DERBYSHIRE County Council

Child Neglect

Public Health Intelligence & Knowledge Services

VERSION CONTROL

Confidentiality
PUBLIC

Version	Publishing Date	Comments	Author
1.0	04/09/2017	Final version	Shaun Trecarten, Public Health, Derbyshire County Council

CONTENTS

1 INTRODUCTION

1.1 Background

In the UK, neglect is the leading manifestation of child abuse and the most frequent reason to implement a child protection plan. Neglect is also the most common reason the National Society for the Prevention of Cruelty to Children (NSPCC) Helpline is contacted, and in 80% of cases, neglect was severe enough to refer to police or children's services [1]. Furthermore, neglect is the most frequently recurring type of child maltreatment [2]
Child neglect has been defined by many authors, but has two statutory definitions in the UK:

- As a criminal offence under the Children and Young Persons Act 1933, it is defined as a failure "to provide adequate food, clothing, medical aid or lodging for [a child], or if having been unable otherwise to provide such food, clothing, medical aid or lodging, he has failed to take steps to procure it to be provided"[3].
- As a civil offence used in child and family law under the Children Act 1989, neglect is defined as "the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food, clothing and shelter (including exclusion from home or abandonment); protect a child from physical and emotional harm or danger; ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs [3]."

Neglect can be further subdivided into physical, emotional and educational neglect, with examples being listed in the Table 1 [4].

Table 1: Subdivisions of neglect with corresponding examples

Type of Neglect	Examples
Physical	Failure to provide adequate nourishment, clothing, personal hygiene or sanitation, supervision or medical attention
Emotional	Failure to provide adequate nurturance, affection and routine/structure, failure to seek help for emotional/behavioural problems, permitting maladaptive behaviour or exposure to traumatic experiences (i.e. Domestic violence)
Educational	Failure to provide the care/supervision required to secure child's learning requirements, failure to enrol in school appropriate for individual needs, permitting chronic absenteeism/truancy

Despite a similar detrimental long term impact on children compared to physical and sexual abuse, neglect has received a smaller amount of focus from research and the public [5].

The impact of child neglect is well established, and can have deleterious consequences for children at any stage of their life, both in the acute and chronic setting. In the short-term, children suffering from neglect are at increased risk of behavioural disturbances and delayed cognitive and emotional development [4]. They may also show physical signs of neglect, such as hunger, accidents, skin rashes, and fatigue [6]. In the long term, neglect is associated with increased substance abuse, risky sexual and violent behaviour, and attachment disturbances. Neglect also increases the likelihood to use social services and for post-traumatic stress disorder, and decreases the likelihood of economic well-being [4]. Children may also suffer from long-term physical effects such as failure to thrive and deliberate self-harm or suicide attempts [7].

1.2 State of child health and neglect in Derbyshire

Unfortunately the exact number of children suffering from neglect is unknown, due to its multifactorial nature and complexity. However, trends in surrogate measures of neglect, such as dental caries and numbers of underweight children, can help provide an estimate of the prevalence of child neglect.

In Derbyshire, 16.8 % of children aged less than 16 years are living in poverty, compared to 20.1% nationally [8]. Both the family homelessness rate and measures for oral hygiene are also significantly better than the UK average [8]. While the numbers of children aged less than 18 admitted to hospital with alcohol specific conditions has decreased in recent years to 70 annually, it is still significantly worse than the UK average of 36.6 [8]. When compared to the UK average, Derbyshire also has significantly higher levels of maternal smoking at time of delivery, and hospital admissions for both substance misuse and deliberate self-harm, Derbyshire has significantly fewer students attaining their GCSEs than the UK average[8].

In Derbyshire, 33.4% of all children in need (CiN) cases are living with or have lived with neglect based on a presenting issue of neglect at any point in time or a child protection plan reason of neglect [9]. For children over 10 years of age, this value drops to 27.1% [9]. The highest numbers of CiN with neglect are in Chesterfield and North East Derbyshire and Bolsover [9]. Chesterfield has highest rate per 10K pop of children in need living with neglect [9]. Further demographic information regarding neglect in Derbyshire can be found in the recent document entitled, “JTAI deep-dive: Children living with Neglect”[9].

The Derbyshire Safeguarding Children Board (DSCB) has recently developed a Strategy for Child Neglect which focuses in part on the identification and future prevention of children suffering from neglect, and effective interventions to help them [3]. Excerpts from the strategy can be found in italics throughout the document.

1.3 Aims:

This paper aims to review the evidence surrounding aspects of the recently developed DSCB Child Neglect strategy, including the recognising a neglected child, prevention of child neglect and effective interventions in child neglect.

2 RECOGNISING A NEGLECTED CHILD

2.1 Risk factors and indicators of child neglect

In recognising a child suffering from neglect there are two important concepts: risk factors and indicators [10]. Risk factors are elements specific to the individual child that are associated with increased likelihood of neglectful circumstances. Risk factors must not be used as predictors of neglect, as the majority of children with risk factors in longitudinal studies will never be neglected [10]. Risk factors must be interpreted cautiously, but can help agencies prioritise limited resources and better understand the children’s circumstances [10].

Risk factors can be divided into those that are related to the child, the family and society [11]:

1. Child related: younger age (especially those <12 months old), low birth weight, prematurity, child disability.
2. Family related: presence of domestic abuse, poor parental emotional well-being, parental substance misuse, parent learning disabilities,
3. Society related: poverty, unemployment, low income, poor community resources and social support, poor living conditions (ex. Overcrowding, unsafe home, instability)

Indicators of neglect are symptoms and signs of actual neglect. It is essential to consider behavioural and developmental indicators alongside physical indicators [12]. However, no single indicator is specific for neglect alone, and the child must be thoroughly evaluated to identify further indicators or co-existing or alternative causes [10]. Indicators of neglect are often best observed as manifestations of the predisposing harmful parent-child relationship, and can be divided according to the age band of the child [10, 13]. Other indicators may be seen as concerns in how the child is functioning. There may be manifestations of neglect if a child is left unsupervised frequently. Accidents, while having many risk factors which are also linked to neglect, are not strong indicators for neglect themselves [10]. Furthermore, neglect may be suspected if there is concern that a child's health needs are not being met. Examples of neglect indicators can be seen in Table 2 [10].

Table 2: Examples of indicators of neglect

	0-12 months	1-3 years	3-5 years
Observed parent-child relationship	mothers lacking sensitivity towards infant, not engaging with infant emotionally during feeding, rarely communicating with baby	parent ignores or fails to respond appropriately to child's cues for help, does not display affection for child, plays minimally and only occasionally with child	neglecting parents continue to infrequently speak with children and display less affection; parents perceive child as having problems with 'conduct'
Observed functional concern	developmental delay (esp speech and language), less separation anxiety	children develop more aggressive and hostile behaviour	learning delay, play is less creativity and more aggressive, disruptive and inattentive in the classroom, less likely to offer help to other peers
		All ages	
Poor parental supervision	Children looking after themselves frequently, hunger, dirty clothing, not receiving medical attention, home alone at night due to other parental priorities (ex. Substance abuse)		
Not meeting child's health needs	failing to receive basic health care (ex. Immunisations), parental failure to seek medical attention as appropriate untreated dental disease and/or poor oral hygiene [14], underweight or obese		

2.2 Barriers to identification

While not every child who is neglected displays indicators or risk factors, there are many occasions where there is evidence of neglect, but the child is not identified. Examples of obstacles in identifying children suffering from neglect are listed below:

1. Professional knowledge/awareness:
    - maintaining up-to-date knowledge and access to educational resources is challenging because of the constantly changing research base [10]
    - Training may not cover the intricacies of safeguarding work and multifaceted role of practitioners- empowering vulnerable parents on one occasion and, when threshold limits are reached, acting more decisively in the child's best interest.
    - Furthermore, as per a recent Ofsted report, the benefits of training do not always translate to clinical practice [15]. However, training was seen as more beneficial when healthcare workers could make practical links between the training and their own day to day work [15].
    - Working with families where children are neglected can be emotionally draining, stressful and leave social workers 'confused and bewildered by what they see'. Proper supervision and support for health care workers (HCWs) will help ensure that they perform at their best, which translates to better patient care [16].
    - *In Derbyshire, "professionals will have, and will be expected to use as appropriate to their role:*
        - *Training around neglect, parental non/disguised compliance and child development*

        - *"Think Family" training*
        - *Regular reflective supervision"*
    - *"Derbyshire Safeguarding Children Board (DSCB) provides multi-agency training to support professionals in recognising and responding to neglect; this includes:*
        - *Identification of neglect including use of the Graded Care Profile (see below)*
        - *Working with babies*
        - *Working with challenging parents"*
    - *"DSCB also promotes the use of assessment processes and tools; these should be used in all situations where there are emerging concerns around neglect:*
        - *Early Help Assessment*
        - *Social Care Single Assessment chronologies*
        - *Graded Care Profile*
        - *DV Risk Identification Matrix and DASH risk assessment in domestic violence situations"*
2. Lack of resources:
    - Increasing demand for child services and falling public expenditure (26.6% reduction in local authority budget since 2010) make providing services difficult for HCWs and families [10].
3. Assumptions:
    - HCWs may make assumptions or have particular mind-sets which hinder taking necessary action upon identifying indicators of neglect [10].
    - HCWs may
        - possess concerns that they are being too judgemental
        - focus on the parent (ex. Learning disability, domestic abuse) instead of the neglected child
        - fail to empathise with the child
        - hold a false fixed view of the family or first impression
        - lack confidence in assessing a child suffering from neglect
        - be reluctant to refer early due to fears of family reaction and previous negative experiences with referrals not being accepted.
4. Parental non-engagement or disguised compliance
    - Parents of children suffering from neglect are more likely to not engage with HCWs
    - Likewise, HCWs may attempt to avoid contacting or challenging families who are volatile and antagonistic.
    - Neglectful parents may show 'disguised compliance' where they deceive HCWs in believing that they co-operate and engage with services (ex. Short-term housing improvements or sporadic hospital visits despite ongoing neglect) [11].
5. False-Resilience
    - Occasionally children who are successful despite difficult circumstances may show very few or none of the indicators of neglect. While resilience is typically a highly regarded trait, it leads to the possibility of 'false-resilience' where the neglectful circumstances are masked by the child minimising their difficulties, which hinders professional recognition [11].
    -

2.3 Assessment tools/framework:

There are currently several assessment tools used to help identify children suffering from an inflicted head injury and sexual or physical abuse, but few specifically for children suffering from neglect [17, 18]. The Graded Care Profile (GCP) is an example of such a tool. This scale assesses the severity of neglect based on four criteria (esteem, love, safety and physical needs) each of which are ranked on a scale of 1-5, with higher numbers associated with increased neglect [19]. While the GCP and newer GCP2 show moderate to high inter-rater reliability and high levels of concurrent and face validity, there is no sensitivity and specificity data published [18-20]. The purpose of this tool is only to aid with professional judgement and should not be used to replace a thorough clinical assessment [21].

Evidence based decisions (EBD) is an intervention developed by the NSPCC to enhance evidence, understanding, and trigger more prompt decision making in complex neglect cases [22]. It combines the North Carolina Family Assessment Scale (NCFAS-G and) a joint review by a local authority social worker and NSPCC practitioner [22]. The

NCFAS-G is a heavily validated scale that measures how a family functions and grades the family from -3 to +2 on different areas of family functioning [23]. The NSPCC has evaluated EBD based on interviews with the joint assessment staff at 6 and 18 months. Based on surveys, it is thought EBD improves practitioner decision making by providing more objective evidence [22]. However, it does not involve families in the review process, and if the practitioner already has sufficient evidence and understanding of the case, EBD added little further insight [22]. It was also felt to be ineffective if parents were unable to understand what parenting adjustments were required or unwilling to undertake any positive change [22].

A systematic review on potential screening tools for child abuse included only 1 other scale that screened for physical neglect. Using self-reporting questionnaires for psychiatric in-patients aged 12-17 years, the study showed a sensitivity and specificity of 78 and 61 respectively for physical neglect [17].
Overall the evidence supporting the accuracy of instruments for identifying children suffering from abuse is lacking [17, 18].

3 EFFECTIVE INTERVENTIONS IN CHILD NEGLECT

While there are many interventions that aim to enhance the lives for underprivileged children and families, there are few developed explicitly for neglect.

3.1 NICE guidance

NICE suggests the following framework for therapeutic interventions following physical or emotional abuse or neglect [24]:

3.1.1 Children under 5 and their parents or carers

Offer an intervention based on attachment theory to parents or carers who have neglected or physically abused a child under 5 years old. Delivering intervention at home, the aim is to improve the parent's nurturing of the child, their understanding of child behaviour, positive responses to the child's cues, and how they manage their emotions when taking care of the child.

Child-parent psychotherapy may also be offered at the parent's home in weekly sessions for over a year, and should be based on the Ciccheti and Toth Model [25]. It should involve direct observation of the child-parent interaction while exploring the parent's understanding of their child's behaviour as well as the parent's emotions and own childhood experiences.

Ciccheti, Rogosch and Toth showed in a randomised trial with intention to treat analysis that infants whose families underwent infant-parent psychotherapy and psychoeducational parenting intervention showed elements of more secure attachment compared to controls [25].

Further information regarding the breadth of interventions to improve the child-parent relationship for children under 5 can be found in a comprehensive review written by Axford et al [26].

3.1.2 Children under 12 and their parents or carers

For children suffering from physical or emotional abuse and/or neglect, a weekly comprehensive parenting intervention should be offered over the course of 6 months. The intervention should focus on improving child-parent interactions, caregiving structures and parenting routines, parental stress, and home safety.

Parent-child interaction therapy can also be used in situations where physical abuse or neglect is apparent. Group sessions for parents should be offered alongside individual child-parent sessions.

3.1.3 Children and young people over 10 and their parents or carers

For children and adolescents aged 10-17, multisystemic therapy (MST) can be offered. This family involving intervention should aim to address the underlying factors contributing to the abuse/neglect, be delivered at home, and include crisis management services with 24/7 on call care if required. There is a plethora of evidence supporting the success of MST in treating delinquency and violence, substance misuse, psychopathology and emotional disturbance, child abuse, and chronic health conditions [27, 28].

3.2 Specific Interventions in the context of neglect

3.2.1 Home visiting/parent training

SafeCare

SafeCare is a preventative programme, which originated at Georgia State University (GSU) in the US. With an established evidence base, it targets parenting behaviour change for families with children under 6 years old. The programme is delivered through 18-20 home based sessions and has 3 areas of focus: parent-infant/child interaction, home safety and child health. The NSPCC conducted a non-randomised study of 32 families who attended the programme and had difficulties necessitating statutory neglect intervention [29]. At the end of the programme, 21 families improved such that statutory intervention was no longer needed, and despite only 27% of families completing the programme, all of the families had seen improvements especially in the areas of home safety, parent-child interaction and health [29]. In the US, a randomised trial of 2175 parents demonstrated benefit of SafeCare, though this was not specifically for neglected children [30].

Video Interaction Guidance (VIG):

VIG is a programme that uses video recorded positive interactions to reinforce and educated parents on positive responsive verbal and non-verbal communication. VIG is appropriate for situations where a child protection plan has not yet been implemented and the child is between 2-12 years old [31]. A recent study undertaken by the NSPCC evaluated before and after measurements of the Strengths and Difficulties Questionnaire (SDQ), the Parenting scale and the Parent-Child Relationship Inventory [31]. The study was not randomised. They found that after VIG in children with concerns over neglect, there were significant improvements in the child-parent relationship, specifically in the parenting strategies and communication, and in the child's behavioural and emotional difficulties [31]. A meta-analysis showed that VIG improved parenting behaviour and attitudes, and child development, but the evidence base has been criticised due heterogeneous techniques for video capture and lack of measurement standardisation [32, 33].

Pathways Triple P

Originating in Australia, the Standard and Pathways Triple P contain elements of the Positive Parenting Programme (PPP), which delivers family interventions for parents of children who have behaviour problems [34]. It was originally intended to be delivered in a group work context, and has recently been adapted for child neglect, specifically for children aged 2-12 years [34]. Standard Trip P involves sessions to teach positive parenting skills with practical opportunities to refine skills. Pathways Triple P delivers 3 educational modules: avoiding parent traps, coping with anger, and maintaining changes [34]. There is a great deal of research supporting the use of PPP, but not in the field of child neglect. A recent NSPCC evaluation of 100 families with children suffering from neglect showed statistically significant improvements in parent's relationship with the child, specifically communication and providing autonomy to the child, in their own parenting strategies, and in the child's behaviour [34]. However, approximately half of the children still had clinical requirements at the end of the programme and the study was non-randomised [34].

3.2.2 Community wide interventions

Thriving communities

Thriving communities is a recent framework that aims to implement various concrete actions across five levels of society- children, parents, communities, universal services and local government- in order to improve child neglect [35].

Three principles form the foundation of this guidance[35]:

- 1. The importance of relationships: aims for all parties to work in unison, from local authorities, safeguarding boards and individual organisations to provide targeted intervention with engaged and trained practitioners.
- 2. Educating communities to identify and respond to neglect
- 3. Use evidence base to inform and guide responses to child neglect.

Examples of community interventions in Derbyshire

"Families with children need adequate income through work and/or benefits, decent housing and access to health and education. Central Government, the Local Authority, Public Health and CCGs and others all have responsibilities for providing these and/or providing accessible information & access.

Most parents will rely on their families, communities and friends for advice and guidance on caring for their children. Support will also be available to parents through universal and targeted services, to enable them to understand their children's needs and how to meet them. This includes:

- *GPs and dentists*
- *Midwifery & ante-natal classes*
- *Health visiting & child health clinics*
    - *Children's health and development will be monitored formally ante-natally by midwifery and at 6 weeks, 2 yrs and 5yrs by Health Visiting / School Nursing. Standardised recording tools are used for these assessments to track a child's growth and development, and identify any problems.*
- *Children's Centres and open access groups*
- *School health and school-based activity for parents*
- *Voluntary and community sector groups"*

3.2.3 School based initiatives

Certain indicators of neglect may be more apparent at school, which provides an opportune location for intervention. An initiative in New Zealand to connect social workers to specific schools significantly improved family meal and bedtime routines and positive communication between child and parent [6]. In the UK, social workers have been paired with some schools, which has showed promise in early detection of cases before they are severe enough to trigger statutory intervention [6]. Despite the initiatives, improvements in communication and strategic local and national coordination between social services and schools are still required.

3.2.4 Interventions with children

There are few specifically for children suffering from neglect, for which the evidence is quite dated. There is some evidence to suggest that increased play therapy, speech and language therapy and educational support can improve functioning in neglected children [36]. A randomised control trial conducted in 1983 showed that emotionally neglected children undergoing imaginative play therapy displayed increased levels of imagination, co-operation with peers, and less aggression than controls [37]. Further interventions that tackle specific indicators of neglect, such as behaviour problems and academic delay, may be of some benefit as well [6].

"In Derbyshire, specialist assessments may also be needed and should be commissioned promptly, to inform future work. This may include child/adult learning disability and mental health teams, and paediatrics, including where a child has a disability."

3.2.5 Interventions with specific parental groups

There are certain parental difficulties that are risk factors for child neglect. While there is much evidence discussing the associated harms of parental mental health pathology and substance misuse and associated interventions, there is little in the way of interventions for neglect in particular [6].

"Some groups are more vulnerable than others, e.g. disabled children, young parents, new migrants to the UK, those with learning disabilities. Targeted services in Derbyshire are available from:

- *Integrated Disabled Children's Service*
- *Ripplez (Family Nurse Partnership)*
- *New Communities Team*
- *Adult Learning Disability Service"*

4 CONCLUSION

Despite the prevalence of neglect in the context of child abuse, there is disproportionately little neglect specific literature. Neglect can be notoriously difficult to recognise, and it is essential that the barriers to neglect identification are mended, and practitioners are educated on the assessment tools available to appropriately manage neglect and prevent progression. Child neglect is also difficult to evaluate from a research setting, due to its co-existence with other forms of abuse, and each family having its own unique circumstances. Evidence for interventions is emerging, but higher quality studies (i.e. randomised trials with intention to treat analysis) are still required to assess interventions specifically in the context of neglect.

5 REFERENCES

1. NSPCC, *Spotlight on preventing child neglect: An overview of learning from NSPCC services and research*. 2015, National Society for the Prevention of Cruelty to Children. p. 1-24.
2. White, O.G., N. Hindley, and D.P. Jones, *Risk factors for child maltreatment recurrence: An updated systematic review.* Medicine, Science and the Law, 2015. **55**(4): p. 259-277.
3. Evans, M., *Neglect Strategy*, D.S.C. Board, Editor. 2017, Derbyshire Safeguarding Children Board: Derbyshire.
4. Stoltenborgh, M., M.J. Bakermans-Kranenburg, and M.H. van IJzendoorn, *The neglect of child neglect: a meta-analytic review of the prevalence of neglect.* Social psychiatry and psychiatric epidemiology, 2013. **48**(3): p. 345-355.
5. Gilbert, R., et al., *Burden and consequences of child maltreatment in high-income countries.* The lancet, 2009. **373**(9657): p. 68-81.
6. Moran, P., *Neglect: research evidence to inform practice.* Action for Children, 2009.
7. Burgess, C. and B. Daniel, *Neglecting the issue: impact, causes and responses to child neglect in the UK: A Briefing Paper for Action for Children*. 2011, London: Action for Children.
8. *Derbyshire Child Health Profile*, P.H. England, Editor. 2017, Public Health England: UK.
9. DCC, *JTAI deep-dive: Children living with Neglect*, D.C.C. (DCC), Editor. 2017: Matlock, UK. p. 1-35.
10. Brandon, M., et al., *Missed opportunities: indicators of neglect–what is ignored, why, and what can be done?* 2014.
11. Rachel Akehurst, R., *Child neglect identification: the health visitor's role.* Community Practitioner, 2015. **88**(11): p. 38.
12. Maguire, S., et al., *A systematic review of the emotional, behavioural and cognitive features exhibited by school-aged children experiencing neglect or emotional abuse.* Child: care, health and development, 2015. **41**(5): p. 641-653.
13. Camilo, C., M.V. Garrido, and M.M. Calheiros, *Implicit measures of child abuse and neglect: a systematic review.* Aggression and violent behavior, 2016. **29**: p. 43-54.
14. Bhatia, S.K., et al., *Characteristics of child dental neglect: a systematic review.* Journal of dentistry, 2014. **42**(3): p. 229-239.
15. Ofsted, *In the child's time: professional responses to neglect*, O.f.S.i.E. Ofsted), Editor. 2014, Ofsted: Manchester.
16. Munro, E., *The Munro review of child protection: Final report, a child-centred system*. Vol. 8062. 2011: The Stationery Office.
17. Bailhache, M., et al., *Is early detection of abused children possible?: a systematic review of the diagnostic accuracy of the identification of abused children.* BMC pediatrics, 2013. **13**(1): p. 202.
18. Hoft, M. and L. Haddad, *Screening children for abuse and neglect: a review of the literature.* Journal of Forensic Nursing, 2017. **13**(1): p. 26-34.
19. Johnson, R. and R. Cotmore, *National evaluation of the Graded Care Profile*. 2015, London: NSPCC.
20. Srivastava, O. and L. Polnay, *Field trial of graded care profile (GCP) scale: A new measure of care.* Archives of Disease in Childhood, 1997. **76**(4): p. 337-340.
21. DSCB, *Neglect & Graded Care Profile Practice Guidance* D.a.D.I. Working, Editor. 2017, Derbyshire Safeguarding Children Board (DSCB): Derbyshire, UK.
22. Williams, M., *Evidence-based decisions in child neglect: An evaluation of an exploratory approach to assessment using the North Carolina Family Assessment Scale.* London: NSPCC, 2015.
23. Kirk, R., *Development, intent and use of the North Carolina Family Assessment Scales, and their relation to reliability and validity of the scales*. 2012, North Carolina, US: National Family Preservation Network.
24. NICE, *Child abuse and neglect*, N.I.f.C.E. (NICE), Editor. 2017, NICE.
25. Cicchetti, D., F.A. Rogosch, and S.L. Toth, *Fostering secure attachment in infants in maltreating families through preventive interventions.* Development and psychopathology, 2006. **18**(03): p. 623-649.
26. Axford, N., et al., *The Best Start At Home: What Works To Improve The Quality Of Parent-Child Interactions From Conception To Age 5 Years.* A Rapid Review Of Interventions. Early Intervention Foundation, 2015.
27. van der Stouwe, T., et al., *The effectiveness of Multisystemic Therapy (MST): a meta-analysis.* Clinical psychology review, 2014. **34**(6): p. 468-481.

28. Henggeler, S.W. and C.M. Schaeffer, *Multisystemic Therapy®: Clinical overview, outcomes, and implementation research.* Family process, 2016. **55**(3): p. 514-528.
29. Churchill, G., *EVIDENCE FROM A HOME BASED PARENTING PROGRAMME FOR NEGLECT.* 2015.
30. Chaffin, M., et al., *A statewide trial of the SafeCare home-based services model with parents in child protective services.* Pediatrics, 2012. **129**(3): p. 509-515.
31. Whalley, P., *Child neglect and Video Interaction Guidance: An evaluation of an NSPCC service offered to parents where initial concerns of neglect have been noted*. 2015, London: NSPCC.
32. Fukkink, R.G., *Video feedback in widescreen: A meta-analysis of family programs.* Clinical Psychology Review, 2008. **28**(6): p. 904-916.
33. Balldin, S., P.A. Fisher, and I. Wirtberg, *Video Feedback Intervention With Children A Systematic Review.* Research on Social Work Practice, 2016: p. 1049731516671809.
34. Whalley, P., *Child neglect and Pathways Triple P: an evaluation of an NSPCC service offered to parents where initial concerns of neglect have been noted*. 2015, London: NSPCC.
35. Haynes, A., et al., *Thriving Communities.* 2015.
36. Daro, D., *Confronting child abuse: Research for effective program design*. 1988: Simon and Schuster.
37. Udwin, O., *Imaginative play training as an intervention method with institutionalised preschool children.* British Journal of Educational Psychology, 1983. **53**(1): p. 32-39.