NICE National Institute for Health and Care Excellence

NICE guideline

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
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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

Overview 5

Who is it for? 5

Key priorities for implementation 6

Principles of care in all contexts 6

Supporting children with attachment difficulties in schools 7

Assessing attachment difficulties in children and young people in all health and social care settings 7

Interventions for children and young people on the edge of care 8

Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care 8

Recommendations 10

1.1 Principles of care in all contexts 10

1.2 Supporting children and young people with attachment difficulties in schools and other education settings (including early years) 15

1.3 Assessing attachment difficulties in children and young people in all health and social care settings 17

1.4 Interventions for attachment difficulties in children and young people on the edge of care 20

1.5 Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care 24

1.6 Interventions for attachment difficulties in children and young people in residential care 27

Terms used in this guideline 28

Recommendations for research 32

1 Screening assessment tools 32

2 Attachment-focused interventions 33

3 Evaluation of extensively used interventions 34

4 Interventions in a school setting 35

5 Relationship between attachment difficulties and complex trauma 36

Children's attachment implementation: getting started 38

The challenge: stability of care 38

The challenge: assessing attachment difficulties 40

The challenge: using video feedback programmes 42

Need more help? 44

Context 45

Update information 47

Appendix 1 48

This guideline is the basis of QS133.

Overview

This guideline covers the identification, assessment and treatment of attachment difficulties in children and young people up to age 18 who are adopted from care, in special guardianship, looked after by local authorities in foster homes (including kinship foster care), residential settings and other accommodation, or on the edge of care. It aims to address the many emotional and psychological needs of children and young people in these situations, including those resulting from maltreatment.

Who is it for?

- Commissioners and providers of health and social care services
- Schools and other education providers
- All health and social care professionals working in a range of community (including fostering, residential and kinship care settings), primary care, secondary care and secure settings who have contact with children and young people who are adopted from care, in special guardianship, looked after by local authorities or on the edge of care
- All educational staff working in schools and other education settings (including early years) who have contact with children and young people who are adopted from care, in special guardianship, looked after by local authorities or on the edge of care
- Children and young people with attachment difficulties and their families and carers

Key priorities for implementation

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

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 whether they:
  - are on the edge of care, accommodated under section 20 of the Children Act 1989, subject to a care order, under special guardianship or adopted from care
  - are placed with birth parents, foster carers (including kinship carers), special guardians or in residential care
  - are from a minority ethnic group
  - have a disability or a mental health problem
  - are from the UK or overseas.
- 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 or key person in school throughout the period the child or young person is in the care system or on the edge of care.

Supporting children with attachment difficulties in schools

- Schools and other education providers should ensure that all staff who may come into contact with children and young people with attachment difficulties receive appropriate training on attachment difficulties, as set out in recommendation 1.2.2.

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 teenage 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, including trauma
  - knowing when and how to refer for evidence-based interventions for attachment difficulties; see the sections on interventions for attachment difficulties in:
    - children and young people on the edge of care
    - children and young people in the care system, subject to special guardianship orders and adopted from care
    - children and young people in residential care.

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.

Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care

Preschool-age children

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

Primary school-age children

- Consider intensive training and support for foster carers, special guardians and adoptive parents (see recommendations 1.5.5 and 1.5.6 before the placement and for 9 to 12 months after, combined with group therapeutic play sessions for the child for the same duration (see recommendation 1.5.7).

Late primary and secondary school-age children

- Consider a group-based training and education programme for foster carers, special guardians 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 late primary and early secondary school-age children and young people in the care system, subject to special guardianship orders and adopted from care to improve social skills and maintain positive peer relationships (see recommendation 1.5.10).
- Modify interventions for young people in the care system, subject to special guardianship orders and adopted from care 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, special guardians and adoptive parents. Discuss making contact with their birth parents or original family sensitively.

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Principles of care in all contexts

Using this guideline

1.1.1 Use this guideline in conjunction with the NICE guidelines on looked-after children and young people and child maltreatment.

Ensuring equal access to consistent care

1.1.2 Ensure that all children, young people and their parents or carers get equal access to interventions for attachment difficulties, regardless of whether they:

- are on the edge of care, accommodated under section 20 of the Children Act 1989, subject to a care order, under special guardianship or adopted from care
- are placed with birth parents, foster carers (including kinship carers), special guardians or in residential care
- are from a minority ethnic group
- have a disability or a mental health problem

- are from the UK or overseas.

1.1.3 Assess all children and young people who enter the UK as unaccompanied asylum-seeking children 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 asylum-seeking children 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.

1.1.4 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, personal adviser or key person in school throughout the period the child or young person is in the care system or on the edge of care.

1.1.5 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

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

1.1.7 Ensure that carers are ready to accept the child or young person's need to be in a loving relationship and are able and, whenever possible, willing to think about providing longer-term care or involvement if needed.

1.1.8 Help arrange kinship placements, if safe and in the best interest of the child or young person. See the Department for Education guidance on information sharing for people who provide safeguarding services to children, young people, parents and carers.

1.1.9 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.

1.1.10 Provide ongoing support and advice, either by telephone or in person, and 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.

1.1.11 If a placement breaks down, aim to maintain the relationship between the child or young person and the foster carers (including kinship carers), adoptive parents or special guardians, whenever possible and if it is in the best interests of the child or young person.

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

1.1.12 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, such as face-to-face meetings, telephone conversations and other appropriate methods of communication
- making sure the child or young person has the opportunity to ask questions and make choices whenever appropriate and possible

- supporting the child or young person in maintaining relationships with their parents or previous carers unless this would not be in the child or young person's best interests
- 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

1.1.13 If a return to the birth parents or original family is not an option, keep siblings together if it is possible and in the best interests of all the children or young people.

1.1.14 Offer 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 **or**
- if there have been frequent changes of placement **or**
- if there is more than 1 child with attachment difficulties in the placement.

1.1.15 When adoption is considered the best outcome for the child or young person, ensure that:

- their wishes are taken into account
- they are offered information that is appropriate to their developmental level about the implications that adoption may have for future contact with their birth parents, siblings, wider family members and others
- a full assessment of need is conducted before adoption
- an assessment of attachment difficulties is offered at any stage after adoption

- they are offered support (based on the assessment of need and attachment difficulties) before, during and after adoption.

Preserving the personal history of children and young people

1.1.16 Social care workers should offer children and young people in the care system, in special guardianship or adopted from care, accurate, comprehensive, up-to-date 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).

1.1.17 Social care workers should keep 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 during interventions

1.1.18 Ensure safeguarding is maintained during any intervention for a child or young person with attachment difficulties. See the Department for Education and Department of Health and Social Care statutory guidance on the planning, commissioning and delivery of health services for looked-after children.

1.1.19 Consider using a parental sensitivity tool (for example, the Ainsworth Maternal Sensitivity Scale) and a parenting quality tool with parents and carers to help guide decisions on interventions and to monitor progress.

Pharmacological interventions

1.1.20 Do not treat attachment difficulties with pharmacological interventions. For the use of pharmacological interventions for coexisting mental health problems, see for example, the NICE guideline on 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 and other education settings (including early years)

1.2.1 Schools and other education providers should ensure that all staff who may come into contact with children and young people with attachment difficulties receive appropriate training on attachment difficulties, as set out in recommendation 1.2.2.

1.2.2 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
- understanding the consequences of maltreatment, including trauma
- how they can support children and young people with attachment difficulties.

  Children and young people with attachment difficulties, and their parents or carers, should be involved in the design of the training courses, wherever possible.

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

- can access mental health services for children and young people and education psychology services for interventions
- are supported at school while they are taking part in interventions following advice from mental health services for children and young people and education psychology services.

1.2.4 When providing support for interventions in schools and education settings, staff

should:

- be aware of the possibility of stigma, bullying and labelling as a result of any absences from school
- take into account the child or young person's preferences for the setting of the intervention.

1.2.5 Schools and other education providers should ensure that the designated teacher:

- has had specialist training:
  - to recognise and understand attachment difficulties and mental health problems
  - in data protection and confidentiality
- 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 or subject to special guardianship orders
  - 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 or young person and to whom the child or young person 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

- maintains an effective referral system with other agencies.

1.2.6 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.

1.2.7 Schools and other education providers should avoid using permanent and fixed-term school exclusion as far as possible for children and young people in the care system with identified 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 teenage 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, including trauma

- knowing when and how to refer for evidence-based interventions for attachment difficulties; see the sections on interventions for attachment difficulties in:
  - children and young people on the edge of care
  - children and young people in the care system, subject to special guardianship orders and adopted from care
  - children and young people in residential care.

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, including:

- 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), parental drug and alcohol misuse or mental health problems, and parents' and carers' experiences of maltreatment and trauma in their own childhood
- 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),

depression, alcohol misuse and emotional dysregulation.

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, the NICE guidelines on antisocial behaviour and conduct disorders in children and young people, attention deficit hyperactivity disorder, depression in children and young people and alcohol-use disorders).

1.3.4 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 to 2 years
- modified versions of the Strange Situation Procedure for children aged 2 to 4 years (either the Cassidy Marvin Preschool Attachment Coding System or the Preschool Assessment of Attachment)
- Attachment Q-sort for children aged 1 to 4 years
- Manchester Child Attachment Story Task, McArthur Story Stem Battery and Story Stem Assessment Profile for children aged 4 to 7 years
- Child Attachment Interview for children and young people aged 7 to 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 Health and social care provider organisations should ensure that health and social care professionals are skilled in the use of the assessment tools in recommendation 1.3.4.

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 Centers for Disease

Control and Prevention (CDC) on 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
- works with other services, including mental health services for children and young people, 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 or re-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 with, or at risk of, attachment difficulties

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 to 4 months
- include filming the parents interacting with their child for 10 to 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 or the child's attachment after 10 sessions of a video feedback programme for parents of preschool-age children on the edge of care, 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 a 6-month period

- is delivered by a trained health or social care professional
- includes:
  - coaching the parents in behavioural management (not applicable for children aged 0 to 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 or 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 an appropriately 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 to 90 minutes) over an 18-month period
- 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 have been or are at risk of being maltreated

1.4.9 Consider parent–child psychotherapy for parents who have maltreated or are at risk of maltreating their child to improve attachment difficulties, ensuring that safeguarding concerns are addressed.

1.4.10 Ensure parent–child psychotherapy to improve attachment difficulties:

- is based on the Cicchetti et al. (2006) and Toth et al. (2002) model
- consists of weekly sessions (lasting 45 to 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 with, or at risk of, attachment difficulties

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

Primary and secondary school-age children and young people who have been, or are at risk of being, 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.

1.4.13 Consider parental sensitivity and behaviour training (as described in recommendation 1.4.5) for parents at risk of maltreating their child to improve attachment difficulties, ensuring that safeguarding concerns are addressed and adapting the intervention for the age of the child or young person.

1.5 Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders 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, subject to special guardianship orders or adopted from care; it also covers their foster carers (including kinship carers), special guardians and adoptive parents.

Preschool-age children

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

1.5.2 If there is little improvement to parental sensitivity or the child's attachment after 10 sessions of a video feedback programme for foster carers, special guardians and adoptive parents of preschool-age children, arrange a multi-agency review before going ahead with more sessions or other interventions.

1.5.3 If foster carers, special guardians 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, special guardians and adoptive parents (see recommendations 1.5.5 and 1.5.6) before the placement and for 9 to 12 months after, combined with group therapeutic play sessions for the child for the same duration (see recommendation 1.5.7).

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

- positive behavioural management methods
- help with peer and parent or carer relationships for the child
- support for schoolwork
- help to defuse conflict.

1.5.6 Ensure intensive support for foster carers, special guardians 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 therapeutic play sessions for primary school-age children after placement:

- consist of weekly sessions (lasting 60 to 90 minutes) over the 9- to 12-month period
- are delivered by a trained health or social care professional

- include monitoring of behavioural, social and developmental progress.

Late primary and early secondary school-age children and young people

1.5.8 Consider a group-based training and education programme for foster carers, special guardians 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 late primary and early secondary school-age children and young people in the care system, subject to special guardianship orders and adopted from care 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, special guardians and adoptive parents:

- consist of twice-weekly sessions (lasting 60 to 90 minutes) in a group 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 late primary and early secondary school-age children and young people in the care system, subject to special guardianship orders and adopted from care:

- consist of twice-weekly sessions (lasting 60 to 90 minutes) in a group for the first 3 weeks, then individual weekly sessions over the remaining school year
- are delivered by trained mentors, which may include graduate level workers, at a time that ensures schooling is not disrupted

- 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 in the care system, subject to special guardianship orders and adopted from care 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, special guardians and adoptive parents. Discuss making contact with their birth parents or original family sensitively.

1.6 Interventions for attachment difficulties in 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 person 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 to 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 in residential care 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.

Terms used in this guideline

Carer

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

Children

Aged 0 to 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. Academies, with their funding agreement with the Secretary of State, are also required to appoint a designated teacher for looked-after children.

Edge of care

This covers children and young people who are considered by social care workers to be 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 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 with 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.

Safeguarding

A multi-agency action to protect children from maltreatment, prevent the impairment of their health and development, ensure that they grow up in circumstances consistent with the provision of safe and effective care, and actively enable all children to have the best outcomes.

Special guardianship

Under the Children Act 1989, amended by the Adoption and Children Act 2002, 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 to 17 years.

Recommendations for research

The Guideline Committee has made the following recommendations for research. The Committee's full set of research recommendations is detailed in the full guideline.

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, social care and education settings.

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 to 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 Attachment-focused interventions

This research recommendation is composed of 2 parts.

- 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.
- 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

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, therefore it is important to know whether similar interventions will work with other populations. Even less evidence is available on children aged over 5 years and young people, therefore attachment-focused interventions should consider targeting this age group.

There is also 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. Evidence from groups aged 11 to 17 years is limited, therefore 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 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 (for example, 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.

A randomised controlled trial should also 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 the above, as well as ongoing maltreatment.

For both trials, 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.

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, such as play therapy, dyadic developmental psychotherapy, and attachment aware schools program with an evidence-based treatment for attachment difficulties. The interventions should address children in a wide variety of placements and ages.

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.

4 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, and for the wide range of children in schools who may have attachment difficulties. The intervention should be deliverable by teachers within the school setting, and not disrupt the delivery of the curriculum. 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.

5 Relationship between attachment difficulties and complex trauma

This research recommendation is composed of 2 parts:

- Assess the prevalence of attachment difficulties (including attachment disorders), complex trauma and the combination of both in children and young people in the care system and on the edge of care.
- Investigate the effect of various factors, such as multiple placements, on the likelihood of having attachment difficulties, complex trauma or both.

Why this is important

Little is known about the prevalence of attachment difficulties, complex trauma or both in children and young people in the care system and on the edge of care in the UK. This information is important for understanding the needs of these populations and will highlight how complex trauma can be considered as a potential explanation for a child or young person's behaviour, with or without the diagnosis of attachment difficulties. The effect various factors have on the outcome of attachment difficulties and complex trauma also needs investigating. For example, multiple placements may decrease the risk of a

child or young person developing a secure attachment with a primary caregiver. This will provide evidence for minimising placement disruption often experienced by children and young people and the importance of finding a stable, supportive home for those in care.

The study design may be a cross-sectional study of children and young people on the edge of care, in care and adopted from care to ascertain the number of children who have attachment difficulties and/or complex trauma.

In addition, data are collected on potential explanatory factors (for example, multiple placement) for the outcome of attachment difficulties, complex trauma or both.

Primary outcome measures may include:

- attachment
- carer sensitivity
- placement disruption
- complex trauma.

A large number of children are needed to attain power to detect a difference and for running a multiple regression analysis. Qualitative data may also be collected on the child or young person's experience in care.

Children's attachment implementation: getting started

This section highlights 3 areas of the children's attachment guideline that could have a big impact on practice and be challenging to implement, along with the reason(s) why we are proposing change in these areas (given in the box at the start of each area). We identified these with the help of stakeholders and guideline committee members (see section 12 of the developing NICE guidelines manual). The section also gives information on resources to help with implementation.

The challenge: stability of care

See recommendation 1.1.3.

> Stable care enables children to form secure attachments and has benefits for a child's education, health and emotional development. Greater stability can be delivered in part by a reduction in the number of care placements for any one child, which in turn will reduce immediate costs to the local authority by reducing social workers' time, use of expensive agency and residential placements, and therapeutic support. Providing more stable care will also help local authorities meet the Department for Education and Department of Health and Social Care's statutory guidance on the planning, commissioning and delivery of health services for looked-after children for promoting the health and wellbeing of looked-after children, and in delivering permanency planning.

Improve placement stability

Frequent moves in and out of care, and frequent placement changes within the care system damage children's capacity to form attachments and reinforce their experiences of transience, separation and loss. In England, the latest from the Department for Education statistics on looked-after children show that 11% (7,572) of all looked-after children had 3 or more placements in the year ending 31 March 2014. This percentage has remained the same since 2010. Multiple placements have significant cost implications, as the more frequently children move, the more difficult they are to place and, as a result, the costs of

both arranging and maintaining new placements increase exponentially (Costs and Consequences of Placing Children in Care; Ward, Holmes and Soper, 2008. pp91–95).

To do this, Children's Service Managers could:

- Use the Department for Education's Looked-after children: improving permanence – data pack (2013) to identify the factors that may impact on success in achieving placement stability.
- Use the National Society for the Prevention of Cruelty to Children (NSPCC) tool Reunification: an evidence-informed framework for return home practice to develop a system that supports parents to overcome the difficulties that precipitated the admission to care; ensures these difficulties have been resolved before reunification, and supports both parents and children through the process of reunification.
- Monitor the number of moves initiated by the local authority and introduce strategies to reduce them. Department for Education statutory guidance, Children Act 1989: care planning, placement and case review (2015) can help with this, setting out how local authorities should carry out the full range of responsibilities in relation to care planning, placement and review for looked-after children.

Increase the pool of available placements

Most of the moves for children in the care system are planned transitions, initiated by the local authority, in order to transfer a child from 1 placement to another that might better meet their needs. Although the vast majority of children who come into care are already known to social services, many admissions (and re-admissions) are unplanned, following the breakdown of an already fragile family. About two-thirds of abused and neglected children who return home from care are subsequently readmitted into care, often as emergencies. When children enter care as emergency admissions, immediate placements need to be found. If the pool of placements available is small, the first placement may not be appropriate. For example, siblings may not be able to stay together or the new circumstances may not meet the child's cultural needs.

The Fostering Network's Update to the cost of foster care report provides an estimate of the investment needed to provide a properly resourced foster care service.

To help increase available placements, Children's Service Managers could:

- Monitor the number of emergency, unplanned admissions to care and introduce strategies to reduce them.
- Identify and act on any changes in the system that could help to reduce delays in recruiting and approving adoptive carers.

Improve continuity of relationships

Creating stability in a child's life is multi-faceted, and instability in 1 area can have a knock-on effect on a number of other important relationships in a child's life. For example, when children change care placement, they may be unable to remain in the same school, to continue in a health programme, or to continue to have support of the Children and Adolescent Mental Health Services (CAMHS) professionals. Encouraging continuity in all aspects of a child's life where possible will involve working across regional boundaries and the development of policies that enable professional and personal relationships to continue where these are beneficial.

To do this, children's service managers could develop policies to:

- Encourage continuity of attachment figures, for example, by maintaining contact with former foster carers where possible after a child has been adopted.
- Promote continuity of friendships, where these friendships are healthy for both parties, by allowing children to keep in contact with friends from home and those they have made in previous placements.
- Enable children to stay in the same school and work with the same mental health worker or team regardless of where they are placed or whether they are in care or on the edge of care. Sometimes this will mean accessing services outside of the child's residential area.
  The Department for Education's Innovation Programme is funding several projects to investigate how best to support stable relationships for children in care.

The challenge: assessing attachment difficulties

See recommendation 1.3.1.

The terms attachment disorder and insecure or disorganised attachment behaviour are often confused and wrongly used interchangeably. Attachment disorder is a recognised mental disorder that affects a very small minority of children experiencing attachment problems. Insecure or disorganised attachment occurs much more commonly and is an indicator of possible dysfunction in a child's attachment system that can lead to poor outcomes, particularly in the case of disorganised attachment. Using terms consistently is important so that professionals can communicate effectively, and commissioners or service managers can plan care appropriately. A clearer and consistent understanding of both types of attachment problem will enable commissioners to distinguish between the capacity needed for more specialist children's services and for primary and secondary level services that are more widely available.

Being able to assess attachment problems may also be helpful for staff working regularly with a child in order to establish whether an intervention has been successful or if more support is needed.

Training

Initially the guidance may present a resource challenge because all health and social care staff working with children and young people in any setting should be trained in the recognition and assessment of attachment difficulties.

To do this, children's service managers could:

- Train staff to use assessment tools to guide decisions on children and young people who have or may have attachment difficulties. There are a number of tools currently available. These are listed in recommendation 1.3.4 of the guideline.

Local authorities and CAMHS services could:

- Consider commissioning high-quality training at 2 levels:
  - A generic training, for everyone who works with children in foster care, special guardianship, and adoption, or children on the edge of care, about what assessment problems are and what they look like. The MindEd e-learning programme has a module on attachment and human development, aimed at a

universal audience, and another module on attachment and attachment problems for experienced or specialist users.

- Face-to-face training that covers how to reliably and consistently conduct an assessment of possible attachment problems using recognised attachment tools. Such training is regularly advertised but creating a 'notice board' shared by local authority teams could be helpful.

Also, organisations responsible for professional training qualifications could:

- Integrate training on attachment into the generic training of psychiatrists, psychologists, social workers, nurses and teachers.
- Work together to develop a national training toolkit for assessing attachment problems and for working with children with attachment needs.

The challenge: using video feedback programmes

See recommendations 1.4.1, 1.4.2 and 1.5.1.

Video feedback is a relatively low-cost intervention that can be used to help improve a carer's responsiveness to a child's emotional needs and to promote secure attachment. About 40% of placement moves occur following a breakdown of the relationship between child and carer. Insufficient emotional and practical support for carers and inadequate therapeutic support for children who have experienced abuse and neglect are major reasons for placement breakdown. The use of video feedback programmes to improve parenting skills should help provide a more stable environment for the child, and may prevent problems from escalating to the point where a child needs to be taken into the care of the local authority.

Training

The guidance recommends that 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. In the UK, Video Interaction Guidance (VIG) is the most widely available training programme. There are other types of video feedback training available in Europe. The Tavistock and Portman NHS Foundation Trust is currently working with the

Consortium of Voluntary Adoption Agencies (CVAA) to introduce Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD), which is a video feedback programme developed by Leiden University that is available on a national scale to all adopters in the Netherlands.

To find out more about training, children's service managers could:

- Visit the website for the Association for Video Interaction Guidance UK (AVIGuk), which has information about how to get started with an introductory training course, as well as details of how to contact members of the association close to you who have been accredited to provide training. Tavistock and Portman NHS Foundation Trust has details of available courses.
- Stay informed about training developments in this field, for example, the Infant Caregiver project in California, USA and attachment training workshops at the University of Quebec, Canada, which were reviewed as part of the evidence supporting the recommendations for this guideline.

Concerns about filming

Both professionals and carers are sometimes wary of using video feedback because of a fear about how the film may later be used.

To help address some of these concerns, the professional delivering a video feedback intervention could:

- Ensure that permission to film is granted by the head of service and that there is a service policy on video recordings.
- Ensure that carers are given a clear explanation of who could potentially view the video and under what circumstances, and that they provide written consent for themselves and their child to be filmed for the purpose of the intervention. The AVIGuk website has a sample permission form that may help you construct your own documents.
- Ensure that any staff booking appointments can talk confidently and competently to carers about the clinical use of video and confidentiality.
- Ensure all filming equipment and footage is stored in accordance with the Data

Protection Act 1998. There needs to be a clear protocol for storing information so that carers can trust a practitioner to store the video clips of their 'better than usual interaction' securely and how these will be used. The AVIGuk website has a sample NHS protocol that may help you construct your own documents.

Need more help?

Further resources are available from NICE that may help to support implementation.

- NICE produces indicators annually for use in the Quality and Outcomes Framework (QOF) for the UK. The process for this and the NICE menu can be found on the NICE Quality and Outcomes Framework indicator webpage.
- Uptake data about guideline recommendations and quality standard measures are available on the NICE website.

Context

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. Early attachment relations are thought to be crucial for later social relationships and for the development of capacities for emotional and stress regulation, self-control and mentalisation. Children and young people who have experienced insecure attachments are more likely to struggle in these areas and to experience emotional and behavioural difficulties.

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, special guardians 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, which can often evolve into coercive controlling or compulsive caregiving patterns in children of preschool age or older. The term 'attachment difficulties' in this guideline also covers 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. On 31 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 to 12 years) and young people (aged 13 to 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 (including kinship foster care), residential settings 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.

Update information

Minor changes since publication

November 2023: We changed Story Stem Attachment profile to Story Stem Assessment Profile in recommendation 1.3.4 and appendix 1.

May 2016: A link to the National Society for the Prevention of Cruelty to Children (NSPCC) framework for return home practice in the implementation section was corrected.

Appendix 1

Table 1 Assessment tools to guide decisions on interventions for children and young people who have or may have attachment difficulties

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

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