NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

SCOPE

1 Guideline title

Children's attachment: the attachment and related therapeutic needs of looked-after children and children adopted from care.

1.1 Short title

Children's attachment

2 The remit

The Department of Health and the Department for Education have asked NICE: 'to develop guidance on the attachment and related therapeutic needs of looked-after children and children adopted from care.'

3 Need for the guideline

3.1 Epidemiology and background

a) The key feature of attachment is seeking out an attachment figure in the face of threat. The main function of attachment behaviour is the regulation of the infant or child's emotional state by the primary caregiver, particularly when they are distressed. This is known as the dyadic regulation of affect. Attachment is widely regarded to be a genetically engendered bio-behavioural feedback mechanism. However, attachment patterns, styles and problems in infants, children and young people are influenced by the caring environment, especially for looked-after children and young people, those at high risk of being looked after (children or young people who are being considered for care or those subject to care proceedings, sometimes called being 'on the edge of care'), and those adopted from care.

b) In 2012 there was a point prevalence of 59 looked-after infants, children and young people per 10,000 in England, amounting to over 67,000 in total (excluding children placed under an agreed series of short-term placements). This figure has risen year on year for the last 5 years. Most of these children fall into the 10-15 year age group, although younger groups have contributed to most of the increased numbers of children going into care over the last 5 years. The period prevalence for looked-after children in 1 year to 31 March 2012 was just over 93,000, with each child remaining in care for an average 261 days.

c) Boys account for 55% of all children in care. Although family problems (family dysfunction, acute family distress or parental illness) led to about a quarter of children going into care, 62% directly resulted from child abuse and neglect.

d) Over 75% of looked-after children are classified as white, with black and black British (7%), mixed (9%) and Asian and Asian British (4%) accounting for most of the rest. Sixty per-cent of looked-after children are placed under either interim or full care orders; and a further 29% are subject to voluntary agreements under Section 20 of the Children Act 1989. Importantly, just over 3% of all looked-after children in England were unaccompanied asylum-seeking children; the vast majority of these being boys aged 16 or over.

e) Of the 67,000 infants, children and young people in care on 31 March 2012, 75% were in foster care, 4% were placed for adoption, 5% were in placements with their parents, 9% were in secure units, children's homes and hostels, and only 1% were in a residential school. Two thirds of children had been subject to a single placement in the preceding year, with 11% experiencing 3 or more placements in that year.

f) Just over 28,000 children started to be looked after in the same year, and about the same number stopped being looked after during that year; with 37% returning to live with their parents or relatives, 13% being adopted and the rest living independently or under a variety of different circumstances, such as guardianship orders for foster parents or with other carers.

g) Children who are adopted from care are mainly adopted between the age of 1 and 4 years old (74%) with a smaller number (21%) between 5 and 9 years. Adopted children have been in care mainly as a result of abuse and neglect (74%) or family dysfunction. Most (72%) adopted children will have been in care continuously for a period of between 1 and 3 years, and for most of these (65%), this period of care will have started in the first year of life.

h) Infant attachment is classified as 'secure', 'insecure' or 'disorganised.' This classification is stable over time in the absence of changes to caregiving because of the 'internal working models' that develop as a result of early interactions between the parent and infant.

i) The parents' attachment status (secure, insecure an disorganised) is a significant predictor of the infant or child's attachment classification, and the transmission of attachment styles, patterns and problems from one generation to the next is a function of a number of aspects of early caregiving, including sensitivity and attunement and parental reflective function. Recent research also suggests that some children are generally more susceptible to their early caregiving environments and that this may have a biological basis.

j) Infants and children who receive responsive and attuned caregiving during the first 18 months of life develop secure attachments to their primary caregiver. These infants and children

can be comforted by their caregivers and use their caregiver as a secure base from which to explore their environment. It is estimated from population samples that around two-thirds of children are securely attached. These children have better outcomes than non-securely attached children across all domains, including social and emotional development, educational achievement and mental health.

k) Infants and children who receive caregiving that is erratic or intrusive typically develop ‘insecure anxious-ambivalent’ attachments. These infants and children maintain proximity to their caregiver by ‘up-regulating’ their emotional states: they become anxious and clingy and cannot be calmed when comfort is offered. Around 8-10% of children are classified as having insecure anxious-ambivalent attachment.

l) Infants and children who receive caregiving that is rejecting or punitive typically develop ‘insecure anxious-avoidant’ attachment. These infants and children maintain proximity to their caregiver by ‘down-regulating’ their emotional state: they appear to manage their own distress and not to need comfort. Around 20% of children are classified as having insecure anxious-avoidant attachment.

m) Infants and children who receive caregiving that is described as being ‘atypical’ and involves distorted parenting practices (including abuse and maltreatment) typically develop disorganised attachments. This is usually in the context of parents being severely stressed (for example, those who are subject to domestic violence, engage in substance misuse or have significant mental health problems). These parents are typically both (psychologically) frightened and (behaviourally) frightening. Around 80% of children who suffer maltreatment are classified as having disorganised attachment. A disorganised

classification is strongly predictive of later social and cognitive problems, and psychopathology.

n) Although particular types of attachment classification (especially, disorganised) may indicate a risk for later problems, these classifications do not represent a disorder.

o) In addition to the classification of attachment as secure, insecure or disorganised, a number of types of 'attachment disorders' have been defined. Reactive attachment disorder (RAD) includes two subtypes: inhibited and disinhibited (DSM-IV-TR). Both types of disorder, which can coexist, include markedly disturbed and developmentally inappropriate behaviours.

p) Children under 5 years who show signs of the inhibited type of RAD typically fail to initiate or respond to social interactions, and do not seek and/or accept comfort at times of distress or threat. Children with the disinhibited type show indiscriminate sociability and are excessively familiar with strangers.

q) Attachment disorders can occur in any setting, although they occur commonly as the result of institutional rearing in which there is a repeated change of primary caregiver and/or neglectful primary caregivers who persistently disregard the child's attachment needs. Looked-after children are clearly at greater risk in this respect than the wider population. In addition, they are also affected by being separated from their primary caregivers, regardless of whether the attachment to them was in itself good or problematic.

r) The limited evidence available about the attachment classification and/or prevalence of attachment disorders in looked-after children and young people and those adopted from care suggests that only 10% are securely attached to their biological parents. Many have experienced significant levels of abuse and neglect, which are strong predictors of both disorganised attachment and

attachment disorder. The prevalence of mental health problems is significantly higher in looked-after children and young people and those adopted from care. For children and young people who have been in care, when compared with those who have not, 42% of children aged 5-10 years and 49% of young people aged 11-15 years develop mental health problems compared with 8% and 11%, respectively.

3.2 Current practice

a) Current practice is divided into approaches to treatment, care and support that focus on:

(i) the needs of looked-after children and young people and those adopted from care, and

ii) the needs of children and young people with identified insecure or disorganised attachment or an attachment disorder.

b) Current approaches aim to prevent or treat problems that are likely to arise in looked-after children and young people or those at high risk of being looked after. Examples of preventive programmes targeting those at high risk of being looked after include:

(i) family drug and alcohol courts, which comprise a new approach to care proceedings where drug dependency in a parent is the major problem

(ii) family group conferencing, which is being used by 60 local authorities to plan care for children at high risk, and

(iii) multisystemic therapy for young people (aged 11-17 years) and their families, when there is a risk of out-of-home placement (care or custody) and there has been poor engagement with services.

c) Examples of prevention and treatment interventions for looked-after children and young people include programmes explicitly aimed at supporting foster carers to meet the needs of those in their care. Examples include Fostering Changes Circle of Security; Attachment and Bio-behavioural Catch-up; the New Orleans Intervention; multidimensional treatment foster care (MTFC); Staying Put; and Social Pedagogy (aimed at local authority children's homes).

d) The alternative approach involves interventions that focus explicitly on children and young people with insecure or disorganised attachment or attachment disorders whether the child or young person is looked after or not. A range of such prevention and treatment programmes have been developed during the past 2 decades. Although their focus reflects the underpinning theoretical model, they are all primarily aimed at improving the child or young person's attachment classification (usually from disorganised/insecure to secure) or RAD. They do this primarily by improving the sensitivity and responsiveness of the carergiver to the child or young person's attachment needs. Attachment-specific interventions are either dyadic (involve both parent or carergiver and child or young person) or focus on the child or young person. They are often combined with other psychological or psychosocial interventions for the child, the parent/caregiver or the family (see 'f') below).

e) Dyadic treatments can be categorised according to the underpinning theory of change, namely:

(i) behavioural approaches, such as video interaction guidance

(ii) psychotherapeutic approaches

(iii) combined behavioural and psychotherapeutic approaches, such as Watch, Wait and Wonder, and

(iv) programmes based on mentalisation, such as Minding the Baby and the Infant and Toddler Program.

f) Treatment plans for children and young people with insecure/ disorganised attachment and attachment disorders may also include a range of other non-specific psychosocial interventions (for example, family therapy, individual psychological counselling, play therapy, special education services and parenting classes).

g) Medication may be used to address some of the symptoms commonly experienced by these children and young people (hyperactivity, anxiety, depression), but is not used to treat insecure/ disorganised attachment or attachment disorder.

h) A range of so-called 'attachment therapies' have also emerged over the past decade and include extreme forms of physical and coercive techniques (for example, holding therapy, rebirthing, rage-reduction and the Evergreen model). These treatments have resulted in a number of child deaths in the US and a US Task Force (2006) was critical of their use, and they have also been strongly opposed by professional groups.

4 The guideline

4.1 Population

4.1.1 Groups that will be covered

a) Infants, children and young people (aged 0–18 years) who:

i) are ‘looked-after children and young people’ defined as those who are looked-after by local authorities under Section 22 of the Children Act 1989 in residential care, foster care, young offender institutions or boarding school

ii) are adopted from care

iii) have left care, including those who have returned to live with their parent(s) or family.

Question for stakeholders: Should the guideline also look at infants, children and young people who are considered to be at high risk of being looked-after (commonly, infants, children or young people who are being considered for care proceedings or are subject to them)?

So that you can comment on the implications of including this group, the relevant parts of the scope are *italicised*.

b) Specific attention will be given to the children of parents with mental health and substance misuse problems and to the needs of groups at increased social disadvantage such as: children and young people from black and ethnic minority groups, those who are unaccompanied immigrants or asylum-seekers, and those with disabilities, including learning disabilities.

4.1.2 Groups that will not be covered

a) Children and young people with attachment problems or disorders who are not looked after, *at high risk of being looked after*, or adopted from care.

b) Children and young people who are adopted internationally.

c) Adults over the age of 18 years.

4.2 Setting

a) Any setting in which health or social care professionals have direct contact with looked-after children and young people, those *at high risk of being looked after*, those adopted from care, or those who have left care, including those who have returned to live with their parent(s) or family. This will include:

i. A range of community settings including fostering, residential and kinship care settings.

ii. Primary care settings.

iii. Secondary care settings.

iv. Young offender institutions

b) All educational settings where looked-after children and young people, *those at high risk of being looked after*, those adopted from care and those who have left care, including those who have returned to live with their parent(s) or family, are educated.

4.3 Management

4.3.1 Key issues that will be covered

a) Identification of the familial/ parental and environmental factors associated with the development of attachment problems and disorders.

b) The short, medium and longer term effects of attachment problems and the extent to which these can be modified through intervention

c) The identification of factors and experiences that may increase or decrease the risk of attachment-related problems, including:

a. factors and experiences that generate the attachment problems in the child or young person's history

b. the child or young person's interpretation of these experiences

c. the child or young person's experience of care proceedings leading to being looked after

d. the child or young person's experience of being looked after

e. the child or young person's experience of adoption.

d) Identification and diagnosis of insecure/disorganised attachment or an attachment disorder in looked-after children and young people, *those at high risk of being looked after*, those adopted from care, and those who have left care, including those who have returned to their parent(s) or family.

e) Psychosocial and pharmacological interventions aimed at the child, the parents/caregivers or the family for prevention and treatment of attachment problems, and the balance of risk and benefit for the child or young person.

4.4 Main outcomes

a) Disorganised attachment and/ or attachment disorders.

b) Child-focused objective measures of cognitive, educational and social functioning with known links to attachment.

c) Child-focused subjective measures of wellbeing and social experience with known links to attachment.

d) Specific indicators of behavioural, cognitive and emotional problems severe enough to indicate clinical intervention (for example,emotional and behavioural difficulties, or violence).

e) Child-focused measures of developmental status based on psychological and biological indicators that are believed to underpin indicators of functioning and experience and which have known links to attachment.

f) Relationship-focused measures of social interaction between the parent or caregiver and child or young person.

g) Relationship-focused measures of parenting attitudes/ behaviour known to predict attachment and linked outcomes for children and young people (for example, sensitivity and attunement).

h) Parent-focused measures of cognitive, emotional and behavioural functioning known to relate to the quality of parenting (for example, reflective function, mental health and substance use).

i) Events and experiences likely to bear on the attachment outcome of being looked after or being adopted from care and indicative of the quality of life (for example, out-of-home placements, care orders, trauma and care processes).

j) Global indicators of quality of life to enable health economic calculations.

4.5 Review questions

4.5.1 Prediction, identification and assessment

a) What familial and environmental factors are associated with the later development of insecure/disorganised attachment or an attachment disorder in looked-after children and young people, *those at high risk of being looked after*, those adopted from care and those who have left care, including those who have returned to live with their parent(s) or family?

b) What procedural features for taking children and young people into local authority care are associated with an increase or decrease in the risk of developing insecure/disorganised attachment or an attachment disorder?

c) What features of arrangements made for children and young people in each looked-after setting (residential, fostering, kinship care), and those related to adoption or when a child or young person leaves care, including returning to parents, are associated with an increase

or decrease in the risk of developing insecure/ disorganised attachment or an attachment disorder?

d) What instruments/ tools can be used to identify insecure/ disorganised attachment or an attachment disorder in looked-after children and young people, *those at high risk of being looked after* and those adopted from care? How valid and reliable are they?

e) What instruments or tools can be used to predict insecure/ disorganised attachment or an attachment disorder in looked-after children and young people, *those at high risk of being looked after* and those adopted from care? How valid and reliable are they?

f) What is the optimal procedure for assessment and identification of attachment problems in looked-after children and young people, *those at high risk of being looked after* and those adopted from care?

4.5.2 Prevention of attachment problems or disorders

a) What interventions are effective in the prevention of insecure/ disorganised attachment or attachment disorders in children and young people at high risk of being looked after? What are the risks associated with the each intervention?

b) What interventions are effective in the prevention of insecure/ disorganised attachment or attachment disorders in children and young people in the early stages of being looked after? What are the risks associated with the each intervention?

c) What interventions are effective in the prevention of insecure/ disorganised attachment or attachment disorders in children and young people who have been adopted from care? What are the risks associated with the each intervention?

d) What interventions are effective in the prevention of insecure/ disorganised attachment or attachment disorders in children and young people who have left care, including those who have returned

to live with their parent(s) or family? What are the risks associated with the each intervention?

4.5.3 Treatment of disorganised attachment and attachment disorders

a) What interventions are effective in the treatment of children and young people with insecure/disorganised attachment or attachment disorders? Are these interventions effective in looked-after children and young people, *those at high risk of being looked after*, those adopted from care and those who have left care, including those who have returned to live with their parent(s) or family? What are the risks associated with each intervention?

4.6 Economic aspects

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is the quality-adjusted life year (QALY) but a different unit of effectiveness may be used depending on the availability of appropriate clinical and utility data for children and young people with insecure/disorganised attachment or an attachment disorder. The costs considered will usually be only from an NHS and personal social services (PSS) perspective, although economic analyses will attempt to incorporate wider costs associated with the care of children and young people with attachment problems or disorders if appropriate cost data are available. Further detail on the methods can be found in 'The guidelines manual' (see ‘Further information’).

4.7 Status

4.7.1 Scope

This is the consultation draft of the scope. The consultation dates are Thursday 3rd October 2013 to Thursday 31st October 2013.

4.7.2 Timing

The development of the guideline recommendations will begin in December 2013.

5 Related guidance

5.1 Published NICE guidance

- Antisocial behaviour and conduct disorders in children and young people. NICE clinical guideline 158 (2013).
- Looked-after children and young people. NICE public health guidance 28 (2010)
- Pregnancy and complex social factors. NICE clinical guideline 110 (2010).
- Alcohol-use disorders – preventing harmful drinking. NICE public health guidance 24 (2010).
- Reducing differences in the uptake of immunisations. NICE public health guidance 21 (2009).
- Social and emotional wellbeing in secondary education. NICE public health guidance 20 (2009).
- When to suspect child maltreatment. NICE clinical guideline 89 (2009).
- Schizophrenia (update). NICE clinical guideline 82 (2009).
- Borderline personality disorder. NICE clinical guideline 78 (2009).
- Antisocial personality disorder. NICE clinical guideline 77 (2009).
- Social and emotional wellbeing in primary education. NICE public health guidance 12 (2008).
- Attention deficit hyperactivity disorder. NICE clinical guideline 72 (2008).
- Behaviour change. NICE public health guidance 6 (2007).

- Interventions to reduce substance misuse among vulnerable young people. NICE public health guidance 4 (2007).
- Prevention of sexually transmitted infections and under 18 conceptions. NICE public health guidance 3 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Obsessive–compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).
- Depression in children and young people. NICE clinical guideline 28 (2005).
- Post-traumatic stress disorder (PTSD). NICE clinical guideline 26 (2005).
- Violence. NICE clinical guideline 25 (2005).
- Self-harm. NICE clinical guideline 16 (2004).
- Eating disorders. NICE clinical guideline 9 (2004).

5.2 Published SCIE guidance

- Experiences of children and young people caring for a parent with a mental health problem.SCIE Research briefing 24 (2008).
- Working with challenging and disruptive situations in residential child care: sharing effective practice. SCIE Knowledge review 22 (2008).
- Fostering. SCIE Guide 7 (2004)
- Preventing teenage pregnancy in looked-after children. SCIE Research briefing 9 (2004).
- Promoting resilience in fostered children and young people.SCIE Resource guide 6 (2004).
- Working with families with alcohol, drug and mental health problems. SCIE Report 2.(2003).
- Returning children home from public care. SCIE research briefing 42 (2012)

5.3 Centre for Excellence and Outcomes in Children's Services (C4EO) publications

- Vulnerable children: knowledge review 1. Improving educational outcomes for looked-after children (2010).
- Vulnerable children: knowledge review 2. Improving the emotional and behavioural health of looked-after children and young people (2010).
- Vulnerable children: knowledge review 3. Increasing the numbers of care leavers in 'safe settled accommodation' (2010).

5.4 NICE Guidance under development

NICE is currently developing the following related guidance (details available from the NICE website):

- Challenging behaviour and learning disabilities. NICE clinical guideline (TBC).

6 Further information

Information on the guideline development process is provided in the following documents, available from the NICE website:

- 'How NICE clinical guidelines are developed: an overview for stakeholders the public and the NHS'
- 'The guidelines manual'.

Information on the progress of the guideline will also be available from the NICE website.