Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care

NICE guideline: short version

Draft for consultation, June 2015

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

Contents

Introduction

Children are born with a range of innate behaviours to maximise their survival. Among these is attachment behaviour, which allows the child to draw their primary caregivers towards them at moments of need or distress.

Children whose caregivers respond sensitively to the child's needs at times of distress and fear in infancy and early childhood develop secure attachments to their primary caregivers. These children can also use their caregivers as a secure base from which to explore their environment. They have better outcomes than non-securely attached children in social and emotional development, educational achievement and mental health.

Attachment patterns and difficulties in children and young people are largely determined by the nature of the caregiving they receive. Attachment patterns can be adaptations to the caregiving that they receive from all primary caregivers, including birth parents, foster carers, kinship carers and adoptive parents. Repeated changes of primary caregiver, or neglectful and maltreating behaviour from primary caregivers who persistently disregard the child's attachment needs, are the main contributors to attachment difficulties.

Attachment difficulties include insecure attachment patterns and disorganised attachments that often develop into coercive controlling or compulsive caregiving. The term 'attachment difficulties' in this guideline covers the full range of attachment problems, including those that are categorised as attachment disorders in the Diagnostic and statistical manual of mental disorders, 5th edition (DSM-5; reactive attachment disorder and disinhibited social engagement disorder) and the International classification of diseases and related health problems, 10th revision (ICD-10; reactive attachment disorder and disinhibited attachment disorder).

The number of children and young people in the care system has risen in recent years. In March 2014, there were approximately 69,000 looked-after children and young people in England. Children and young people in the care system, or on the edge of care, are at particular risk of attachment difficulties.

This guideline covers the identification, assessment and treatment of attachment difficulties in children (aged 0–12 years) and young people (aged 13–17 years) who are:

- adopted from care (and those adopted in England who are from overseas)
- in special guardianship
- looked after by local authorities in foster homes, residential units and other accommodation
- on the edge of care.

Children and young people in these situations have many needs, including those resulting from maltreatment. This guideline will only address their needs in relation to attachment relationships.

Safeguarding children

Remember that child maltreatment:

- is common
- can present anywhere
- may coexist with other health problems.

See the NICE guideline on child maltreatment for clinical features that may be associated with maltreatment.

Person-centred care

This guideline offers best practice advice on the care of children and young people with attachment difficulties.

People who use healthcare services and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. People should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the person is under 16, their family or foster carers should also be given information and support to help

the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

If a young person is moving between child and adolescent services and adult services, care should be planned and managed according to the best practice guidance described in the Department of Health's Transition: getting it right for young people.

Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people with attachment difficulties. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Committee makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Committee is confident that, given the information it has looked at, most people would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the person about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also ‘Person-centred care’).

Interventions that must (or must not) be used

We usually use ‘must’ or ‘must not’ only if there is a legal duty to apply the recommendation. Occasionally we use ‘must’ (or ‘must not’) if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a ‘strong’ recommendation

We use ‘offer’ (and similar words such as ‘refer’ or ‘advise’) when we are confident that, for the vast majority of people, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, ‘Do not offer…’) when we are confident that an intervention will not be of benefit for most people.

Interventions that could be used

We use ‘consider’ when we are confident that an intervention will do more good than harm for most people, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the person’s values

and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the person.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in section 1.

Principles of care in all contexts

- Ensure that all children, young people and their parents or carers get equal access to interventions for attachment difficulties regardless of their placement (foster, special guardianship, kinship or residential care), whether they
  - are on the edge of care or adopted from care
  - are from a minority ethnic group
  - have a disability or a mental health problem
  - are from the UK or overseas. **[1.1.1]**

- Ensure that the health, education and social care processes and structures surrounding children and young people with attachment difficulties are stable and consistent. This should include:
  - using a case management system to coordinate care and treatment
  - collaborative decision making among all health, education and social care professionals, the child or young person if possible and their parents and carers
  - having the same key worker, social worker or personal adviser throughout the period the child or young person is in the care system or on the edge of care. **[1.1.3]**

Supporting children with attachment difficulties in schools

- Educational psychologists and health and social care provider organisations should work with local authority virtual school heads and designated teachers to develop and provide training courses for teachers of all levels on how:
  - attachment difficulties begin and how they can present in children and young people

- how attachment difficulties affect learning, education and social development
- they can support children and yong people with attachment difficulties. **[1.2.1]**

Assessing attachment difficulties in children and young people in all health and social care settings

- Health and social care provider organisations should train key workers, social care workers, personal advisers and post-adoption support social workers in the care system, as well as workers involved with children and young people on the edge of care, in:
  - recognising and assessing attachment difficulties and parenting quality, including parental sensitivity
  - recognising and assessing multiple socioeconomic factors (for example, low income, single or adolescent parents) that together are associated with an increased risk of attachment difficulties
  - recognising and assessing other difficulties, including coexisting mental health problems and the consequences of maltreatment
  - knowing when and how to refer for evidence-based interventions for attachment difficulties. **[1.3.1]**

Interventions for children and young people on the edge of care

- Health and social care professionals should offer a video feedback programme to the parents of preschool-age children on the edge of care to help them:
  - improve how they nurture their child, including when the child is distressed
  - improve their understanding of what their child's behaviour means
  - respond positively to cues and expressions of the child's feelings
  - behave in ways that are not frightening to the child
  - improve mastery of their own feelings when nurturing the child. **[1.4.1]**

Interventions for children and young people in care and adopted from care

Pre-school age children

- Health and social care professionals should offer a video feedback programme to foster carers and adoptive parents, as described in recommendation 1.4.2. **[1.5.1]**

Primary school-age children

- Consider intensive training and support for foster carers and adoptive parents (see recommendation 1.5.5 and 1.5.6) before the placement and for 9–12 months after, combined with group cognitive and interpersonal skills sessions for the child for the same duration (see recommendation 1.5.7). **[1.5.4]**

Late primary and secondary school-age children

- Consider a group-based training and education programme for foster carers and adoptive parents to maintain stability in the home and help transition to a new school environment (see recommendation 1.5.9), combined with a group-based training and education programme for children and young people to improve social skills and maintain positive peer relationships (see recommendation 1.5.10). **[1.5.8]**

- Modify interventions for young people when needed to allow for:
  - physical and sexual development
  - transition to adolescence
  - re-awakening of emotions about their birth parents or original family.

  Take into account that these factors can complicate therapeutic interventions and relationships with foster carers and adoptive parents. Discuss making contact with their birth parents or original family sensitively. **[1.5.11]**

1 Recommendations

The following guidance is based on the best available evidence. The full guideline [hyperlink to be added for final publication] gives details of the methods and the evidence used to develop the guidance.

Terms used in this guideline

Carer A foster carer, professional carer in residential care, special guardian or kinship carer.

Children Aged 0–12 years.

Designated teacher A teacher who must be appointed by the governing body of all maintained schools, as set out in the Children and Young Persons Act 2008, to promote the educational achievement of looked-after children.

Edge of care This covers children and young people who are at high risk of going into care (for example, because of maltreatment, parental mental health problems or parental substance misuse). This includes those currently living with their birth parents or original family (such as step-parents), and those adopted from care but who are at high risk of returning to care.

Foster care The placement of a child or young person with a foster carer, who may or may not be related to the child or young person. This might be an emergency, short-term or long-term placement in a private family home.

In the care system This covers all children and young people looked after by a local authority, including those subject to care orders under section 31 of the Children Act 1989 and those provided with accommodation under section 20.

Kinship care Care provided by adults who have a relationship with or connection to the child or young person, including grandparents, siblings, aunts, uncles, godparents or step-grandparents. Kinship care includes children and young people living in an informal arrangement, looked after by the local authority and placed with kinship foster carers or special guardians, or in an arrangement planned to lead to adoption by a relative or friend.

Looked after A child is looked after by a local authority if they have been provided with accommodation for a continuous period of more than 24 hours (in the circumstances set out in sections 20 and 21 of the Children Act 1989), or placed in the care of a local authority by virtue of an order made under part 4 of the Act.

Maltreatment This is physical, sexual or emotional abuse or neglect.

Parent A birth parent, adoptive parent or step-parent who has parental responsibility for a child or young person.

Personal adviser Someone who is responsible, as set out in Children (Leaving Care) (England) Regulations 2001, for making sure that children and young people receive care and support from appropriate services when they leave the care system. They provide advice and support to the child or young person, are involved in preparing a 'pathway plan' (covering health and development, education training and employment, contact wth parents, wider family and friends and managing finances), and are responsible for keeping it up to date.

Placement A home environment, whether in a family or residential setting, which may be temporary or permanent for a child or young person who is either voluntarily, or by order of a court, 'looked after' or placed with a view to adoption by a local authority.

Post-adoption support worker A social worker or family support worker who is employed by local authorities and other regulated adoption agencies to assess adoption support needs when requested by an adopted child, their adoptive parents or former guardians, and who provides appropriate services if needed.

Residential care Care provided under the Children Act 1989 in a children's home run by a local authority, voluntary or private provider, where 1 or more children or young people are cared for by a team of employed staff.

Special guardianship care Under the Children Act 1989, special guardianship is a legally secure placement for children and young people who cannot live with their birth parents that confers parental responsibility on the special guardian.

Virtual school head An officer who must be appointed by local authorities, as set out in the Children and Families Act 2014, who ensures that the authority properly carries out its duty to promote the educational achievement of its looked-after children.

Young people Aged 13–17 years.

1.1 Principles of care in all contexts

Ensuring equal access to consistent care

1.1.1 Ensure that all children, young people and their parents or carers get equal access to interventions for attachment difficulties regardless of their placement (foster, special guardianship, kinship or residential care), whether they:

- are on the edge of care or adopted from care
- are from a minority ethnic group
- have a disability or a mental health problem
- are from the UK or overseas.

1.1.2 Assess all children and young people who enter the UK as unaccompanied immigrants for attachment difficulties once a stable placement has been found, and offer interventions and support if needed.Take into account that, in addition to attachment difficulties, children and young people who enter the UK as unaccompanied immigrants are highly likely to have been traumatised, especially when coming from war zones. If they have post-traumatic stress disorder, offer treatment in line with the NICE guideline on post-traumatic stress disorder.

1.1.3 Ensure that the health, education and social care processes and structures surrounding children and young people with attachment difficulties are stable and consistent. This should include:

- using a case management system to coordinate care and treatment
- collaborative decision making among all health, education and social care professionals, the child or young person if possible and their parents and carers
- having the same key worker, social worker or personal adviser throughout the period the child or young person is in the care system or on the edge of care.

1.1.4 Ensure that the stability or instability of the child or young person's placement does not determine whether psychological interventions or other services are offered.

Improving the stability of placements

1.1.5 Ensure that, whenever possible, children and young people enter the care system in a planned manner rather than in response to a crisis.

1.1.6 Ensure carers are ready to accept the child or young person's need to be in a loving relationship and are able and willing to consider longer-term care or involvement if needed.

1.1.7 Help arrange kinship placements, if safe and in the best interest of the child or young person.

1.1.8 Consider comprehensive education and training for potential carers to prepare them for the challenges involved in looking after children and young people with attachment difficulties and the likely impact on them and their families.

1.1.9 Provide ongoing support and advice to carers when needed, either by telephone or in person.

1.1.10 Proactively monitor difficulties in placements to identify opportunities to provide additional support if there are significant attachment difficulties or if disruption to the placement is likely.

Preparing the child or young person before they enter the care system or change placement

1.1.11 Actively involve children and young people, and their parents or current carers, in the process of entering the care system or changing placement. This may include:

- explaining the reasons for the move

- familiarising the child or young person with their new carers and placement (for example, by arranging a pre-placement visit or showing them photographs of their new carers and home)
- providing ongoing support during transitions
- making sure the child or young person has the opportunity to ask questions and make choices whenever appropriate and possible
- supporting the child in maintaining relationships with their parents or previous carers for as long as they feel the need to
- taking account of the needs of children at different ages and developmental stages, including needs related to their mental health and any physical disabilities.

Improving the likelihood of a more permanent placement, including adoption

1.1.12 Keep siblings together if it is possible and in the best interests of all the children or young people.

1.1.13 Consider providing additional support and resources (such as mentoring or day visits with a social worker) to children and young people and/or their carers:

- at the first sign of serious difficulties in the placement
- if there have been frequent changes of placement.

Preserving the personal history of children and young people

1.1.14 Social care workers should consider giving children and young people in the care system, or adopted from care, accurate, comprehensive and age-appropriate information about their history and family in a form that they are able to use and revisit at their own pace (for example, through photographs and life story work in line with the NICE guideline on looked after children and young people).

1.1.15 Social care workers should consider keeping a record of the significant people and places in the child or young person's life while they are in the care system.

Safeguarding and monitoring

1.1.16 Ensure safeguarding is maintained during any intervention for a child or young person with attachment difficulties.

1.1.17 Consider monitoring the effects of interventions using routine outcome measurement that includes parenting quality and parental sensitivity.

Pharmacological interventions

1.1.18 Do not treat attachment difficulties with pharmacological interventions. For the use of pharmacological interventions for coexisting mental health problems, see for example, antisocial behaviour and conduct disorders in children and young people, attention deficit hyperactivity disorder, depression in children and young people and alcohol-use disorders.

1.2 Supporting children and young people with attachment difficulties in schools

1.2.1 Educational psychologists and health and social care provider organisations should work with local authority virtual school heads and designated teachers to develop and provide training courses for teachers of all levels on how:

- attachment difficulties begin and how they can present in children and young people
- attachment difficulties affect learning, education and social development
- they can support children and young people with attachment difficulties.

1.2.2 Staff in education settings and health and social care professionals should work together to ensure that children and young people with attachment difficulties:

- can access child and adolescent mental health services (CAMHS) and education psychology services for interventions
- are supported at school while they are taking part in interventions following advice from CAMHS or an educational psychologist.

1.2.3 Schools and other education providers should ensure that children and young people in the care system who have attachment difficulties feel safe and supported at school by ensuring that the designated teacher:

- is aware of and keeps accurate and comprehensive records about all children and young people in their school who:
  - are in the care system
  - have been adopted
  - have or may have attachment difficulties
- has contact details for the parents, carers and health and social care professionals for all the above groups
- maintains an up-to-date plan (a personal education plan for children and young people in the care system) setting out how they will be supported in school
- provides a key person who can advocate for the child and to whom the child can go for support.

- allocates a safe place in school, for example a room where a child or young person can go if they are distressed
- attends looked-after children reviews.

1.2.4 Social care professionals, schools and other education providers should ensure that changes or gaps in the education of children and young people in the care system are avoided by:

- helping them to keep attending school when there are changes to their placements
- supporting them while they develop new relationships and if they are worried about the new placement.

If a change is unavoidable, it should be planned in advance so that disruption is minimal.

1.2.5 Schools and other education providers should avoid using permanent and fixed-term school exclusion as far as possible for children and young people with attachment difficulties.

1.3 Assessing attachment difficulties in children and young people in all health and social care settings

1.3.1 Health and social care provider organisations should train key workers, social care workers, personal advisers and post-adoption support social workers in the care system, as well as workers involved with children and young people on the edge of care, in:

- recognising and assessing attachment difficulties and parenting quality, including parental sensitivity
- recognising and assessing multiple socioeconomic factors (for example, low income, single or adolescent parents) that together are associated with an increased risk of attachment difficulties
- recognising and assessing other difficulties, including coexisting mental health problems and the consequences of maltreatment

- knowing when and how to refer for evidence-based interventions for attachment difficulties.

1.3.2 Health and social care professionals should offer a child or young person who may have attachment difficulties, and their parents or carers, a comprehensive assessment before any intervention, covering:

- personal factors, including the child or young person's attachment pattern and relationships
- factors associated with the child or young person's placement, such as history of placement changes, access to respite and trusted relationships within the care system or school
- the child or young person's educational experience and attainment
- parental sensitivity
- parental factors, including conflict between parents (such as domestic violence and abuse) and parental drug and alcohol misuse or mental health problems.
- the child or young person's experience of maltreatment or trauma
- the child or young person's physical health
- coexisting mental health problems and neurodevelopmental conditions commonly associated with attachment difficulties, including antisocial behaviour and conduct disorders, attention deficit hyperactivity disorder, autism, anxiety disorders (especially post-traumatic stress disorder) and depression.

1.3.3 Offer children and young people who have or may have attachment difficulties, and who also have a mental health problem or neurodevelopmental condition, interventions as recommended in the relevant NICE guideline (for example, antisocial behaviour and conduct disorders in children and young people, attention deficit hyperactivity disorder, autism, post-traumatic stress disorder, social

anxiety disorder, depression in children and young people and alcohol-use disorders).

1.3.4 Consider using the following assessment tools to guide decisions on interventions for children and young people who have or may have attachment difficulties:

- Strange Situation Procedure for children aged 1–2 years
- modified versions of the Strange Situation Procedure for children aged 2–4 years (either the Cassidy Marvin Preschool Attachment Coding System or the Preschool Assessment of Attachment)
- Attachment Q-sort for children aged 1–4 years
- Manchester Child Attachment Story Task and McArthur Story Stem for children aged 4–7 years
- Child Attachment Interview for children and young people aged 7–15 years
- Adult Attachment Interview for young people (aged 15 years and over) and their parents or carers.

See the table in appendix 1 for further information about these tools.

1.3.5 Consider using a parental sensitivity tool, for example the Ainsworth Maternal Sensitivity Scale, to guide decisions on interventions for children and young people who have or may have attachment difficulties and to monitor progress.

1.3.6 Only diagnose an attachment disorder if a child or young person has attachment difficulties that meet diagnostic criteria as defined in the Diagnostic and statistical manual of mental disorders, 5th edition (DSM-5; reactive attachment disorder and disinhibited social engagement disorder) or the International classification of diseases and related health problems, 10th revision (ICD-10; reactive attachment disorder and disinhibited attachment disorder).

1.3.7 Do not offer genetic screening (including measuring specific gene polymorphisms) in children and young people to predict or identify attachment difficulties.

1.3.8 If, following assessment of attachment difficulties, an intervention is required, refer the child or young person, and their parents or carers, to a service that:

- has specialist expertise in attachment difficulties in children and young people and their parents or carers
- is integrated with other services, including CAMHS, education and social care
- actively involves children and young people with attachment difficulties in staff training programmes.

1.4 Interventions for attachment difficulties in children and young people on the edge of care

This section covers children and young people with attachment difficulties (or at risk of attachment difficulties) who currently live with their birth parents or original family and who are at high risk of entering the care system. It also covers children and young people who have been maltreated or are at high risk of being maltreated (see recommendations 1.4.9, 1.4.10 and 1.4.12).

Preschool-age children

1.4.1 Health and social care professionals should offer a video feedback programme to the parents of preschool-age children on the edge of care to help them:

- improve how they nurture their child, including when the child is distressed
- improve their understanding of what their child's behaviour means
- respond positively to cues and expressions of the child's feelings
- behave in ways that are not frightening to the child
- improve mastery of their own feelings when nurturing the child.

1.4.2 Ensure video feedback programmes are delivered in the parental home by a trained health or social care worker who has experience of working with children and young people and:

- consist of 10 sessions (each lasting at least 60 minutes) over 3–4 months
- include filming the parents interacting with their child for 10–20 minutes every session
- include the health or social care worker watching the video with the parents to:
  - highlight parental sensitivity, responsiveness and communication
  - highlight parental strengths
  - acknowledge positive changes in the behaviour of the parents and child.

1.4.3 If there is little improvement to parental sensitivity and the child's attachment after 10 sessions of a video feedback programme, arrange a multi-agency review before going ahead with more sessions or other interventions.

1.4.4 If parents do not want to take part in a video feedback programme, offer parental sensitivity and behaviour training to help them:

- understand their child's behaviour
- improve their responsiveness to their child's needs
- manage difficult behaviour.

1.4.5 Ensure parental sensitivity and behaviour training:

- first consists of a single session with the parents followed by at least 5 (and up to 15) weekly or fortnightly parent–child sessions (lasting 60 minutes) over 6 months
- is delivered by a trained health or social care professional
- includes:
  - coaching the parents in behavioural management (for children aged 0–18 months) and limit setting
  - reinforcing sensitive responsiveness
  - ways to improve parenting quality
  - homework to practise applying new skills.

1.4.6 If parents do not want to take part in a video feedback programme or parental sensitivity and behaviour training, or if there is little improvement to parental sensitivity and the child's attachment after either intervention and there are still concerns, arrange a multi-agency review before going ahead with more interventions.

1.4.7 If the multi-agency review concludes that further intervention is appropriate, consider a home visiting programme to improve parenting skills delivered by a trained lay home visitor or a healthcare professional such as a nurse.

1.4.8 Ensure home visiting programmes:

- consist of 12 weekly or monthly sessions (lasting 30–90 minutes) over a period of up to 18 months
- include observing the child (not using video) with their parents
- give the parents advice about how they can improve their communication and relationship with their child by:
  - supporting positive parent–child interaction using role modelling
  - reinforcing positive interactions and parental empathy
- provide parental education and guidance about child development.

Preschool-age children who are at risk of maltreatment

1.4.9 Consider parent–child psychotherapy for parents at risk of maltreating their child, ensuring that safeguarding concerns are addressed.

1.4.10 Ensure parent-child psychotherapy:

- is based on the Cicchetti and Toth model[1]

[1]Cicchetti D, Rogosch FA, Toth SL (2006) Fostering secure attachment in infants in maltreating families through preventive interventions. Development and Psychopathology 18: 623–49 and Toth SL, Maughan A, Manly JT et al. (2002) The relative efficacy of two interventions in altering maltreated preschool children's representational models: implications for attachment theory. Development and Psychopathology 14: 877–908.

- consists of weekly sessions (lasting 45–60 minutes) over 1 year
- is delivered in the parents' home by a therapist trained in the intervention
- directly observes the child and the parent–child interaction
- explores the parents' understanding of the child's behaviour
- explores the relationship between the emotional reactions of the parents and perceptions of the child, and the parents' own childhood experiences.

Primary and secondary school-age children and young people

1.4.11 Offer parental sensitivity and behaviour training to parents of primary and secondary school-age children and young people (as described in recommendation 1.4.5), adapting the intervention for the age of the child or young person.

Primary and secondary school-age children and young people who have been maltreated

1.4.12 For children and young people who have been maltreated, and show signs of trauma or post-traumatic stress disorder, offer trauma-focused cognitive behavioural therapy, and other interventions in line with the NICE guideline on post-traumatic stress disorder.

1.5 Interventions for attachment difficulties in children and young people in the care system and adopted from care

This section covers children and young people with attachment difficulties (or at risk of attachment difficulties) who are in the care system or adopted from care, and their foster carers and adoptive parents. Recommendations in this section might also be relevant to children and young people in kinship or special guardianship care, and their kinship carers or special guardians.

Preschool-age children

1.5.1 Health and social care professionals should offer a video feedback programme to foster carers and adoptive parents, as described in recommendation 1.4.2.

1.5.2 If there is little improvement to parental sensitivity and the child's attachment after 10 sessions of a video feedback programme, arrange a multi-agency review before going ahead with more sessions or other interventions.

1.5.3 If foster carers or adoptive parents do not want to take part in a video feedback programme, offer parental sensitivity and behaviour training as described in recommendation 1.4.5.

Primary school-age children

1.5.4 Consider intensive training and support for foster carers and adoptive parents (see recommendations 1.5.5 and 1.5.6) before the placement and for 9–12 months after, combined with group cognitive and interpersonal skills sessions for the child for the same duration (see recommendation 1.5.7).

1.5.5 Ensure intensive training for foster carers and adoptive parents includes:

- behavioural management methods
- help with peer relationships for the child
- support for schoolwork
- help to defuse conflict.

1.5.6 Ensure intensive support for foster carers and adoptive parents includes:

- supervision by daily telephone contact
- weekly support group meetings
- a 24-hour crisis intervention telephone line.

1.5.7 Ensure group cognitive and interpersonal skills sessions for children after placement:

- consist of weekly sessions (lasting 60–90 minutes) over the 9–12-month period
- are delivered by a trained health and social care professional
- include monitoring of behavioural, social and developmental progress.

Late primary and secondary school-age children

1.5.8 Consider a group-based training and education programme for foster carers and adoptive parents to maintain stability in the home and help transition to a new school environment (see recommendation 1.5.9), combined with a group-based training and education programme for children and young people to improve social skills and maintain positive peer relationships (see recommendation 1.5.10).

1.5.9 Ensure group-based training and education programmes for foster carers and adoptive parents:

- consist of twice-weekly sessions (lasting 60–90 minutes) for the first 3 weeks then weekly sessions over the remaining school year
- are delivered by a trained facilitator
- have a behavioural reinforcement system to encourage adaptive behaviours across home, school, and community settings
- provide weekly telephone support if needed
- give homework to practise applying new skills.

1.5.10 Ensure training and education programmes for children and young people:

- consist of weekly sessions (lasting 60–90 minutes) over the school year

- are delivered by trained mentors, which may include graduate level workers
- teach skills to help reduce involvement with peers who may encourage misbehaviour, and to increase their levels of self-confidence
- encourage them to get involved in a range of educational, social, cultural and recreational activities
- help them develop a positive outlook.

1.5.11 Modify interventions for young people when needed to allow for:

- physical and sexual development
- transition to adolescence
- re-awakening of emotions about their birth parents or original family.

Take into account that these factors can complicate therapeutic interventions and relationships with foster carers and adoptive parents. Discuss making contact with their birth parents or original family sensitively.

1.6 Interventions for children and young people in residential care

1.6.1 Professionals with expertise in attachment difficulties should:

- work with the residential staff group and identify any key attachment figures to work specifically with the child or young people in residential care
- offer parental sensitivity and behaviour training adapted for professional carers in residential care.

1.6.2 Ensure parental sensitivity and behaviour training for professional carers:

- first consists of a single session with the carers followed by at least 5 (and up to 15) weekly or fortnightly carer–child sessions (lasting 60 minutes) over 6 months
- is delivered by a trained health or social care professional
- includes:
  - coaching the residential carers in behavioural management (for children aged 0–18 months) and limit setting
  - reinforcing sensitive responsiveness
  - ways to improve caring quality
  - homework to practise applying new skills.

1.6.3 Modify interventions for young people when needed to allow for:

- physical and sexual development
- transition to adolescence
- re-awakening of emotions about their birth parents or original family.

Take into account that these factors can complicate therapeutic interventions and relationships with professional carers. Discuss making contact with their birth parents or original family sensitively.

2 Research recommendations

The Guideline Committee has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and the care and treatment people receive in the future. The Guideline Committee's full set of research recommendations is detailed in the full guideline.[hyperlink to be added for final publication]

2.1 Screening assessment tools

Develop reliable and valid screening assessment tools for attachment and sensitivity that can be made available and used in routine health and social care.

Why this is important

Validated attachment and sensitivity tools are needed. They must be sensitive enough to detect children and young people at risk of attachment difficulties and changes in behaviour in response to an attachment-based intervention.

The window of opportunity to intervene before a child develops attachment difficulties is small, therefore the sensitivity tool should have strong psychometric properties.

Tools are needed for assessing sensitivity and attachment for biological parents and foster or adoptive parents of children and young people across all groups (0–17 years).

The tool must be readily available and able to be used in routine and social care settings before and after an intervention.

A cohort study is needed to validate any tool (new or existing) that can identify children and young people who have attachment difficulties at different ages. The study should include the following outcomes:

- sensitivity and specificity
- predictive validity (more than 12 months for outcomes such as behavioural problems and ongoing attachment difficulties).

A cohort study is also needed to validate any tool (new or existing) that can measure the sensitivity of parenting (by biological parents and new carers and adoptive parents) in relation to the child (of any age). The study should include the outcomes listed above.

2.2 Attachment-focused interventions

Develop attachment-focused interventions to treat attachment difficulties in children aged over 5 years and young people who have been adopted or are in the care system.

Why this is important

Attachment-focused interventions targeting adoptive parents, carers and children and young people are scarce. Most studies have targeted families of children on the edge of care and the evidence suggests some interventions are effective, so it is important to know whether similar, albeit appropriately adapted, interventions will work with other populations.

The majority of the evidence to date has been collected in non-UK settings that have different healthcare systems and types of care provided. For NICE guidelines it is important that more studies are carried out in a relevant UK setting.

Even less evidence is available on children aged over 5 years and young people, therefore attachment-focused interventions should consider targeting this age group.

A randomised controlled trial should be carried out to compare the clinical and cost effectiveness of attachment-focused interventions to treat attachment difficulties in children aged over 5 years and young people who have been adopted or are in the care system.

The intervention (that is, parental sensitivity and education training) should target the adoptive parents and carers with or without the children. Primary outcome measures may include:

- attachment

- parental sensitivity
- placement disruption
- educational performance
- behavioural problems.

There should be at least a 6-month to 1-year follow-up. Qualitative data may also be collected on the parents' and child's experiences of the intervention.

2.3 Evaluation of extensively used interventions

Evaluate currently unevaluated but extensively used interventions for attachment difficulties.

Why this is important

Various interventions are currently used to help address attachment difficulties that may be clinically effective, but without good quality evidence they cannot be considered by NICE.

A randomised controlled trial should be carried out that compares currently unevaluated interventions with an evidenced-based treatment for attachment difficulties.

Primary outcome measures may include:

- attachment
- parental sensitivity
- placement disruption
- educational performance
- behavioural problems.

There should be at least a 6-month to 1-year follow-up. Potential harms also need to be captured. Qualitative data may also be collected on the parents' and child's experience of the intervention.

2.4 Interventions to promote secure attachment

Develop attachment-based interventions to promote secure attachment in children and young people who have been, or are at risk of being, maltreated.

Why this is important

There is limited evidence on attachment-based interventions targeting attachment difficulties and parental sensitivity in children and young people who have been, or are at risk of being, maltreated. Maltreatment is strongly associated with children entering care. If ways to improve the parent-child relationship and prevent maltreatment can be identified, the likelihood of children and young people entering care and having attachment difficulties can be minimised.

The majority of the evidence to date has been collected in non-UK settings that have different healthcare systems and types of care provided. For NICE guidelines it is important that more studies are carried out in a relevant UK setting.

In addition, evidence from groups aged 11–17 years is limited, so age-appropriate interventions targeting this age group are needed.

A randomised controlled trial should be carried out to compare the clinical and cost effectiveness of an attachment-based intervention to promote secure attachment in children and young people who have been, or are at risk of being, maltreated, with usual care.

The intervention may target the child and/or the parent depending on the type of maltreatment (for example, sexual abuse or neglect). Primary outcome measures may include:

- attachment
- parental sensitivity
- placement disruption
- educational performance
- behavioural problem
- ongoing maltreatment.

There should be at least a 6-month to 1-year follow-up. Qualitative data may also be collected on the parents and child’s experience of the intervention.

2.5 Interventions in a school setting

Assess the clinical and cost effectiveness of an attachment-based intervention delivered in a school setting for children and young people on the edge of care, in the care system or adopted.

Why this is important

Providing an attachment-based intervention in a school setting is important for 3 reasons: teachers may be the first to identify some of the broader problems associated with attachment difficulties in children and young people; school may be one of the only stable environments for children and young people moving in and out of care; and school may provide a safe environment for the child or young person to take part in a therapeutic intervention.

The majority of the evidence to date has been collected in non-UK settings that have different healthcare systems and types of care provided, therefore it is important that more studies are carried out in a relevant UK setting. In addition, evidence on young people is limited, therefore age-appropriate interventions targeting attachment difficulties in this age group are needed.

A randomised controlled trial should be carried out to assess the clinical and cost effectiveness of an attachment-based intervention that can be delivered in a school setting for children and young people on the edge of care, in the care system or adopted. The intervention should be deliverable by teachers within the school setting. It should focus on improving the functioning of children and young people with attachment difficulties within the school setting, as well as more widely, and increasing the skills of teachers to meet the children and young people's needs.

Primary outcome measures may include:

- attachment
- teacher sensitivity
- placement disruption
- educational performance
- behavioural problems.

There should be at least a 6-month to 1-year follow-up. Qualitative data may also be collected on the child or young person's experience of the intervention.

3 Other information

3.1 Scope and how this guideline was developed

NICE guidelines are developed in accordance with a scope [add hyperlink] that defines what the guideline will and will not cover.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Committee (see section 4), which reviewed the evidence and developed the recommendations.

The methods and processes for developing NICE guidelines are described on the NICE website.

3.2 Related NICE guidance

Details are correct at the time of consultation on the guideline (XXX 20XX). Further information is available on the NICE website.

Published

- Antenatal and postnatal mental health (2014) NICE guideline CG192
- Antisocial behaviour and conduct disorders in children and young people (2013) NICE guideline CG158
- Looked-after children and young people (2010) NICE guideline PH28
- Pregnancy and complex social factors (2010) NICE guideline CG110
- Alcohol-use disorders – preventing harmful drinking (2010) NICE guideline PH24
- Reducing uptake in the uptake of immunisations (2009) NICE guideline PH21

- Social and emotional wellbeing in secondary education (2009) NICE guideline PH20
- When to suspect child maltreatment (2009) NICE guideline CG89
- Schizophrenia (2009) NICE guideline CG82
- Borderline personality disorder (2009) NICE guideline CG78
- Antisocial personality disorder (2009) NICE guideline CG77
- Social and emotional wellbeing in primary education (2008) NICE guideline PH12
- Attention deficit hyperactivity disorder (2008) NICE guideline CG72
- Behaviour change: the principles for effective interventions (2007) NICE guideline PH6
- Interventions to reduce substance misuse among vulnerable young people (2007) NICE guideline PH4
- Prevention of sexually transmitted infections and under 18 conceptions (2007) NICE guideline PH3
- Drug misuse: opioid detoxification (2007) NICE guideline CG52
- Obsessive–compulsive disorder and body dysmorphic disorder (2005) NICE guideline CG31
- Depression in children and young people (2005) NICE guideline CG28
- Post-traumatic stress disorder (2005) NICE guideline CG26
- Violence (2005) NICE guideline CG25
- Self-harm (2004) NICE guideline CG9

Under development

NICE is developing the following guidance:

- Challenging behaviour and learning disabilities. NICE guideline. Publication expected May 2015.
- Child abuse and neglect. NICE guideline. Publication date to be confirmed.

4 The Guideline Committee, National Collaborating Centre and NICE project team, and declarations of interests

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4.4 Declarations of interests

The following members of the Guideline Committee made declarations of interests. All other members of the Committee stated that they had no interests to declare.

Member	Interest declared	Type of interest	Decision taken
Sara Barratt	Team Manager – Fostering, Adoption and Kinship Care Team, Tavistock and Portman NHS Trust	Non-personal pecuniary	Declare and participate
Tony Clifford	Member of Institute for Recovery from Childhood Trauma	Personal non-pecuniary	Declare and participate
Tony Clifford	Member of Virtual Head's Action research group	Personal non-pecuniary	Declare and participate
Tony Clifford	Advocated including an attachment module in the Initial Teacher Training curriculum	Personal non-pecuniary	Declare and participate
Pasco Fearon	Research grant from the NSPCC	Non-personal pecuniary	Declare and participate
Pasco Fearon	Executive Board Member of the Society for Emotion and Attachment Studies	Personal non-pecuniary	Declare and participate
Pasco Fearon	Scientific Consultant to the Foundation Years Action Group	Personal non-pecuniary	Declare and participate
Pasco Fearon	One-off financial payment from	Personal	Declare and

	Shire for a workshop on attachment at a London conference, March 2014.	pecuniary	participate
Peter Fonagy	Two adopted children	Personal non-pecuniary	Declare and participate
Danya Glaser	Co-author of 'Understanding attachment and attachment disorders: theory, evidence and practice'	Personal non-pecuniary	Declare and participate
Danya Glaser	Author on NIHR Health Technology Assessment Report 'A systematic review and meta-analysis of the clinical and cost-effectiveness of parenting interventions for children with severe attachment difficulties'	Personal non-pecuniary	Declare and participate
Judith James	Director of Therapeutic Practice, to an independent child-care provider, to children in the looked-after system	Non-personal pecuniary	Declare and participate
Judith James	Director/Trustee of British Association of Play Therapists	Personal non-pecuniary	Declare and participate
Àine Rose Kelly	Conducted research on the attachment of looked-after children and the impact upon eating behaviour in adolescence	Personal non-pecuniary	Declare and participate
Àine Rose Kelly	PhD on looked after children in progress	Personal non-pecuniary	Declare and participate
Àine Rose Kelly	Wellcome Trust grant	Non-personal pecuniary	Declare and participate
Àine Rose Kelly	Fostering panel for Buckinghamshire	Personal non-pecuniary	Declare and participate
Rosemarie Roberts	Director of a service responsible for training and consultation on interventions including multidimensional foster care, initially funded by the Department for Education	Non-personal pecuniary	Declare and participate
David Shemmings	Provider of training in attachment and child protection	Personal pecuniary	Declare and participate
David Shemmings	Author of 'Understanding disorganised attachment' and 'Assessing disorganised attachment behaviour'	Personal non-pecuniary	Declare and participate
Miriam Silver	Director of LifePsychol Ltd, providing clinical psychology services	Personal pecuniary	Declare and participate

Miriam Silver	Director of Evolving Families Ltd	Personal pecuniary	Declare and participate
Miriam Silver	Research grant from the Health Foundation paid through Milton Keynes Hospital Trust	Non-personal pecuniary	Declare and participate
Miriam Silver	Employment with an organisation providing residential care for children	Personal pecuniary	Declare and participate
Doug Simkiss	NIHR Programme Development grant awarded to look at young people in care with mental health concerns	Non-personal pecuniary	Declare and participate

Appendix 1

Tool	Setting	Format	Age (years)	Classification	
				Insecure attachment	Disorganised attachment
Strange Situation Procedure	Clinic	Observation	1–2	Y	Y
Cassidy–Marvin Preschool Attachment Coding System	Clinic	Observation	2–4	Y	Y
Preschool Assessment of Attachment	Clinic	Observation	2–4	Y	Y
Attachment Q-sort	Home	Observation	1–4	Y	N
Manchester Child Attachment Story Task	Any setting	Interviewer-researcher/clinician	4–7	Y	Y
McArthur Story Stem	Any setting	Interviewer-researcher/clinician	4–7	Y	Y
Child Attachment Interview	Any setting	Interviewer-researcher/clinician	7–15	Y	Y
Adult Attachment Interview	Any setting	Interviewer-researcher/clinician	15+ and parents or carers	Y	Y