

1 Language Difficulties Among Children Experiencing Neglect: A Public Health Approach
2 Aimed at Narrowing the Gap

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Abstract

23 **Purpose:** Child neglect affects approximately 1% of children under the age of six in the
24 United States and Canada annually. Nearly 50% of children who experience neglect
25 present significant language difficulties before starting school. Child neglect can thus be
26 considered a major public health issue. Child neglect is an ecological and systemic
27 phenomenon characterized by a dual disruption: first, in the relationship between the
28 parent and child and second, in the relationship between the family and the wider
29 community. Empirical research has quite convincingly demonstrated that parenting
30 behaviors constitute a malleable variable upon which it is possible to act to foster the
31 language development of young children. However, given the multidimensional nature of
32 child neglect, interventions aimed directly at parents are simply not enough to support the
33 language skills of children in this context. Based on a complex family and social
34 conception of neglect, the objective of this article is to propose a logical model
35 illustrating public health services for children experiencing neglect. Such a logical model
36 provides for multiple interventions at the child, family and community levels.

37 **Conclusions:** Broader efforts should be made to support the parents in overcoming the
38 challenges of parenthood by addressing the multiple risk factors to which they are
39 exposed. This can be achieved both by striving towards positive environmental
40 conditions, characterized by responsive caregiving in the home and community, and by
41 implementing multilevel interventions within an interdisciplinary and intersectoral
42 approach. The resulting recommendations align with the Individuals with Disabilities
43 Education Act (IDEA), a law that requires states to provide services to children in early
44 intervention programs (Part C) and kindergartens/schools (Part B).

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45 *Keywords:* Child neglect, language development, logical model, public health

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47 Early childhood experience is a social determinant of children’s health and well-
48 being (Commission on Social Determinants of Health, 2008). Healthy early childhood
49 development hinges on positive environmental conditions, including responsive
50 caregiving by parents, family members and other caregivers in both the home and
51 community settings (Bernard, Lee, & Dozier 2017; Greenwood et al., 2017). Children
52 who experience adversity in their early caregiving environment, including those
53 experiencing neglect, are at elevated risk for developmental language deficits (Boparai et
54 al., 2018; McDonald, Milne, Knight, & Webster, 2013; Sylvestre, Bussièrès, &
55 Bouchard, 2016). Early language difficulties can have deleterious consequences on
56 cognitive and socioemotional development (Snow, 2013; St Clair, Pickles, Durkin, &
57 Conti-Ramsden, 2010) and school readiness (Law, Charlton, & Asmussen, 2017;
58 Snowling & Hulme, 2012). Language and communication skills are also crucial for brain
59 development, parent-child attachment, expressing and understanding others, thinking and
60 learning, social interactions, and emotional well-being (Bercow, 2018; Norrie McCain,
61 2020). Thus, children with a history of child neglect are especially in need of
62 interventions supporting early language development (Bernard et al., 2017).

63 **Current Situation**

64 **Child Neglect: An All Too Common Phenomenon**

65 Almost 65% of reported cases of maltreatment involving children under the age of
66 6 pertain to neglect (Quebec Association of Youth Centers, 2019; US Department of
67 Health & Human Services, 2020). More specifically, in 2019, in the Canadian province
68 of Quebec, 62.6% of reported cases involving preschool aged children retained by the

69 directors of youth protection agencies concerned a situation of neglect. These case
70 numbers represent 1% of all children in this age group in Quebec, a statistic that also
71 applies in the United States (Quebec Association of Youth Centers, 2019; Statistics
72 Canada, 2019; US Department of Health & Human Services, 2020). In fact, since neglect
73 often goes unnoticed, it can be assumed that these already worrying figures actually
74 underestimate the real extent of the problem (Blumenthal, 2015). Moreover, of all the
75 forms of child maltreatment, neglect has the most profound and long-lasting
76 consequences (Romano, Babchishin, Marquis, & Fréchette, 2015). It is also associated
77 with the highest risk of intergenerational transmission (St-Laurent, Dubois-Comtois,
78 Milot & Cantinotti, 2019).

79 **Child Neglect: Important Consequences for Language Development**

80 By age three, roughly one out of two of children who experience neglect show
81 serious delays in language development (Sylvestre & Mérette, 2010). Depending on the
82 language components assessed, this rate is five to ten times higher than that observed
83 among same-aged children in the general population, which averages around 20%
84 (Reilly, McKean, & Levickis, 2014; Zubrick, Taylor, Rice, & Slegers, 2007). Globally,
85 compared to their peers, children who experience neglect understand a smaller number
86 and lower variety of words (Eigsti & Cicchetti, 2004; Fox, Long, & Langlois, 1988;
87 Perry, Doran, & Wells, 1983), display lower morphological and syntactic abilities
88 (Beeghly & Cicchetti, 1994; Coster, Gersten, Beeghly, & Cicchetti, 1989; Eigsti &
89 Cicchetti, 2004; Fox et al., 1988; Julien, Sylvestre, Bouchard, & Leblond, 2019), have
90 weaker pragmatic skills (Coster et al., 1989; Di Sante, Sylvestre, Bouchard, & Leblond,

91 2019), and show delayed expressive lexical development (Beeghly & Cicchetti, 1994;
92 Coster et al., 1989).

93 **How and Why Child Neglect Compromises Language Development**

94 Child neglect hinders language development because language is acquired in the
95 context of responsive and sensitive caregiving (Golinkoff, Hoff, Rowe, Tamis-LeMonda,
96 & Hirsh-Pasek, 2019; Hirsh-Pasek et al., 2015). Both the quantity and quality of parent-
97 child interactions are crucial for language development (Golinkoff et al., 2019; Romeo et
98 al., 2018). Hart and Risley (1995) showed that, at 3 years of age, children from
99 disadvantaged backgrounds are exposed to 30 million fewer words than children from
100 more advantageous backgrounds. Children who are economically disadvantaged present
101 more language difficulties as compared with their peers from economically secure or
102 advantaged backgrounds (Locke, Ginsborg, & Peers, 2002). Moreover, while the quantity
103 of interactions is important, their quality plays an equally if not more determining role in
104 language development. Indeed, contiguity (e.g., temporal connectedness of the adult's
105 response to the child's utterance) and contingency (e.g., relevance of the adult's response
106 to the child's statement and to the context of the exchange) with a child's statements are
107 crucial for language learning (Romeo et al., 2018).

108 More specifically, current literature suggests that the three dimensions of
109 responsive parenting that most strongly predict later language development are sensitivity,
110 responsivity and reciprocity (Hirsh-Pasek et al., 2015; Hudson, Levickis, Down, Nicholls
111 & Wake, 2015). *Sensitivity* refers to the parent's awareness and understanding of what
112 captures the child's attention (game, activity, interests, etc.). It also includes the parent's

113 ability to detect the child's communication signals—including gestures (e.g., pointing) and
114 vocalizations—and to interpret them as communication attempts (Guttentag et al., 2014;
115 Levickis et al., 2014; Roberts & Kaiser, 2011; Warren et al., 2006). Sensitivity represents
116 the first necessary stage of a response which can be adjusted to the developmental level of
117 the child, that is, within his zone of proximal development (Kuusisaari, 2014). *Responsivity*
118 refers to the consistency and relevance of the parent's responses to the child's behaviors.
119 Relevant responses relate to the child's actions, requests and intentions, and allow the
120 conversation or activity to continue. They include, for example, acting or commenting in
121 relation to the child's actions or comments, repeating or rephrasing what the child says,
122 expanding on and providing interpretations of their own comments, or acting in response
123 to the child's direct or indirect requests. Responsivity implies paying attention to the child's
124 interests and reacting to them in a quick and contingent manner (i.e., following the child's
125 lead). *Reciprocity* refers to the parent's ability to engage the child or engage with the child
126 in a collaborative and balanced exchange or activity that has a common goal and in which
127 the parent and child participate equally. Examples of reciprocity include interacting
128 without interrupting the child, asking open-ended questions that help maintain or pursue
129 the interaction, creating balanced turn-taking or conversations, and successfully engaging
130 the child in lasting interactive sequences. These parental behaviors encourage
131 communicative exchanges during which children initiate a topic of interest and parents
132 respond in a way that is meaningful to the child (Hudson et al., 2015). Such mutual turn-
133 taking supports the children's understanding of the rules and structure of conversation and
134 allows children to be highly receptive to new words and language (Smith et al., 2018). The
135 quantity and quality of the language to which children are exposed in their very early years

136 constitute the active ingredients of language learning by providing them with the
137 opportunity to hear, observe, apply and, gradually, refine their own language skills (Hirsh-
138 Pasek et al., 2015; Romeo et al., 2018).

139 **Child Neglect: Beyond Parental Failure**

140 Child neglect is generally defined as a deficit in meeting a child's basic needs,
141 including the failure to provide adequate supervision and health care, among other
142 physical and educational needs (Dubowitz et al., 2005; Milot, Grisé Bolduc, Gascon,
143 Turgeon, & St-Laurent, 2019). It is characterized by a severe disruption in the parent-
144 child relationship, creating an experience marked by a reduced number of interactions
145 (Milot, St-Laurent, Ethier, & Provost, 2010; Wilson, Rack, Shi, & Norris, 2008). In
146 addition, when parent-child interactions do occur, a significant number of them tend to be
147 characterized by aversiveness, indifference and unpredictability (Lacharité, 2019; Wilson
148 et al., 2008). Children who experience neglect are deprived of the responsive interactions
149 essential for their development (Commission on Social Determinants of Health, 2008).

150 Child neglect refers to a failure on the part of parents who have difficulty fully
151 exercising their role (Milot et al., 2019). The significant vulnerability of neglectful
152 families, the vast majority of whom face multiple risk factors, may explain this failure
153 (Pauzé, 2018). These families are most often poor, with the parents presenting a range of
154 personal difficulties (e.g., drug addiction, psychological distress) and conjugal difficulties
155 (e.g., marital instability, conjugal violence). These challenges increase the stresses related
156 to the exercise of their parental role and, consequently, the quality of their child-rearing
157 practices (Mersky, Berger, Reynolds, & Gromoske, 2009; Pauzé, 2018).

158 Child neglect also exposes the inability of society to support vulnerable parents in
159 exercising this role (Milot et al., 2019). Healthy parenting does not hinge solely on the
160 characteristics of people. It also depends on a set of resources and social relationships.
161 Families in a context of neglect are often isolated and receive little support from those
162 around them. Community and government services have difficulty translating into
163 relevant and timely support for parents, who tend, rather, to feel subject to a system of
164 surveillance, control and blame (Lacharité, 2019). Child neglect can therefore be
165 conceptualized as the result of a double disruption. To the disruption of the parent-child
166 relationship is added a deteriorated relationship between the family and community
167 (Lacharité, 2014). This breakdown in the family-community relationship also reduces the
168 normative developmental opportunities for children, including positive interactions with
169 children and adults other than parents (Lacharité, 2019). This conceptualization of
170 neglect suggests that the disruption in the parent-child relationship (proximal factor) is
171 directly related to children's language development, while the breakdown in the family-
172 community relationship (distal factor) appears to have an indirect effect through the
173 pressures exerted on parents in the exercise of their parental role (Lacharité, 2014; Pauzé,
174 2018).

175 Child neglect is thus viewed as a complex family and social phenomenon,
176 resulting in an inadequate response to a child's needs. Since one of the mandates of public
177 health is to meet the needs of the most vulnerable in society (Government of Quebec,
178 2019), the neglect of children is certainly a major public health concern in the very sense
179 of the law (Government of Quebec, 2020). The objective of providing a better response to
180 the developmental needs of children can only be reached by improving the living

181 conditions of parents and children as well as the quality of parenting skills and family-
182 community relationships (Tarabulsky, Poissant, Saïas, & Delawarde, 2019). It is also
183 essential to provide for activities that allow children to catch up on their developmental
184 delays (Lacharité, 2019). Despite their high developmental needs, only a minority of
185 children experiencing neglect under the age of 6 receive services pertaining to support
186 and harmonious language development (Allen, Hyde, & Leslie, 2012; Casanueva, Cross,
187 & Ringeisen, 2008; Stahmer et al., 2005).

188 **When, on What, and How to Intervene**

189 **When: The Importance of Early Actions**

190 The most rapid period of human development occurs in the earliest years of life
191 (Cummings & Berkowitz, 2014; Shonkoff & Phillips, 2000). The foundation for brain
192 development begins to form before babies are born and is well established by age two.
193 This is explained by the action of neurotransmitters, which is particularly high up until
194 this age (Kolb, Wishaw, & Teskey, 2019; Norrie McCain, 2020; Romeo et al., 2018).
195 Robust interaction among genes, early experiences and the environment shape the
196 developing brain and construct brain architecture (Bernard et al., 2017; Garner, 2013;
197 Greenwood et al., 2017).

198 For this action to be initiated and reinforced, human and social experience, in a
199 "serve and return" interaction between children and their parents, is essential (Friedman
200 & Rusou, 2015; Lytle & Kuhl, 2018). Children who experience neglect are likely to miss
201 out on the reciprocal interactions necessary for language development. If no socio-
202 emotional supports are provided by caregivers to buffer a child's response to repeated

203 negative experiences (Garner, 2013), the brain’s architecture will not form as expected
204 (Twardosz & Lutzker, 2010). As mentioned by the Center of the Developing Child
205 (2020), “It is easier and less costly to form strong brain circuits during the early years
206 than it is to intervene or ‘fix’ them later.” The ability to change the brains of children
207 decreases over time. Prevention and early intervention among children who experience
208 neglect is compelling and urgent (Albee & Gullotta, 1997; Shonkoff & Levitt, 2010). The
209 recognition of these risks and the benefits of early intervention, align with the Individuals
210 with Disabilities Education Act (IDEA), a federal law in the USA that requires states to
211 provide services to children in early intervention programs (Part C) and
212 kindergartens/schools (Part B) (Child Welfare Information Gateway, 2018).

213 **On What: More than Parental Behaviors**

214 A variety of programs that address child maltreatment have been provided over
215 the past fifty years. The Head Start program, and its Early Head Start version for families
216 of children under three, is one example. The HighScope Perry Prechool, Carolina
217 Abecedarian and Incredible Years programs (Tarabulsky et al., 2019) are examples for
218 families with older children. These programs aim to redress compromising situations for
219 children by improving parental behavior (Barth & Liggett-Creel, 2014; van Wassenauer-
220 Leemhuis et al., 2016).

221 Some positive impacts of these programs on children’s early language
222 development have been documented, but their effects have proven to be modest and not
223 always enduring (Abbott-Shim, Lambert, & McCarty, 2003; Love et al., 2005; Ludwig &
224 Phillips, 2008). This is because these programs include very few or no direct

225 interventions on the children's development (Lacharité, 2019). In addition, when such
226 interventions are included, they do not consider the social complexity in which situations
227 of neglect take place. To help children develop harmoniously, it is important to also
228 improve the living conditions of families and communities (Lacharité, 2019; Pauzé,
229 2018).

230 **How: Child Neglect as a Public Health Issue**

231 Public health services can be represented in a logical model illustrating the
232 relationships between input, theoretical context, intervention targets, activities and
233 anticipated outcomes for children and families (Law, 2019). Such a logical model
234 provides for multiple interventions at the child, family and community levels (Fawcett,
235 Schultz, Watson-Thompson, Fox, & Bremby, 2010). Based on the complex family and
236 social conception of neglect presented above, a logical model comprising seven
237 intervention targets and six types of activities can be developed (Figure 1). In the short
238 and medium term, this set of services aims to eliminate, or at least reduce, the language
239 difficulties presented by children experiencing neglect, while improving the full social
240 participation of these children, promoting greater school readiness among them, and
241 setting them on a better educational path. Over the long term, the expected benefits
242 include better integration into employment and a reduction in the intergenerational
243 transmission of child neglect.

244 **General framework of interventions.** Since child neglect is a multi-faceted
245 phenomenon including personal, family and social aspects, multidimensional actions
246 need to be promoted in an intensive, consistent and continuous manner. Part C of the

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247 IDEA requires that early intervention services assist family members in enhancing their
248 child's learning and development through everyday opportunities within natural
249 environments such as the home (Child Welfare Information Gateway, 2018). However,
250 parents' resistance to engaging in interventions is a frequent phenomenon in situations of
251 neglect (Boulet, Éthier, & Couture, 2004). The analysis of children's needs and well-
252 being is very often based on an approach controlled exclusively by clinicians is a part of
253 the explanation (Lacharité, 2011). Interventions are implemented in a non-voluntary
254 context imposed on parents (Rooney, 2009) and this legal context has an impact on their
255 self-esteem. Parents are pressured, formally or informally, to engage in services that they
256 have neither requested nor chosen, and that they generally see as unneeded or
257 unnecessary (Rooney, 2009). Consequently, they perceive such interventions as a form of
258 humiliation, resent the guilty verdict pronounced, feel powerless, and experience a loss of
259 personal, family and social recognition (Poissant, 2014). There is often a gap between
260 what these parents experience (helplessness, shame) and what they show (indifference,
261 anger). This may manifest itself in a refusal to recognize and accept intervention, or as
262 resistance and a closed attitude (Dale, 2004). With decisions being made for them and
263 faced with multiple and extensive requests for change, parents often give up and
264 disengage from the child.

265 In this non-voluntary context, it is particularly crucial that the speech language
266 pathologist (SLP) and all other clinicians involved with the child and family take the time
267 needed to establish a quality therapeutic alliance with parents. The therapeutic alliance can
268 be conceived of as the organizing principle guiding the relationship between the clinician
269 and parents in the clinical-relational process. It involves a therapeutic relationship of trust

270 (affective bond) that fosters shared decision making. The aim is for the clinician and
271 parents to develop a common view of the problem to be resolved, the goals of the
272 intervention, and the explicit tasks and intervention intensity required to meet these goals
273 (Sylvestre & Gobeil, accepted). Making decisions together helps the parents find their own
274 answers, experience a sense of internal control, and evolve towards new perspectives and
275 the confidence that they can care for themselves and their children (Riley, 2002). It
276 encourages adherence to the treatment and helps retain neglectful families within the
277 services (Selp, Bougatsos, Blazina, & Nelson, 2013; Serbati, Gioga, & Milani, 2012).

278 Home-visit sessions are considered the best approach for establishing such a
279 therapeutic alliance (Tosh, Arnott, & Scarinci, 2017). Offering in-home services to parents
280 who are socially isolated or impoverished increases their sense of control and comfort,
281 resulting in their greater openness to the relationship with the clinician (Peacock, Konrad,
282 Watson, Nickel, & Muhajarine, 2013). Research suggests that home visits are the most
283 likely to reach very vulnerable families and lead to positive changes at the parental and
284 child development levels, particularly with regard to language development (Avelar &
285 Supplee, 2013; Selph et al., 2013; Serbati et al., 2012). Home interventions promote the
286 generalization of acquired knowledge (Brunk, Henggeler, & Whelan, 1987). They also
287 appear to be the most effective way to avoid the recurrence of child neglect (DePanfilis,
288 2006).

289 To effectively provide community and home-based services, there is also a need
290 to foster intersectoral collaboration between the institutional and community resources
291 supporting adults, families and those working to protect children (DePanfilis, 2006;
292 Jancarik, 2012; Menear et al., 2020). The objective of such collaboration is to optimize

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293 the environmental structures that influence individual behavior, with a focus on the
294 synergy of multilevel interventions rather than any particular intervention in isolation
295 (Biglan, Flay, Embry, & Sandler, 2012). The success of this collaboration depends on the
296 capacity of the various stakeholders concerned—those providing special instruction,
297 family training, occupational or physical therapy, psychological services, speech-
298 language pathology—to work as a team, forming an alliance, not only with each other,
299 but also with the parents. Seeing parents as an integral part of the team promotes the
300 development of their sense of competence. Their participation in decision making about
301 needs and services reinforces their adherence to intervention (Fragasso, Pomey, &
302 Careau, 2018). However, the challenges linked to the implementation of such
303 initiatives—within institutional frameworks based on the organizing principle of
304 delivering services in silos and defining these services around individuals who present
305 difficulties (children and parents) rather than around families and communities (Honta,
306 2019)—are considerable. This points to the important role of a service coordinator who
307 can help the families and clinicians navigate the intervention process and ensure that the
308 needed services are provided (Child Welfare Information Gateway, 2018)

309 Best practices with regard to child neglect also provide for the presence of a
310 pivotal clinician, a significant figure with whom the family can especially develop this
311 high quality therapeutic alliance. This ensures the transfer of learning, consistency in the
312 actions of the stakeholders, and continuity in the interventions carried out with the
313 family. This clinician must act as a guide and avoid fueling the family's dependence on
314 protective services. He/She builds on the strengths and development of family

315 empowerment, helping to enable families to solve their own problems and manage their
316 stresses (DePanfilis, 2006).

317 **The importance of evaluation.** The needs of the child and family must be
318 assessed in a comprehensive manner, incorporating knowledge on child neglect and its
319 multidimensional nature. All members of the clinical team will assess the full range of
320 the family's unmet needs and challenges (employment opportunities, education, substance
321 abuse, etc.) as well as the type of neglect involved and its chronic or circumstantial nature
322 (DePanfilis, 2006; Hearn, 2010). Risk and protective factors must be identified, the latter
323 acting as a buffer between the risk factors and the child's development. Each clinician,
324 according to his/her specialized expertise, should participate in assessing the child's
325 development. The SLP will thoroughly assess the child's strengths and developmental
326 needs in the language sphere. He/She will also observe the parental behaviors directly
327 related to language development—in particular, the parents' sensitivity, responsivity and
328 reciprocity—and determine their level of adjustment to the developmental needs of the
329 child.

330 These actions will give rise to (1) an Individual Education Program (IEP:
331 <https://ectacenter.org/topics/iep/iep.asp>) for the child and (2) an Individualized Family
332 Service Plan (IFSP: <https://ectacenter.org/topics/ifsp/ifspprocess.asp>) for the family.
333 These plans must reflect a common vision, a consensus within the clinical team about the
334 child's developmental needs, the parents' capacities to meet them, and the resources and
335 obstacles present in their environment. This shared vision will allow the different
336 professionals to clarify the messages communicated among themselves and with the
337 family (Serbati et al., 2012), share responsibilities with regard to the child, and

338 collaborate to ensure the latter's well-being and optimal development (Lacharité, 2019).
339 Outcomes must also be identified and should describe the context (family routines or
340 activities that will provide the opportunity to work on outcomes) and the "end point" (the
341 measurable or observable skills and behaviors that mark successful completion; Child
342 Welfare Information Gateway, 2018).

343 This assessment must also be continuous, in terms of analyzing both the child's
344 developmental needs and the ability of his/her parents, family and different environments
345 to respond to them adequately. This is necessary in order to adapt the intervention to the
346 progress made, and the progress that remains to be made, and thus ensure follow-up that
347 will lead to change (DePanfilis, 2006).

348 **Specific intervention targets to be prioritized based on evaluation results.**

349 Intervention strategies must focus on both the child, aiming to ensure the child's
350 safety while promoting his/her development (DePanfilis, 2006), and the parents, helping
351 to enable them to meet the needs of their family (DePanfilis, 2006; Jancarik, 2012).
352 Interventions aimed at promoting the language development of children who experience
353 neglect should foster the emergence of parental behaviors that are favorable to the child's
354 development, while promoting the parents' sensitivity, responsivity and reciprocity and
355 strengthening their sense of parental competence. Children's language stimulation can be
356 improved by an intensive approach at home, based on modeling and coaching (Gershater-
357 Molko, Lutzker, & Sherman, 2002). Specifically, the SLP can model the parental
358 behaviors by interacting with the child in the presence of the parent (Pinard, Savard, &
359 Côté, 2018). It is important to help parents improve their knowledge of child
360 development and develop realistic expectations for their child (St-Laurent et al., 2008).

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361 Addressing some key questions will give meaning to the new skills. For example, why is
362 this parental behavior favorable to the development of language? How does the child
363 react to it? How does this modify the child's language productions? This information will
364 also help to stabilize the use of the new skills. Video feedback can be used, as it is a
365 proven method to promote parental awareness and encourage the adoption of desired
366 behaviors (Moss et al., 2014).

367 The SLP can provide constructive feedback to the parents, indicating and guiding
368 them towards what is expected. This will enable parents to deepen their knowledge and
369 skills (van de Ridder, Stokking, Mcgaghie, & Ten cate, 2008). By commenting on what is
370 positive and what needs to be improved, the SLP can encourage change. Feedback can be
371 given during or following direct observations, or focus on a topic by synthesizing
372 multiple observations (Weinstein, 2015). Following constructive feedback, parents
373 should know where they stand in relation to a given behavior, where they should be and
374 how to go about getting there (Ramani, 2015).

375 Jancarik (2012) also suggests that the clinical team offer group interventions that
376 address psychological needs, sensitivity to the child, and the problem-solving skills
377 employed in parenting. This will promote healthy family functioning and a better
378 definition of family roles (Lacharité, Fafard, & Bourassa, 2005). It is also very important
379 to consider the family's social and environmental network, which can act as a support
380 system for positive parenting (Serbati et al., 2012). Such groups can be made the
381 responsibility of the SLP, thus focusing the content on behaviors that are favorable to
382 language development. The SLP can also participate on an ad hoc basis in a group of
383 parents led by another member of the clinical team, acting as a coach for other

384 stakeholders. The nature and extent of the involvement will be decided by the clinical
385 team so as to meet priority needs as set out in the intervention plans.

386 Another way that the children can be exposed to normative learning situations is
387 by attending high quality early childhood care and education programs. Here, it is not
388 enough to provide daycare spaces to guarantee that the children will receive various types
389 of stimulation that tend to be limited within their families. It is also necessary to ensure
390 that the early childhood educators who care for them understand the specific
391 developmental needs of children who experience neglect in order to provide them with an
392 enriching childcare experience (Lacharité, 2019). In this context, the SLP can play a key
393 role by making educators aware of the importance of the adult-child interaction in the
394 child's language development and providing language stimulation strategies tailored to
395 the child's developmental needs. In order to support the adoption of these behaviors, the
396 SLP can also offer guidance to educators, similar to that provided to parents. Finally, of
397 course, direct language therapy interventions with the children deemed to need them,
398 based on the clinical evaluation by a SLP, is essential.

399 **Dosage needed to reach the objectives.** To support improvements in the family's
400 current living situation and remedy the wounds of the past, interventions, adapted to their
401 needs, must be of significant intensity and sufficiently long from 18 to 24 months on
402 average. Some researchers found that the interventions that produced the best results
403 were those that included at least 12 home visits and lasted more than six months (Carr,
404 2014; Macleod & Nelson 2000). The intensity at the beginning of interventions, whether
405 with the child or the parents, has been found to be particularly important (Pauzé, 2018).

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428 between parents or caregivers and children, at home, in childcare settings and out in the
429 community.

430 Defining child neglect in terms of the unmet needs of the child greatly reduces the
431 burden generally placed on parents and thus invites us, as a society, to question how we
432 support parents (Lacharité, 2014; Proctor & Dubowitz, 2014). We must recognize that
433 child neglect is a major concern and engage in a constant struggle against it and its
434 considerable consequences for children’s language development. Being able to
435 communicate effectively must also be recognized as a basic need of children. We must
436 make this a national public health issue. Such a commitment will oblige us to drastically
437 increase proximity prevention services for the most vulnerable families. This is where we
438 can make a real difference. To respond to the urgent need to better protect the health,
439 development and security of all children, governments must commit to adequately
440 supporting the efforts of public health agencies and the stakeholders mobilized in
441 programs and services with proven preventive effectiveness. Governments must also
442 ensure that workers have adequate working conditions and access to the tools they need
443 to fulfill their mandate.

444 The urgency to intervene early to promote the development of children who
445 experience neglect could not be clearer. All must be involved, resolutely engaged in a
446 merciless fight against child neglect. SLPs, given their in-depth expertise in children's
447 language development and in parental behaviors that are favorable to language
448 development, can make a major difference for these children and their communities. SLPs
449 are called upon to use diverse activities as part of the multidimensional intervention

450 necessary to meet the many needs of families experiencing neglect. Our profession must
451 mobilize now.

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Figure 1. Logic model for a public health approach towards supporting the language development of children experiencing neglect

