of an effect on actual child maltreatment remains insufficient (Mikton and Butchart 2009).

77. **Family Midwives**, until recently, existed in Germany only in one area since the 1980s, but due to child death reports in the media, this approach has been given more attention. The goals of Family Midwives are to support and safeguard the physical and emotional health of infants who are born into psychosocially and health-related vulnerable families. This service offer care by continuously home-visiting the families depending on their needs beginning in pregnancy and following through up to the child's first birthday. Visits comprise a 'portfolio' of various interventions which includes health promoting and preventive care, health-care measures for the child and the mother, as well as psychosocial and practical support, and counselling.

78. A recent study (Ayerle, Makowsky and Schucking 2012) gathered data from 33 Family Midwives using a mostly standardized documentation sheet on a total of 814 vulnerable families from May 2006 to December 2008 and 757 cases (93%) were included based on the completeness of documentation. The study reported that the regular visit of the Family Midwife to the home over an extended period of time supports the conjecture that they were intimately familiar with the state of affairs of the families and thus enabled to make an expert assessment at the beginning and closure of care, acceptance of care and access to providers proved to be a key prerequisite in the supportive system for families and the availability of the FM by telephone, text and visits was highly appreciated by the mothers.

Summary points: Interventions and programmes

- Universal parenting programmes delivered as a universal or population wide service appear to have more success at engaging families more isolated in communities and where children may be experiencing neglect. These programmes have shown to be successful in improving the child's circumstance, their relationship with parents and reducing the prevalence of conduct disorders and social behaviours in families where risks have been identified. There is less evidence in the preventative ability of such programmes at a population level. However, families may be more inclined to access services and neglect may more likely to be identified in families not previously known to services.
- Intensive family-based therapies, specifically for older children and teenagers who may have experienced neglect, have shown improvements in family relationships and a reduction in criminal behaviour and re-offending rates both in the short and long terms. Critical to their success are fidelity to the model and the solution-focussed approach. By nature these approaches are short and intense and some involved have felt that the intervention ends too soon or abruptly, and recommend a longer intervention for some young people or some follow-up sessions
- Family based therapies working with parents, particularly those with problematic substance use, are beginning to suggest that in many cases these approaches engage, stabilise, and effectively treat parents while promoting healthy parent-child attachment Some have shown that expected rates of neglect have reduced, but there is little longitudinal data to show if this is maintained over time.
- Messages about the impact of home visitation and parent education programmes are mixed. Overall, both approaches appear effective in reducing risk factors for child maltreatment, but it is less clear whether programmes prevent actual neglect or its recurrence long term. However, fidelity to the programme is critical, but not always achieved. Factors essential for success is gaining access to children and families and working with them in their homes, long-term home visitation (2 years or more) and the enhancement of social support. Use of technology in parent training programmes can be used to effectively engage parents and help model appropriate parenting behaviours.
- Parents with limited social support, high levels of poverty-related stress, and mental health problems derived the least benefit from behavioural parent training. In essence: the most effective interventions for high-risk families were long-term, multidimensional and used an individual approach to address the problems of each member of the family.

Working with communities

'The neighborhood is an important venue for child development and, more specifically, child welfare prevention efforts, given concentrated disadvantage that occurs among the child welfare-reported and investigated population. Understanding the risk factors that affect families reported into the child welfare system might be a way to help build place-based initiatives to better serve these families.'

[Abner 2014, p.133]

79. Bronfenbrenner's seminal work in the 1970s argued that public policy focused on children must take into account the enduring environment of the child: the *immediate* surroundings of the child's life; and also the *supporting and surrounding* layers. The immediate layer is embedded within the supporting and surrounding layer, which includes geographic surroundings as well as institutions that function in the social system around the child. Within this perspective, child abuse is considered a dysfunction of the social system and a sign of societal stress. Abner (2014) writes that sociological research has shown that neighbourhood characteristics shape social processes, including crime, attitudes, health, well-being, and child and adolescent development (Brooks-Gunn, Duncan, and Aber, 1997; Brooks-Gunn, Duncan, Klebanov, and Sealand, 1993; Kling, Liebman, and Katz, 2006; Samp- son, Morenoff, and Gannon-Rowley, 2002; Wilson, 1987 all cited in Abner 2014).

80. Understanding how social capital - relationship between tangible (public spaces, property) and intangible (neighbours, social networks) resources - or the structural determinants of communities may impact on child abuse and neglect is growing. Children who live in neighbourhoods characterised by poverty, a high ratio of children to adults, high population turnover, and a high concentration of female-headed families are, not unexpectedly, at highest risk for maltreatment (Daro and Dodge 2009). A study of residents views on their community by Abner (2014) revealed that in addition to traditional notions of community being at low risk - if high or medium social order and high or medium social capital is identified - or at high risk - if low social order and low social capital is identified - there was third category where a community may have high social order, but low social capital.

81. Abner (2014) concludes that these results show that classifying families based on either "high" or "low" risk may not fully capture the story for families at risk for child maltreatment. Families who reside in communities that might appear to be lower risk based on social order might have a lack of social capital; social capital being an important factor in preventing child maltreatment. Daro and Dodge (2009) conclude that both individual responsibility and a strong formal service infrastructure are important to prevent child abuse and promote child protection. The challenge, however, is how to develop a community strategy that strikes the appropriate balance between individual responsibility and public investment.

82. **Durham Family Initiative** is a population-wide effort to expand the consistency and scope of universal assessments designed to identify families needing prevention services and to link them with appropriate community-based resources. It aims to enhance community social and professional capital and improve community capacity to provide evidence-based resources and increase families' ability to access these resources. Its activities fall into four main areas. First, it fosters local interagency cooperation regarding adoption of a coordinated and consistent preventive system of care. Second, it increases social capital within a number of communities through the targeted use of outreach

workers and community engagement. Third, it develops and tests innovative direct service models to improve outcomes with high-risk families and increase supports for high-risk new parents. Finally, it reforms county and state policies affecting the availability and quality of child welfare and child protection services.

83. As part of an evaluation of the initiative, anonymous surveys were completed with 1,741 family-serving professionals in Durham and one comparison site in 2004 and 2006. Professionals' estimates of the proportion of children who had been neglected decreased 18 percent in Durham but only 3 percent in the comparison site. Repeated population-based surveys also found significant reductions in parental stress and improvements in parental efficacy over time. These data, however, did not reveal any significant changes in parental self-reports of positive or potentially abusive interactions with their children, changes in observed acts of potential abuse in other families in the community, or any changes in resident interactions, collective efficacy, or neighborhood satisfaction (Daro and Dodge 2009).

84. **Strong Communities** places emphasis on changing residential attitudes and expectations regarding collective responsibility for child safety and mutual reciprocity. Its aim is to help the general public and local service providers within those communities understand how their individual and collective efforts can directly address the complex and often destructive web of interactions contributing to child maltreatment. Its premise is that once residents feel their neighbourhood is a place where families help each other and where it is expected that individuals will ask for and offer help, public demand will drive service improvement.

85. Daro and Dodge (2009) report that the success of these community engagement efforts is reflected in improved parent-child interactions as measured by repeated surveys of randomly selected parents of young children in both the intervention and matched comparison areas. The surveys found significant improvement over time in parent self-reports of positive interactions with their children and a corresponding reduction in parent reports of acts suggestive of neglect. Local administrative records, however, revealed no significant declines in child abuse reports, substantiation rates, or hospitalisations related to injuries suggestive of maltreatment when compared with similar records in the comparison community.

86. **Personal, Family and Community Help Programme** (PFCHP) addresses multiple dimensions of child neglect and aims to enhance parental competencies, and the family environment. The programme includes four aspects: home-visiting family assistance; group meetings for parents that focused on parental competency issues (meetings were held weekly for 44 weeks and were conducted by an experienced therapist); stimulation of the children through educational activities aimed at enhancing their language, cognitive and social skills; and individual counselling offered by the social worker assigned to each family. The entire programme lasted 18 months.

87. In 2000, Ethier and colleagues published their evaluation of the effects of this programme applied to families at risk for child neglect. Twenty-nine families were recruited assigned either to the Personal, Family and Community Help Programme or to the local community centre for support and intervention. The study found that both types of intervention are equally associated with improved family situation and satisfaction with the social network increased significantly at the end of the intervention period, but the impact on social support networks varied noticeably. PFCHP participants sought less help from professionals and less support from their children. They relied more on friends and members of their family for support. In summary, the results of the quantitative analyses therefore suggest that both types of intervention were equally effective in decreasing the risk of child neglect but that the PFCHP was superior regarding the mother's relationship with her environment, which is key to sustained improvements.

88. **Communities That Care (CTC)** engages all community members who have a stake in healthy futures and sets priorities for action based on community challenges and strengths. It is a community prevention system that addresses factors suggested as essential for community coalition success. The premise underlying CTC is that a reduction in the prevalence of problem behaviours in a community can be achieved by identifying risk and protective factors and then implementing interventions that will help. In a randomized controlled trial of CTC in 12 pairs of communities across seven states, CTC has shown positive effects at reducing the initiation of mental, emotional and behavioural disorders, specifically, drug use and delinquent behaviour (Hawkins et al., 2008; Hawkins, Oesterle, Brown, Abbott and Catalano, 2014; Hawkins et al., 2009, 2012 cited in Salazer et al. 2016).

89. **Keeping Families Together Initiative (KFT)** has adapted the Communities that Care approach to address prevention of abuse and neglect in families with children aged 0 to 10. Keeping Families Together brings together housing providers and child welfare agencies to strengthen vulnerable families and protect children. It recognises that poverty and housing instability are often linked to child neglect, child welfare involvement and family separation uses supportive housing to offer stability to families with children who are at risk of abuse and neglect. Preliminary evaluation findings regarding the adoption by communities of a science-based approach to prevention look promising (Salazer et. al. 2016).

90. Salazer and colleague (2016) conclude:

> '*As attention to the prevention of mental, emotional and behavioural disorders increases and input is needed from community and key leaders, frameworks are needed to help communities with their strategic planning. Communities That Care provides communities with an approach that has demonstrated outcomes in youth problem behaviors and can be applied to preventing child abuse and neglect and promoting child well-being across the community.*'
> (Salazar et al. 2016, p.153).

Summary points: Working with communities

- Classifying communities as 'high' or 'low' risk may not fully capture the story for children at risk of abuse and neglect. Families who reside in communities that might appear to be lower risk based on social order might have a lack of social capital; social capital being an important factor in preventing recurring neglect.
- Individual responsibility and a strong formal service infrastructure are important to prevent child abuse and protect children. The challenge, however, is how to develop a community strategy that strikes the appropriate balance between individual responsibility and public investment.
- Interventions with a focus on the community and social networks can be effective in decreasing the risk of neglect and improving a parent's (mother) relationship with the environment: key to sustaining improvements.
- Community approaches in the US have shown to have some impact on the risk factors associated with abuse and neglect: mental health, emotional and behavioural disorders, drug use and delinquent behaviour.

Relationships: Direct support to children and families

91. Throughout this background paper, the important role of relationships to engage neglecting families in services is apparent, however, the issues and processes relating to building working relationships with these families, in particular, remain complex. In her review of relationship-based practice, Reimer (2013) found the development of a relationship that is collaborative and authentic to be important when working with families where neglect is an issue and it is important to balance empathy with objective distance along with linking clients to a range of community and social supports.

92. Reimer notes that in building trust some have argued for the worker as seen confidant, because this helps reduce client resistance and hopelessness. The relationship is a useful tool to model relationship and conflict resolution skills. Building a relationship is assisted when workers calm clients' anxiety by being clear about worker and client roles, boundaries, and expectations and includes approaching family members from a position of respect, equality, mutuality, and reciprocity. Clients may also come to the relationship with barriers to developing effective relationships and a history of poor relationships and communication difficulties.

93. In drawing on the findings from one case study, Reimer identified perceived factors as reported by parents and workers at the point of building relationships:

    - **Parents' desperation and ambivalence** is characterised by parents feeling vulnerable, desperate and ambivalent with some feelings of unfamiliarity, anger or fear, and a pressure to engage. Previous poor experiences impacted negatively on the early part of the relationship. The parents were often unwilling, commonly making it difficult for the workers to engage them. This was resolved by parents putting aside their fear and becoming sufficiently motivated, or willing, to give their worker a chance to prove why the parent would want to engage. It was also common for workers to feel

apprehensive as some were concerned the parent would not be willing to engage or work on the identified issues.

- **Parents assessed worker qualities** or tested workers during this phase such as testing the character of the worker to decide whether or not they were trustworthy, judgemental, and if the parent felt comfortable with the worker. It required getting to know the worker, but at the same time not revealing too much about themselves until they decided the worker was ‘‘right’’. It also involved being guarded when discussing their issues, telling varied accounts of situations, remaining silent and avoiding contact, or making contact randomly and intermittently. Knowing a worker was ‘‘right’’ was also promoted through discovering some similarity with the worker, for example a common experience of parenting. Parent identification with the worker seemed to mark a turning point in the building relationship.

- **Worker actions and attributes** included workers providing a first impression that they were genuine/authentic, active in their attention to the parent, willing to help, focused on capacities, empathic, non-judgemental, patient, flexible, collaborative, and confident in their dealings with the parent. Underpinning all of this was a perception of worker respect for the parents. Being attentive and responsive remained important throughout the entire relationship. It involved providing solutions to parents’ concrete and emotional needs, but not in such a way that they felt disempowered. Worker empathy was important; parents needed to feel that workers understood what they experiencing to some degree and workers showing that they cared about the parent. It was considered important that workers were interested in more than just the professional issues. Worker patience and flexibility, along with being available as needs arose helped form strong foundations.

- **Collaboration** was characterised by open and honest communication and negotiation, particularly about the parents’ needs, what the workers could offer, and the relationship parameters. It also involved the parents feeling some sense of choice and power regarding the process. Some parents noted that it was important to perceive the workers as confident or competent. They described the workers as resourceful, knowledgeable about a range of areas of professional expertise and life in general, able to respond to the parents’ changing needs, and able to connect with people from a variety of backgrounds.

- **Trust** for the workers had strong practical implications. Parents described becoming more attentive and responsive to what the worker was saying once trust was built, and both described parents progressing from unwillingness to willingness as they got to the point of connection and feeling comfortable, the lynchpin of which was trust.

94. Reimer (2013) concludes that it could be argued that parental resistance could actually be a reasonable and protective response to new individuals coming into their lives, rather than a sign that such families are difficult or unwilling to engage.

Relationships: Social support for children and families

95. Another emerging message is that sustained change will only be brought about if attention is given to a family's social support and networks in addition to more individualised interventions. Thirty years after experiencing childhood adversities, individuals can still experience significantly lower levels of social support impacting in terms of perceptions of lower tangible support and lower levels of self-esteem (Sperry and Widom 2013). Social support was found to mediate the relationship between abuse and neglect, and anxiety and depression, although specific types of social support were important. The introduction of total social support, which included having someone to talk to, people with whom one can do things, others with whom one feels they compare favourably and the availability of help, reduced the direct effect of child neglect on anxiety and depression.

96. Thompson's (2014) review of the two decades since publication of a review of research on social support and the prevention of child maltreatment conducted in the US in 1994 summarised the lessons learned:

- **Social support and risk for child maltreatment** is not simply about families isolated from the community networks. Some parents feel isolated in neighbourhoods, but others are embedded in community networks that afford considerable affirmation and mutual assistance or may support the parents' concerning behaviour. The reasons for social isolation can vary: some parents have heightened distrust of others that contributes to their social marginality; some parents actively avoid detection of family or personal practices including substance abuse and domestic violence as well as neglect; and some parents may be so exhausted by personal difficulties that they do not extend the time and energy to make contacts with others in their social networks, even if they desire greater social contact. Indeed, their network associates may also be drained by the same stressors and have little capacity for providing support. Different parents have different social support needs, requiring a fine-tuned appraisal of social support and social networks as a foundation for intervention efficacy.

- **Social support and the prevention of child maltreatment** consists of social relationships that provide (or can potentially provide) material and personal resources that are of value to an individual, such as access to information and services and sharing tasks and responsibilities. These elements provide important social, emotional, and material resources and, in doing so, can enhance social engagement, reduce isolation, and promote child protection goals by integrating social norms into parenting practices. Some parents enjoy the emotional support afforded by their social networks without altering harmful parental conduct, in part because family or friends justify or rationalise harmful practices rather than challenging them. Thompson (2014) comments on an additional function of social monitoring, which can be friends noticing signs of depression and supporting an individual to seek help, however, this can be interpreted as meddling and intrusive; balancing child-centered monitoring with efforts

to socialise parenting and maintain strong connections to parents is a difficult challenge.

- **Social networks** for informal support from family, friends and neighbours have the benefits of being readily accessible, and non-stigmatising. However, informal helpers are likely to lack the skill and knowledge to provide meaningful assistance that can address serious psychological problems. Formal social support can offer more intensive services when needed and referrals to other services or resources, although formal social support tends to more limited. The challenges of coordinating formal and informal helpers should not be underestimated. Differences in values and goals, and mutual distrust in many communities can undermine the effort to create partnerships of this kind.

97. Thompson (2014) reflects that receiving social support can result in feelings of vulnerability, humiliation, and resentment, whether aid comes from formal or informal sources. When support is normalised for the recipient's neighbourhood or community, provided in places that avoid stigma and when it is broadly available rather than targeted, it is more likely that received support will be perceived as beneficial. Stress is also a factor that can undermine access to social support through erosion of social networks as distressed individuals withdraw because of pain, shock, or humiliation, or potential helpers withdraw because the individual's needs are emotionally taxing or their conduct repels. Intervention programs might distinguish different kinds of stress in the design of social support.

98. Many would argue that the most beneficial and comprehensive form of social support is through direct relationships, however, the internet is one means of increasing social support without direct face-to-face contact with individuals or groups. Two distinct social networks are emerging: networks of individuals who are known and seen on a regular basis; and networks which consist of individuals who are only known online, such as through chat rooms, virtual gaming and blog posts. Research findings suggest higher rates of self-reported depressive symptoms for adolescents and adults in online communication with strangers compared with lower depression scores for those communicating online with friends (Thompson 2014).

Summary points: Relationships

- The important role of relationships between the parent and child, family and worker, and family with the community for sustaining change cannot be underestimated. Relationships need to be collaborative and authentic.
- Parental anger, ambivalence and testing of relationships may be part of a process of building trust, and a worker's action to find solutions to immediate difficulties may be the building blocks for tackling more entrenched behaviours. Trust is practical as well as emotional.
- Parental resistance to support initially could be a protective response rather than an unwillingness to engage.

- Sustained change in families will only be brought about if attention is given to social support as well as direct interventions. Social support for parents included having someone to talk to, people with whom one can do things, others with whom one feels they compare favourably and the availability of help. Together this reduced the direct effect of child neglect on adult wellbeing.
- Social networks and supports are unique to individual families: some feel isolated; some are embedded in networks that may support concerning behaviours; some withdraw from communities to avoid challenge; and some may too exhausted by personal difficulties. Indeed, their network associates may also be drained by the same stressors and have little capacity for providing support.
- Different parents have different social support needs, requiring a fine-tuned appraisal of social support and social networks as a foundation for intervention efficacy.
- Balancing child-centred monitoring with efforts to socialise parenting and maintain strong connections to parents is challenging.
- When support is normalised for the recipient's neighbourhood or community, provided in places that avoid stigma and when it is broadly available rather than targeted, it is more likely that received support will be perceived as beneficial.
- Virtual social networks are emerging with mixed results: networks online of known individuals can be supportive, but networks of individuals who are only known online are less so. When support is normalised for the recipient's neighbourhood or community, provided in places that avoid stigma and when it is broadly available rather than targeted, it is more likely that received support will be perceived as beneficial.
- Virtual social networks are emerging with mixed results: networks online of known individuals can be supportive, but networks of individuals who are only known online are less so.

Conclusion

99. The messages emerging from this rapid review of the literature is that at the outset it is important to understand clearly what is happening in a family. Each family is unique. The reason a parent may be unable or unwillingly to give their child or teenager the care is individual to them and any interventions needs to respond to this. Children and young people may also experience neglect in very different ways. Relationships are key within the family, between the family and professionals, and the family's interaction with the community and effective early engagement is essential for interventions to have the greatest impact. To address neglect long term needs an individual response to that family which is sustained, multi-dimensional and flexible.

100. A range of interventions has emerged through this review, some of which have been subject to more rigorous examination. Intensive and focused interventions have much to offer in addressing specific and targeted issues, but these alone will not address neglect. Interventions which offer therapy, support and education to all family members have

shown to have success in increasing family cohesion, improving family interaction and relationships and improving the prevalence of prosocial and conduct disorders in children. These programmes have been effective at addressing the risk factors associated with abuse and neglect, however, when applied at a population level it is unclear whether an effective dissemination strategy alone is effective in preventing neglect in the first place.

101. The results for parenting and home visitation programmes is more mixed. There is an emerging broad consensus from this review that these approaches also appear more effective in reducing risk factors for child maltreatment, and for promoting healthy child development and school readiness, and positive parenting practices. Fewer programmes documented evidence in preventing actual neglect or its recurrence long term. Fidelity to these approaches is critical particularly seeing the family in the home over a sustained period of time, but this is not always achieved due to complex relationships with families and a lack of the intensive comprehensive packages of support that may be required. The research also identified that parents with limited social support, high levels of poverty-related stress, and mental health problems derived the least benefit from behavioural parent training. These approaches may help a whole range of families in our communities but their impact for our most vulnerable families is perhaps more limited.

102. Communities have an important role to play: when support is normalised within the neighbourhood or community, provided in places that avoid stigma and when it is broadly available rather than targeted, it is more likely that the received support will be perceived as beneficial. The more families can feel they can ask for help, the more we can achieve in responding to neglect.

103. This review has focused on a range of interventions for which there is available evidence, however, there are many more approaches and strategies that continue to be developed. Every day practitioners in Scotland are working effectively with families to address these complex issues. Neglect is complex at all levels and should not been seen in isolation of a family's wider informal and formal networks. Great care must be taken in assessing and putting together comprehensive, multi-layered and flexible package of intervention and support at each ecological level: individual, family and community. Each member of the family should be recognised in their own right.

104. How neglect is understood, how we recognise neglect and how we respond to each situation is how we will impact our children's futures. To address fully the impact of neglect in our society we cannot look at changing parenting alone. Children's lives must be understood within the context of both the strengths and difficulties within families, especially when children are exposed to a range of risks resulting from mental health, substance misuse and domestic abuse, the social order and social capital available within our communities and the wider structural issues, such as poverty and unemployment, within our society. We need to intervene to reduce the neglect experienced by children today, but perhaps we also need to target our energy and resources to consider how we can help prevent neglect for future generations.

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Appendix 1

DATA FILTER FORM
Child Protection Improvement Programme

Record number:

Author(s):

Title:

Reviewer **Date of Review**

Primary Study (level 1) Yes/No

Guidance/Review (level 2) Yes/No

Does the study focus on interventions, effective practice or effective strategies when working with neglect?
Yes/No/Maybe

If no, discard immediately.

Main foci: e.g. neglect; programme; policy; legislation; etc

Subject: e.g. interventions, programme, approaches

Relevant Professional Group(s): e.g. social workers; health visitors; all

Research Design:

☐ RCT ☐ Cohort study ☐ Case control study ☐ Survey

☐ Qualitative study ☐ Review ☐ **Other (please state)**

Is it an intervention? ☐ Yes ☐ No

Should the paper be reviewed? ☐ Yes ☐ No ☐ Unsure

What level is it? ☐ Level 1 ☐ Level 2

If excluded, please state reasons why:

Appendix 2

DATA APPRAISAL FORM
Child Protection Improvement Programme

Record number:

Reviewer: **Date of Review**:

Primary Study (level 1) Yes/No/Unsure

Guidance/Review (level 2) Yes/No/Unsure

Does the study focus on interventions, effective practice or effective strategies when working with neglect?
Yes/No/Maybe

If NO, discard immediately and record reasons at the end of this form

Geographical location of study (level 1)/publication (level 2)

- ☐ UK
- ☐ Europe
- ☐ North America & Canada
- ☐ Australia & NZ
- ☐ Other:_____

Main foci

- ☐ Neglect only
- ☐ Neglect and other forms of child abuse
- ☐ Interventions
- ☐ Factors associated with neglect
- ☐ Community approaches
- ☐ Approaches or programmes
- ☐ Infancy and pre or primary schoolage
- ☐ Secondary school age
- ☐ Other: _____

Professional group (please all relevant groups):

- ☐ Social workers
- ☐ Education
- ☐ Medical professionals
- ☐ Housing
- ☐ Allied health professionals
- ☐ Police

☐ Non-statutory ☐ Other: _____

Research design, methods and rigour

Research design described by authors:

☐ RCT
(a follow-up of participants randomly allocated to intervention or control groups with a comparision of outcome rates during the time period. Randomisation with concealment of allocation avoids bias)

☐ Quasi-experimental
(a study in which the allocation of participants to different in terventions is controlled by the investigator, but the method falls short of genuine randomisation and allocation concealment)

☐ Cohort study
(comparison of outcomes between participants who have received an intervention and a group that has not (i.e. not allocated by investigator) in a follow-up study. These studies are usually prospective)

☐ Case-control study
(comparison of the exposure to interventions between participants with the outcome (cases) and those without the outcome (controls). These studies are usually retrospective)

☐ Cross-sectional study
(examination of the relationship between disease/isses and other variables of interest as they exist in a defined population at one particular time)

☐ Before-and-after study
(comparison of findings in study participants before and after an intervention)

☐ Case series
(description of a number of cases of an intervention and an outcome (without comparision with a control group)

☐ Other: _____

Rigour of research

For RCTs and quasi-experimental research designs, please answer the following:

1. Was the assignment to the treatment groups really random?	Yes/No/Unsure
2. Was the allocation concealed?	Yes/No/Unsure
3. Were the groups similar at baseline?	Yes/No/Unsure
4. Were the eligibility criteria established?	Yes/No/Unsure
5. Was the outcome assessor blinded?	Yes/No/Unsure
6. Was the care provider blinded?	Yes/No/Unsure
7. Was the client/patient blinded?	Yes/No/Unsure

For all other studies, please answer the following:

1. is there sufficient detil of the theoretical framwork informing the study and methods used	Yes/No/Unsure
2. Is the description of the context clear?	Yes/No/Unsure

3. Is there adequate justification and description of sampling strategy?	Yes/No/Unsure
4. Is description of the fieldwork clear?	Yes/No/Unsure
5. Are research methods appropriate to the questions asked?	Yes/No/Unsure
6. Are procedures for analysis clear?	Yes/No/Unsure
7. Is sufficient evidence provided to support realtionship between interpreatation and evidence?	Yes/No/Unsure

Summary

1. Estimate methodological quality (*1 poor/doubtful, 3 very good*) 1 2 3

2. How useful was this paper to the review question? (*1 not at all, 1 very*) 1 2 3

If 3 for both, then discard

Please record key findings or themes discussed

Please list any tools or measures used. Please state if the focus of the article or measures used as part of the research

Further thoughts and comments

Should the paper be included? Yes/No/Unsure

If excluded, please state reasons why: