NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Children's attachment

Date of Quality Standards Advisory Committee post-consultation meeting:
14 July 2016

2 Introduction

The draft quality standard for children's attachment was made available on the NICE website for a 4-week public consultation period between 23 May and 21 June 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 16 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1, 2 and 3.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Implementation relies upon health and social care practitioners with an expertise in attachment difficulties.
- Population and key attachment terminology needs to be more clearly define to explain the differences between attachment disorders and attachment difficulties.
- Need to promote the development of secure and healthy attachment relationships to prevent attachment relationship difficulties.
- Increase age range to 21 years to account for young people with learning disabilities and the responsibilities of local authorities under the Children Leaving Care Act (2000).
- Strengthen and include additional overarching outcomes, such as educational achievement, absences and school exclusions, understanding among carers of the role of schools and the ability to form stable relationships as an adult.
- Lack of services and trained professionals, particularly for adolescents .
- Lack of statements for older children.
- Acknowledge the role of the midwife.

Consultation comments on data collection

- National variability in quality of data collection and reporting.
- Electronic patient records and databases in place in some areas so additional collections would be possible.
- Relies on workforce being skilled in assessments, having IT equipment and budgets.
- Possible if systems and structures were in place.
- Difficulties in measurement as categorisation in the absence of a diagnostic label.

Consultation comments on resource impact

- Achievable, but training needs of staff need to be taken into consideration.

- Additional funding is required to improve delivery of existing intervention programmes.
- Absence of specialist mental health services in some areas.
- Support required from local virtual school, bought in by schools.
- Cost associated with training and accreditation of video feedback programmes.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Children and young people with attachment difficulties, and their parents or carers, have a comprehensive assessment before any referral to specialist services for an intervention.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Attachment difficulties and disorders should be assessed by a qualified and experienced mental health professional.
- Reference should be made to the ages and stages questionnaire used by health visitors.
- Access to specialists is limited in some services and there are gaps in provision for different ages of children.
- Outcomes should include practitioners, children and carers understanding of needs.
- Unaccompanied asylum seeking children should be assessed as soon as possible.
- Assessment should precede identification of the difficulty.
- Assessment should be combined with offer of intervention.
- Assessment of children should be a broad mental health assessment.
- Include recommended questionnaires to aid assessment.
- The definition of comprehensive assessment needs expanding.
- Include the threshold for specialist support after assessment.

Consultation question 5

Which services and practitioners currently carry out comprehensive assessments of children and young people with attachment difficulties?

Stakeholders made the following comments in relation to consultation question 5:

- Mostly within social care; child in need teams or post-permanency teams, or by CAMHS.
- Assessments not generally done.
- Inappropriate for health visitors to do routinely but infant mental health pathways should be in place to allow health visitors to escalate concerns. Funding should be made for training to allow health visitors to identify families at risk.
- Social workers, therapeutic social workers, family therapists, psychologists, child mental health practitioners, specialist educational psychologists, psychotherapists and psychiatrists.

5.2 Draft statement 2

Children and young people with attachment difficulties have an education plan setting out how they will be supported in school.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Role of virtual school is key for supporting children and ensuring consistency.
- Plan can further marginalise children unless within an inclusive school that's supports all children.
- Education staff should have an awareness and basic understanding of attachment approaches.
- Schools should work with specialist agencies to support needs.
- Clarification is required on the name of the education plans and the relationship between it and other 'plans' that children in care should have.
- One stakeholder commented that there would need to be a 10 fold increase in children needing education, health and care plans (EHC). They commented that currently less than 3% pupils get EHC plans.

5.3 Draft statement 3

Parents and carers of preschool age children with or at risk of attachment difficulties are offered a video feedback programme.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Should specify training requirement for professionals.
- Resources are required to account for the time and cost of training.
- Video feedback programme can lead to identification of additional therapeutic needs and referral to specialist services.
- Make clear the relationship between 'at risk' group and suspected group in statement 1.

5.4 Draft statement 4

Health and social care provider organisations provide training, education and support programmes for carers of primary and early secondary school aged children and young people with attachment difficulties

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- The evidence base for the programmes is subject to question.
- Training should not be restricted to those about to provide a placement to a child with attachment difficulties; all foster carers should be trained.
- Carers currently struggle to access training.
- Further detailed definition of programmes is required.
- Refer to ‘developmental age of child’ rather than ‘age of child’.
- Further specify the provider.

Consultation question 6

Is there currently national variation in access to training, education and support programmes for carers of children and young people in care with attachment difficulties provided by health and social care organisations? Are there any specific age groups where provision of this training, education and support for carers is lower than other groups, if so please provide details?

Stakeholders made the following comments in relation to consultation question 6:

- Currently national variation.
- Flexibility is required in delivery of programmes.
- Lack of service for infants, children under 5yrs, school age children and teenagers.
- Highly variable training and support networks for schools.
- Focus on adopters, special guardians and foster carers.
- Lack of services for high risk families.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements:

- At least one member of staff in every school is trained in recognising, supporting and making appropriate referrals for children and young people exhibiting attachment difficulties.
- A statement focussing on the specific attachment needs of looked after young people aged 15-18 years and those leaving care (18-25 years), as psychological difficulties can be heightened when previously stable placements come to an end and the young person makes the transition into independent living.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
1	CoramBAAF	General	This response is being submitted on behalf of the CoramBAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence. Our area of concern is the particularly vulnerable group comprised of looked after and adopted children and young people.
2	Department of Health	General	Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
3	NHS England	General	Thank you for the opportunity to comment on the above QS. I wish to confirm that NHS England have no substantive comments to make regarding this consultation.
4	RCGP	General	This is a worthwhile quality standard. For it to be effective it requires health and social care practitioners who have an expertise in attachment difficulties. Similarly as the guidance states the challenge would be to have an awareness of the regional variation in training, support and video analysis
5	RCN	General	This is to inform you that the RCN has no comments to submit to inform on the above draft quality standard consultation at this time.
6	Royal College of Paediatrics and Child Health	General	The main and really important concern is the difficulty with definition of attachment difficulty (not attachment disorder which is clearly defined) and hence denominators for any meaningful measurement.

[1] PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

7	The Association for Family Therapy and Systemic Practice in the UK	General	It would be helpful, and is important, to include consideration of the prevention of attachment relationship difficulties and the promotion of healthy and secure attachment relationships over time, and the contexts that support this.
8	University of Surrey, Psychology Dept.	General	The guidance defines the age limits of document as being up to 18 years but it would benefit from being up to 21 years for the following reasons: • If a young person has a learning disability their needs should be addressed until they are 19 to align with their education provision • The Children Leaving Care Act (2000) sets out a duty for Local Authorities to support care leavers who are in education until their 21st birthday, including advice and support.
9	Bath Spa University	Introduction	The reference to 'Educational achievement, absences and school exclusions' needs strengthening. Academic literature (see Jackson S (2013) *Pathways through education for young people in care* or Cameron C, Connelly G and Jackson S (2015) *Educating children and young people in care*) is increasingly recognising the crucial role which schools can play in supporting children and young people with significant attachment needs. Cameron (2015) argues that not only do schools need to become more caring communities, but care home staff and foster carers need to develop learning placements, which better support children's aspirations and social interactions at school – including the potential for some school staff to become alternative attachment figures (see Bergin C and Bergin D: *Attachment in the classroom,* Educational Psychology Review, v21 n2 p141-170 Jun 2009) We would therefore suggest the following additional bullet points: Between current bullets 3 and 4 • Better understanding among carers as to the potential role of the school in supporting educational, attachment and other needs After current bullet 8 • Increased capacity in schools to support children and young people with attachment difficulties
10	Bath Spa University	Introduction	add bullet point 1.6 school performance and outcomes
11	Bath Spa University	Introduction	Add 'All Education, public health and social care practitioners … '
12	The Association for Family Therapy and Systemic	Introduction	A richer, relational definition of attachment is required, one that takes into account both the theory about attachment relationships and the neuro-scientific research. A rich, relational definition of attachment is central to a helpful and effective quality standard.

	Practice in the UK		Defining attachment as “a type of behaviour displayed by children to draw their primary caregiver towards them at moments of need or distress” (page 1) only refers to one aspect of attachment. Attachment is a relationship co-constructed over time. A co-constructed neuro-social system including all participants, a relationship between caregiver and child and the system in which they live including family, professional experts and social care agencies. (Ref: Burroughes, C. Attachment and neurobiology, Context 86 (2006); Burroughes, C. Towards a mentally healthy looked after children’s system, Context 87 (2006). Defining attachment as just ‘behaviour’ and within only the child, runs the risk of the child’s behaviour being seen as pathological rather than a successful adaptation to damaging social circumstances. It does not reflect attachment theory or neuro-scientifc research. It tends towards a treatment of the child as pathological, rather than having achieved a successful hard-wired brain adaption to damaging social circumstances. It thus also avoids addressing the corrosive effects on social functioning of poor housing, poor health and low income which lead to children coming into care. (Ref: Dimigen et al (1999), British Medical Journal). A more suitable definition might be: ‘Attachment is the complex co-construction of brain connections and social functioning patterns through intimate relationships, mediated by the wider context of societal conditions’.
13	The Association for Family Therapy and Systemic Practice in the UK	Introduction	“Attachment patterns and difficulties in children and young people are largely determined...” (Page 1). The use of the word ‘determined’ contradicts the understanding of the plasticity of the brain in the context of changed relationships. Linking attachment patterns so closely to difficulties misses the wider context that all people, adults and children (including professionals) have attachment relationships or patterns which may shape, and be shaped by, interactions. These may be on a continuum of security. All attachment patterns need to form the focus of a quality standard for looked after children.
14	The Association for Family Therapy and Systemic Practice in the UK	Introduction	The quality standard is expected to contribute to improvements in the following outcomes: This should include: The ability to form stable relationships as an adult
15	University of Surrey, Psychology Dept.	Introduction	The guidance would benefit from clear definitions of key attachment terms for example ‘insecurely attached’ and ‘parental sensitivity’
16	University of Surrey, Psychology Dept.	Introduction	The guidance gives consideration to the difference between secure and insecure attachment styles but does not refer to a ‘disorganised’ attachment type which has been evidenced in children whose attachment experiences have been profoundly chaotic an abusive (REF)

17	University of Surrey, Psychology Dept.	Introduction	The guidance would benefit from additional recognition of the acquired attachments and losses that Looked After Children and Young People experience through multiple placement breakdowns
18	University of Surrey, Psychology Dept.	Introduction	The guidance would benefit from making reference to how attachment difficulties negatively impacts a child or young person's ability to access and make use of available care and nurture from carers in new placement settings.
19	University of Surrey, Psychology Dept.	Introduction	The reports states' The prevalence of attachment disorders in the general population is not well established, but is likely to be low.' This may not necessarily be the case given the level of psychological distress present in the child and adult populations therefore this statement would benefit from being qualified with evidence.
20	University of Surrey, Psychology Dept.	Introduction	The guidance document would benefit from a stronger statement regarding the evaluation of evidence based interventions. Specifically there should be indication that if services choose to undertake such interventions they should be required to evaluate and evidence findings of their utility. This needs to be made part of the commissioning process with funds allocated to support this development.
21	Royal College of Psychiatrists	Introduction	By conflating children with 'insecure attachment', with 'disorganised attachment' and 'attachment disorders' as "children and young people with attachment difficulties" we are creating a group that represents at least a quarter of the general population of children and the majority of children in care or on the edge of care. Such a group would be way beyond the resources of the current health and social care services (or indeed any conceivable service) to assess or treat. Furthermore the children who should be our greatest priority, which are the children with attachment disorders, are more likely 'get lost in the crowd'.
22	After Adoption	Question 1	We felt that the quality standard offers helpful advice for the younger age group, but is lacking in details and recommendations for interventions for the older age group, especially those who may be out of education. We felt there is a real benefit to dyadic therapeutic work with families with school-age children, and it would be of benefit to consider how practice could be supported in this work. We wondered about how to ensure that attachment needs were recognised widely, as a potential impact for all vulnerable families, not just those where children have been in care, or are on the edge of care.
23	Bath Spa University	Question 1	Add Statement 5: At least one member of staff in every school is trained in recognising , supporting and making appropriate referrals for children and young people exhibiting attachment difficulties
24	Institute of Health Visiting	Question 1	This draft quality standard accurately reflects the key areas for quality improvement, however in addition to the need for comprehensive assessment prior to specialist services, children at risk of attachment disorder require identification. This can be delivered by a comprehensive infant mental health pathway built on the foundation of the Healthy Child Programme. (See Q4, below). We would suggest adding an additional key area for improvement: "All areas require a clear integrated attachment pathway that ensures seamless access and transition between services for children experiencing and at risk of attachment difficulties; this should include prevention and early intervention for at risk groups and commence in the antenatal period"

25	The Association for Family Therapy and Systemic Practice in the UK	Question 1	This needs to be set against a backdrop of high quality care for all looked after children. It is important that assessment is a process that includes how the child is managing the imposition of out of home care. There is a need for training in how to complete the analysis of information contained in a comprehensive assessment. In Salford, comprehensive assessments are carried out by social workers, therapeutic social workers, family therapists, psychologists, child mental health practitioners, specialist educational psychologists, psychotherapists, psychiatrists.
26	The Royal College of Midwives	Question 1	The RCM considers that this quality standard reflects some key areas for quality improvement.
27	The Royal College of Midwives	Question 1	We also think the quality standard should include a discussion about infant mental health. As highlighted by Balbernie (2013) • The first few months and years of life are a sensitive period when children learn about emotions and social interactions in their family • The period in our lives when we are most influenced by what happens to us is the first 3 years, beginning at conception • In the first 3 years of life, we are most dependent upon the environment; and the most important aspect of the environment is defined by relationships • The basic neuronal networks in the developing brain are laid down on a 'use it or lose it' basis such that the architecture of the child's brain will reflect early experiences. Help, when necessary, can be most effectively offered Balbernie, Robin. "The importance of secure attachment for infant mental health." *Journal of Health Visiting* 1.4 (2013): 210-217.
28	University of Surrey, Psychology Dept.	Question 1	The guidance would benefit from an additional statement defining the specific attachment needs of Looked After young people aged 15-18 years and those leaving care (18-25 years) as psychological difficulties can be heightened when previously stable placements come to an end and the young person makes the transition into independent living.
29	After Adoption	Question 2	As a national voluntary adoption agency, it is difficult for us to comment on local reporting procedures. However, we did wonder about how the baseline of children with attachment needs will be identified in the population.
30	Institute of Health Visiting	Question 2	There is national variability in quality of data collection and reporting. Electronic patient records and data collection systems provide the most accurate method and in areas where these are in place, the additional collection of attachment data would be fairly straightforward. However, this relies on practitioners having access to appropriate training in assessing attachment (e.g. Parent Infant Interaction Observation Scale), necessary IT equipment (e.g. Tablets for video recording interactions), sufficient budget to offset additional staffing costs to cover practitioners time and recourse to high

			quality supervision.
31	The Association for Family Therapy and Systemic Practice in the UK	Question 2	No, these are not in place.
32	The Royal College of Midwives	Question 2	We consider it would be possible to collect the data for the proposed quality measures if the systems and structures were in place.
33	After Adoption	Question 3	We know that social workers have considered the NICE guidelines when deciding to refer into our services: for example from one referral we have received *"X has a formal diagnosis of Attachment Disorder. The National Institute for Clinical Excellence suggest several interventions and that these need to be modified for older adolescents. For X I am suggesting a combination of three interventions:* 1. *Group based education programme for parents (Safe Base or equivalent)* 2. *Attachment focused relational work with X and parents (Theraplay or equivalent)* "
34	Bath Spa University	Question 3	See the attachment aware schools programme (http://attachmentawareschools.com/), which is being implemented in a number of local authority virtual schools, including Bath and North East Somerset, Dudley, Haringey, Leicestershire and stoke on Trent. This provides a robust and evidence- informed framework for developing individual school capacity to manage and support children who have significant attachment needs.
35	The Association for Family Therapy and Systemic Practice in the UK	Question 3	Two examples: a) Use of network meetings to ensure everyone in the system contributes to the attachment needs of the child b) Whole school initiatives to develop attachment awareness
36	The Association for Family Therapy and Systemic Practice in the UK	Question 3	We can submit a description of the First Step Model
37	After Adoption	Question 4	We would consider that the first two statements in relation to the need for comprehensive assessments and educational plans would be achievable, but careful consideration will need to be given to the training needs of current staff to enable them to deliver on these standards. In relation to standards 3 & 4, this is likely to require additional funding to widen the delivery of already existing programmes, and train specialist staff.

38	Association of Child Psychotherapists (ACP)	Question 4	Question 4: Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed…..? Local services are under resourced despite promised money linked to service transformation funds and recommendations made in the MH Taskforce report. When local services are stretched or struggling, it appears to be relationships which suffer most. CYP with ADD often need a longer-term and relationship focused approach. This isn't possible in services where most resources are thrown at bringing down waiting times and shorter term interventions. Specialist mental health services for children and young people in care do not exist in all localities.
39	Bath Spa University	Question 4	The development of the attachment aware schools framework across a local authority is dependent upon the support of the local virtual school, a viable support framework, and buy in from individual schools. Our current research proposal has costed this support at the level of an individual Education Psychology post, or equivalent, dependent upon the size and configuration of the particular authority.
40	CoramBAAF	Question 4	There is a wide variety of services currently on offer that have attachment difficulties as their focus but the standard, quality and effectiveness of the offer is highly variable. It is very difficult to anticipate the impact of these quality standards on the future strategic and operational direction of travel. Some areas have had excellent specialist services from CAMHS available in the past but some of these have been lost due to financial constraints. The resources issues previously mentioned apply here as well. The gap in provision of services to adolescents is more significant than younger age groups.
41	Institute of Health Visiting	Question 4	The resources for universal identification of children at risk of attachment difficulties are at risk through insufficient resourcing of the healthy child programme following transfer of commissioning of Children's public health services to Local Authorities and the likely lapse in the mandation of a minimum of 5 reviews of health and development from pregnancy to pre-school entry. The health visiting workforce and specialist health visitors working in Looked after children's teams are well placed to deliver the early identification and attachment screening outlined in this guideline. However, this will only be possible with additional funding to support this very specialised, but extremely important area of work. The long term savings created by intervening early are well documented (James Heckman's return on investment work provides the most robust evidence). To ensure that this work is afforded the priority it deserves I would suggest that it is delivered by Specialist Health Visitors in Infant Mental Health; the requirements for this role are described in the Health Education England Report (2016)
42	The Association for Family Therapy and Systemic	Question 4	There are cost implications for training and accreditation for VIG. Many services offer training, consultation and supervision to carers in a more flexible way than the model prescribed in the guidance.

	Practice in the UK		The age group with the lowest level of support is the 14+ age group.
43	Association of Catholic Nurses England and Wales	Draft statement 1	For Health Visitors the Ages and Stages SE (Social and Emotional) assessment needs to be recognized as an essential early tool to be used alongside ASQ 3 assessments for making an in depth assessment of early attachment problems and used in conjunction with clinical observations on the level and quality of attachment based on Bowlby/Ainsworth 1965 and Main and Solomon 1986 . Parents and carers who are dysfunctional in their parenting behaviours may have difficulties in accepting what they may perceive to be a subjective health professional interpretation of a video recording without other evidence .
44	Association of Child Psychotherapists (ACP)	Draft statement 1	Statement 1: CYP with attachment difficulties... have a comprehensive assessment before any referral to specialist services ... We would argue that attachment Difficulties and Disorders (ADD) need to be assessed by a qualified and experienced mental health professional. This may also be hard to measure in terms of what is judged to be experienced. In some services, there is limited access to specialists who would have an understanding of complexities around attachments and the overlaps with other disorders and diagnoses.
45	Association of Child Psychotherapists (ACP)	Draft statement 1	Example of QSI - Social worker or CAMHS practitioner has better understanding of the child's needs.
46	Association of Child Psychotherapists (ACP)	Draft statement 1	Health and Social Care Practitioners…: Attachment difficulties need to be assessed by qualified and experienced mental health professionals.
47	Association of Child Psychotherapists (ACP)	Draft statement 1	All ...unaccompanied asylum -seeking children should be assessed As soon as practicable (rather than once a stable placement has been found - as this could take a long time and children are left without much needed input.)
48	CoramBAAF	Draft statement 1	The comprehensive assessment of attachment difficulties is a welcome quality standard. But this statement presumes that an attachment difficulty has been identified. Surely an assessment precedes the identification of the difficulty. The key issue here is the range of issues that may be at the core of the child's difficulties with attachment playing a part alongside other possible issues - trauma, ADHD, autism or cognitive impairments etc etc. Assessment also needs to be combined with the local offer of interventions that will help in a timely and evidence informed way. This requires a national strategy coordinated across social care, health and education.
49	CoramBAAF	Draft statement	The document reads as if it is a given that there is an abundance of services available with sufficient capacity of

		1	practitioners with the appropriate competencies to carry out the comprehensive assessment described, whereas in the experience of our members this is far from the reality. The majority of those in the list of health and social care professionals either do not have the required competencies or lack the capacity to carry out such assessments. Where services are provided our members are concerned that these are rarely available to adolescents. We are concerned that very little of the standard can be delivered within the current resource framework. The resource implications of training health and social care professionals to develop competencies in the first instance and then in the second instance to provide the services outlined should be recognised.
50	CoramBAAF	Draft statement 1	As there is considerable local variation in data collection this may not be readily available.
51	Essex Adoption Agency	Draft statement 1	This looks really good. Even within the context of the Adoption Support Fund (recently extended to SGO children who have been in care) post-adoption cases continue to be assessed by the Post-Adoption Team before interventions are arranged. 1. Children subject to SGO who have not been in the care system (e.g. who have gone to live with their Special Guardians directly from their birth families) are not entitled to accessing the Adoption Support Fund and "automatic" assessment, but can still be assessed, of course. 2. The guidelines might want to explicitly mention that "specialist services for an intervention" can include therapeutic and support input, as well as more specialist assessments [whether in the sense of by a specialist discipline (e.g. a neuro-sensory assessment by an Occupational Therapist) or more in-depth by a multi-disciplinary team specialised in trauma and attachment]. A more explicit link between attachment difficulties and trauma could be expressed, perhaps.
52	Essex Adoption Agency	Draft statement 1	Although the idea of local collection of data around referrals and interventions is really relevant, I can envisage difficulties in this: 1. Because "attachment difficulty" is not (neither does it need to be, clinically speaking) a diagnostic label, it is unlikely that it appears widely within primary care, but often even specialist CAMHS / EWMHS, measured data / labels. 2. Because "attachment difficulty" is not a diagnostic label (e.g. that can be checked against DSM-V or ICD-10 criteria), significant variation in what is categorised as "attachment difficulty" can be expected. 3. Because attachment difficulties share similarities in presentation with, are often mistaken for and often overlap with other disorders (e.g. ASD, ADHD, ODD), the likelihood of these data being skewed (and, I suspect, under-represented) is high. 4. As it is often the case in mental and physical health, the access to assessment does, in the first place, heavily rely on the children's / young people's carers' ability to identify the need for assessment / intervention. This is particularly relevant when the carers in question are at the very origin of the attachment issues (e.g. abusive and/or neglectful parents) or closely linked to the attachment figures who "caused" the issues (e.g. relatives and

			friends who become Special Guardians, kinship carers, private foster carers).
53	Essex Adoption Agency	Draft statement 1	Satisfaction is a good measure. Even more relevant, though harder to measure, is child's and carer's UNDERSTANDING of the attachment difficulties.
54	Essex Adoption Agency	Draft statement 1	"Service providers ensure that health and social care practitioners are trained in the recognition and assessment of attachment difficulties, developmental trauma and parenting quality so they can identify families in need of assessment." + Question 5 in the draft consultation: 1. Currently, primary care professionals (e.g. GPs, health visitors and school nurses) are not uniformly trained and sensitised to attachment difficulties. Schools are gradually becoming more aware and receiving training, but my experience is that this is often insufficient and certainly not uniformly spread. Locally, the setting up of groups for adopters led by a specialist educational psychologist (TEA - Talking Education and Adoption - groups) to discuss issues around traumatised children's education has been proving positive. 2. People providing assessments are Post-adoption and SGO Support social workers with clinical expertise in trauma, attachment and mental health, clinical psychologists, CAMHS / EWMHS practitioners (some teams are really competent and some less); as already stated in Comment 1, we sometimes refer to other agencies, too (to name a few: Great Ormond Street Hospital, Family Futures, Adoption Plus). 3. In my experience, often trauma and attachment difficulties are not thought about in children and young people outside the looked after, child protection and adoption systems.
55	Essex Adoption Agency	Draft statement 1	The guidelines should include, in the list, 1. antenatal trauma, such as *in utero* exposure to alcohol / drugs / domestic violence, and at birth, e.g. withdrawal from drugs. 2. I also wonder whether it would be acceptable to mention carers' attachment and/or relationship style explicitly. 3. Under the coexisting conditions, I would suggest adding "sensory modulation and sensory integration difficulties". 4. Equality and diversity ought to be mentioned here, too, in terms of the fact that different cultures and backgrounds express attachment giving/seeking differently.
56	Essex Adoption Agency	Draft statement 1	This paragraph is spot-on! I wonder about the feasibility of setting this up in smaller localities but also for bigger entities (e.g. adoption agencies now joining up into "regions"). As the ideal would be, in my mind, for these services to be multi-professional and multi-agency, I wonder which agency might be best driving these services.
57	Royal College of Psychiatrists	Draft statement 1	Is parent and carer satisfaction enough of an outcome measure if the main risk here is huge unmet need?
58	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 1	All children need to have their attachment needs articulated on their entry to care: All children, not just those with identified 'difficulties' coming into care will have had an attachment trauma, being separated from their primary caregiver(s).

59	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 1	Comprehensive assessment of children should be a broad based mental health assessment and provision, not just of attachment problems, but including social situation such as housing, health, Equality Act 2010 protected characteristics, family deprivation, and social exclusion. There are trends within CAMHS which undermine the child being seen as having normal needs first, to be met primarily by the whole caring system with responsibilities for attachment, and enhancing thinking, behaviour and decision making. These trends include 1) services having reduced overall over the past 10 years, 2) the requirement of services to focus on specific categories of mental illness, over a certain threshold, 3) the focus on simple, single modality assessments and treatments eg to do with education or cognitive based treatments. These trends increase stigma and compartmentalise the attachment needs of looked after children.
60	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 1	We suggest an amendment to statement 1 so that it reads: Children and young people with attachment difficulties, and their parents or carers, have a comprehensive assessment by a qualified and experienced mental health professional before any referral to specialist services for an intervention.
61	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 1	However, specialist mental health services for children and young people in care do not exist in all localities, and many mental health services do not provide a service for babies and children under 5. There are significant gaps in service which are important to address.
62	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 1	Not all services are able to carry out comprehensive assessments, for example, in one area assessments are not offered unless there is a comorbid mental health issue.
63	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 1	The outcome of this quality standard needs to go beyond the parent or carer satisfaction of the support provided, to consider how support provided addresses the needs identified by the Social Worker or CAMHS practitioner who would have a better understanding of the child's needs.
64	The Association for Family	Draft statement 1	Attachment difficulties need to be assessed by qualified and experienced mental health professionals.

	Therapy and Systemic Practice in the UK		
65	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 1	Add – when practicable – rather than once a stable placement has been found – as this could take a long time
66	The Royal College of Midwives	Draft statement 1	However the role of the midwife should be referred to in 'what these statements mean for health practitioners 'as they are the key point of contact during pregnancy and the early postnatal period and therefore in a prime position to promote infant mental health and attachment and be able to assess and identify early attachment difficulties and refer to the appropriate services.
67	The Royal College of Midwives	Draft statement 1	As above, the role of midwives should be included as they have such an important role in identifying influential parental factors listed here, such as domestic violence and drug and alcohol abuse
68	University of Surrey, Psychology Dept.	Draft statement 1	When recommending the use of questionnaires as supplements to a comprehensive assessment, the statement does not make suggestions of appropriate or valid questionnaires for the purpose of measuring attachment. In a recent literature review Denton et al. (2016) highlighted a number of questionnaires which may be helpful in the assessment of children whose traumatic early life experiences have resulted in a complex picture of trauma and attachment needs. Of those recommended were the Assessment Checklist for Children (Tarren-Sweeney, 2007), The Assessment Checklist for Adolescents (Tarren-Sweeney, 2013a), the Brief Assessment Checklist for Children and the Brief Assessment Checklist for Adolescents (Tarren-Sweeney, 2013b).
69	University of Surrey, Psychology Dept.	Draft statement 1	In addition to the definition of a 'comprehensive assessment' the follow items may be of value: • It is vital that any available information from a young person's social care chronology be made available and considered as part of the assessment process • In addition to parental factors, the young person's sibling relationships, birth order and ongoing contact arrangements should be considered • Any comprehensive assessment should hear from the professional network around the child (Golding, 2006) as views of the young person's needs/attachment behaviours can change across contexts (school, carers, social care) • the assessment of attachment behaviours should ideally be made in the context of any recent placement change

			as well as considering historic placement changes • Consideration of young person's relational/personal strengths • Taking into account whether any life history work has been completed with the young person and what sense they have made • Consideration of peer relationships in addition to care-giver relationships.
70	University of Surrey, Psychology Dept.	Draft statement 1	The description and definition of a comprehensive assessment consider attachment needs and mental health disorder as distinct entities. Researchers in the field of Developmental Clinical Psychology researchers have highlighted how children with histories of disrupted caregiving, abuse and neglect often present to mental health services with a range of mental health symptoms, frequently leading to multiple diagnoses (DeJong, 2010), suggesting attachment difficulties and mental health need are not necessarily distinct. Moreover, Child and Adolescent Mental Health Looked After Children's Services often do not use a diagnostic referral criteria but instead focus on behaviours which impact upon placement permanence (e.g. West Sussex Child and Adolescent Mental Health Looked After and Adopted Children's Service based in Shoreham-by-sea).
71	University of Surrey, Psychology Dept.	Draft statement 1	The statement would benefit from clearly defining the aims of a comprehensive assessment of attachment, which professional group should be responsible for carrying out such assessments and how the assessment should differ from that which would be offered as part of a specialist intervention.
72	University of Surrey, Psychology Dept.	Draft statement 1	The statement would benefit from a clear statement for when attachment needs as defined by a comprehensive assessment, reach the threshold to warrant specialist support. There should be an explicit rationale to support this threshold.
73	University of Surrey, Psychology Dept.	Draft statement 1	The statement should be explicit about the specialist services which are suitable for young people with attachment and mental health needs to be referred to. Our view is that professional staff with appropriate training are needed to meet the needs of these young people and their carers. A broad multidisciplinary skill set is required as there is a need to provide assessment and interventions for young people with complex needs attachment needs with frequently a number of comorbid conditions. Additionally their carers need support and guidance in how to therapeutically support the young person alongside the interaction with their own mental health and that of the young person. This level of need would be best developed within a specific service that is co -located with Specialist CAMHS but is discrete with sufficient capacity to meet the local needs which vary significantly across the country

74	After Adoption	Question 5	Again, as a national voluntary agency, this is a question that is difficult for us to answer. However, our experience suggests that currently these comprehensive assessments are mostly done within social care i.e. Child in Need teams/ Post-permanency Teams, or by CAMHS. In our role within Post-Adoption services, we undertake some assessments which are similar, before families access our services such our Therapeutic Parenting Programme, Safebase and our TALKadoption Camps and Short Breaks.
75	Association of Child Psychotherapists (ACP)	Question 5	Question 5: *ADD* comprehensive assessments that include psychological needs are not generally done
76	Institute of Health Visiting	Question 5	Comprehensive Assessment: It is inappropriate for health visitors to undertake a comprehensive assessment routinely; however, as part of an infant mental health pathway, consultation should be available for HVs to escalate concerns for an infant or child at the 'Universal Partnership Plus' tier of the health visiting service for such an assessment to be undertaken informed by the HV's earlier assessment e.g. NBAS. The universal health visiting service is well placed to identify families and children experiencing and at risk of attachment difficulties. With sufficient investment (detailed in Q4) the health visiting workforce would be ideally placed to assess attachment for these children. I do not support the provision of universal screening of attachment for all children as this may cause unnecessary distress and anxiety to families where there are no concerns, it would also be prohibitive from a cost perspective and current local authority commissioning budgets.
77	The Association for Family Therapy and Systemic Practice in the UK	Question 5	Comprehensive assessments that include psychological needs are not generally done.
78	Association of Catholic Nurses England and Wales	Draft statement 2	www.gov.uk/children-with-special-needs/overview define special needs as being inclusive of needs around behaviour or ability to socialise e.g. not being able to make friends, ability to understand things or needs around concentration levels e.g. attention deficit hyperactivity disorder –some of the children within these categories may need an Education and Healthcare Plan (Children and Families Act 2014 and SEND Code of Practice 2014) to ensure all of their needs are met.
79	Association of Child Psychotherapists (ACP)	Draft statement 2	Statement 2: CYP with attachment difficulties have an up to date education plan setting out how they will be supported in school… The ACP has feedback from members about this not being the case and schools who repeatedly penalise CYP with ADD, without providing support for challenging behaviour and replicating experiences of loss. We would argue that there

			is an inconsistent approach to support in schools for CYP with ADD. Withdrawal of tutors in some schools has impeded the one-to-one positive relationship setting for helping these CYP to settle. The role of the Virtual School has been key where we seen CYP with good education planning and support.
80	Bath Spa University	Draft statement 2	There are three key issues which need to be highlighted throughout this section: i. While it is important that vulnerable children do have an education plan, this in itself can serve to further marginalise individuals unless it is developed within a school setting which is inclusive and geared towards supporting the needs of all children regardless as to whether or not they have (or need) a plan. Children in care have highlighted to us in many of our development projects their resentment at being treated as 'different' yet at the same time the need for their particular issues to be understood (see http://www.incareinschool.com). This can only happen if all staff, in all lessons, have a basic understanding of attachment aware approaches. ii. At the same time it is unreasonable to expect teachers to take on the roles of clinicians or therapists, and indeed it is highly dangerous to encourage non-clinical diagnoses of specific attachment disorders. For this reason, schools need to be encouraged to work with specialist agencies on a multi-agency basis to support individual needs. iii. The guidelines fail to take into account the changing educational landscape. While local authorities at present still hold some accountabilities for social care and a statutory responsibility for maintaining the virtual school, the White Paper envisages the effective abolition of their responsibilities for maintaining and managing schools. Many of these responsibilities will be taken on by Multi-Academy Trusts, who will be accountable for the strategic and day to day management of individual schools. The quality statement should therefore make some reference to these new responsibilities alongside those of local authorities.
81	CoramBAAF	Draft statement 2	Children who have an assessed and identified attachment difficulty will need a plan that works for them at school. This is likely to need to address a range of issues alongside attachment. Co-occurrence is likely be the norm for many of the children within the scope of this standard and this will return schools and others to considering what a focussed and detailed plan needs to address and how.
82	CoramBAAF	Draft statement 2	Currently there is a dearth of local systems and structures to collect data and there is nothing that strongly suggests that this is a development that is about to, or is taking place.
83	CoramBAAF	Draft statement 2	While we fully support the importance of attachment difficulties being recognised within educational plans, we are concerned that the same issues noted above re training apply equally to within education.
84	Essex Adoption Agency	Draft statement 2	Granted that the statement is excellent, collection of data will depend on issues already raised at comments 2 and 4 above. 1. If anything, these difficulties are likely to be amplified, as schools will be "one step removed" in the identification of attachment problems. 2. Also, because the denominator (children with attachment difficulties) in this equation will already be hard to measure, the whole data collection will be negatively affected.
85	Essex Adoption Agency	Draft statement 2	I would advise that explicit focus is given to the fact that interventions in school for children with attachment difficulties are often through relationship-building and providing the child with a (often unfamiliar) sense of safety. The draft touches

			on it; I would suggest it is spelt out. The same applies to the fact that practical understanding of attachment styles will be at the basis of schools' success. Often SENCOs are "lumbered" with attachment and trauma issues on top of all other additional needs categories; I wonder whether a school should have "champions". Collaboration between carers and school should be highlighted as very important.
86	Royal College of Psychiatrists	Draft statement 2	There is a very similar problem here. Is an "education plan" the same as an 'Education, Health and Care (EHC) plan'? If so EHC plans are currently provided for less than 3% of pupils. What seems to be envisaged would be a ten-fold increase.
87	Association of Catholic Nurses England and Wales	Draft statement 3	With such a wealth of information presented in the Solihull Behaviour Management Programme and The All Party Document 1001 Critical Days 2014 about neurophysiological development particularly in the first two years of life contributing to hard wired and embedded behaviours , and the longer these behaviours continue the harder they become to change , there is need for some basic education of parents and carers around this to understand the need for early intervention and why behaviours seem more difficult to change as the child gets older . Conception to the Age of 2 – The Age of Opportunity Wave Report 2013 can also be built into some basic education programme ' with their statement 'How we treat 0-2 year-olds shapes their lives – and ultimately our society' and association, like Bowlby 1951, 1956 of early dysfunctional or affectionless parenting with long term anti-social behaviour.
88	CoramBAAF	Draft statement 3	This is important given the evidence base for such interventions. However, as a universally available programme of available interventions there will need to be a strategic approach in delivering and resourcing this standard which the sector is massively not in a position to do. There needs to be an exploration of how to prioritise this as a standard and fully resource it. A pilot project for video feedback is underway at the Tavistock and Portman NHS Trust in partnership with TACT and the a number of north London local authorities.
89	Essex Adoption Agency	Draft statement 3	"Breakdown in care placements for preschool aged children with or at risk of attachment difficulties.": the sentence might need to read "Prevention of" or "Avoiding of"… something on those lines, I believe.
90	Essex Adoption Agency	Draft statement 3	We do not utilise this exact programme at EAA at present, although our interventions have the exact same aims mentioned in the guidance draft. Interventions we find effective are: • Theraplay • Dyadic Developmental Psychotherapy • Attachment-focussed counselling (for carers) We also have group interventions, such as: • Swimming for attachment • Attune (music therapy with elements of Theraplay)
91	Essex Adoption Agency	Draft statement 3	Should "carers" not include biological parents, too? I am thinking of those cases where reintegration in or support to families of origin is the plan for the child. You later say to deliver the programme in the parental home; this should refer to

			adoptive and biological parents alike.
92	Essex Adoption Agency	Draft statement 3	“a trained health or social care worker who has experience of working with children and young people” perhaps should specify what extra knowledge and/or expertise would be required.
93	Royal College of Psychiatrists	Draft statement 3	There are resource issues here too. At the moment video feedback techniques are not widely available. Luckily the time and cost of training is not huge but some injection of resources will be needed to prime the pump.
94	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 3	Children in the care system first need to be offered an opportunity for forming a secure attachment. This is the end being sought, and video feedback is one means towards this.
95	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 3	Add to end of rationale – the video feedback programme can also identify further therapeutic needs and refer to specialist services, where these exist
96	The Royal College of Midwives	Draft statement 3	However the role of the midwife should be referred to in ‘what these statements mean for health practitioners ‘as they are the key point of contact during pregnancy and the early postnatal period and therefore in a prime position to promote infant mental health and attachment and be able to assess and identify early attachment difficulties and refer to the appropriate services.
97	University of Surrey, Psychology Dept.	Draft statement 3	For health visitors and social workers to be able to offer this additional support recommendations should be made for an increase in staff capacity owing to the current demands associated with their role.
98	Association of Child Psychotherapists (ACP)	Draft statement 4	Statement 4: Carers of children and young people with attachment difficulties can access training and support programmes applicable to the age of the child. It is hard to measure if this really happens, as there is little evidence about what works for families as a whole and addressing their attachment patterns. As psychoanalytic practitioners, we have expertise in addressing underlying issues and dynamic processes which affect and impede attachments. We are involved in running therapeutic parenting approaches but it would be useful to formalise and evidence more of these programmes.
99	Association of Child Psychotherapists	Draft statement 4	Intensive training….. We would recommend training for carers, Special Guardianships and adoptive parents in promoting child-led play for preschool children and in recognising and responding to infant mental health difficulties.

	(ACP)		
100	Association of Child Psychotherapists (ACP)	Draft statement 4	Group based training…. We would also recommend more group work for young people with attachment difficulties who can steadily become more socially isolated and withdrawn, reporting feeling different and unable to maintain friendships and secure relationships throughout life.
101	CoramBAAF	Draft statement 4	This is an important standard but there are issues about the evidence base for implementing these training and support programmes.
102	Essex Adoption Agency	Draft statement 4	These pieces of information can be gathered with ease once an appropriate system is set up, both where training and support interventions are concerned. This also includes children's and carers' satisfaction, which is regularly gathered through evaluation forms, as well as formal & informal conversations. I suspect this would be harder in the wider population (i.e. where children outside the care, SGO and adoption system are concerned), despite the fact that they might suffer from attachment issues.
103	Essex Adoption Agency	Draft statement 4	Having a behavioural reinforcement spin on training and support – i.e. in the attitudes and strategies we recommend to carers – is known to have frequent shortcomings, in as much as traumatised children's experiences skew their views and psycho-emotional reactions to relationships in a way that makes social reinforcement and behavioural strategies non-effective and often triggering of attachment difficulties & trauma-based reactions. What Dan Hughes and Jon Baylin define as "brain-based parenting" is often more appropriate in parenting traumatised children.
104	Royal College of Psychiatrists	Draft statement 4	Follows on from the earlier comments about lack of specificity in the definition of "children and young people with attachment difficulties" and the need to rollout support programmes with some evidence base.
105	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 4	All carers (male and female) need to be recruited according to their ability to offer attachment opportunities for all foster children. Training related to attachment should not be restricted to carers who have had a child placed with an identified disorder. All children need attachment patterns attending to by their carers.
106	The Association for Family Therapy and Systemic Practice in the UK	Draft statement 4	Add – training for carers, special guardians and adoptive parents in promoting child-led play for preschool children and in recognising and responding to infant mental health difficulties
107	The Royal College of	Draft statement 4	However the role of the midwife should be referred to in 'what these statements mean for health practitioners 'as they are the key point of contact during pregnancy and the early postnatal period and therefore in a prime position to promote

	Midwives		infant mental health and attachment and be able to assess and identify early attachment difficulties and refer to the appropriate services.
108	University of Surrey, Psychology Dept.	Draft statement 4	The statement is highly relevant as our research suggests carers frequently struggle to access training and support in their roles
109	University of Surrey, Psychology Dept.	Draft statement 4	The statement would benefit from a clear definition of what best practice 'training and support for carers' involves.
110	University of Surrey, Psychology Dept.	Draft statement 4	The statement states that carer training programmes should be applicable to the 'age of the child' however carers would benefit most from training programmes which are suited to the developmental age of the child as looked after children often have not reached the same developmental milestones as their peers (Silver, 2013).
111	University of Surrey, Psychology Dept.	Draft statement 4	The 'intensive training' for foster carers recommended on page 20 would benefit from including a therapeutic parenting programme which helps carers to understand the emotional needs underlying behavioural challenges, understanding of attachment, understanding of the impact of trauma on children's belief systems and ability to self-regulate etc. The professional service best-placed to provide this is a specialist mental health service situated within CAMHS.
112	After Adoption	Question 6	Within our experience offering Therapeutic Parenting Programmes, we would suggest that there is currently national variation in access to training, as it is often dependant on what a local authority has decided to provide within their area. Consideration needs to be given in developing programmes aimed at the parents of teenagers. In addition, we would consider that there should be flexibility in the model of delivery of these programmes. Though we recognise that the suggestions for the structure of group-based training is only an example, we feel that an extended programme of evening training sessions over a term may be a challenging commitment for some. We have found a structure of four day-long training sessions, spread over a fortnight, has been a successful model for delivering this training. It would be important to have variety of options to suit parents/ carers of children with attachment needs.
113	Association of Child Psychotherapists (ACP)	Question 6	Question 6: The ACP is aware that many mental health services do not provide a service for babies and children under 5. Understanding of early relationships is recommended in 1001 Critical days and can help prevent intergenerational attachment difficulties but there are national as well as local variations. Our members have also seen evidence and numerous examples of how severe postnatal depression can seriously affect quality of attachments and influence patterns of attaching for the next generation, but there is little training in understanding ADD in under 5's.
114	Association of Child Psychotherapists (ACP)	Question 6	'Are there specific age groups where provision is lower...' Yes- widespread feedback indicates that many foster care agencies and local authority programmes provide no training in recognising and responding to infant mental health difficulties. Fostering Matters - the training that is being disseminated nationally, does not address the needs of infants aged 0-2.
115	Association of Child Psychotherapists	Question 6	'Are there specific age groups where provision is lower…' As already stated, Yes- widespread feedback indicates that many foster care agencies and local authority programmes

	(ACP)		provide no training in recognising and responding to infant mental health difficulties. Fostering Matters, the training that is being disseminated nationally , does not address the needs of infants aged 0-2. There also appears to be limited provision for adolescents, where there is child to parent violence linked to ADD and a lack of investment in relationships and resulting high levels of distress. We would recommend more research into evidencing intensive therapeutic support for the individual child or young person along-side couples work for parents.
116	Bath Spa University	Question 6	At present the availability of training and support networks for schools is highly variable across different areas, depending on policy priorities and the configuration of local services. This variability is likely to be exacerbated, given the priority given in the recent White Paper *Educational Excellence Everywhere* towards school- based and determined training, unless there is clear and directed leadership from the Department for Education, backed up by specific requirements under the Ofsted framework.
117	Essex Adoption Agency	Question 6	Question: Is there currently national variation in access to training, education and support programmes for carers of children and young people in care with attachment difficulties provided by health and social care organisations? Are there any specific age groups where provision of this training, education and support for carers is lower than other groups, if so please provide details? • Based on experience with other authorities whose adopters we come into contact with, I would say that there certainly is variation. • Speaking of EAA, training is one of the main ways we support adopters, Special Guardians and foster carers. Training around trauma and attachment is integral part of adopters' preparation and, in some instances, of their friends & family's. They receive training on Theraplay principles and strategies, communicating and connecting, matching and introductions, the PACE model; attachment is touched upon when adopters are required to reflect on their experiences in filling the Stage 1 workbook and throughout their Stage 2 assessment. They are encouraged to read, watch DVDs and programmes and attend seminars / workshops. I believe putting attachment at the centre of all of the conversations we have with prospective & approved adopters and delivering information on attachment, trauma and brain-based parenting through a variety of media and methods "normalises" these themes and makes them integral part of these carers' way of thinking. Naturally, this is also part of post-adoption and post-placement therapeutic parenting support. • At present, we are running group and individual training for Special Guardians, too. This is particularly relevant, as these carers have less formal training and less opportunities for self-reflection during assessment than adopters; they are often relatives who have shared the events that have led to the child's attachment difficulties; therefore, intensive psycho-education and support of their personal and parenting needs are paramount for the success of these placements. We also use therapeutic life story work to address attachment difficulties when we can engage the carers in that way. • Training-wise, the ages we seem to concentrate most on are pre-school and, later on, adolescence. Having said

			this, school-age children receive more interventions to do with school support and, as we often place older children for adoption and SGOs in Essex, those families will receive specific support around attachment difficulties, too, though less often through formal training. • We deliver training also as part of support groups meeting and coffee mornings. • Support to families encompasses: therapeutic parenting support and psycho-education, early placement and later attachment-focussed counselling, systemic and family therapy, Theraplay, Dyadic Developmental Psychotherapy, advice on the practical implications of parenting children with attachment difficulties / disorders. We also use therapeutic life story work to address attachment difficulties when we prepare children for adoption and, later, during placement when issues arise that are linked to the child's history. All of the above often runs alongside the child's own therapy, support at school and other interventions relevant to their presentation. This applies to all ages, according to specific needs and circumstances.
118	Institute of Health Visiting	Question 6	There is widespread national variation in provision of high quality assessment of attachment for children under 5 years, with many areas having no commissioned specialist intervention service. In addition, national variation in access to high quality prevention and early intervention programmes for at risk parent-child dyads (e.g. NSPCC Babysteps; PipUK) is also widespread with many high risk families receiving no service. The provision of support for school age children is also very poor with widespread national variation with a focus on "too little, too late". Most CAMHS teams have extremely high thresholds. The provision of an enhanced level 3 service would improve outcomes for these children.
119	The Association for Family Therapy and Systemic Practice in the UK	Question 6	Yes, feedback suggests that many foster care agencies and local authority programmes do not provide training in recognising and responding to infant mental health difficulties. Fostering Matters – the training that is being disseminated nationally, does not address the needs of infants aged 0 – 2 years.
120	The Association for Family Therapy and Systemic Practice in the UK	Question 6	Yes, feedback suggests that many foster care agencies and local authority programmes do not provide training in recognising and responding to infant mental health difficulties. Fostering Matters – the training that is being disseminated nationally, does not address the needs of infants aged 0 – 2 years.
121	University of Surrey, Psychology Dept.	References	Denton, R., Frogley, C., Jackson, S., John, M., & Quertret, D. (2016) The assessment of developmental trauma in children and adolescents: A systematic review. *Clinical Child Psychology and Psychiatry*. DeJong, M. (2010). Some reflections on the use of psychiatric diagnosis in the looked after or "in care" population. *Clinical Child Psychology and Psychiatry, 15*(4), 589-599.

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Registered stakeholders who submitted comments at consultation

- After Adoption
- Association of Catholic Nurses England and Wales
- Association of Child Psychotherapists (ACP)
- Bath Spa University
- CoramBAAF

- Department of Health
- Essex Adoption Agency
- Institute of Health Visiting
- NHS England
- Royal College of General Practitioners (RCGP)
- Royal College of Midwives
- Royal College of Nursing (RCN)
- Royal College of Paediatrics and Child Health (RCPCH)
- Royal College of Psychiatrists (RCPsych)
- The Association for Family Therapy and Systemic Practice in the UK
- University of Surrey, Psychology Dept.

Appendix 2: Quality standard consultation comments table – non-registered stakeholders

ID	Stakeholder	Statement number	Comments[2]
1	Blackpool Centre for Early Child Development, NSPCC	Draft statement 3	The report is very positive in its recognition of early intervention we were particulary pleased to see the inclusion of Video Interactive Guidance, however we feel that there could be more focus on the 0-2 age group as there are some very well evidenced measures which can be used with this age group.

[2]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.