# Children's Attachment

## Consultation on draft guideline - Stakeholder comments table
## 01/06/2015 to 13/07/2015

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| Adoption UK | Short | | 3<br>-4 | The scope of the recommendations and guidance is narrowly focused and doesn't satisfactorily address the fact that attachment difficulties are often part of the wider impact of early trauma/abuse; which is more helpfully explained within the context of neurobiology and brain development than one of mental illness. Adoptive parents would find it more helpful for their children's difficulties to be understood consistently by the professional community as linked to developmental immaturity. This would allow all interventions to be considered in the light of a child's previous experience and prioritise the need to equip parents and carers to provide the main therapeutically safe and secure base for their child - which then would need to be followed through and supported, particularly within the school setting.<br>Adoption UKs experience from over 40 years of supporting adopters is that adopters who are empowered and supported to use counter-intuitive therapeutic parenting techniques e.g. those shaped from Dyadic Developmental Psychotherapy have more success in understanding their child's world, revising their parenting approach accordingly and helping their child to manage their behaviours and emotions. Should the same preventative understanding and 'normalising' approach be taken within other professional communities it is conceivable that fewer children may be referred for an assessment of attachment difficulties? | Thank you for your comment. There was no evidence to suggest Dyadic Developmental Psychotherapy is effective but accept many people have been helped by this. |
| Adoption UK | Short | | 170 | Given the comment above this section could be broader and also | Thank you for your comment. Understanding trauma |

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| | | | -179 | refer to all children who have experienced developmental trauma, neglect, abuse in early childhood | has been added to this recommendation (1.3.2). |
| Adoption UK | Short | | 183<br>-195 | Whilst welcoming the clear message that key workers across disciplines need to be better trained in recognising and assessing attachment difficulties is critical that this is applied across the broader context as described above | Thank you for your comment. The Guideline Committee feels that it has addressed the 'broader context' of early trauma and abuse in the guideline – see recommendations 1.3.1-1.3.2, 1.4.9-1.4.10 and 1.4.12-1.4.13. We feel we have included all the relevant health care workers that should respond to this recommendation. |
| Adoption UK | Short | | 198 | VIG intervention within the family environment is welcomed as appropriate for those families where a child has been 'diagnosed' as having an attachment difficulty within the narrow definition applied in this guidance – however there are concerns about the cost of training, supervision, equipment and delivery. There are a range of other, less costly, interventions including Dyadic Developmental Psychotherapy, Great Behaviour Breakdown, Non Violent Resistance that adoptive parents report have been effective in e.g. helping their child regulate which helps parents cope with the range of behavioural challenges they face from their traumatised child.<br>Adoption UK would welcome further research on the use and effectiveness of various therapeutic parenting tools | Thank you for your comment. Given the lack of evidence pertaining to the interventions you mention the decision regarding VIG was made by the Guideline Committee. |
| Adoption UK | Short | | 219<br>-225 | Access to programmes to improve social skills and maintain positive relationships should be part of, as a minimum, for the wider group of children who experienced early trauma, and preferably as part of whole school curriculum | Thank you for your comment. Recommendations relating to education settings are made for <u>all</u> children who may have attachment difficulties |

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| Adoption UK | Short | | 227<br>-234 | Parental experience is that trauma linked behaviours are potentially ever present and it is not possible to logically anticipate when to modify interventions, therefore a group work experience may not be sufficient and 1:1 support also needs to be readily available, possibly outside of the school environment | The Guideline Committee agree that complex trauma often overlaps with attachment difficulties. Due to the lack of evidence available on this topic, the Guideline Committee identified this as a key area of uncertainty and generated a research recommendation to better understand how big this problem is. The Guideline Committee have also added a comment to the beginning of the guideline to ensure issues surrounding past trauma are addressed separately to helping the child develop an attachment to their foster carer or adoptive parents |
| Adoption UK | Short | | 350<br>-352 | Helpful to include the need to proactively monitor difficulties, however there are also opportunities to deploy a range of alternative early interventions, as mentioned in point 4 above. | Thank you for your comment. The Guideline Committee agree that early interventions should be deployed. For this reason, this recommendation comes after a recommendation to offer comprehensive education and training for potential carers.<br><br>The recommendation to "proactively monitor difficulties" was based on RCT and observational evidence that placement breakdown is reduced if carers receive on-going support from social care workers when needed.<br><br>The details of the interventions and the support that could be provided are described elsewhere later in the guideline . |

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| Adoption UK | Short | | 372 | It is helpful to have a sound principle about keeping siblings together if possible – however this needs to be expanded to give some guidance to explain what makes this possible – i.e. not connected to any financial/organisational issues but as a result of a sound assessment of the determining factors including children's wishes, each child's individual needs and the capacity of potential parents to meet these; plus an examination of the level and types of support likely to be required to achieve this. | Thank you for your comment. The recommendation is made in the context of improving the likelihood of more permanent placements, based on evidence that keeping siblings together is a factor in this regard. The recommendation does have a caveat that this should only be done if it is in the best interests of children. However, the Guideline Committee recognises that parenting groups of children with attachment difficulties is challenging and has modified recommendation 1.1.13 to alert professionals to such situations. |
| Adoption UK | Short | | 379 -389 | This is very welcome reminder and adoptive parents would like to see even greater emphasis given to the importance of a record of all significant people from a child's life being recorded | Thank you for your comment. In light of your comment, and comments from others, the recommendation has been changed to say that social workers 'should keep a record' rather than 'should consider' (1.1.17). |
| Adoption UK | Short | | 391 | Safeguarding – context should be broadened to include safeguarding for the whole family. This should include a better understanding of assessing the likelihood of false allegations and parental partnership and involvement continuing beyond placement disruption | Thank you for your comment. The recommendation is specifically regarding the safeguarding/monitoring during treatment because this is an area where safeguarding can be neglected. More specifically, the recommendation is asking professionals to monitor good and bad outcomes during treatment with a particular focus on safeguarding. It is not a general recommendation on safeguarding. Therefore, the heading has been amended. |
| Adoption UK | Short | | 397 | Adoptive parents welcome the clear message to avoid use of medication to treat attachment difficulties and would like to see | Thank you for your comment. The Guideline Committee have made a research recommendation for |

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| | | | | more research conducted in relation to appropriate treatments for children who have suffered early trauma and have coexisting mental heath problems. | more studies on interventions that target older children with attachment difficulties and those who have been maltreatment. |
| Adoption UK | Short | | 405 -408 | Adopted children and their parents should have a voice in the design and delivery of awareness raising programmes for schools | Thank you for your comments. The Guideline Committee has changed the recommendation to say that children and young people and their parents and carers should be involved in designing training courses for teachers (1.2.2). |
| Adoption UK | Short | | 427 -431 | This section needs to recognise and take account of differing views from adoptive parents about accurate and safe record keeping in schools in relation to their child's adoption status – this is through fear of information being shared too widely/inappropriately and children becoming labelled. However the adopter community strongly support the need for all adopted children to continue post order to have a Personal Education Plan and for their interests to be monitored and promoted through the Virtual School | Thank you for your comment. The Guideline Committee appreciates your concerns about safe record keeping and sharing of information and has made an addition to recommendation 1.2.4 that designated teachers should be trained in data protection and confidentiality. |
| Adoption UK | Short | | 469 -491 | Adopters would like to see greater emphasis in this section in involving the child and taking full account of their wishes and feelings | Thank you for your comment. Taking account of the child's wishes, needs and preferences is covered in the 'Person-centred care' section at the start of the short version. |
| Adoption UK | Short | | 451 | Re school exclusions – Adoption UK fully supports this part of the guidance and would contend that the active role of the Virtual School would go some way to ensure that neither fixed term or permanent exclusions are used inappropriately or too readily for adopted children | Thank you for your comment. It is important to note that the statutory role and responsibility of Virtual School Heads is for Looked After Children and not for all children who may have attachment difficulties. |

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| Adoption UK | Short | | 456 -468 | It is very important that this section be expanded to include the assessment of children who have experienced early trauma/abuse /neglect | Thank you for your comment, however the Guideline Committee judges that trauma and maltreatment are adequately covered in recommendations 1.3.1 and 1.3.2. |
| Adoption UK | Short | | 500 -514 | Given the narrow approach throughout this proposed guidance it is really important that there is clarity about the knowledge and skills required to apply and interpret findings in relation to the specified assessment tools. Many of these will be unfamiliar to children's social work practitioners for example. | Thank you for your comment. The Guideline Committee has added a further recommendation stating that health and social care practitioners should be trained in the use of the assessment tools (1.3.5). |
| Adoption UK | Short | | 521 -527 | As above – who is considered to be suitably skilled and qualified to diagnose an attachment disorder? | Thank you for your comment. The Guideline Committee did not consider it appropriate to state this in the recommendation because of the range of possible professionals involved. |
| Adoption UK | Short | 22 -30 | | Re proposed interventions – this section is aspirational and welcomed but needs, alongside it, a range of less intensive interventions – as raised above - for the broader group of children who have experienced early trauma. It also needs to indicate where costs and responsibilities of such service delivery are to be found | The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered.<br><br>Identifying interventions that target children who have experienced early trauma is outside of our scope.<br><br>. |
| Association of Child Psychothera | Short | 26 | 633 | The ACP would like to add that children and young people who have been maltreated show signs of developmental trauma, which is more complex than post-traumatic stress disorder, as it | Thank you for your comment. NICE generally do not specify who should deliver the intervention, unless it's an area of concern that qualified practitioners are not |

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| pists | | | | is experienced during their crucial developmental years and impacts on their levels of functioning at a sensory level, cognitively, socially, emotionally and behaviourally. The treatment therefore needs to be delivered by practitioners who are experienced in working with developmental trauma sooner than a pure model of cognitive behavioural therapy. | delivering the care. |
| Association of Child Psychothera pists | Full | General | | The ACP believes the guideline is set out well – detailed and sensitively covers most of the challenges, problems, behaviours and presentations connected to attachment patterns, difficulties and disorders. | Thank you for your comment. |
| Association of Child Psychothera pists | Full | 18 | 10 | Parent-child psychotherapy is mentioned as a psychodynamic intervention which is positive as so often psychoanalytic interventions are not highlighted, however, psychodynamic child psychotherapy can also work with the individual child to help focus on internal working models and version of attachment figures while the parents receive therapeutic work alongside individual work with the child. | Thank you for your comment. The Guideline Committee made recommendations on interventions based on the best evidence available. Thus, some interventions we recommended will target the parents/carers with or without the child. The Guideline Committee acknowledge there are other interventions currently being used that lack high quality evidence, and agreed that they were key areas of uncertainty. For this reason they made a research recommendation to: "Evaluate currently unevaluated but extensively used interventions for attachment difficulties." |
| Association of Child Psychothera pists | Full | 22 | 51 | The ACP would like to edit the following sentence …disturbed parenting or primary loss of a parent early in the development of the personality. | Thank you for your comment. The Guideline Committee was not aware of any evidence of this and have therefore not changed the text as you have suggested. |
| Association | Full | 23 | 33 | This paragraph should include something about lying, stealing, | Thank you for your comment. In the absence of any |

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| of Child Psychotherapists | | | -38 | apparent dishonesty and difficulty in establishing a moral code – linked to valuing of an attachment and authority figures. | reference for this, the Guideline Committee agreed to add the difficulty of the child establishing a moral code – linked to their value of an authority figure. |
| Association of Child Psychotherapists | Full | 27<br>-29 | | The ACP would like to challenge that there is no evidence for efficacy of any form of individual therapy done with primary aged children in terms of addressing attachment difficulties.<br><br>Also efficacy is mentioned re: EMDR, CAT, CBT etc but not STPP for older children/adolescents – a NICE recommended treatment for depression.<br><br>These children who suffer from insecure or disorganised attachment can also present as anxious and depressed in late childhood and adolescence. Individual therapy which includes parent work supports the evidence that the therapeutic alliance is key in any therapeutic intervention. | The Guideline Committee agree, they found no evidence of individual therapy that addresses children with attachment difficulties, except for those who have been maltreated. For this reason, recommendations were based on the evidence that included group therapy sessions for children in care. |
| Association of Child Psychotherapists | Full | 28 | 35<br>-38 | There are many reasons why individual psychotherapy is requested for children who have experienced maltreatment and have developed complex co-morbid psychological and relationship difficulties, or who are in transitional foster placements awaiting adoption. Although it has not been possible for ethical reasons to carry out randomised clinical trials with this population there are parallels with children with severe depression for whom individual child psychotherapy has shown demonstrable gains and is among treatments recommended by NICE. | Thank you for your comment. A more extensive NICE guideline on children who have been maltreated is currently being developed. In this guideline we only studies on maltreated children that included an attachment measure were included. For this reason some studies will have been excluded, however they may be picked up in the new NICE guideline on maltreated children.<br><br>Thank you for your comment regarding the potential parallels for the effects of psychotherapy in children |

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| | | | | | who have been maltreated and those with depression. The Guideline Committee does recommend parent-child psychotherapy for preschool age children who have been maltreated, and trauma- focused CBT for primary and secondary school age children.<br><br>The Guideline Committee felt there was sufficient evidence to make a recommendation on this population without referring to the NICE depression guideline.<br><br>The Guideline Committee also made a recommendation for addressing any comorbidities in children with attachment problems and refers to the NICE guideline on depression. |
| Association of Child Psychotherapists | Full | General | | The ACP would like to highlight that there is a real need to give specific space within this guideline about very young children who experience fostering and adoption. These are the age group who will often make very profound attachments with their foster carers prior to adoption and yet whose expression of distress may be least understood, leading to possibly, and unwittingly, re-traumatising a young child.<br>The ACP also feels that overall more could be said in this guideline about the attachments that children make during foster care, and often have to give up when they move to adoption, or to another placement. It would be important to | Thank you for your comment. The Guideline Committee agree that attachment difficulties have profound effects in very young children. For this reason the Guideline Committee included in the "Key Priorities for Implementation" a number of recommendations on how to improve attachment difficulties for preschool aged children on the edge of care and those in foster care or are adopted (1.5.1, short version).<br><br>The Guideline Committee agree that the attachments children make during foster care are important, that is |

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| | | | | note something of the quality of these attachments, what they might mean to a child, and whether more could be done to support children having contact with their previous carers, and also to make transitions at a pace that enables them to understand something of the processes involved, and allows for their feelings of loss to be recognised and acted upon. The ACP would like to reference this article, the authors of which have conducted a small piece of qualitative research in support of the ideas outlined above: 'The children were fine': acknowledging complex feelings in the move from foster care into adoption in Adoption & Fostering Volume 38 Issue 1, March 2014. BAAF Sophie Boswell and Lynne Cudmore. | why the Guideline Committee recommended that "Social care workers should offer children and young people in the care system, in special guardianship or adopted from care, accurate, comprehensive and age-appropriate information about their history and family in a form that they are able to use and revisit at their own pace (for example, through photographs and life story work in line with the NICE guideline on looked after children and young people) and which is kept up to date." (1.1.16).<br><br>The Guideline Committee agree that it is important to ensure the transitions into care are at a pace that enables the child to understand the processes involved, and for their feelings of loss to be recognised and acted upon. For this reason the Guideline Committee recommended:<br>"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:<br>• explaining the reasons for the move<br>• 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)<br>• providing ongoing support during transitions, such as face-to-face meetings, telephone conversations |

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| | | | | | and other appropriate methods of communication<br>• making sure the child or young person has the opportunity to ask questions and make choices whenever appropriate and possible<br>• supporting the child or young person in maintaining relationships with their parents or previous carers for as long as they feel the need to<br>• taking account of the needs of children at different ages and developmental stages, including needs related to their mental health and any physical disabilities." (1.1.12).<br><br>Thank you for the reference. Unfortunately it did not fulfil our inclusion criteria for the review on risk factors that predispose to developing or worsening attachment difficulties in children. The studies needed to have quantified the impact of a risk factor on the likelihood of having attachment difficulties or a placement change and adjusted for any potential confounders. |
| Association of Child Psychotherapists | Full | 395 | 14<br>-17 | In these circumstances it can be that little meaning is attributed to what may be significant attachments formed during temporary relationships. | Thank you for your comment. The Guideline Committee agree that significant attachments can be formed during temporary relationships that is why we developed recommendations to minimise placement disruption.<br><br>The Guideline Committee have also made the changes you suggested in another comment. |

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| Association of Child Psychotherapists | Full | 395 | 28 | The ACP would like to edit the following sentence: Placement changes, particularly for older children and adolescents – which may be effected rapidly and allow little time for an acknowledgment of the attachments they have formed – may therefore involve multiple, or repeated losses. | Thank you for your comment. The Guideline Committee agree with your point and have added this to the guideline. |
| Association of Child Psychotherapists | Full | 436 | 9 -15 | Sometimes, these may have been unstable arrangements. But often – and particularly for very young infants – the foster care has engendered highly significant relationships, in which the child's first secure attachments have been formed.<br>The transition from foster care to adoption often takes place quickly, and the attachments are not always given the priority or acknowledgment the child needs, particularly when he or she is very young and unable to articulate their feelings of loss or distress.<br>This can be particularly so when so much emphasis is being placed on the child's move to a permanent home, and the significance of previous attachments is correspondingly downplayed. For very young children, the impact of losing an important attachment figure – often equivalent to their mother, and one who may have been a part of most of their lives to that point – can be dramatic and severe. | Thank you for your comment. The Guideline Committee has added a comment relating to this in the introduction for Chapter 9. |
| Bath Spa University & Bath and North East Somerset | Full | 13 | 44 | We suggest that a further bullet point should be added referring to<br>• **schools** | Thank you for your comment. This section of the full guideline has been revised to make it clear that the guideline covers educational settings. |

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| Local Authority (joint submission) | | | | | |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Full | 17 | 28 | We suggest the addition of the following sentence: **'More recent work related to education contexts, such Bergin and Bergin (2009) has pointed to the importance of 'attachment-like' relationships between children and other care givers, such as teachers, especially where there are other risk factors such as poverty or domestic abuse, or where the relationship with the primary attachment figure has become strained'** . | Thank you for your comment. The sentence you have suggested has been added to the full guideline. |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Full | 21 -32 | | We suggest that these 2013 statistics be updated in line with the DfE Statistical First release on Outcomes for Children Looked after by Local Authorities in England as at 31 March 2014, published on 10 December 2014 | Thank you for your comment. Where possible, the Guideline Committee have updated these statistics in the guideline. |
| Bath Spa University & Bath and North East | Full | 198 | | We believe that it is important to cross-reference these recommendations with those relating to schools. There is an implication here of a false dichotomy between social care placement stability and school place stability. For many children | Thank you for your comment. These recommendations already refer to 'health, education and social care processes' therefore the Guideline Committee thinks that a cross-reference to the section on schools is not |

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| Somerset Local Authority (joint submission) | | | | in care, school is the only stable point in their lives (see Bentley, in Jackson, 2013) and the guidelines must emphasise the importance of considering both of these aspects at the same time, rather than separately.<br><br>The third bullet point should be amended to read: 'having the same key worker, social worker, personal advisor **and key adult in school** throughout the period the child or young person is in the care system, adopted from care or on the edge of care.'<br><br>*Full reference is Bentley C 'Great Expectations: supporting 'unrealistic' aspirations for children in care' in Jackson S (ed) (2013) Pathways through education for young people in care. London, British Association for Adoption and Fostering.* | needed.<br><br>'Key person in school' has been added to the recommendation (recommendation 9). |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Full | 201 | | As for comment 2 above<br>Recommendation 12 should be amended to read 'Consider comprehensive education and training for potential carers **and other adults such as school teachers and support staff** to prepare them for the challenges involved in looking after children and young people with attachment difficulties and the likely impact on them, their families **and schools**.' | Thank you for your comment, however the Guideline Committee considered the evidence on which this recommendation was based and it was for potential carers only, not teachers and support staff. |
| Bath Spa University & Bath and | Full | 201 | | Recommendation 15 should be amended to read 'Ensure that the stability or instability of the child or young person's **care and/or school** placement does not determine whether | Thank you for your comment, however the Guideline Committee will not be changing the recommendation as you have suggested. The term 'placement' here, as |

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| North East Somerset Local Authority (joint submission) | | | | psychological interventions or other services are offered'. | defined in the short version, is referring to a home environment, not school. |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Full | 205 | | Recommendation 16 – add bullet point:<br>• **Ensuring that education issues are given a high priority with a presumption that existing school placements should be maintained wherever possible** | Thank you for your comment. Your point is already covered in recommendation 1.2.5. |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Full | 213 | | We strongly support recommendations 23-27. | Thank you for your comment. |
| Bath Spa University & | Full | 213 | | For recommendation 25 we propose the following additional bullet points **(in bold)** | Thank you for your comment. Regarding your first suggestion, the Guideline Committee agrees and has |

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| Bath and North East Somerset Local Authority (joint submission) | | | | • **has specialist training in recognising and addressing attachment difficulties**<br>• is aware of and keeps accurate and comprehensive records about all children and young people in their school who:<br>o are in the care system<br>o have been adopted<br>o have or may have attachment difficulties<br>• has contact details for the parents, carers and health and social care professionals for all the above groups<br>• 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<br>• provides a key person **trained in recognising and addressing attachment difficulties** who can advocate for the child and to whom the child can go for support.<br>• allocates a safe place in school , for example a room where a child or young person can go if they are distressed<br>• attends looked-after children reviews.<br>• **maintains an effective referral system with other agencies** | added a bullet point to the recommendation.<br><br>Regarding your second suggestion, the Guideline Committee has added a recommendation to say that all staff who come into contact with children with attachment difficulties should be trained (recommendation 24). |
| Bath Spa University & Bath and North East | Full | 214 | | We suggest that recommendation 27 should read:<br>Schools and other education providers should avoid using permanent and fixed-term school exclusion as far as possible for children and young people with attachment difficulties **and** | Thank you for your comment, but the Guideline Committee found no evidence for nurture units, Theraplay and emotion coaching. |

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| Somerset Local Authority (joint submission) | | | | **should consider alternative age-appropriate approaches, such as nurture units, theraplay or emotion coaching.** | |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Full | 216 | | We strongly support the research recommendation to assess the clinical and cost effectiveness of an attachment-based intervention delivered in a school setting, not only for children on the edge of care, in the care system or adopted, but also for the wide range of children in schools who may have attachment difficulties. This research should also take into account the impact of different whole school behaviour strategies on children and young people with attachment difficulties (please see also comments 22 and 23) | Thank you for your comment. The Guideline Committee agrees and has added the additional population "of a wide range of children who may have attachment difficulties" in the research recommendation. |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Full | 386 | | We suggest that recommendation 37 should read:……. Offer parental sensitivity and behaviour training to parents **and teachers** of primary and secondary school-age children and young people (as described in recommendation 35), adapting the intervention for the age of the child or young person. | Thank you for your comment. Unfortunately the Guideline Committee cannot add teachers to this recommendation since our recommendations are based on the evidence identified, none of which includes teachers as part of the parental sensitivity and behaviour training. However, this area was identified as a key uncertainty by the Guideline Committee which is why they generated a research recommendation to identify effective attachment-focused interventions that can be run through the schools. |
| Bath Spa University & | Short | 9 | 180 | Add<br>- **how they can access advice and information about** | Thank you for your comment, however the Guideline Committee did not feel it was necessary to make the |

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| Bath and North East Somerset Local Authority (joint submission) | | | | **relevant research and evidence-based intervention strategies (eg www.attachmentawareschools.com; DfE and DoH (2015) Statutory guidance on promoting the health and wellbeing of looked-after children').** | addition your have suggested because the necessary information and advice would be available for them to access on the training courses. |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Short | 10 | 222 | This principle, which we strongly endorse, would apply to all transitions including pre-school to infant, primary to secondary and secondary to post 16. | Thank you for your comment, however the evidence reviewed was for this age group only. |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Short | 15 | 334 | Please see comment 6:<br>Recommendation 15 should be amended to read 'Ensure that the stability or instability of the child or young person's **care and/or school** placement does not determine whether psychological interventions or other services are offered'. | Thank you for your comment, however the Guideline Committee will not be changing the recommendation as you have suggested. The term 'placement' here, as defined in the short version, is referring to a home environment, not school. |
| Bath Spa | Short | 15 | 345 | Please see comment 5: | Thank you for your comment, however the Guideline |

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| University & Bath and North East Somerset Local Authority (joint submission) | | | | As for comment 2 above<br>Recommendation 12 should be amended to read 'Consider comprehensive education and training for potential carers **and other adults such as school teachers and support staff** to prepare them for the challenges involved in looking after children and young people with attachment difficulties and the likely impact on them, their families **and schools**.' | Committee will not be changing the recommendation as you have suggested. The evidence on which this recommendation was based was for potential carers only, not teachers and support staff. |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Short | 18 | 427 | Please see comment 9:<br>For recommendation 25 we propose the following additional bullet points **(in bold)**<br>• **has specialist training in recognising and addressing attachment difficulties**<br>• is aware of and keeps accurate and comprehensive records about all children and young people in their school who:<br>o are in the care system<br>o have been adopted<br>o have or may have attachment difficulties<br>• has contact details for the parents, carers and health and social care professionals for all the above groups<br>• 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<br>• provides a key person **trained in recognising and addressing attachment difficulties** who can advocate for | Thank you for your comment. Regarding your first suggestion, the Guideline Committee agrees and has added a bullet point to the recommendation (1.2.5).<br><br>Regarding your second suggestion, the Guideline Committee has added a recommendation to say that all staff who come into contact with children with attachment difficulties should be trained (1.2.1). |

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| | | | | the child and to whom the child can go for support.<br>• allocates a safe place in school , for example a room where a child or young person can go if they are distressed<br>• attends looked-after children reviews.<br>• **maintains an effective referral system with other agencies** | |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Short | 18 | 438 | Please see comment 9:<br>For recommendation 25 we propose the following additional bullet points **(in bold)**<br>• **has specialist training in recognising and addressing attachment difficulties**<br>• is aware of and keeps accurate and comprehensive records about all children and young people in their school who:<br>o are in the care system<br>o have been adopted<br>o have or may have attachment difficulties<br>• has contact details for the parents, carers and health and social care professionals for all the above groups<br>• 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<br>• provides a key person **trained in recognising and addressing attachment difficulties** who can advocate for the child and to whom the child can go for support. | Thank you for your comment. Regarding your first suggestion, the Guideline Committee agrees and has added a bullet point to the recommendation (1.2.5).<br><br>Regarding your second suggestion, the Guideline Committee has added a recommendation to say that all staff who come into contact with children with attachment difficulties should be trained (1.2.1). |

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| | | | | • allocates a safe place in school , for example a room where a child or young person can go if they are distressed<br>• attends looked-after children reviews.<br>• **maintains an effective referral system with other agencies** | |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Short | 19 | 453 | Please see comment 10:<br>We suggest that recommendation 27 should read:<br>Schools and other education providers should avoid using permanent and fixed-term school exclusion as far as possible for children and young people with attachment difficulties **and should consider alternative age-appropriate approaches, such as nurture units, theraplay or emotion coaching.** | Thank you for your comment, but the Guideline Committee found no evidence for nurture units, Theraplay and emotion coaching. |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Short | 26 | 627 | Please see comment 12:<br>We suggest that recommendation 37 should read:<br>Offer parental sensitivity and behaviour training to parents **and teachers** of primary and secondary school-age children and young people (as described in recommendation 35), adapting the intervention for the age of the child or young person. | Thank you for your comment. The evidence reviewed did not include teachers, and indeed this kind of training would not be appropriate for teachers. |
| Bath Spa University & | Short | 31 | | Add to section 2.1<br>Develop reliable and valid screening assessment tools for | Thank you for your comment, the change you have suggested has been made. |

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| Bath and North East Somerset Local Authority (joint submission) | | | | attachment and sensitivity that can be made available and used in routine health, social care **and education settings**. | |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Short | 33 | | We strongly support the need to evaluate currently unevaluated but extensively used interventions for attachment difficulties, **especially in schools,** and would urge NICE to make this a research priority. (see also comment 11) | Thank you for your comment. The high-priority research recommendation to which you refer is relevant for all settings including schools therefore the Guideline Committee did not feel it necessary to specify this. Another high-priority research recommendation is provided that relates to schools specifically. |
| Bath Spa University & Bath and North East Somerset Local Authority (joint submission) | Short | 35 | | In the school context there is a particular need for research into **the impact of current behaviourist /sanctions and rewards approaches in school behaviour policies on children and young people with significant attachment needs, and the potential impact of alternative approaches**. Again we would urge NICE to make this a research priority. | Thank you for your comment. As the NICE research recommendations methods and process guide (2015) sets out, it is the Guideline Committee's role to identify and prioritise key uncertainties in the evidence that directly impact on their ability to produce guidance for service provision. The factors that you have suggested were not identified as key uncertainties in the evidence. |
| British | Short | 14 | 312 | It is difficult to understand the term ' once a stable placement is | Thank you for your comment. The recommendation is |

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| Association for Adoption and Fostering | | | | found'. Does this mean once the asylum claim has been resolved, or when the young person is in a stable but temporary placement such as residential care or supported lodgings. This paragraph recognises the range of issues these young people are likely to face and establishing stable, secure and meaningful relationships are a part of this but it is a complex issue to assess attachment in the way the guidance describes when finding a relationship that will endure over time is likely to be very challenging because of the contextual factors. | referring to the latter – when the young person is in residential care or supported lodgings. The term placement is defined in the glossary and will be hyperlinked in the final document, therefore this should be clear. Regarding your second point, the Guideline Committee recognises that these situations can be complex, but would urge you to read it in the context of the rest of the guideline, which addresses improving stability of placements. |
| British Association for Adoption and Fostering | Short | 14 | 321 | While we agree with this set of principles, they repeat what is the NIHCE guidance on looked after children. That Guidance has little, if any, impact on ensuring that they have reliably guided practice to the degree required. This issue needs to be explored with more robust solutions discussed that reflect the realities of current practice and the severe constraints that many services are under. | Thank you for your comment. The Guideline Committee do not entirely agree, the guideline is for children with attachment problems who are looked after or on the edge of care. |
| British Association for Adoption and Fostering | Short | 15 | 336 | The above comment applies to this recommendation as well: While we agree with this set of principles, they repeat what is the NIHCE guidance on looked after children. That Guidance has little, if any, impact on ensuring that they have reliably guided practice to the degree required. This issue needs to be explored with more robust solutions discussed that reflect the realities of current practice and the severe constraints that many services are under. | Thank you for your comment. The Guideline Committee do not entirely agree, the guideline is for children with attachment difficulties who are looked after or on the edge of care. |
| British Association | Short | 15 | 353 | The above comment applies to this recommendation as well: While we agree with this set of principles, they repeat what is | Thank you for your comment. The Guideline Committee do not entirely agree, the guideline is for |

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| for Adoption and Fostering | | | | the NIHCE guidance on looked after children. That Guidance has little, if any, impact on ensuring that they have reliably guided practice to the degree required. This issue needs to be explored with more robust solutions discussed that reflect the realities of current practice and the severe constraints that many services are under. | children with attachment difficulties who are looked after or on the edge of care. |
| British Association for Adoption and Fostering | Short | 16 | 372 | We agree with this recommendation but it needs to be evidence informed by assessments of sibling relationships – something that is not well done currently and often leads to confusion and uncertainty in progressing the plan for the child/children. It cannot be stressed highly enough the importance of fully preparing and supporting prospective carers and then supporting them following placement. There is also a serious issue in the shortfall of carers who can take sibling groups. This needs to be subject to rigorous exploration of the issues and possible solutions. | Thank you for your comment. The recommendation is made in the context of improving the likelihood of more permanent placements, based on evidence that keeping siblings together is a factor in this regard. The recommendation does have a caveat that this should only be done if it is in the best interests of children and where it is possible.<br>However, the Guideline Committee recognises that parenting groups of children with attachment difficulties is challenging and has modified recommendation 1.1.13 to alert professionals to such situations. |
| British Association for Adoption and Fostering | Short | 16 | 374 | It is not clear why the term 'consider is used here. If there are serious difficulties or changes of placement, then support and resources must be made available in a sensitive, proactive and evidence informed way. The use of the word consider should be replaced by a suitable form of the word "Assessment'. | Thank you for your comment. The Guideline Committee agrees and has changed the recommendation on providing additional support and resources (1.1.14) to say 'offer' rather than 'consider'. |
| British Association for Adoption | Short | 17 | 380 | Again it is unclear why the word 'consider' is used. Information must be given and life story work is required currently and these need to informed by the very best standards of | Thank you for your comment. The recommendation (1.1.16) has been changed to say that social care workers should offer children and young people |

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| and Fostering | | | | professional/family placement practice. 'Consider' may lead to a view that this is optional when it s not. | information about their history and family. |
| British Association for Adoption and Fostering | Short | 17 | 393 | It would be irresponsible to only 'consider' monitoring outcomes of interventions. They must be monitored and in adoption and special guardianship these are required by Regulation. In this sense the recommendation is unlawful. The issue of how to do this and what measures should be used is another question and that does need to be explored in itself. | Thank you for your comment, the recommendation has been replaced to say: 'Consider using a parental sensitivity tool, for example the Ainsworth Maternal Sensitivity Scale, and a parenting quality tool to help guide decisions on interventions and to monitor progress' (1.1.19). |
| British Association for Adoption and Fostering | Short | 17 | 397 | We fully support this. | Thank you for your comment. |
| British Association for Adoption and Fostering | Short | 17 | 405 | We fully support the need for training of staff in school settings. | Thank you for your comment. |
| British Association for Adoption and Fostering | Short | 18 | 415 | We fully support this and the following issues to 1.2.5. However, the issues are much wider than attachment related and should be available to all children who are stressed or distressed at school. Due consideration should also be given to the thoughts and feelings of children where they receive school based services or monitoring that mark them out as 'difficult' or 'special'. Stigma, bullying and labelling generally can be serious issues in | Thank you for your comment. The guideline's scope is children with attachment difficulties, therefore the Guideline Committee cannot widen the recommendations as you have suggested. However a recommendation has been added to take account of the child's preferences about where interventions should take place and for school staff to consider issues |

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| | | | | themselves. Being called out of the classroom can be very difficult if the child has to then explain why. Sensitivity and the balancing of the need to act supportively in whatever way that is required but ensuring that these do not create another set of problems is very important. | of bullying, stigma and labelling (1.2.4-1.2.5). |
| British Association for Adoption and Fostering | Short | 19 | 456 | While we agree with this recommendation, we are concerned about the enormous challenge to the sector in implementing this. As the NIHCE review establishes, the assessment of attachment issues (1.3.4) takes considerable, skill, knowledge and training and support is using the measures identified. Identifying the part that attachment plays when for many children there are complex presentations suggesting co-existing problems is challenging and requires high levels of skill, knowledge, training and support. There must be considerable concern that this an significant aspirational recommendation unlikely in the current context to be implemented without significant changes to the resourcing and organisation of services and the capacity and expertise of the workforce. | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| British Association for Adoption and Fostering | Short | 22 | 1.3.7 | We agree with this recommendation. | Thank you for your comment |
| British Association for Adoption | Short | 22 | 1.3.8 | This is a seriously aspirational recommendation given the post-code lottery of current provision. | Thank you for this comment – the Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of |

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| and Fostering | | | | | NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| British Association for Adoption and Fostering | Short | 23 | 548 | We support this recommendation through to 1.4.8 but this is a seriously aspirational recommendation given the post-code lottery of current provision. | Thank you for this comment – the Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| British Association for Adoption and Fostering | Short | 25 | 613 | 'Consider' is right but there needs to be a 'comprehensive assessment of need and risk' given how complex many of these situations can be and what will need to be provided to mitigate risk and support change | Thank you for your comment. The Guideline Committee agrees, and directs your attention to the assessment recommendations in section 1.3. |
| British Association for Adoption and Fostering | Short | 25 | 616 | This recommendation will need considerable investment of resources to enable this intervention to become available in the way described. | Thank you for this comment – the Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| British Association for Adoption and Fostering | Short | 26 | 643 | These recommendations are 'very likely' to be relevant to children and young people in kinship care etc. | Thank you, we have clarified this. |
| British | Short | 27 | 647 | While we agree with this recommendation, we are concerned | Thank you for this comment. The Guideline Committee |

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| Association for Adoption and Fostering | | | | about the enormous challenge to the sector in implementing this. Video feedback is very limited in its availability and beyond what is currently available across organisations and in the workforce. | agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| British Association for Adoption and Fostering | Short | 27 | 658 | We generally agree with these recommendations. They need to build on what is currently available but they will also require significant investment of resources and development of service provision to enable this recommendation to implemented.<br><br>What is unclear is the recommendation from 665. Is this a specific model or set of models. Many models may fall within this set of objectives with little or no testing or evidence base to them whatsoever. As such the recommendation runs counter to the care with which the evidence based is set out in the main document. | Thank you for this comment – the Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered.<br><br>The model we referred to is based on the evidence we reviewed in the guideline for children who have been maltreated and have attachment difficulties. Given the paucity of data to base our recommendations on, the Guideline Committee decided to specifically refer to the Cicchetti model since it was the best evidence available. |
| British Association for Adoption and Fostering | Short | 28 | 674 | There is lack of specificity of the meaning of 'group cognitive and interpersonal skills'. Is this a defined intervention? This opens the door for a wide range of models being delivered with the same issues as set out in the comment above. | Thank you for your comment, this has been changed to 'group therapeutic play sessions'. |
| British Association | Short | 28 | 689 | We agree with this but the lack of specificity of this training support model creates the same difficulty set out in the two | Thank you for your comment. The Guideline Committee have developed the recommendations for |

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| for Adoption and Fostering | | | | comments above. | the interventions based on the evidence available. It is difficult to be too prescriptive when a number of studies with slight variations of the (same) intervention is used to generate the overall estimate of the effect. |
| British Association for Adoption and Fostering | Short | 29 | 720 | There are challenging issues for the concept of parenting and the connected issue of attachment in residential care. This is given some acknowledgement in this section but the lack of detail and specificity will not help this be designed and implemented. | Thank you for your comment. The evidence was extremely limited in this area. The Guideline Committee has been as specific and detailed as it can be in this situation.<br>The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| British Association for Adoption and Fostering | Short | 31 | 2.1 | We fully support this recommendation | Thank you for your comment. |
| British Association for Adoption and Fostering | Short | 32 | 2.2 | We fully support this recommendation | Thank you for your comment. |
| British | Short | 33 | 2.3 | We fully support this recommendation but an additional issue | Thank you for your comment. The Guideline |

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| Association for Adoption and Fostering | | | | that will need to be addressed is the wide variety of placements, the age range of the children, the complexity of presentation, the likelihood of other issues for the child and carers other than or interacting with attachment issues. | Committee has made changes to the research recommendation based on your suggestion. |
| British Association for Adoption and Fostering | Short | 33 | 2.4 | We fully support this recommendation | Thank you for your comment. |
| British Association for Adoption and Fostering | Short | 35 | 2.5 | We support this recommendation but there needs to be more development of the relevance and priority of attachment related matters in a school setting. The capacity to learn, learning difficulties, executive function, emotional regulation, developing relationships with other children, managing transitions etc all potentially have an attachment relevant issue connected to them but what this means in the context of the other issues is a very challenging question needs to be explored in much more detail. It needs to be explored on a case-by-case basis and it needs to be explored more fully in this guidance. | Thank you for your comment. As the NICE research recommendations methods and process guide (2015) sets out, it is the Guideline Committee's role to identify and prioritise key uncertainties in the evidence that directly impact on their ability to produce guidance for service provision. Educational performance as a broad category was identified by the Guideline Committee as a critical outcome of the research. |
| British Association for Adoption and Fostering | Short | General | General | In the discussions leading up to this response, there was considerable uncertainty expressed how useful the document and recommendations are. Some of this relates to previous NIHCE guidance on looked after children. This has had little positive impact. The style of this guidance is similar with questions then raised about its potential positive impact on the sector. | Thank you for your comment. Whether the recommendations are specific or lacking in detail is purely a reflection of the evidence.<br><br>The Guideline Committee is aware that some recommendations might be considered 'aspirational' but the function of NICE guidelines is to set the |

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| | | | | The review of the research evidence is of the highest standard. It is important in reminding the sector of what is well established through research but more starkly how little of what is currently driving assessment and intervention that is evidence based let alone evidence informed. There are important lessons in this that the sector needs to reflect on.<br>However, when it comes to the recommendations, some are either very specific as with Cicchettti and Toth model (617) with no room for manoeuvre, or specific in outline but lacking in detail about the model – video feedback - or very general such as training for adopters/foster carers where almost anything might be argued to fit the recommendations. There are also many recommendations that are truly aspirational in the demands that they would make on services and the workforce in terms of training, support and resourcing with a serious question about whether they are actually deliverable – the strange situation procedure for example in clinical assessments rather than as a research tool.<br>The recommendations as they stand will create significant upheaval in the sector – commissioners using these recommendations will start to require services that are simply not available or affordable.<br>The recommendations will not help the further development of the Adoption Support Fund where most interventions are delivered because they are available, have strong commitment and belief from service providers but do not even figure in the research review let alone subject to any discussion in the | standard of what should be available nationally, and for the NHS to ensure these services are delivered.<br><br>The interventions that are recommended have sound evidence base – those that do not, even if they are available and 'have a strong commitment and belief from service providers' would not have been recommended. However, the Guideline Committee has made a research recommendation for research to be conducted into under-evaluated interventions. |

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| | | | | recommendations. On the basis of these recommendations the interventions funded by the Adoption Support Fund, should not be made available through public funds! There may be a strong argument for being more rigorous in what the Fund funds but that needs to be a more open discussion about the current state of play in the sector.<br>It may be the protocols that drive NIHCE recommendations and guidance lead inevitably to the approach taken in this guidance. But we fear that their implementation will cause considerable instability to current services and may will as a result have little direct positive impact. We would like to see these issues more openly and supportively addressed. | |
| British Psychological Society | Full | General | General | The Society welcomes the endeavour to be clear about what is helpful, what has no evidence and what is harmful when it comes to therapy. We believe that it should be ensured that historical focus on delivering something individual doesn't detract from the need to focus on relationship based approaches with clear links to attachment theory. There are some excellent recommendations made and if achieved as a standard, it would be a significant improvement for children and young people. | Thank you for your comment. |
| British Psychological Society | Full | General | General | The Society welcomes the view and subsequent recommendations related to the lack of evidence base currently for individual therapies for primary age children with attachment difficulties and the focus of the work should therefore be at the level of dyad / family/ parent sensitivity training. | Thank you for your comment. The relevant tools and references for these interventions will be available from NICE Implementation. |

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| | | | | We welcome that the needs of children adopted from care have been recognised in this guidance. We recommend that resources will follow to enable these interventions to be provided. | |
| British Psychological Society | Full | General | General | The Society would welcome acknowledgement that the most complex end will always require highly skilled practioners to deliver. We would however welcome acknowledgement that the most complex end will always require highly skilled practioners to deliver. Young people within this group have a high incidence of co-occurring difficulties including developmental delay. For this reason detailed assessment and formulation for this group of young people should not be limited to one theoretical modality alone. Moran (2010) suggests the need for:<br><br>*"A psychological approach which considers behaviour in its wider context (e.g. social, cultural, gender, class and race) is important, as some children who appear on first assessment to have neurodevelopmental difficulties may, in fact, have attachment difficulties; this is particularly so for children where there is no reliable early history, such as looked after children, where there is a risk of a 'false positive' conclusion of neurodevelopmental difficulties leading to ineffective interventions."* (Moran, 2010).<br><br>Children with neurodevelopmental conditions are the largest group of disabled children in the UK (Chief Medical Officer, 2012); recent prevalence estimates are 1.7% of children for autism spectrum disorders, 1.4% for ADHD (Russell et al., 2014), | Thank you for your comment. The Guideline Committee agrees with your comment and that of Moran, that it is important that during an assessment the practitioner needs to consider the child's behaviour in its wider context because of the risk of a 'false positive' conclusion of a child having neurodevelopmental difficulties, instead of attachment difficulties, leading to ineffective interventions. For this reason the Guideline Committee included the following:<br>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:<br>• recognising and assessing attachment difficulties and parenting quality, including parental sensitivity<br>• recognising and assessing multiple socioeconomic factors (for example, low income, single or adolescent parents) that together are associated with an increased risk of attachment difficulties<br>• recognising and assessing other difficulties, |

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| | | | | and 2-5% for foetal alcohol spectrum disorders (May et al., 2009). | including coexisting mental health problems and the consequences of maltreatment, including trauma<br>• knowing when and how to refer for evidence-based interventions for attachment difficulties (see sections 1.4, 1.5 and 1.6).<br>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:<br>• personal factors, including the child or young person's attachment pattern and relationships<br>• 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<br>• the child or young person's educational experience and attainment<br>• parental sensitivity<br>• 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<br>• the child or young person's experience of maltreatment or trauma<br>• the child or young person's physical health |

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| | | | | | • 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.<br><br>Regarding the need for highly skilled practitioners, NICE do not typically specify who should carry out the recommendation/s. However, the Guideline Committee have included, where relevant, when a specific health care worker should take responsibility for the delivery of care. This includes people who have "specialist expertise" in attachment difficulties. |
| British Psychological Society | General | General | General | A key concern for the current guidance is that it is narrowly constrained by the focus on attachment interventions with little recognition of the trauma needs and relationship fears of children and the need to ensure that interventions focusing on increasing attachment security in this population of children also needs to reduce impact of relational trauma and to decrease relationship fears. We were concerned that this guidance does not appear to have been influenced by the work of acknowledged experts and researchers in this field such as (Perry, 2006; Schore, 2001; Seigel, 2007; Van der Kolk, 2005; Panksepp, 2004; Porges, 2007) amongst others. Focusing too narrowly on attachment needs without the associated trauma | Thank you for your comment. The Guideline Committee agree, trauma is an important issue in this population. However, it was beyond the scope to explore this population. NICE are currently developing a guideline that addresses maltreatment in children. |

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| | | | | needs will limit the interventions and their efficacy. | |
| British Psychological Society | Full | General | General | The Society would however recommend the following:<br>1. Use of a wider variety of evidence (as is outlined below)<br>2. Expanding the understanding of the child by not only consideration of the impact of attachment experience but also the closely related impact of trauma which also has significant impact.<br><br>We understand that all processes have limitations and it will not be possible to meet with every expert in the field, however, it is possible that the recommendations would have been strengthened by allowing more:<br>1. Evidence presented by experts in the fields of attachment and of trauma presented to the programme group.<br>2. More attention being given to the expertise of clinicians who have worked with this population of children and young people for many years, and have developed interventions guided by theory and research.<br>3. Evidence gained from talking to the parents and carers looking after these children who have experienced different services and interventions.<br><br>Evidence gained from talking with young people who have experienced the services and interventions. | Thank you for your comment. The Guideline Committee was made up of experts in the field of attachment including several clinicians who have worked with this population of children for several years and who have also been involved in research.<br><br>In addition, the Guideline Committee also included two care-leavers (who have experienced different services and interventions) and two parent/carers. All contributed fully at all meetings (which included a special 'carer/care-leaver concerns' item on every meeting agenda) and made a major contribution to the development of the 'Information for the Public' version of the guideline. Furthermore, a number of carer/care-leaver organisations have registered as stakeholders for this guideline. |
| British | Full | General | General | It appears that the importance of working with the parents on | Thank you for your comment. Any intervention was |

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| Psychological Society | | | | their own regulation, capacity for reflective function/mentalisation; ability to stay open and engaged to their child, and support to avoid or recover from blocked care and/or secondary trauma in order that they can help their child recover from trauma and achieve a more secure attachment was missed throughout this guidance despite the evidence related to the importance of this (Hughes & Baylin, 2012; Jernberg & Booth, 2001; Golding, 2008; Elliott, 2013).<br><br>t might also have been valuable to speak to some of the many adopters and carers who have direct experience of the interventions. In not considering the research in this area the paper has potentially missed important aspects of what needs targeting when developing and using interventions. | included if the authors measured parental sensitivity or attachment in the child. There were no studies identified that purely addressed the parent's own regulation, capacity for reflective functioning etc. However, the parent-focused interventions recommended in the guideline do include components that focus on the parent's difficulties in nurturing and caring for the child.<br><br>The Guideline Committee also recommended a comprehensive assessment of factors that place a child at high risk of attachment difficulties. The Guideline Committee has now added to this list of factors "the parents' and carers' experiences of maltreatment and trauma in their own childhood".<br><br>Unfortunately the references you provided are books that do not appear to include any primary research that could be meta-analysed. For this reason they were not included in the guideline.<br><br>The Guideline Committee included two care-leavers (who have experienced different services and interventions) and two parent/carers. All contributed fully at all meetings (which included a special 'carer/care-leaver concerns' item on every meeting agenda). |

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| British Psychological Society | Full | General s. 2 | General s. 2 | In terms of other possible more global critiques of the current guidelines, we would recommend that it may be useful for consideration to be given to and/or acknowledgement made that:<br>• There is no attribution for the conceptual model used in the guideline and no comment is made that other models of behavioural development exist.<br>• The conceptual model is speculative; the term 'thought to' is used four times in the introductory section.<br>• The model is normative: the introduction refers to normative development, parenting and care.<br>• Evidence in support of the features included in the model is cited but not evaluated.<br><br>An alternative model for behavioural development is that of emergence – essentially the one used by Bowlby. Bowlby's model differs from modern emergence models primarily in respect of the complexity of genetic variation involved; genetics has come a long way since 1969. An emergent model of development recognises that each child has a unique genome, occupies a unique environment and that unique behavioural patterns emerge from the interaction between genetic expression, environmental factors and the child's behaviour itself (Mareschal, 2007).<br><br>According to the guideline's introduction, apart from a group | Thank you for your comment. The Guideline Committee do not posit that attachment is a model *of* behavioural development. Rather it is one domain *of behavioural development*.<br><br>Further, interventions to prevent or treat attachment difficulties mostly target the parent. Thus, we do not "blame" the children for failing to learn how to interact with others. For this reason, the interventions target the parents to help them create an environment that compliments the internal model of the child's innate desire to create a secure development.<br><br>The Guideline Committee have amended the introduction to acknowledge there is some controversy in the field whether attachment is an innate mechanism, nevertheless, it is broadly accepted that children have a basic biological need to form a lasting bond with their carers. |

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| | | | | showing a persistent lack of caution in relation to unfamiliar adults, the pattern of interpersonal interactions shown by children varies with context. This suggests the possibility that there may be no need to posit a hypothetical innate instinct called attachment or the existence of attachment 'disorders'. The evidence for interventions suggests that children who have for whatever reason failed to learn how to interact with others in an appropriate manner need to learn how to do that and benefit from doing so.<br><br>Evidence relating to assessment and intervention is rigorously evaluated by the guideline. The same degree of rigour is not applied to the conceptual model on which the guideline is based and we would suggest this would have been a useful and valid exercise. | |
| British Psychological Society | Full | General | Questions 1 and 2 | It is worth consideration that the guideline are (in relation to the point made above) based on an unevaluated assumption that there is an innate instinct called attachment and that it is responsible for all interpersonal interactions with a primary caregiver. This of course has several implications for practice:<br><br>a. Patterns of care and patterns of interaction are likely to be seen as normative. Caregivers are likely to overlook what is most appropriate for a particular child at any given time.<br>b. There is a risk that the origins of inappropriate interpersonal interactions will be located only in the | Thank you for your comments.<br>A): The majority in the field believe there is an innate instinct called attachment that is responsible for interpersonal interactions with a primary caregiver. Whilst the Guideline Committee acknowledges there are a number of conceptual models that describe the parent-child relationship it is beyond the scope of the guideline to review these. For the purposes of the NICE guideline the Guideline Committee are assuming an acceptance of the parent-child attachment conceptual model. |

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| | | | | child's attachment behaviours; the child will be seen as showing consistently abnormal interaction pattern or as having a medical 'disorder'. Systems factors (e.g. multiple placements), the behaviour of professionals or foster parents, and the impact of un-investigated medical conditions are likely to be marginalised.<br>c. There is a risk that inappropriate interpersonal interactions will be assumed to indicate maltreatment or neglect by primary caregivers. Professionals have found it so difficult to discriminate between 'attachment' behaviours (generally assumed to be caused by parenting styles) and autistic behaviours (generally assumed not to be caused by parenting styles) that Moran developed the Coventry Grid http://www.drawingtheidealself.co.uk/drawingtheidealself/Downloads_files/Coventry%20Grid%20Version%202%20-%20Jan%202015.pdf to make the distinction clearer. There is no mention of the Coventry Grid in the guideline.<br><br>Conceptual models are crucially important because they shape research and practice. We would suggest that practitioners cannot reasonably be expected to critique all the conceptual models they use, but the publication of a national guideline offers an opportunity to inform practitioners of the reliability and validity of conceptual models in use, and of the evidence that supports those models. | B) It was agreed by the Guideline Committee that the ways children manifest attachment behaviour is largely the result of their dyadic relationship with their primary caregiver. Thus, if the caregiver shows sensitivity or in contrast frightening or sufficient care (due to maltreatment and neglect) it will influence the child's attachment behaviour. Further, we emphasised in Chapter 2, that the parent's capacity to do this takes place, or is influenced by, the systemic context (contextual stressors, personal history, couple relationship etc).<br><br>Also in Chapter 2 …"Therefore, a child who experiences insecure attachments, possibly due to neglect or being placed in numerous foster care homes, are more likely to struggle in these areas and to experience emotional and behavioural difficulties"<br><br>C) The Guideline Committee agree that it is important to distinguish between attachment and other conditions such as autism. And care needs to be taken to consider some children may have both disorganised attachment and other comorbidities, such as autism. We mention in Chapter 2. "Other children, such as those on the autistic spectrum, can also exhibit DAB in the absence of maltreatment, so great care is needed when making assessments. Similarly, it is possible for |

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| | | | | Additionally Colwyn Trevarthen has highlighted that attachment isn't responsible for all interpersonal interactions with primary caregivers. He has demonstrated the importance of the intersubjective relationship experience that children need, which complements but is different to their attachment relationship experience. It is important to understand what happens when this experience is not provided, or is frightening to the child and the implications of this for interventions. (Trevarthen & Aitken, 2001). | children who are abused not to show DAB (for example, if the abuse is less severe and less frequent).".<br><br>Finally, we have added to the introduction in Chapter 2, "It is worth noting that attachment may not responsible for all interpersonal interactions with primary caregivers. For instance, Trevarthen et al. has demonstrated the importance of the intersubjective relationship experience between the infant and the carer, and that this complements but is different to their attachment relationship experience ({Trevarthen, 2001 #43599})." |
| British Psychological Society | Full | 17 | 8 | The concept of attachment originated with Bowlby but the model set out in the guideline doesn't appear to be his.<br><br>The guideline makes the explicit assumption that there is an "innate instinct for attachment, which is shared by most mammals". Innateness and instinct have been hotly debated amongst zoologists since Darwin. Bowlby explores both concepts in detail in *Attachment* (1969). He explicitly rejects the concept of 'an instinct' (p.134) and suggests that the term 'innate', be 'cast into limbo' (ibid, p.38); both conclusions based on the findings of zoologists. | Thank you for your comment. The Guideline Committee have now replaced innate with instinctive. |
| British Psychologica | Full | 27 | 46 -48 | We would advise consideration be given to The Sunderland Project and research by P.O. Svanberg as it is highly relevant and | Thank you for your comment. "Svanberg PO, Mennet L, Spieker S. Promoting a secure attachment: A primary |

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| l Society | | | | has clear cost effectiveness evaluations. (Svanberg & Jennings, 2002; Svanberg et al, 2010). | prevention practice model. Clin Child Psychol Psychiatry. 2010;15(3):363-78" does not report sufficient detail on the cost analysis for it to be included in the review. Similarly the study by Svanberg & Jennings (2002) discusses only potential cost effectiveness. |
| British Psychologica l Society | Full | 28 | 27 - 29 | 'Standard parenting programs such as the incredible years have been shown to improve sensitive responding, which is likely to lead to more attachment security.' This research is not with populations of children who are looked after or adopted. The research of Mary Dozier illustrates that sensitive responding without a gentle challenge to the child's miscuing can lead parents into replicating the child's attachment pattern. This would suggest that programmes such as The Incredible Years will need some adaptation to the specific needs of these populations. Similarly our clinical experience tells us that this population of children tend to be emotionally immature and much more prone to experiencing shame than more secure/less traumatized children. It is essential that this knowledge informs parenting interventions. (Dozier, 2003; Dozier et al, 2006)<br><br>We would recommend that in evaluating the Fostering Attachments Group work Programme (as described in the Nurturing Attachments Training Resource, Golding, 2014) has not been considered for inclusion in the review. We believe that this may be worth reconsidering. | Thank you for your comment. The Guideline Committee acknowledge there are a number of interventions that are currently in use that have not been evaluated using a RCT. However, the Guideline Committee identified this as a key area of uncertainty which is why they generated a research recommendation to: "Evaluate currently unevaluated but extensively used interventions for attachment difficulties." |

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| British Psychological Society | Full | 28 | 32 - 35 | The Society has concerns regarding the implied connection between the coercive interventions listed in the foot note being linked to changes in brain functioning. While we believe that unsubstantiated claims and the practice of making outcomes sound scientific by alluding to neurobiology should be criticized; this ignores the very broad range of understanding gained through the study of interpersonal neurobiology which can usefully and helpfully guide interventions (Siegel, 2012). | Thank you for your comment. The Guideline Committee feel it is important to highlight that these techniques do make unsubstantiated claims relating to brain functioning. They feel they have given due credit for the potential role of interpersonal neurobiology on attachment in the introduction. |
| British Psychological Society | Full | 11 | 39 | 'Guidelines are not a substitute for professional knowledge and clinical judgement.' We welcome this statement but since this is not always recognised by commissioners it would be useful to have the statement appear near the beginning of the short version as well. | Thank you for your comment. This statement is not currently part of the template for the short version, but the Guideline Committee has passed your suggestion to the NICE editorial team. |
| British Psychological Society | Full | 23 | 36 - 38 | We welcome the attention to difficulties within schools in this guidance. The Society would recommend that it may be helpful for the work of Louise Bomber in relation to helping teachers recognise and meet the needs of children with attachment difficulties in school to also be considered in informing this section. (Bombèr, L. M, 2007). | Thank you for your comment. Recommendation 1.1.1 'Schools and other education providers should ensure that all staff who may come into contact with children with attachment difficulties receive appropriate training on attachment difficulties, as set out in recommendation 1.2.2' allows for the development of training which could encompass the work of a range of trainers and experts in the field such as Louise Bomber. |
| British Psychological Society | Full | 29 | 12 - 18 | This guidance which recommends standard evidence based interventions ignores theory and research related to the trauma needs of this population of children which co-exist with their attachment needs. This work guides clinicians to the need for | Thank you for your comment. The scope allowed the Guideline Committee to review evidence on interventions for children who had experienced (or are at risk of) maltreatment and the authors measured |

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| | | | | bottom-up interventions which helps to calm over-aroused nervous systems (Perry, 2006; Howe, 2005). | attachment or sensitivity as an outcome. Any other studies that address trauma (without attachment as an outcome) may be covered in the scope of the new NICE guideline on maltreated children or in the NICE PTSD guideline. |
| British Psychological Society | Full | 29 | 28 - 30 | The Society has concerns that the time out strategy to be singled out as something to comment on specifically as having an absence of evidence to suggest it should not be used. This is something that could be said of a lot of parenting strategies. Behavioural parenting strategies generally need to take into account the trauma needs of this population which means that strategies can be usefully adapted. For example, using time in rather than time out can reduce the risk of children feeling rejected or neglected (Sunderland, 2008). Additionally the importance of recognising how early parenting experience can leave children mistrusting and therefore experiencing ordinary parenting as indicating that they are not loved unconditionally needs to be recognised when providing parenting advice to parents/carers of this population of children (Baylin, 2015). | Thank you for your comment. The Guideline Committee agree that time out should not be singled out as something to not be used in the absence of evidence. In fact, there is some evidence to show that it can useful for parents of children in care but only when they have formed a healthy loving relationship with the child. This section has been amended to better reflect this. |
| British Psychological Society | Full | 196 | 481 -483 | Responsibility and recognition of difficulties in parental factors such as domestic violence, abuse, drug and alcohol misuse and/or mental health problems would be helpful here. | Thank you for your comment. Unfortunately the Guideline Committee are unsure of which part of the guideline the comment specifically relates to. Nevertheless, they did investigate the evidence on the impact of the factors you mentioned on the likelihood of a child developing attachment difficulties and made recommendations relating to this. |

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| British Psychological Society | Full | 208 | Rec 17 | Whilst the importance of sibling relationships cannot be underestimated, the Society does not believe that this recommendation went far enough in acknowledging the difficulty of parenting 2 or more children with attachment difficulties.<br><br>Parenting sibling groups of three or more can put a significant strain on the family with a high risk of placement breakdown, and/or the scapegoating of one of the children as the 'naughty one' in the family. We feel that this difficulty must be acknowledged in any recommendation which guides decisions to place siblings together. This guidance could have been informed by experts in this area and note the useful training provided by British Association for Adoption and Fostering and by Family Futures. (Lord & Borthwick, 2008; Argent, 2008) | Thank you for your comment. The Guideline Committee agrees that parenting groups of children with attachment difficulties is challenging and has modified recommendation 1.1.13 to alert professionals to such situations. |
| British Psychological Society | Full | 384 | | The Society has concerns about the following statement: "Child-focused outcomes were chosen over and above parent-focused outcomes such as the parent's mental health because the focus of the review was on improving outcomes for the child, therefore benefits for the parent were viewed as subsidiary and were not considered in this review. "<br><br>This ignores the significant body of evidence that indicates that not only does parental mental health impact on the likelihood of behavioural and emotional difficulties (Totsika et al., 2011; Tough et al., 2008 but even more specifically impacts on attachment security (Atkinson et al., 2000). This seems therefore | Thank you for your comment. The Guideline Committee agree that this approach meant that some interesting results would have been omitted, but the Guideline Committee agreed that their decision making would focus on the success of the intervention on the children, since ultimately this is what we hoped to achieve. |

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| | | | | to be a serious omission for this guidance. | |
| British Psychological Society | Full | 386 | Rec. 34 | Parents have to decline an intervention before being offered an alternative. It would be more empowering for parents to be offered a positive choice in collaboration with a practitioner to ensure that they are properly informed about the choices. | Thank you for your comment. The Guideline Committee was guided by the evidence in sequencing these recommendations, and the evidence for video feedback programmes was stronger than that for parental sensitivity and behaviour training. |
| British Psychological Society | Full | 391 | Rec. 41 | The Society believes the recommendations to be ambitious given the often low quality of the evidence that they rested upon. For example in Recommendation 41 it is advised that services ensure that parent-child psychotherapy is based on the Cicchetti & Toth model despite the earlier statement that "precision in estimate of this effect was poor" | Thank you for this comment. The Guideline Committee agree that in some reviews there was little good quality evidence, and they went as far as they could in terms of offering guidance given this situation. |
| British Psychological Society | Full | 392 | Rec. 42 | CBT trauma based interventions do not claim to cover complex trauma. The work of Bessel Van Der Kolk which has looked at trauma from within the family and early in life (complex developmental trauma) is an important body of knowledge to guide interventions tailored to the specific trauma needs of this population. These trauma needs are an important influence on the development of attachment difficulties, therefore it is concerning to see so little acknowledgement of these within this guidance. Differences between single event and complex trauma need to be acknowledged. (van der Kolk, 2005) | Thank you for your comment. Whilst the Guideline Committee recognise that the impact of maltreatment may manifest in different presentations, the only available evidence for school aged children came from one trial which found trauma-focused CBT for children who had been sexually abused to be effective. In the absence of any other evidence, the Guideline Committee extrapolated to children who had been maltreated. |
| British Psychologica | Full | 397 | 26 -27 | The guidance states that the carers may not be insensitive or a contributing cause of the child's attachment difficulties" | Thank you for your comment. The Guideline Committee agree that there are a myriad of factors |

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| l Society | | | | While we agree with this we suggest it would also be useful to present the the research of Mary Dozier which demonstrates that sensitive caregiving without a gentle challenge can reinforce patterns of relating developed when the children were parented insensitively. Thus the parents/carers may unwittingly have a maintaining influence without appropriate parenting support. There is also a potential for secondary trauma in carers (Cairns, 2002) or to move into blocked care (see Hughes & Baylin, 2012), and this can lead to parents/caregivers being less sensitive as they are less available to the children.<br><br>We note in line 41 on this page that you acknowledge that one aim use of video interaction guidance is for carers to over-ride their own attachment issues in order to be more sensitive to their children which supports this point. | that may influence the parents' sensitivity towards the child. The Guideline Committee feel they addressed some of these when they reviewed the parental factors (such as history of abuse) that influence attachment difficulties.<br><br>Moreover, the Guideline Committee agree that is important to provide support for parents so that they can show more sensitivity towards their children. That is why a number of interventions have been recommended, such as video feedback, that can achieve this. |
| British Psychologica l Society | Full | 398 | 4 | Researchers such as Dan Siegel (Siegel, 2007), Bruce Perry (Perry, 2006) and Bessel Van Der Kolk (Van Der Klok, 2005) have highlighted the limited effectiveness of cognitive heavy interventions which are reliant on top down functioning and do not take into account the over aroused nervous system. In relation to this we note that on page 23 (line 44) you refer to children in fight/flight sates not being able to learn, but the relevance of this for the success of cognitive interventions is not apparent in the recommendations. Bruce Perry talks about the importance of State dependent interventions, but this knowledge in not reflected in this guidance. | Thank you for your comment. The majority of the recommendations target the parents in helping them become more sensitive towards their children. No recommendations were made that targeted the children alone, without the additional therapy for their carers or parents. |

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| British Psychological Society | Full | 399 | 17 | We note that studies where children were diagnosed with conduct disorder were excluded but do not understand what the rationale for this was and suggest this was unhelpful. There is evidence that the rate of conduct disorder in the population of young people in foster and/or adoptive placements is high and more importantly hugely underdiagnosed (Woolgar & Baldock, 2015) therefore excluding due to this diagnosis seems inappropriate. Recent evidence suggests that conduct disorder may be 10 times more prevalent than the rate at which it is diagnosed (Woolgar & Baldock, 2015). This obviously has impact when thinking about any recommendations made regarding the best interventions for this group of young people. | Thank you for your comment. The Guideline Committee excluded studies where the risk of the child going into care cannot be attributed to the parent. i.e. children with conduct disorder/behavioural problems and whose parents do not display any of the risk factors.<br><br>Thus the Guideline Committee did not exclude studies of children with a dual diagnosis of attachment difficulties and conduct disorder. |
| British Psychological Society | Short | 8 | 151 | The Society has concerns about Equal access to interventions and whether this can be practically implemented and believes that it should be made clear who is going to provide this. We believe that there are issues of inconsistency and inaccessibility of CAMHS and that there is a need to increase the attachment focus in IAPT programmes. There is also a need for services to have the capacity to provide parenting work as well as dyadic work with child and parent.<br><br>We would hope that these recommendations can be followed by practical resources. | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| British Psychological Society | Short | 22 | 536 - 537 | The recommendation for the practitioner to be: 'integrated with other services, including CAMHS, education and social care' will be difficult to implement in practice given the constraints on | Thank you for your comment. The recommendation has been changed to say 'works with' rather than 'integrated with' (1.3.8). |

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| | | | | these services and the lack of resources. The guidance acknowledges that interventions need to be longer term but public services are often constrained to offer limited interventions. It is also important to acknowledge that practitioners working in the independent or voluntary sectors can provide a valuable service with the proviso that they are appropriately trained and supervised and that they maintain good liaison with the networks around the children.<br>For example:<br>http://www.theguardian.com/society/2015/may/02/crisis-in-childrens-mental-health-nhs-insider-speaks | The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| British Psychological Society | Short | 24 | 587 - 588 | Behavioural management is not likely to be needed for children aged 0-18months. Attachment theory as described in Chapter Two would suggest that this is a developmental period when the most important focus is helping parents to be sensitively attuned to the child's attachment and exploratory needs, bringing in boundaries to keep the child safe as they become mobile. | Thank you for your comment, and for drawing the Guideline Committee's attention to this error, which has been corrected. |
| British Psychological Society | Short | 27 | 663 - 668 | Intensive training needs to initially focus on the attachment with carer/parent before behavioural management, peer relationships/school work. Parents need to understand the impact of early experience on the child's current relationships, starting with relationships with adoptive parents/foster carers. As they understand this they need help to parent the children in ways which allows them to connect emotionally and increase feelings of safety and security. It is vital that this is done alongside behavioural management or the children will not | Thank you for your comment. The Guideline Committee has changed recommendation 1.5.5 to say 'peer *and parent/carer* relationships'. |

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| | | | | achieve security even if their behaviour does improve. The work of Dan Hughes (Hughes, 2009) John Baylin, (Baylin, 2015) and Dan Siegel (Sigel & Hartzell, 2003) amongst others clearly articulates this. | |
| British Psychological Society | Short | 27 | 659 - 660 | It is helpful to have a recommendation that recognises the need for intensive support for a reasonable length of time. A constraint on implementing this in practice will be the cost of this. There is also no consideration of what happens at the end of this time. We know that challenges will remain and therefore some continuing, albeit less intensive support will be essential. | Thank you for your comment, however the Guideline Committee will not be changing the recommendation as you have suggested.<br><br>The Guideline Committee do however have a number of recommendations that address what to do when an intervention does not work, e.g 1.5.2 |
| British Psychological Society | Short | 27 | 647 | Concerned about the strength of the recommendation, in that is states 'should' based on the limited evidence. This could limit the use of alternative interventions which may be under-researched but show promise. | Thank you for your comment, however the Guideline Committee will not be changing the recommendation as you have suggested.<br><br>The evidence for video feedback for children on the edge of care clearly showed a benefit. There was one study on video feedback for children in care that showed a benefit. So together the Guideline Committee felt confident in making this recommendation |
| British Psychological Society | Short | 28 | 695 696 | The Society has concerns that this does not fully address what a parent in these circumstances requires in order to ensure the child reaches their full potential. If the parents are not helped to connect emotionally with their children then any behavioural management however sensitively applied will fail because the | Thank you for your comment. The Guideline Committee acknowledge the importance of ensuring the parent's needs are addressed in order to ensure the child reaches their full potential. The interventions that have been recommended mostly target the |

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| | | | | children will remain with core feelings of shame and fears of being bad and of the inevitability of losing these parents too (Hughes, 2009; Baylin, 2015). This has been translated into parenting advice by psychologists in the UK (Golding, 2008; Elliott, 2013; Silver, 2013) and is well articulated by adoptive parents who have real life experience of parenting these children (Donovan, 2014) | parents and aim to help them with their emotions to become more sensitive parents. If an intervention does not work, the Guideline Committee did recommend considering alternative options. Moreover, some of the interventions include group therapy for the parents and 24 hour telephone support services, and such support has been shown to be beneficial. |
| British Psychological Society | Short | | Rec 1.3.4 | The strange situation is a very stressful situation and morally, some professionals have concerns about using this despite the good evidence. There is no mention of the Marschak Interaction Method (MIM) which may be more suitable for the adopted or fostered child (Booth & Jernberg, 2010). | Thank you for your comment. The Guideline Committee agree that the clinician has to decide whether it is helpful to conduct the assessment in terms of the overall needs of the child, however, many clinicians in the field have found the strange situation to be very useful clinically. The procedure is always curtailed if the child is distressed, so in many instances (where there is upset) the two episodes of separation are often no more than 30 seconds each (up to 3 minutes if little or no distress).<br><br>Due to time and resource constraints it was not possible to review all tools of assessment. The Guideline Committee selected from a long list of tools those they considered the most important and relevant to include in the review. Unfortunately, the Marschak Interaction Method was not selected. |
| British Psychologica | Short | 32 - 33 | Rec 2,2 and 2.3 | The Society welcomes these research recommendations but a constraint on realising this is the cost and time needed. RCT trials | Thank you for your comment. The Guideline Committee acknowledge the difficulties in receiving |

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| l Society | | | | are very expensive, and often bids for project money is for time limited periods which makes it impossible to carry out essential follow-up, In addition numbers that can be included in the research group are also limited by funding, further diluting the usefulness of the research. (eg a current grant to evaluate the delivery of the Nurturing Attachments Group (Golding, 2014) by the DfE only provides funding for 20 hours of research time, and half the money needed for an RCT trial. In addition the timescale that the project has to be completed in does not allow for a follow-up, and the original plan to deliver the group in 8 geographical areas (n = 120) has had to be halved because of the amount of money awarded).<br>These same comments apply to other research recommendations. | funding and being able to access the numbers of participants needed to achieve significant results. NICE and the NIHR have a close working relationship to ensure that research recommendations are taken up (see the NICE research recommendations methods and process guide (2015)) and NICE research recommendations are often funded. |
| British Psychological Society | Short | General | General | The Society believes that there needs to be more of a link between theory of how attachment develops naturally for children with parents and the treatment approach – going back to:<br>1) Parents mind<br>2) Parent child relationship<br>3) Child's internal working model.<br>4) Impact of child's experience on parent<br>5) Dyadic work | Thank you for your comment. The theoretical underpinnings of the interventions would require significant additional text. In an attempt to keep the full guideline as brief as possible the Guideline Committee have not added this background information. |
| British Psychological Society | General | General | General | **References:**<br><br>Atkinson, L., Paglia, A., Coolbear, J., Niccols, A., Parker, K. C., & | Thank you for the references. |

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| | | | | ***18*(5)**, 385-388<br><br>Woolgar, M. and Baldock, E. (2015) Attachment disorders versus more common problems in looked after and adopted children: comparing community and expert assessments, *Child and Adolescent Mental Health*, **20**, 34-40 | |
| Department for Education & Department of Health (joint response) | General | General | General | These comments reflect the views of colleagues leading on policy relating to children adopted from care and looked-after children. | Thank you for your comment. |
| Department for Education & Department of Health (joint response) | General | General | General | **General comments**<br>The full guidance is very long and dense. For guidance of this length it is very unlikely that busy social workers and professionals in schools are going to use it to help them understand what interventions to use based on the evidence available. We think even health professionals may struggle.<br><br>We understand that there is a certain level of detail required to ensure readers know that the recommendations are based on evidence. We do therefore think that in order to make the document easier to navigate:<br><br>• It would be helpful for there to be some restructuring of | Thank you for your comments. It is unavoidable that the full guideline is a long document as it provides all the evidence reviewed to make the recommendations and we work within a set template provided by NICE. Your other points are addressed in order:<br>• The key recommendations can be found in the short version, and the evidence statements are clearly signposted in the full guideline.<br>• Where the evidence has allowed, the Guideline Committee has prioritised some interventions over others (for example video feedback). This is clearly stated in the full guideline. An explanation of the strength of |

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| | | | | the document so that all of the key evidence and key recommendations are signposted<br><br>• It would be helpful to have some clearer and more explicit signposting (so that they can be found quickly) to the interventions that have the strongest evidence in relation to each of the client groups<br><br>• More consideration given to the language used so that it is accessible to non-clinicians such as social workers and teachers. At the moment the language in places is not as accessible as it could be for these audiences. We want social workers (and there are recommendations that are targeted at them) and teachers to engage with this guideline. From experience, they are just not going to read a document of nearly 500 pages.<br><br>• Perhaps one approach could be for the shorter version be expanded so that it includes more than the recommendations but also a summary of the findings and a sense of which recommendations are more important than others. What are the recommendations which, if implemented, will have the biggest impact?<br><br>• On pages 13 and 14 of the full guideline there is useful information about who has developed the guideline and | recommendations is also provided in the short version.<br>• Regarding your point about the language used in the guideline, the short guideline is the version that most health and social care professionals and school staff will read and it is written in plain English and technical terms are defined at the start of the guideline.<br>• As things currently stand, all short versions of the NICE guidelines present the recommendations only, not the summary of findings.<br>• NICE produces a full suite of tools to support implementation of the guideline, which will be helpful to commissioners. The short version will also contain information on what the guideline covers and who it is for.<br>• The Guideline Committee feels that it has been explicit about which interventions are prioritised over others. For example, in section 1.4 of the short version it is clear from the order in which the recommendations are listed and the strength of the wording that video feedback programmes are more effective in pre-school-age children on the edge of care than home visiting programmes. |

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| | | | | for whom it is intended. We think it would be really helpful to include something for practitioners about **how they should use this guidance**. There are a number of references to commissioners, for instance. Given that they will be purchasing interventions it would be useful to say something specific at the front (possibly in section 1.2.2) about how they should engage with this guideline.<br><br>• There are sections throughout which give an indication of the strength of the evidence for particular interventions. It would be helpful to be more explicit about what broad conclusions might be drawn about **whether there is a hierarchy of interventions, where the gaps in evidence are and what more needs to be done to fill those gaps**.<br><br>• Perhaps the research specifically in relation to social care could be drawn out in one place<br><br>• Greater clarity is needed regarding which specific interventions have been reviewed. In terms of the interventions we know about I spotted references to KEEP and MTFC but there are others that we didn't spot such as Multi-Systemic Therapy, SafeBase, Dyadic Developmental Psychotherapy (DDP). | • Because of the way the research questions were formulated and the evidence reviewed it was not possible to present the research for social care in one place. Some interventions, for example, are applicable to a number of different settings – schools, health and social care.<br>• The Guideline Committee feels it has been clear which interventions have been reviewed – see the review protocols at the start of each chapter. The Guideline Committee only reviews interventions for which there is sufficient high-quality evidence.<br>• It is not NICE methodology to use the RAG rating as you have suggested. The review protocols clearly set out which interventions are reviewed.<br>• The Guideline Committee felt that most readers would understand the meaning of therapeutic.<br>• Finally the guideline has been as clear as it can be about which interventions are effective in particular age groups. |

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| | | | | • Would it be possible to have a list in an Annex of all the interventions explored and in what context (i.e. edge of care, adopted, looked after)? Perhaps one way of quickly gauging how strong or weak the evidence is for each of these interventions would be to use a RAG rating (Red, Green and Amber and shades in between) to make it easier to identify which intervention might be appropriate?<br><br>• Is there a definition of therapeutic that is used throughout the guideline. If so, it's not obvious.<br><br>• Some parts of the guideline have references to ages but we did not get a sense of which interventions that are not already age related work better or less well with particular age groups. | |
| Department for Education & Department of Health (joint response) | General | General | General | **Guideline and recommendations comments (1)**<br>In the preface it would be helpful to highlight the need for this guideline. Something like: 'Children's attachment and its impact, particularly where children are looked after or for whom being adopted from care is the permanence plan for them, is poorly understood among a range of professionals. The purpose of this guideline is to help professionals ensure that children presenting with characteristics that suggest problems with attachment are diagnosed accurately and that their needs are addressed quickly.' | Thank you for your comment, a paragraph based on the text you have suggested has been added to the preface of the full guideline. |

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| Department for Education & Department of Health (joint response) | General | General | General | **Guideline and recommendations comments (2)**<br>The guideline states that it will be relevant but not cover the practice of those working in social services but goes on to make specific recommendations in relation to social services practice (as well as education practice). This appears confusing and inaccurate. Is a key objective of the guideline not to help better inform and advise social service practices in effectively identifying and supporting children with attachment difficulties? Furthermore on occasion some of the language used is of a clinical and technical nature and will not be accessible to non-healthcare professionals to whom the guideline is relevant. Language needs to be more tailored for education and social service professionals if they are targeted users of this guideline. | Thank you for your comment. The text to which you are referring in the preface to the full guideline has been amended to make it clear that the guideline is relevant to social care and education.<br><br>The full guideline is by definition technical, but the short guideline is written in plain English and will be the product that most professionals read. |
| Department for Education & Department of Health (joint response) | General | General | General | **Guideline and recommendations comments (3)**<br>The guideline seems to be recommending that adopters, foster carers and special guardians engage with the same interventions to address a child's attachment disorder as those offered to the parents of children on the edge of care i.e. video feedback and parental sensitivity and behaviour training. This doesn't seem to recognise the fact that the carer's position is different to that of the birth parents – carers are not the root of the children's difficulties it was the damage inflicted on them before they came into care or from earlier placements. | Thank you for your comment, however the evidence suggests that the recommended interventions would still be helpful for foster carers and adopters and their children, even though they themselves were not the cause of the attachment difficulties.<br><br>The evidence used to generate recommendations for foster children and adopted children was from RCTs in this same population. The interventions, e.g. video feedback, parental sensitivity and behaviour training, were also used for children on the edge of care. In cases where the evidence was thin due to a small number of studies, the Guideline Committee referred to the results on the edge of care population to see if |

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| | | | | | the same trends were identified. In each case they were.<br><br>Although the Guideline Committee agrees that carers are not the root cause of the children's attachment difficulties, the interventions aim to help the carers understand their child's behaviour, learn how to manage difficult behaviour and how to respond to their child's needs.<br><br>So although they may not be the reason the child has attachment difficulties, the carer will need help in finding ways to nurture and bond with their child, and the results support their use. |
| Department for Education & Department of Health (joint response) | General | General | General | **Guideline and recommendations comments (4)**<br>It's not always clear to whom the recommendations are addressed. For instance those on page 201. And are the recommendations here about looked after as well as adopted children? | Thank you for your comment. All the recommendations are addressed to health and social care professionals unless otherwise specified. The context of each recommendation is made clear in the short version. |
| Department for Education & Department of Health | General | General | General | **Guideline and recommendations comments (5)**<br>Do some of the recommendations (e.g. 19 on page 210) almost go without saying? Who would give a child inaccurate information? And is there really a choice about this? Surely it's something that social workers should do, not consider doing? | Thank you for your comment. There is some evidence that children are being given inaccurate information about their life history, therefore the Guideline Committee wished to stress the accuracy of the information provided. The recommendation (1.1.16) |

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| (joint response) | | | | There are other recommendations throughout which are really quite basic and essentially what social workers are already required to do. | has, been changed to say social workers should offer children and young people this information.<br><br>The other 'basic' recommendations to which you refer were all considered important by the Guideline Committee as they apply to children and young people with attachment difficulties in many different contexts, including education, and there some evidence that some of the 'basics' were not being adhered to in all contexts. |
| Department for Education & Department of Health (joint response) | General | General | General | **Guideline and recommendations comments (6)**<br>Page 195: it needs to be clear when referring to children and young people from overseas that you are talking about unaccompanied asylum seeking children ( UASC) and not children whose parents are seeking asylum. | Thank you for your comment, the Guideline Committee has changed the terminology to 'unaccompanied asylum seeking children'. |
| Department for Education & Department of Health (joint response) | General | General | General | **Guideline and recommendations comments (7)**<br>Recommendations on page 423 and 424: are the ones relating to residential care also not appropriate for looked-after children in other settings? It's not clear why they just relate to residential care. | Thank you for your comment. Two of the recommendations (1.6.2 and 1.6.3) have been extrapolated from the looked-after children review. The first recommendation is specific to residential carers, |
| Department | General | General | General | **Guideline and recommendations comments (8)** | Thank you for your comment, these have been |

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| for Education & Department of Health (joint response) | | | | Recommendation 53 on p433 appears to make incorrect references to recommendations 52 & 53. Should this instead reference recommendation 51 & 52 respectively? | corrected. |
| Department for Education & Department of Health (joint response) | General | General | General | **Guideline and recommendations comments (9)**<br>Page 427. The paragraph beginning 'in conclusion' seems key to saying that video feedback works but the message is lost. Key messages need to be much more prominent. | Thank you for your comment. The 'key messages' are in essence the recommendations themselves. It is clear from strength of the wording of the recommendations that video feedback is effective. |
| Department for Education & Department of Health (joint response) | General | General | General | **Guideline and recommendations comments (10)**<br>Page 433: recommendation 55. Surely these weekly sessions are not during the school day. We should not be making recommendations that suggest children should be missing huge chunks of time out of school. | Thank you for your comment. The Guideline Committee agrees that this needs addressing and have added the following bold text to recommendation 1.5.10:<br>"Ensure training and education programmes for children and young people:<br>• are delivered by trained mentors, which may include graduate level workers. **at a time that ensures schooling is not disrupted**." |
| Department for Education & Department | General | General | General | **Guideline and recommendations comments (11)**<br>Within section 11) Interventions for young children and young people who have been adopted, it is important for health professionals to understand that a child's behaviour is very | The Guideline Committee agree it is important for health professionals to understand the point you raised. For this reason the following has been added to the introduction of the guideline in section 2.11: |

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| of Health (joint response) | | | | complex and has as much to do with past trauma as it does with his/her current relationship with adoptive parents and his/her new family. It is important for professionals to avoid making assumptions about the reasons behind a child's behaviour and giving out the message implicitly or explicitly to adoptive parents that they are to blame for the child's behaviour. This point is made to address some of the anecdotal evidence on adoptive parents being 'blamed' for prior experiences/neglect by birth parents and of adoptive parents ending up wrongly in the safeguarding system as a result of the identification of trauma and abuse by professionals. | It is important for health care professionals to understand that a child's behaviour in care can be very complex and may be due to a past trauma, not the result of poor parenting provided by foster carers or adoptive parents. Thus, complex trauma should be addressed separately to an attempt to improve the attachment between the child and their current carers or adoptive parents. |
| Department for Education & Department of Health (joint response) | General | General | General | **Guideline and recommendations comments (12)**<br>Are there any specific additional challenges (and associated additional needs) faced by adopted children due to them having a complete break from their birth parents? | Thank you for your comment.<br><br>In response to your comments, the Guideline Committee has generated a consensus recommendation to address the specific challenges faced by adopted children due to them having a complete break from their birth parents.<br><br>The recommendation was modelled on the Department of Education's Statutory Guidance on Adoption 2013 and the guideline committee's expertise. It reads:<br><br>"When adoption is considered the best outcome for the child or young person ensure that:<br>- their wishes are taken into account |

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| | | | | | - they are offered information about the implications that adoption may have for future contact with their birth parents, siblings, wider family members and others<br>- a full assessment of need is conducted before adoption<br>- an assessment of attachment difficulties is conducted sometime after adoption<br>- they are offered support (based on the needs and attachment assessment) before, during and after adoption" |
| Department for Education & Department of Health (joint response) | General | General | General | **Research recommendation comments (1)**<br>Overall the research recommendations are incredibly broad (e.g. Research recommendation 7 on p432). It would be helpful to have more clearly defined parameters recommended for developing attachment-focused interventions. | Thank you for your comment. The research recommendations are explained in more detail in the short version of the guideline. |
| Department for Education & Department of Health (joint response) | General | General | General | **Research recommendation comments (2)**<br>In relation to recommendation 5(p394) it would be helpful if the guideline could provide more direction in advising specifically which currently unevaluated but extensively used attachment-focused interventions are recommended to be evaluated and reviewed as well as which specific attachment-focused interventions target different age groups. | Thank you for your comment. The research recommendations are explained in more detail in the short version of the guideline. Some examples of under-evaluated interventions have been added to the research recommendation. |

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| Department for Education & Department of Health (joint response) | General | General | General | **Research recommendation comments (3)**<br>It would be helpful to have guidance on what evidence levels to use in assessing the clinical effectiveness of attachment-focused interventions to inform what type of evidence base is required. | Thank you for your comment. The research recommendations are explained in more detail in the short version of the guideline. |
| Department for Education & Department of Health (joint response) | General | General | General | **Research recommendation comments (4)**<br>Due to the ethics of RCTs presenting difficulties in this field it would be helpful if the guidelines can advise how RCTs have been conducted for other mental health interventions for children and young people. Would the assessment validity work have to come first so that we can control for the variation in attachment/other disorders when we are organising intervention and control groups for the proposed RCTs? Presumably there is a wide range in terms of what counts as attachment disorder. | Thank you for your comment. The Guideline Committee understand the difficulty in designing RCTs for children. Nevertheless, there are numerous studies that have been published in children who are on the edge of care, in care or adopted from care who have attachment difficulties. They can be used as a guide for how to design a new well-controlled RCT and the assessment tools recommended in this guideline can be used as a guide for what could be used to assess attachment difficulties or maternal sensitivity |
| Department for Education & Department of Health (joint response) | General | General | General | **Presentation and formatting comments (1)**<br>Presentation of tables could be improved by presenting in a landscape format to avoid use of small text and optimise use of page space. Would tables be better presented in an appendix? The document is cumbersome and could be organised to be more reader friendly. | Thank you for your comment. The guideline has been reformatted and further work will be done to improve its presentation in time for publication, however it is usual NICE style to present summary evidence tables and study characteristics in the body of the full guideline. |
| Department for | General | General | General | **Presentation and formatting comments (2)**<br>Not all statistics used in the guideline appear to be clearly | Thank you for your comment. In response to your query on the source of evidence on page 18 the |

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| Education & Department of Health (joint response) | | | | referenced e.g. p18 line 41, p20 line 18. And are all the stats taken from the latest published Statistical First Releases? | Guideline Committee have now referenced the Van Ijzendoorn (1999) meta-analysis which provides the most recent estimates of attachment patterns for children under 2 in normative samples that the Guideline Committee were aware of. Regarding the statistics taken from the latest published Statistical First Releases, these were originally taken from the 2013 report, however these have now been updated using the latest statistics from the Department for Education in 2014. |
| Department for Education & Department of Health (joint response) | General | General | General | **Presentation and formatting comments (3)**<br>Greater use of sub headings in certain sections of the guideline would provide better presentation and make the guideline more user friendly e.g. in section 2.3 use a sub heading for each attachment classification. | Thank you for your comment. The Guideline Committee have added sub-headings where we thought it worthwhile. |
| Department for Education & Department of Health (joint response) | General | General | General | **Presentation and formatting comments (4)**<br>There are some formatting inconsistencies/errors throughout the guideline e.g. inconsistent formatting of recommendations in tables such as different font sizes; rogue bullet point on p78 etc. | Thank you for your comments. These errors have been addressed. |
| Department for | General | General | General | **Presentation and formatting comments (5)**<br>There are some 'Error!' messages within the guideline where | Thank you for your comment, the cross-references have been updated. |

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| Education & Department of Health (joint response) | | | | there should be a reference source e.g. p439. | |
| Department for Education & Department of Health (joint response) | Full | General | General | If possible, we would be additionally interested to know the evidence base for Playtherapy and Dyadic Developmental Psychotherapy (DDP) - even if this is only to confirm that the evidence is lacking. A recent survey of Tier 3 CAMHS services indicates that up to 50% are employing the former and up to 39% the latter. Therefore there is great potential to positively impact practice if the evidence base for these therapies were known and considered in a guideline context. | Thank you for your comment. Unfortunately no RCT evidence was identified in this area. Thus, this area was identified as a key uncertainty by the committee which is why they generated a research recommendation to: "Evaluate currently unevaluated but extensively used interventions for attachment difficulties." This research recommendation includes Playtherapy and Dyadic Developmental Psychotherapy (DDP)**.** |
| Family Futures | Full | 7 | 1 | It would have been helpful for there to have been more representation from practitioners working with the population of children who are on the edge of care, looked after or adopted and who present as having attachment difficulties. Attachment difficulties per se are not a psychiatric condition but a developmental problem and consequently there may be an over representation from the field of psychiatry and insufficient representation from those practitioners carrying out assessment of attachment difficulties related to maltreatment and carrying out interventions with them. | Thank you for your comment. The Guideline Committee were recruited based on their expertise and experience of children's attachment. Members of the group do indeed work with these populations. In addition, carers and care-leavers on the group also provided invaluable input throughout development of the guideline. |
| Family Futures | Full | 21 | 4 | The panel appear to have chosen to look at attachment as a very narrow field of child development though recognise that attachment difficulties arise from early childhood maltreatment. | Thank you for your comment. NICE is currently developing a new guideline that will address childhood maltreatment, hence it will be a better place for NICE |

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| | | | | It seems unhelpful therefore not to embrace all the other developmental consequences of childhood trauma as now being defined in the literature (and largely working by those working clinically in the field) as Developmental Trauma. | to explore other developmental consequences of childhood trauma. |
| Family Futures | Short | 16 | 372 | The complexity of sibling relationships and the trauma bond that they can often share as a consequence of their maltreatment and the poor availability of caregivers and maltreatment is not made clear here. It is important that this complexity is indicated and that often it is not in the best interest of each child to remain in placement together if their attachment needs are to be met. Reference to Sibling: Together or Apart assessments such as that offered by our own Service or by BAAF would be helpful as these take into consideration the complexity of the formation of sibling attachments in the context of trauma and the competing needs of the children and how these can be transferred into future care and adoptive placements and undermine the success of these. | Thank you for your comment. The recommendation is made in the context of improving the likelihood of more permanent placements, based on evidence that keeping siblings together is a factor in this regard. Whilst we recognise that some children may be better placed in separate placements because it may detract them from forming a secure attachment to their new carers and difficulties surrounding their trauma, the recommendation does have a caveat that this should only be done if it is in the best interests of children (1.1.13).<br><br>We have also made a comment relating to this in the Linking Evidence to Recommendations for this recommendation |
| Family Futures | Short | 18 | 418 | CAMHS services are frequently unable to offer specialist services for attachment difficulties as they are not classified as a mental health disorder. Specialist therapeutic services that work with trauma and attachment difficulties should therefore be included in this section. This will be important when supporting parents and children through Education and Health Care Plan | Thank you for your comment. The Guideline Committee agreed that referring to CAMHS might be restrictive and have therefore revised the recommendation to say any mental health service for children and young people, which would include the kinds of services you mention. |

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| | | | | assessments and in supporting education settings with understanding the impact of attachment difficulties (as a consequence of developmental trauma) on learning and behaviour. These specialist services are referenced later in the guidelines and so the recommendations should be joined up and consistent to avoid confusion. | |
| Family Futures | Short | 19 | 460 | Parenting factors appear to have been reduced down to parental sensitivity. When referring to children in care parental sensitivity of the birth parent is only one factor that has led to developmental trauma and attachment difficulties. In addressing the attachment difficulties of the child going forward it is important to consider not only parental sensitivity of foster carers or prospective adoptive parents but their own attachment history, history of trauma and the likely interplay of these with the child's attachment needs and behavioural presentation. Further consultation with professionals working in this field, such as our own service, would lend itself to providing a fuller understanding of how carers/adoptive parents can struggle to meet the needs of children with attachment difficulties and therefore what assessment and intervention should be put in place to address and support this. | Thank you for your comment. The Guideline Committee agree it is important to recognise the attachment history, history of trauma of foster carers and prospective adopters. These factors have been included as part of an overall assessment before embarking on an intervention in recommendation 1.3.2. The interventions that have been recommended will aid in helping foster carers provide sensitive/non-frightening parenting responses when dealing with the challenges of working with children with complex needs in a way that maintains structure, predictability, feelings of safety, and an experience that the carer responds to their needs. |
| Family Futures | Short | 20 | 469 | Again, carer or prospective adoptive parents are not considered fully enough here in terms of what their own history of trauma and their own attachment difficulties bring to the dynamic of caring for a child with a trauma history and attachment difficulties. To ignore this is to ignore the complexity of the | Thank you for your comment. The Guideline Committee agree it is important to recognise the attachment history, history of trauma of foster carers and prospective adopters. These factors have been included as part of an overall assessment before |

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| | | | | caregiver/child relationship and what each brings to it. | embarking on an intervention in recommendation 1.3.2. The interventions that we have recommended will help helping foster carers provide sensitive/non-frightening parenting responses when dealing with the challenges of working with children with complex needs in a way that maintains structure, predictability, feelings of safety, and an experience that the carer responds to their needs. |
| Family Futures | Short | 20 | 492 | There is insufficient evidence for the efficacy of these interventions with the looked after or adopted from care population of children. Underlying developmental trauma and attachment difficulties can often present in ways that can lead to multiple diagnoses such as those presented here, the treatment for each of which is often ineffective for this population. Further elaboration of this should be made to represent the complexity of the presentation of many of these children and young people. | Thank you for your comment. The Guideline Committee considered that there was no evidence or reason to think that these interventions would not be effective in looked-after or adopted children, and were of the view that it would be inappropriate not to recommend them for this group. |
| Family Futures | Short | 21 | 500 | Insufficient breadth of attachment tools discussed here. Why has the panel not considered the use of the Story Stem Assessment Profile (Hodges et al, 2004) which is widely used amongst clinicians in the UK and is a reliable and valid tool for measuring attachment in children. Also whilst many screening tools are not validated for the looked after and adopted from care population the Assessment Checklist for Children (Tarren Sweeney, 2007 ) and the Assessment Checklist for Adolescents (Tarren Sweeney, 2013 ) is a reliable and valid tool which effectively screens for | Thank you for your comment. The Guideline Committee have re-considered the clinical utility of the Story Stem Assessment Profile (SSAP) and although no evidence was found for its validity, they agree that this is a useful tool for measuring attachment difficulties and in response to your comment the SSAP has been added it to the list of story stem tools in recommendation 2.3.4- we thank you for drawing our attention to this tool. |

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| | | | | the symptomatology of children who present with attachment difficulties. In particular in the ACC there are three categories directly related to attachment strategies used by children – Indiscriminate, Non-reciprocal and Pseudomature. It seems remiss of the panel not to discuss such a clinically relevant and useful tool that is increasingly being taken up by clinicians in the UK. | With regard to the Assessment Checklist for Children and the Assessment Checklist for Adolescents, whilst the Guideline Committee acknowledged these are widely used tools, it was outside of the scope to consider tools which had not been validated against another tool specifically relating to an accepted definition of attachment. The consequence of this is that a number of potentially useful tools did not enter into the consideration of the Guideline Committee. However, in response to this, the Guideline Committee made a research recommendation for the validation of an existing tool (such as the ACC or ACA) or the development of a new tool which can be used to screen for attachment difficulties. Furthermore, concerning the use of tools in adolescents, it was the view of the Guideline Committee that for assessing attachment status in late adolescence, the Adult Attachment Interview is currently the best well-validated tool that exists, and therefore wished to recommend this tool in the absence of evidence validating other tools (such as the ACA) in this population. |
| Family Futures | Short | 22 | 517 | Again we are unsure of the focus solely on maternal sensitivity. It can be reasonably concluded that there was a lack of maternal sensitivity and responsiveness to the child's needs within the birth family. For children in care or about to be placed in | Thank you for your comment. The Guideline Committee agree it is important to recognise the attachment history, history of trauma of foster carers and prospective adopters. These factors have been |

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| | | | | adoptive care, parental sensitivity is only one aspect of parental factors that should be considered. Foster carers' and prospective adoptive carer's own history and attachment strategies should also be considered to ensure that children are correctly matched with carers/ prospective adoptive parents. | included as part of an overall assessment before embarking on an intervention in recommendation 1.3.2. The interventions recommended will help helping foster carers provide sensitive/non-frightening parenting responses when dealing with the challenges of working with children with complex needs in a way that maintains structure, predictability, feelings of safety, and an experience that the carer responds to their needs. |
| Family Futures | Short | 27 | 647 | There appears to be significant reliance on this video guidance feedback when the evidence for it is very low quality for adopted children and children in care and when the evidence is moderate it was still uncertain and imprecise. How can the National Guidance be based on this research evidence? A difficulty with NICE reviews only reviewing RCT's is that models that are clinically effective but for which there are not the resources to conduct RCT's are missed. Further exploration with specialist therapeutic services would provide information on what clinicians' in the field experience as being effective. Consultation with the user groups such as foster carers and adoptive parents would also provide insight into what the preferred models of intervention are. | Thank you for your comment, however the Guideline Committee will not be changing the recommendation as you have suggested.<br><br>The Guideline Committee acknowledge there are other interventions that have no RCT evidence. However they agreed that this is a key area of uncertainty. For this reason they generated a research recommendation: "Evaluate currently unevaluated but extensively used interventions for attachment difficulties" |
| Family Futures | Short | 27 | 654 | Whilst some of the evidence for parental sensitivity training for parents of children on the edge of care is positive the evidence does not exist for sensitivity training for foster carers of adoptive | Thank you for this comment. The Guideline Committee agree that there was in some reviews little good quality evidence, and they went as far as they could in terms of |

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| | | | | parents and so the guidelines should not be extended to this presentation. The evidence for this modal is very low quality and largely shows no effect. Where there is some effect in two small studies there was some uncertainty. For children in care the evidence was also of low or very low quality and there was uncertainty for those that had some effect. To based national clinical guideline on such evidence is concerning and focus should be on exploring and funding trauma and attachment based programmes that are specific to this population of children's presentation. | offering guidance given this situation. |
| Family Futures | Short | 27 | 658 | Whilst the recommendation for intensive training and support for foster carers and adoptive parents is welcomed the evidence on which this recommendation is based is very low quality and variable at best. For two studies reviewed the training was linked to an increase in reactive attachment disorder and others had no effect. | Thank you for this comment. The Guideline Committee agree that there was in some reviews little good quality evidence, and they went as far as they could in terms of offering guidance given this situation. |
| Family Futures | Short | 27 | 665 | Where is the evidence for this type of parenting programme for this population of children? The quality of evidence for adopted children was of very low quality and most had no effect on maternal sensitivity or disorganised attachment. Parenting programmes focussing on behavioural interventions tend only to reduce externalising difficulties and do not address attachment difficulties nor affect change with regard to them. There is no more evidence for this type of intervention than for others and there appears to be a generalisation from the 'Normal' population of children to those in alternate care provision. This is | The Guideline Committee agree that there is little evidence for interventions that target adoptive parents.<br><br>The recommendation given was based on an intervention that was shown to be effective for foster carers and their children. Rather than not make any recommendations and only make a research recommendation for this population (which we did do), the Guideline Committee felt it was appropriate to extrapolate the findings from the studies on children in foster care to those who have been adopted. |

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| | | | | not a good enough extrapolation for national guidance on clinical practice and this model should not be weighted above others. It would be important to know the rationalisation and justification for this. Again consultation with providers of therapeutic support to this population for early trauma related attachment difficulties and with those in receipt of it would be crucial. It would make sense for parenting programmes targeted at parents/carers of children who have experienced maltreatment (trauma in the context of early development) to receive programmes which target the effects of such maltreatment and provide strategies that respond the attachment difficulties. | The evidence on children who have been traumatised due to maltreatment and who have attachment difficulties was even more scarce. The Guideline Committee did make recommendations on the limited evidence available and NICE are currently developing a guideline that will address the needs of children who have been maltreated. |
| Family Futures | Short | 28 | 674 | There is no evidence for the efficacy for cognitive and interpersonal skills sessions for children after placement. Children who have experienced maltreatment (including in utero exposure to drugs and alcohol and high levels of cortisol) and who present with attachment difficulties often have a plethora of concomitant difficulties that include disorders of the nervous system, sensory processing difficulties and executive functioning difficulties that present a barrier to their being able to engage in higher order metacognition and reflective functioning that is required to engage in cognitive and interpersonal skills sessions. Given the trauma and attachment related difficulties that they present with the focus post placement should be on establishing a sense of felt security and developing their relationship (attachment security) with their carer/adoptive parent. | Thank you for your comment.<br>The Guideline Committee have adapted the wording of this recommendation to better reflect the description in the study that this recommendation was based on.<br><br>The evidence on children who have been traumatised due to maltreatment and who have attachment difficulties was scarce. The Guideline Committee made recommendations based on the limited evidence available and NICE are currently developing a guideline that will address the needs of children who have been maltreated. |
| Family | Short | 28 | 695 | Whilst we welcome the recommendation for group-based | The recommendation you are referring to was based on |

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| Futures | | | | training and education programmes for foster carers and adoptive parents we would question the use of a behavioural reinforcement system. There is no evidence for the effectiveness of these strategies on the attachment of children in care or who are adopted from care. We recommend that the panel consult the literature on the impact of trauma in the context of development for children who have been maltreated and that such behavioural programmes are counterintuitive. Instead there should be a focus on regulation and relationship/attachment focus. It is interesting that throughout the guidance reference to the impact of trauma and to the child/carer relationship is almost absent when these are the organising factors for the development of the attachment system. | the positive findings from the study by Kim 2011 Substance Use and Delinquency Among Middle School Girls in Foster<br>Care: A Three-Year Follow-Up of a Randomized Controlled Trial.<br><br>Regarding children with trauma the Guideline Committee reviewed the evidence that addressed their attachment difficulties. There was very little evidence on this, however the Guideline Committee did make recommendations on this and referred to the NICE PTSD guideline. NICE are currently in the process of developing a guideline on children who have been maltreated. |
| Family Futures | Short | 29 | 726 | Whilst we welcome the recommendation that focusses on increasing residential carer's sensitive responding there is little to no evidence with regard to the efficacy of behavioural training for professional carers on residential settings. | Thank you for your comment. The Guideline Committee recognises the limited evidence in this area, but wished to make recommendations for this group of carers and judged that extrapolation from the evidence from the review of looked-after children was appropriate in these circumstances. |
| Institute of Health Visiting | Full | 104 | Table 5.8 no 2 | This implementation of this recommendation in practice will require adequate additional commissioning resources. Health visitors are ideally placed to recognise and assess attachment in the 0-5 age group, however this will require additional high quality training, sufficient additional time in practice to complete | Thank you for your comment.<br>The recommendations are based on the best available effectiveness and cost effectiveness evidence but the Guideline Committee recognises the challenges of implementation. |

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| | | | | these assessments, high quality supervision and most importantly, local referral pathways to support families where there are concerns about attachment. In many parts of the country, specialist CAMHS services are not commissioned to provide evidence based intervention for children under 5. Health visitors are often working closely with families in this area but may have caseloads in excess of 500 plus families making it challenging to carry out this work and many have not had the opportunity to access the relevant training on evidence based interventions. | |
| Institute of Health Visiting | Full | 104 -5 | Table 5.8 no 3 | Comments as above: finding professionals with the capacity and expertise to conduct these assessments in the current cash strapped organisations is becoming increasingly difficult. Without investment in training and staff to support these recommendations it is unlikely to become a reality, although the content of the recommendations are wholeheartedly supported. | Thank you for your comment. We agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Institute of Health Visiting | Full | 105 | Table 5.8 no 4 | Agree with this but the reality is children & young people do not currently get the interventions required despite the NICE Guidance there is a dearth of provision for them and they are a much neglected user group. | Thank you for your comment. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| Institute of Health Visiting | Full | 105 | Table 5.8 no 5 | We fully support this recommendation. Children need access to specialist expertise to prevent attachment difficulties (ideally this should include primary preventative work with high risk parents during pregnancy and the first years of a child's life) as well as | Thank you for your comment. The recommendations are based on the best available effectiveness and cost effectiveness evidence but the Guideline Committee recognises the challenges of implementation. |

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| | | | | support when attachment difficulties have been identified. Currently there is not sufficient provision to meet demand for children, young people & their parents or carers who need specialist expertise in attachment difficulties, this needs urgent attention and substantial investment. | The Guideline Committee agree this is an important recommendation. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| Institute of Health Visiting | Full | 108 -109 | Table 5.8 other consider ation | When developing the recommendation on assessment (recommendation 3), the GUIDELINE COMMITTEE also saw the need to highlight that environmental factors associated with the development of attachment difficulties in children and young people in any setting should be trained in the recognition and assessment of attachment difficulties.<br>Whilst agreeing with this I again refer to the points already made in comment number 1 regarding the feasibility of this given the present economic constraints within both the NHS, The Local Authority and CAMHS services. There is an overwhelming current demand for services that cannot be met and what is treated is only the tip of the iceberg. | Thank you for your comment. The recommendations are based on the best available effectiveness and cost effectiveness evidence but the Guideline Committee recognises the challenges of implementation.<br><br>We agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| Institute of Health Visiting | Full | 109 | Table 5.8 other consider ation | Children with disabilities (including learning disabilities) were highlighted as a group that need special consideration.<br>We would totally agree with this, sadly the reality is that specialist minority groups like this appear to have suffered more than most by the cutbacks in NHS services & Local Authority and whilst lip service is paid to their needs, the provision of specialist services to this group remains inadequate. | Thank you for your comment. The recommendations are based on the best available effectiveness and cost effectiveness evidence but the Guideline Committee recognises the challenges of implementation<br><br>The Guideline Committee agree that children with |

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| | | | | Research recommendations: Whilst universal screening for attachment would potentially identify children with suspected attachment disorders at the earliest opportunity, further research needs to be undertaken to assess the acceptability of this intervention universally and any "side effects" that may be caused. Health visitors have no statutory authority to assess all parents and some might be suspicious about this level of universal scrutiny. As part of the NHS we also have a duty to "do no harm" and it is possible that being labelled as having poor attunement in the earliest weeks of a parenting journey may be a cause of psychological distress and have unknown consequences on the developing parent-child relationship. Many parents struggle in the early post natal period and these difficulties resolve with good health visiting strengths based intervention that does not require an assessment tool with a score. | disabilities and specialist minority groups need special considerations and need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team.<br><br>With regard to your comment referring to the research recommendation, the Guideline Committee are not suggesting a tool is developed for universal use by health visitors during the early post- natal period. Rather, the recommendation is for the validation of a tool that is 'readily available and able to use in routine and social care settings before and after an intervention', and therefore would be used in situations where there is a suspected attachment difficulty. |
| Institute of Health Visiting | Full | 195 | 38 | Recommendation 6 Agree but refer to above comments re cutbacks, financial constraints and inadequate services & provision | Thank you for your comment.<br><br>The recommendations are based on the best available effectiveness and cost effectiveness evidence but the Guideline Committee recognises the challenges of implementation . |

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| Institute of Health Visiting | Full | 196 | | Recommendation 7 as above | Thank you for your comment. The NICE implementation team takes into consideration the allocation of resources. |
| Institute of Health Visiting | Full | 198 | 2 | Recommendation 8: A team approach to managing attachment difficulties is important and should include key periods of transition, for example early years to school and transition to adulthood, involving other services like further education, training, employment, housing etc... We agree it is laudable to have the same key worker however this may be difficult in some areas due to high turnover of staff. | Thank you for your comment. The recommendation covers all phases of the child or young person's development, including transitions.<br><br>Regarding having the same key worker, it is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| Institute of Health Visiting | Full | 199 | | Trade off between health benefits and resource use: We would totally agree with the GUIDELINE COMMITTEE regarding the need for the processes and structures surrounding children and young people with attachment difficulties are stable and consistent. In practice these services are affected by the 5 year political cycle and policy changes for the NHS & local authorities. This lack of a stable long term plan results in a constant state of change with the associated costs and disruption to services and staff. The commissioning transfer of public health responsibility to Local authority will also lead to widespread national variation in provision. Differing local priorities may fail to address the importance of prevention, early intervention and specialist treatment for attachment difficulties with all the associated long | Thank you for your comment. The Guideline Committee are glad you agree that consistency of case workers for all children in care or on the edge of care will be beneficial. Whilst we acknowledge the logistical difficulties relating to this, it is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |

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| | | | | term financial, social and emotional costs that lack of adequate provision will incur. | |
| Institute of Health Visiting | Full | 213 | All | The same level of provision should be provided for children in early years settings | Thank you for your comment. The Guideline Committee has now made this clear in the short version of the guideline in heading 1.2. |
| Institute of Health Visiting | Full | 234 | 35 | The recommendation that a parental sensitivity tool is used will have resource implications for health visiting, to include training, additional practice time and ongoing supervision. It would be unethical to screen parental sensitivity without recourse to local evidence based interventions to address identified need. | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| Institute of Health Visiting | Full | 282 | Point 29 | To be fully implemented, this recommendation will require a substantial increase in the CAMHS budget and changes to commissioning as many area do not commission specialist CAMHS for children under 5 years. | Thank you for your comment.<br><br>The recommendations are based on the best available effectiveness and cost effectiveness evidence but the Guideline Committee acknowledges the challenges of implementation.<br><br>It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| Institute of | Full | 383 | 9.3 | Recommendations: we welcome the recommendation to offer | Thank you for this comment. |

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| Health Visiting | | | | video feedback programmes to parents of preschool children; health visitors who have undergone additional specialist training are ideally placed to provide this intervention in a way that many parents would find acceptable. This will require investment in evidence based training, funding for additional health visiting specialist posts and recourse to ongoing high quality supervision. | The recommendations are based on the best available effectiveness and cost effectiveness evidence but the Guideline Committee acknowledges the challenges of implementation.<br><br>The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| Institute of Health Visiting | Full | 386 | 34<br>35 | Health visitors are ideally placed to provide parental sensitivity and behaviour training but this will require additional investment in the health visiting service as outlined for point 14 above. It is important that funding to support the delivery of evidence based programmes is provided and local authorities are discouraged from delivering "home grown" cheaper alternatives which are likely to be less effective. | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Institute of Health Visiting | Full | 388 | 38<br>39 | We welcome the recommendation to deliver home visiting programmes and would support their delivery by trained healthcare professionals, ideally health visitors as these have been shown to achieve the best outcomes. | Thank you for your comment. |
| Institute of Health | Full | 391 | 40<br>41 | The delivery of this recommendation will require a substantial increase in the CAMHS budget and changes to commissioning as | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by |

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| Visiting | | | | many area do not commission specialist CAMHS for children under 5 years. | service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Institute of Health Visiting | Full | 423 | 43 -45 | Comments 15,16 and 17 apply to this recommendation for children in care | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Institute of Health Visiting | Full | 428 | 49 -52 | Comments 15/16/17 apply. | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Institute of Health Visiting | Full | 458 | 57 | We fully support this recommendation, however this will require sensitive management of parental expectations as a diagnosis of an attachment disorder has an implicit element of perceived "blame" that is not associated with other diagnoses like ADHD or social communication disorders. However it is important that children with attachment difficulties avoid unnecessary medication and have recourse to an accurate diagnosis and the most appropriate treatment | Thank you for your comment. The Guideline Committee did not deem it appropriate to discuss perceived blame in the context of this recommendation because they wanted to make the point that while children and young people may receive pharmacological interventions for some comorbid problems they should not be offered medication to treat attachment difficulties because there was no evidence to support its use. |
| Institute of | Short | 8 | 167 | How will they ensure a consistent social worker and other | Thank you for your comment. It is important that |

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| Recovery from Childhood Trauma | | | -169 | significant adult professional? Currently there is a constant change of professionals with the traumatised children and young people who we work with which adds further ruptured attachment experiences and the professionals are often frustrated themselves. | Health and Social Care professionals and those who work in education attempt to maintain consistency as this leads to better outcomes. The Guideline Committee nevertheless recognise this isn't always possible but should be aspired to. |
| Institute of Recovery from Childhood Trauma | Short | 17 | 405 -408 | In what way are educational psychologists and virtual school heads and designated teachers going to be trained in understanding trauma and attachment? What will be the process of evidence of their knowledge as it has not been a part of their professional training and currently there is no kite marking of trauma training? Currently we are aware, due to delivering our own training in the UK that few virtual school heads have an thorough understanding of trauma and attachment across the continuum n a way that trauma experts do, and we question why clinicians who have specialised in trauma would not be delivering the training? Educational psychologists, clinical psychologists, CAMHS, psychotherapists, teachers, social workers and other professionals do not have knowledge of trauma although attachment is usually a part of the curriculum in those training in mental health. We also recommend that the training is kite marked so that there is a high and similar standard of training delivered by trauma experts across the UK. | Virtual Heads, who have a statutory role to promote the education of looked after children under the Children and Families Act 2014, should be made aware of the NICE guideline and should respond appropriately, as key leaders, to its recommendations and the need to implement them. |
| Institute of Recovery from Childhood | Short | 9 and 23 | 198 -200 and 548-550 | In what way are educational psychologists and virtual school heads and designated teachers going to be trained in understanding trauma and attachment? What will be the process of evidence of their knowledge as it has not been a part of their | Thank you for your comment. The Guideline Committee anticipate that implementation of recommendation 1.1.1. and follow up research will be an important topic for further discussion by the |

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| Trauma | | | | professional training and currently there is no kite marking of trauma training? Currently we are aware, due to our own training in the UK, that few virtual school heads have an understanding of trauma and attachment in a way that trauma experts do, and we question why clinicians who are trauma experts would not be the ones primarily delivering the training? | professionals highlighted in the recommendation |
| Institute of Recovery from Childhood Trauma | Short | 18 | 418 -422 | Again we ask why CAMHS and educational psychologists are being asked to train others when they do not consistently evidence knowledge of attachment and trauma knowledge or frameworks for recovery in the full trauma continuum. This training should only be delivered by trauma experts who have mental health qualifications and additional trauma training. | Thank you for your comment. The recommendation has been revised to say 'mental health services for children and young people' rather than CAMHS, which would open this up to the kinds of professionals you mention (1.2.3, 1.3.8). |
| Institute of Recovery from Childhood Trauma | Short | 25 | 601 -611 | A lot of these suggested interventions seem rather prescriptive and do not seem to take into account the context of the child and family. 9 months is a short amount of time to facilitate a significant change in what is often a generational pattern that has formed over many generations. We would assume that there would be provision for further specialized support | Thank you for your comment. The duration of the interventions recommended are based on the best evidence available that has shown positive changes in parental sensitivity and attachment. The Guideline Committee did include a recommendation 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. |
| Institute of | Short | 27 | 631 | Although trauma focused CBT has been shown to be effective in | Thank you for your comment, however the Guideline |

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| Recovery from Childhood Trauma | | | -637 | treating post-traumatic stress disorder in children we would be concerned that it was seen as the only intervention on offer. For children who show signs of trauma or post traumatic stress disorder, trauma focused CBT may not be effective. CBT is reliant on cognition, which is severely affected by trauma which is primarily stored in the right hemisphere. In these cases, creative, relational therapies are essential for trauma recovery. It seems imperative to offer a range of interventions to suit the various needs of traumatised children. Attachment disorder arising from childhood trauma is not a diagnosis and as such can't be thought of and treated in that way. | Committee will not be changing the recommendation as you have suggested.<br><br>The Guideline Committee made their recommendations based on the limited evidence available. The studies included children have been maltreated where they measured an attachment based outcome, in-line with our scope. The Guideline Committee acknowledge this a broad topic and NICE are developing a guideline on children who have been maltreated. |
| Institute of Recovery from Childhood Trauma | Short | 27 | 657 -662 | We question what intensive training the foster carers would get? And also question the effectiveness of group cognitive and interpersonal skills sessions for the child who is traumatised as it is dependent on the full use of cognition rather than an intervention that understands the nature of trauma recovery and the need for a variety of interventions including creative therapies to facilitate trauma recovery. | Thank you for your comment. The intensive training is spelt out in recommendations 1.5.5 and 1.5.6.<br><br>The recommendations regarding trauma are based on the limited evidence available that showed what interventions for children with a history of trauma also improve their attachment to their primary caregiver. NICE are developing a specific guideline for children who have been maltreated. The Guideline Committee have also referred to the NICE PTSD guideline for further advice. |
| Institute of Recovery from | Short | General | | We are concerned over the guidelines being based on the use of randomized controlled trials rather than considering other evidence based models. We also question if it is ethically sound | Thank you for your comment. Randomised controlled trials were considered by the Guideline Committee as the highest quality data available to generate |

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| Childhood Trauma | | | | to work with traumatised children in a random controlled framework? There are other robust evidence based research projects that demonstrate effective interventions and frameworks which need to be utilized in this study. | recommendations, therefore they were used in place of observational studies. The Guideline Committee agree it can be unethical to randomise maltreated children to a control arm with no care provided. A number of trials we included did use an alternative intervention for the control arm. Also, because of the little evidence available in this area, the Guideline Committee identified this as a key area of uncertainty and in a research recommendation suggested that another intervention or usual care is used as the control arm. |
| Institute of Recovery from Childhood Trauma | Short | General | | The one thing that would make the biggest impact in practice would be a workforce that was trained, supported and empowered to offer children consistent and sustainable relationships across the board.<br>At the moment, all too often untrained, inexperienced disenfranchised workers are offering transitory relationships and short term care to some of the most vulnerable children in our society. | Thank you for your comment. The Guideline Committee agree and have highlighted this in the following recommendations**:**<br><br>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:<br>• has specialist expertise in attachment difficulties in children and young people and their parents or carers"<br><br>It was also recommended that:<br>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 |

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| | | | | | the care system, as well as workers involved with children and young people on the edge of care…."<br><br>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<br><br>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:<br>• using a case management system to coordinate care and treatment<br>• collaborative decision making among all health, education and social care professionals, the child or young person if possible and their parents and carers<br>• having the same key worker, social worker or personal adviser throughout the period the child or young person is in the care system or on the edge of care. [1.1.34] |
| Institute of Recovery from Childhood | Short | General | | Our overall concern with the document is that it seems to be based very much on a medical model of treating disorders without much reference to the fact the attachment disorders are based on trauma that happens in the context of relationships | Thank you for your comment.<br>The Guideline Committee agrees that there is a focus in the guideline on interventions that can help children with attachment problems, however, consistent with |

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| Trauma | | | | and thus needs a psycho-social view. Based on their view that attachment disorders can be diagnosed they can therefore prescribe treatment - again traumatised children all respond very differently to trauma / neglect they have experienced and short term interventions that don't provide long term relationship can be significantly counter productive in some cases. | the NICE approach, it also covers identification and contains many other recommendations on personal and psycho-social needs, that address these needs across non-medical settings. |
| Lancashire Care NHS Foundation Trust | Short | 11 -13 | General | We are pleased that the group covered is wider than 'LAC' or 'Adoption' or 'Edge of care' as this population may have similar needs arising from disrupted attachments, however, we wondered about implementation of this guidance across a population which receives variable levels of attention from Commissioners of NHS / Social Care services (i.e. local offer may include a psychologist for LAC and/or adoption, but not for children on an SGO or edge of care) suggesting variation in the implementation of this guidance for children with different legal status, but similar interventional needs | Thank you for your comment. It is important that Health and Social Care professionals and those who work in education attempt to maintain consistency as this leads to better outcomes. The Guideline Committee nevertheless recognise this isn't always possible but should be aspired to. |
| Lancashire Care NHS Foundation Trust | Short | 11 -13 | General | We note that the implications of childhood adversity on adult attachment behaviour has not been included, this might include the importance of intervening in intergenerational patterns of attachment disruption and distress and/or considering assessment and preventative work on attachment with biological parents (carer's attachment presentation may predict the child's attachment pattern) | Thank you for your comment. The Guideline Committee agree there is a high likelihood of an intergenerational affect on attachment difficulties. We feel our interventions that address parental sensitivity should help decrease the likelihood of this from continuing. |
| Lancashire Care NHS Foundation | Short | 1.1.2 | General | We are not convinced that the existing NICE guidance on PTSD in CYP meets the needs of this client group (complex and relational trauma vs single incident trauma in otherwise healthy CYP) | Thank you for your comment. However the PTSD NICE guideline does cover this group. See recommendation 1.9.5.2: "Children and young people with PTSD, |

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| Trust | | | | | including those who have been<br>sexually abused, should be offered a course of trauma-focused cognitive behavioural therapy adapted appropriately to suit their age, circumstances and level of development." |
| Lancashire Care NHS Foundation Trust | Short | 1.1.3 | General | This would be hard to implement as social care systems do not allow one social worker (assuming they stay in post for the duration of an individual's childhood) to work in the duty and assessment, locality and LAC / Adoption teams. It also assumes that the allocated worker is the best personal match for the duration of the individual's entire childhood | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Lancashire Care NHS Foundation Trust | Short | 1.1.3 | General | Even with the best intentions of joint working, case management between health, education and social care is complex. Additionally, there are often other services that step-in and out at various points (e.g. 3rd sector organisations, school based counselling) based on reduction of specific symptoms (e.g. anger) which may, or may not be helpful if the underlying concern is attachment distress. | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Lancashire Care NHS Foundation Trust | Short | 1.1.4 | General | Much of the attachment-focused work we carry out is predicated on the child having some degree of stability (i.e. a commitment on the part of the carer to continue for at least 6 months). For shorter term placements, training and consultation to the carer becomes much more important than individual, dyadic or group work involving the child. We agree that a service should not be declined on the basis that stability is not present – but think services should be more flexible about who in the child's system | Thank you. The Guideline Committee have added a point relating to this in the Linking Evidence to Recommendations for recommendations for children in care.<br><br>"The Guideline Committee acknowledged that is important to consider the potential length of the placement before commencing a long-term |

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| | | | | they are working with. Access to skilled consultation is often dependent on commissioning of targeted services. | intervention (> 6 months) for children and their carers. For short-term placements it may be better to focus on preparing the carer before the child arrives." |
| Lancashire Care NHS Foundation Trust | Short | 1.1.8 | General | We are in agreement with the need for comprehensive training for carers. This appears to be open to interpretation – many fostering agencies (for example) offer lots of workshops on specific topics, but there is little evidence of a joined-up national approach to training foster carers (and other carers/ adopters) using a full evidence-based programme in re-parenting children who have attachment/trauma issues. | Thank you for this comment.<br><br>NICE generate the recommendation based on the best clinical and cost effectiveness evidence available. However, we do acknowledge the resource implications this may bring.<br><br>We agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Lancashire Care NHS Foundation Trust | Short | 1.1.13 | General | We were unclear what the 'additional support and resources' referred to and what the best practice for intervening might be at this stage | Thank you for your comment, but the Guideline Committee thinks it is clear that this refers to mentoring or day visits with a social worker. |
| Lancashire Care NHS Foundation Trust | Short | 1.1.16 | General | As safeguarding is paramount in any work with CYP, we were unclear if this statement relates to specific concerns or if it is a general reminder to safeguard children where there are chronic concerns about parenting behaviours | Thank you for your comment, this recommendation is a 'general reminder' to safeguard children while they remain vulnerable. |

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| Lancashire Care NHS Foundation Trust | Short | 1.2.2 | General | We felt the reference to 'CAMHS' was too specific (e.g. locally this is interpreted as meaning the Tier 3 Team only – and they do not specialise in attachment-focused work per se) – there are other health and social care services outside of CAMHS which may be better placed to meet the recommendations in the guidance (e.g. targeted services for LAC, Health visitors etc ) | Thank you for your comment. The Guideline Committee agreed that referring to CAMHS might be restrictive and have therefore revised the recommendation to say any mental health service for children and young people, which would include the kinds of services you mention. |
| Lancashire Care NHS Foundation Trust | Short | 1.3.2 | General | Research suggests that Foster / Alternate Carers attachment style also impacts on parental sensitivity and the child's move toward a more secure attachment pattern. However, our clinical experience is that carers (particularly foster carers) may not feel prepared to explore their own attachment history and how it is impacting on the current reparenting environment for the child. This in turn has implications for permanence decisions. | Thank you for your comment. The Guideline Committee acknowledge that this may be a sensitive and difficult topic for carers to explore. Addressing the complexities of this is beyond the scope of our guideline. |
| Lancashire Care NHS Foundation Trust | Short | 1.3.4 | General | Whilst we recognise the value of evidence-based tools for assessment of attachment style the suggested tools require significant resources in terms of staff time and skills. We also wondered if the evidence for these tools is based in research settings rather than clinical settings and so their clinical utility may be less evident in day-to-day practice. | Thank you for your comment.<br><br>NICE generate the recommendation based on the best clinical and cost effectiveness evidence available. However, we do acknowledge the resource implications this may bring.<br><br>The Guideline Committee agrees this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |

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| Lancashire Care NHS Foundation Trust | Short | 1.3.5 | General | We welcome differentiation between survival mechanisms of 'attachment styles' rather than the (mis)use of Attachment style as though it is a diagnosis of Attachment disorder (which is all too common). It would be helpful to clarify what assessment tools are considered to separate attachment style vs attachment disorder and qualifications required for making a diagnosis that a 'disorder' is present. It would be helpful to clarify at what point an intervention might be considered; is intervention recommended for insecure attachment, or is the priority disorganised patterns? | Thank you for your comment. The recommendations are addressed to all health and social care professionals unless otherwise specified, therefore the Guideline Committee did not specify which professionals would make a diagnosis of attachment disorder. The interventions are suitable for all attachment difficulties (a term which is defined as covering insecure attachment patterns, disorganised attachment and attachment disorders).<br><br>There were no tools identified which specifically aimed to separate attachment styles from attachment disorders, rather tools which aimed to either assess attachment styles or to assess attachment disorders, as a result these tools were reviewed separately. The Guideline Committee felt it was the judgement of the professional to decide when and where to use a tool to identify attachment style difficulties (both insecure and disorganised) or a tool to assess<br>for attachment disorders. |
| Lancashire Care NHS Foundation Trust | Short | 1.4 | General | It would also be helpful to also clarify what the interventions might be for attachment *disorder*. | Thank you for your comment. The term 'attachment difficulties' covers attachment disorder as well as insecure attachment patterns and disorganised attachment. |
| Lancashire Care NHS | Short | 1.4.1 | General | We wondered why interventional research outside of the UK had not been considered, given that much research has been carried | Thank you for your comment. The Guideline Committee did not intentionally omit any evidence |

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| Foundation Trust | | | | out elsewhere (especially the US) – whilst we might have an ambition to increase UK-based research to inform NICE guidance, not considering the range of research available seemed limiting at this stage. This exclusion also seemed inconsistent with research considered in other NICE guidance for emotional wellbeing in CYP where US-based research (for example) has been considered | from the UK and included many studies from the UK and the USA when they fit the guideline's inclusions criteria. |
| Lancashire Care NHS Foundation Trust | Short | 1.4.3 | General | We were concerned from this statement that a multiagency review might be called on the basis of the response to the VIG intervention alone – additional safeguarding concerns may be required to reach threshold for multi-agency involvement | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Lancashire Care NHS Foundation Trust | Short | 1.4.7<br>1.4.8 | General | This appears to suggest that if VIG is not providing helpful, a rather loosely defined intervention should be offered by a healthcare professional – which seemed to be the wrong direction of intervention order (e.g. locally we would consider a VIG intervention to be a more specialist intervention than re-parenting advice) | Thank you for your comment. If video feedback is unsuccessful or not preferred we then make the recommendation to offer parental sensitivity and behaviour training as described in recommendation 1.4.4. |
| Lancashire Care NHS Foundation Trust | Short | 1.5.6 | General | Given the anticipated number of LAC and adopted children who might benefit from attachment-focused support this recommendation would be well outside of commissioned resources. | Thank you for this comment.<br>The evidence for this recommendation came from an intervention which provided intensive training to ensure the carers were prepared to take on the foster child and to continue to support the carers via a 24-hour telephone support help line for 9–12 months. The results clearly showed a reduction in placement |

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| | | | | | breakdown. The Guideline Committee therefore wished to make a recommendation based on this evidence.<br><br>The Guideline Committee agrees this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Lancashire Care NHS Foundation Trust | Short | 1.5.7 | General | This recommendation is outside of commissioned resources | Thank you for this comment.<br>The evidence for this recommendation came from an intervention in which the child participated in group therapeutic play sessions. The results clearly showed a reduction in placement breakdown compared with usual treatment. The Guideline Committee therefore wished to make a recommendation based on this evidence.<br><br>The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Lancashire Care NHS Foundation Trust | Short | 1.5.8<br>1.5.9 | General | Whilst we agree that re-parenting training is essential for foster carers and adopters, as it is not a requirement foster carers the uptake is likely to be low due to other demands on their time / other trainings they are required to attend. Additionally, it is not | Thank you for this comment. The Guideline Committee based this recommendation on a study in which foster carers were provided with this level of training and showed a decrease in placement disruptions, a |

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| | | | | clear how health and social care would find the resources to deliver these programmes | decrease in composite delinquency, which the Guideline Committee felt warranted making a recommendation. The Guideline Committee agrees this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered.<br><br>The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Lancashire Care NHS Foundation Trust | Short | 1.5.10 | General | This is a significant resource issue. Additionally we wondered about CYP uptake of such a high frequency programme | Thank you for this comment. The recommendation is for individual training and education sessions for children and young people twice per week for the entire school year. We agree this would indeed involve significant resource implications. This recommendation is based on evidence from one trial that found an improvement in placement stability but no effect on behavioural or emotional outcomes for children. We realise the weakness of this evidence and it is reflected in the 'consider' recommendation, however the GC felt it was important to include a recommendation that considers the crucial role of schools may play for |

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| | | | | | children in care. It may be on the only permanent place the child may experience in an out of care. And as a result it may have high uptake by CYP. We have added a comments about this in the LETR. |
| Lancashire Care NHS Foundation Trust | Short | 1.6.2 | General | Whilst we agree that re-parenting training is essential for keyworkers / residential staff it is not clear that we will have the resources to provide this / that staff time will be freed-up to take part in this type of intervention | Thank you for this comment.<br><br>The recommendation was generated based on the best clinical and cost effectiveness evidence available. However, the Guideline Committee does acknowledge the resource implications this may bring.<br><br>The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Lancashire Care NHS Foundation Trust | Full | 17 - 22 | General | We questioned the internal consistency of the document's descriptions of attachment styles and attachment 'problem' / attachment 'difficulty' and also statement regarding attachment security of children with ASD and ADHD to their caregivers | Thank you for your comment. This has been corrected and attachment difficulties is now used throughout.<br><br>In the recommendations, ADHD is spelt out. Elsewhere in the guideline it is abbreviated. |
| Lancashire Care NHS Foundation Trust | Short | General | General | We are concerned that the only psychologists mentioned are educational psychologists. I would expect that clinical psychologists may also be involved in offering interventions to schools and families and to simply subsume them under the heading of the health and social care professionals is | Thank you for your comment. All recommendations unless otherwise specified apply to all health and social care professionals, including clinical psychologists. |

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| | | | | unhelpful. We would like to see greater recognition of the psychological workforce in health and social care. There's no mention of clinical psychologists who work with Looked After Children either. | |
| NHS England | General | General | General | No comments. | |
| NHS England | Short | | General | The document is focused on the specialist intervention. It would benefit from a focus on the contribution of health professionals in early intervention e.g. role of Health Visitors School Nurses and Midwives. The professionals work with these children from 0-18 whether they are in the care system or not. | Thank you for your comment. These recommendations apply to all health and social care professionals, therefore, we anticipate that the professionals you refer to can follow this guideline. |
| NHS England | Short | | 1.4.7 | There is a major difference in the skill set between a nurse and a lay home visitor. Would suggest a nurse follow up for further intervention as agreed by the multi-agency review. | Thank you for your comment. The evidence on which this recommendation is based specified these disciplines, but the Guideline Committee has added that the lay home visitor should be 'appropriately' trained. |
| Northamptonshire County Council | Full | General | General | The Consultation rightly puts evidence based assessments, tools and interventions at the heart of how we effect change for children and young people and we are encouraged that it recognises that this must also be at the Edge of Care, prior to children becoming Looked After by the Local Authority | Thank you for your comment. |
| Northumbria University | Full | General | General | This response has been submitted by academic researchers at Northumbria University ([redacted]) in collaboration with leading international attachment researchers at University of California, Berkeley ([redacted]) and also Harvard University ([redacted]). The Northumbria University team are working on a Wellcome Trust funded project | Thank you for your comment. |

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| | | | | investigating the concept of disorganised attachment, and the implications of perspectives on disorganised attachment for clinical and welfare interventions. | |
| Northumbria University | Full | General | General | Thank you for the opportunity to comment on the first draft of the Children's Attachment Clinical Guideline. We think it is important that research on attachment is translated into clinical practice and so we welcome the development of this Guideline. We are broadly impressed with the draft Guideline, though we have some specific comments regarding expression and content about disorganised attachment in particular, as detailed below. Overall we feel that the general orientation of the Guideline is relevant but that it is important that the concept of disorganised attachment is not reified in misleading ways. | Thank you for your comment. |
| Northumbria University | Full | 18 | 28 | *"a disorganised attachment pattern."*<br><br>Disorganisation is not a 'pattern' of the same kind as secure, avoidant and resistant (introduced by Mary Ainsworth). Disorganisation runs orthogonal to the Ainsworth patterns and is a classification, rather than a pattern, derived from behaviour. It is behaviour from which a trained coder can infer a disruption or unravelling of the infant's attachment system. Disorganised behaviours take a variety of forms – from freezing, to approaching the caregiver with a depressed face, to misdirected behaviours – and do not form a unitary pattern. Whilst the word 'pattern' was used in Main and Solomon's 1986 chapter announcing the "discovery of a new, insecure- | Thank you for your comment. The full guideline has been revised to say 'disorganised attachment', which is in keeping with terminology used elsewhere in the guideline. |

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| | | | | disorganised/disoriented attachment pattern", it was not used by Main and Solomon 1990 in announcing the procedures for coding the classification, or subsequently. There may indeed be different subtypes of disorganised attachment, and this is still being examined by researchers such as Elizabeth Carlson, Karlen Lyons-Ruth and Judith Solomon; it would be premature and confusing to refer to disorganised attachment as a whole as a "pattern". We therefore recommend that all references to "disorganised attachment pattern" are replaced with "disorganised/disoriented attachment classification". | |
| Northumbria University | Full | 18 | 42 - 44 | *"Children who develop an 'avoidant' attachment pattern are thought to maintain proximity to their caregiver by 'down-regulating' their attachment behaviour: they appear to manage their own distress and do not strongly signal a need for comfort."*<br><br>It should be clarified that this is a description of avoidant attachment behaviour displayed in the very particular circumstances involving stress imposed by the Strange Situation procedure. Ainsworth et al. (1978) highlighted that "Group-A [avoidant] babies, who showed little or no distress in the separation episodes of the strange situation, were more frequently distressed than B [secure] babies in separation situations at home" (p. 127).<br><br>It may also be worth mentioning that 1) the proximity achieved by an avoidant infant is 'conditional': they do not achieve comfort through bodily contact; and 2) that 'down-regulation' | Thank you for your comment. We have added the following to Chapter 2, section 2.3: "It is worth noting that these behaviours are observed during the Ainsworth Strange Situation Procedure when the child is exposed to a stressful situation (separation-reunion procedure) and avoidant children are not necessarily avoidant all the time." |

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| | | | | occurs in the infant exhibiting the avoidant pattern in the Strange Situation through the redirection of attention away from the caregiver, and towards the toys. These points were raised in Main (1990).<br><br>• Main, M. (1990) Cross-Cultural Studies of Attachment Organisation, *Human Development*, 33: 48-61. | |
| Northumbria University | Full | 19 | 3 - 4 | "In addition to children being classified as secure or insecure, they are also rated in terms of the extent to which they show signs of a disorganised attachment."<br><br>The disorganised attachment classification was a fourth taxonomic component of the Strange Situation introduced by Main and Solomon. Reference should be made here and/or elsewhere to Main and Solomon (1990).<br><br>Main, M., & Solomon, J. (1990) Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M.T. Greenberg, D. Cicchetti & E.M. Cummings (Eds.), Attachment in the preschool years: Theory, research and intervention (pp. 121-160). Chicago: University of Chicago Press.<br><br>Main and Cassidy (1988: 423-4) state that "disorganisation operates as a category only in extreme cases… in other cases operating as a dimension". It is therefore unduly concrete to say that infants show "signs of a disorganised attachment", as if it | Thank you for your comment. The Guideline Committee have amended the description of disorganised attachment based on your suggestion. |

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| | | | | were a categorical medical diagnosis.<br><br>Main, M. & Cassidy, J. (1988) Categories of response to reunion with the parent at age six: Predicted from infant attachment classifications and stable over a one-month period, Developmental Psychology, 24(3): 415-426.<br><br>We recommend the wording is amended and suggest the following: "In addition to children being classified as secure or insecure, infants under 20 months can also be rated in terms of the extent to which observable behaviour suggests a disruption at the level of the attachment system, using the Main and Solomon (1990) indices of disorganisation and disorientation. Such a disruption is understood to mean that the infant is not able to resolve their distress within the context of their relationship either by signalling their anxiety to their caregiver, or by directing their attention away from them. Where the unresolved disruption of the attachment system is regarded as substantial and/or pervasive, the coder gives a higher rating, and considers the infant for inclusion within the disorganised attachment classification." | |
| Northumbria University | Full | 19 | 4 - 7 | *"This refers to behaviours that appear to be contradictory in terms of the child's approach to the attachment figure and examples include where the child approaches but with the head averted or with fearful expressions, oblique approaches or disoriented behaviours such as dazed or trance-like expressions or freezing of all movement"* | Thank you for your thorough description of disorganised attachment. The Guideline Committee have amended this section based on your comments and those given by another stakeholder. We have highlighted that unlike insecure attachment, disorganised attachment cannot be diagnosed in the |

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| | | | | The text here confuses two levels of analysis, resulting in an inaccurate/incomplete formulation. Avoidant behaviour is in contradiction to a child's expected propensity to approach their attachment figure when needed. In ambivalent/resistant infants the approach to the caregiver is often contradicted by brief bouts of tantrum or anger. However neither of these Ainsworth patterns are, in themselves, considered disorganised as they are purposeful expressions of ambivalence. Conversely, approaching the caregiver with a dazed expression is not in contradiction to an approach at the level of behaviour, but is among the indices of disorganisation because the presence of underlying conflict and/or fear was inferred by Main and Solomon as probably influencing the form of this behaviour.<br><br>Furthermore, it is misleading that the text fails to specify at this stage that disorganised attachment behaviour cannot be coded in naturalistic settings, such as the home. Main and Stadtman (1981) found that infants classified as avoidant in the Strange Situation, including in the paradigmatic Ainsworth Baltimore sample, not infrequently display behaviours at home and in free play which would fit under the Main and Solomon indices. At this time, it is assumed that the underlying mechanisms for this behaviour at home and in free play differ from those that cause disorganised behaviour in the Strange Situation.<br><br>• Main, M., & Stadtman, J. (1981) Infant Response to Rejection | home. |

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| | | | | of Physical Contact by the Mother, *Journal of the American Academy of Child Psychiatry*, 20(2): 292–307.<br><br>It is important not to confuse contradiction of *observable* behaviour and contradiction of *intention* when discussing disorganisation. As the proposed guidelines rightly observe in 2.1, the attachment system is an imputed mechanism which directs a child who is hurt, anxious or scared to seek the physical and attentional availability of their caregiver. Disorganised attachment is coded when an infant in the Strange Situation displays behaviours, listed in the Main and Solomon indices, from which the observer can infer a disruption or unravelling of the attachment system, a process understood to be the result of a countervailing affect such as fear, anger or confusion.<br><br>We recommend the wording is amended and suggest the following: "Main and Solomon (1990) identify behaviours shown by children between 11 and 20 months within the Strange Situation from which a trained coder may discern a disruption at the level of the attachment system. They represent behaviours – by virtue of intensity, duration, abruptness and/or occurrence immediately upon reunion with the caregiver – from which a viewer can with sufficient confidence infer disruption at the level of the infant's attachment system. The attachment system is otherwise expected to enjoin the infant to approach the caregiver when distressed. Disorganised attachment behaviours differ from the contradictory behaviour shown by an organised | |

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| | | | | ambivalent/resistant infant in that the latter coordinates the contradiction between distress and anger in a concerted way which is responsive to the caregiver's actions and serves to retain the attentional availability of the caregiver. Disorganised attachment behaviours also differ from the contradiction between distress and inhibition experienced by an organised avoidant infant in that the latter retains regulatory control and a conditional proximity with their caregiver by directing their attention away from their distress and towards the environment (though many infants classified as avoidant in the Strange Situation have been found to show behaviours at home and in free play that would fit within the indices of disorganised attachment, see Main & Stadtman, 1981).<br><br>Behaviours indexed by Main and Solomon as on their own sufficient to give a Strange Situation coder confidence that a disruption at the level of the attachment system include, for example: calling for the caregiver strongly during separation but on reunion turning sharply away; approaching the caregiver with an expression of fear; extensive crying in the caregiver's presence without any move towards them; greeting the stranger brightly on the moment of reunion with the caregiver. Such behaviours are marked in italics by Main and Solomon. Other behaviours, not in italics, are also listed in the indices. These suggest disruption at the level of the attachment system, but are less definitive as a result of diminished intensity, duration, or abruptness, or occurring outside of a reunion context. Such | |

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| | | | | behaviours include, for example, falling whilst approaching the caregiver if the infant is otherwise a good walker; an oblique or parabolic approach to the caregiver; or the infant interrupts anger at the caregiver with a dazed expression and a move away from the caregiver." | |
| Northumbria University | Full | 19 | 13 - 33 | *"in this guidance we have used the term 'attachment problem' to refer to children who have a disorganised attachment or an attachment disorder."*<br><br>It should be mentioned here that disorganisation and attachment disorder largely do not overlap. This is noted on p.253 (referencing Borris et al. 2004 – and Smyke 2010 is referenced elsewhere) – but this is so far into the text that we recommend it also be mentioned here.<br><br>Two other studies are pertinent, but are not currently referenced in the Guideline. Lyons-Ruth et al. (2009) found that disorganised attachment predicted the disinhibited form of attachment disorder. Gleason et al. (2014) found a link, regardless of the quality of care the child received, between disorganised attachment assessed in a Romanian orphanage (mean age 22 months) and the disinhibited form of attachment disorder, assessed behaviourally at 54 months.<br><br>• Lyons-Ruth, K., Bureau, J-F., Riley, C., Atlas-Corbett, A. (2009). Socially indiscriminate attachment behavior in the Strange | Thank you for your comment and highlighting this important point. We have clarified this under the section on terminology in Chapter 2 and in the 'linking evidence to recommendations' section for the recommendations relating to attachment disorder. |

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| | | | | Situation: Convergent and discriminant validity in relation to caregiving risk, later behavior problems, and attachment insecurity, *Development & Psychopathology*, 21, 355-372.<br>• Gleason, M. M., Fox, N. A., Drury, S. S., Smyke, A. T., Nelson, C. A. 3rd, & Zeanah, C. H. (2014) Indiscriminate behaviors in previously institutionalized young children, *Pediatrics*, 133(3), 657-665.<br><br>We recommend the wording is amended and suggest the following: "Disorganised/disoriented attachment as assessed by a trained, reliable coder in the Strange Situation and an attachment disorder as diagnosed by a psychiatric assessment are very different phenomena. They largely do not overlap (Borris et al. 2004). For instance, Smyke et al. (2010) found that, though rates of disorganised attachment substantially declined for those infants placed in foster care, rates of attachment disorder did not differ between infants who remained institutionalised and those who were placed in foster care. However, there is some evidence that disorganised attachment in infancy and toddlerhood predicts the disinhibited form of attachment disorder in high risk samples (Lyons-Ruth et al. 2009). Nonetheless, in this guidance we have used the term 'attachment problem' to refer to children who have either a diagnosis of an attachment disorder or who have been placed by a reliable coder in the disorganised/disoriented attachment classification." | |

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| Northumbria University | Full | 20 | 22 - 24 | *"'Disorganised attachment behaviour' (DAB) refers to what Mary Main, one of John Bowlby's students, evocatively termed 'fear without solution'. It occurs when a child is simultaneously frightened of – or for – someone who they should be able to rely upon."*<br><br>There is lack of clarity here between both i) behaviour and intentions and ii) between the proximal and ultimate cause of behaviour.<br><br>i) "Disorganised attachment behaviour". As stated above, it is important to distinguish observable behaviour from disruption of intention at the level of the attachment system. Disorganisation occurs at the level of the attachment system – this can be inferred from behaviour, but the phrasing here is over-concrete.<br><br>ii) Not all behaviours listed in the Main and Solomon indices suggest that the child is frightened of or for their caregiver, or at least without a great extension of the term "frightened" or a long chain of inferential reasoning. That is to say, that most infants showing behaviour listed in the Main and Solomon indices *can be inferred* to have experienced fear which was not solved within the context of the attachment relationship at some point in their history. However, there may be infants who experienced such fear without solution at some point in their developmental history, but within the context of a relationship which has otherwise permitted them to organise a sufficiently | Thank you for your comments.<br>i) The Guideline Committee have made the comment "less concrete" by saying" it is theorized to occur".<br><br>ii) In section 2.3. the points you raised have been added: "disorganised attachment may only be short-lived and can be resolved once the child is reunited and in a stable relationship with their primary caregiver."<br><br>ii) Whilst it is true that the fear may not be present at the precise moment the child is being observed using the Main and Solomon indices, bur rather it was present at some point in their history, we feel this is a very fine distinction that will be lost on the vast majority of readers.<br><br>Addressing your final point, the Guideline Committee added to section 2.3 that "neither the behaviour described by the Main and Solomon indices, nor a classification of disorganised attachment in the Strange Situation Procedure, can be used in any valid way to assess a child for maltreatment. Although correlated with it, maltreatment cannot be inferred from infant disorganised attachment." |

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| | | | | coherent Ainsworth pattern in the Strange Situation.<br><br>Furthermore, for those infants who do show behaviour listed in the Main and Solomon indices, it is not necessarily fear which is the proximal cause. The behaviours in Index VI (direct indices of fear of the caregiver) likely have their proximal cause in an immediate sensation of fear of the caregiver; and they are more common in maltreatment samples. Yet crying at the stranger's leave taking and interrupting approach with brief anger away from the parent (both Index III) do not immediately suggest that the infant is experiencing fear without solution in the time of observation. Even if unresolved fear can be inferred to have occurred at some point in the child's experience, these behaviours cannot be simply described as "occurring when a child is frightened of or for" their caregiver. It may, for instance, be considered that a child whose approach to their caregiver has been disrupted by a short burst of anger has been dysregulated by anger, rather than by "fear without solution".<br><br>We recommend the wording is amended and suggest the following: "The behaviours listed in the Main and Solomon indices of disorganisation/disorientation are those which suggested to the authors the potential presence of disruption of the infant's attachment system. Such a disruption may have many different causes and facilitating conditions within the context of the relationship between infant and caregiver. 'One highly specific and sufficient, but not necessary, pathway to D | |

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| | | | | attachment status' was proposed by Main and Hesse (1990; 2006: 310-11), and has subsequently received empirical support (Madigan et al. 2006). In this pathway, the attachment system is disrupted by fear elicited in the context of the attachment relationship, which means that the fear conflicts with or confuses the injunction of the attachment system to seek direct or conditional proximity with the caregiver. Such fear may be caused by abusive caregiving, but without question has other potential causes. Other caregiver behaviours, such as dissociative (Abrams, Hesse & Rifkin 2006) and helpless or withdrawing (Solomon & George, 1996; Hesse & Main 1999; Lyons-Ruth et al. 2013) behaviours have also been found to predict an infant's disorganised/disoriented attachment classification. A parent's ongoing experience of an anxiety disorder (Manassis et al. 1994) or multiple forms of social and economic disadvantage (Cyr et al. 2010) have also been found to predict infant disorganised/disoriented attachment behaviour to the same degree as if the child is known to be being maltreated. Hazen et al. (2015) found an increase in attachment disorganisation if time in daycare exceeded 60 hours per week (an important finding in the context of government tax policies encouraging parents quickly to return to fulltime work). Furthermore, Solomon and George (2011) have documented that a chronic lack of regulation of the caregiving environment can predict disorganised/disoriented infant attachment in the Strange Situation Procedure. For example, major separation alone – in the absence of maltreatment (e.g., in care or divorce | |

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| | | | | proceedings) – can increase the prevalence of disorganised attachment in the Strange Situation. In the context of this causal complexity, neither the behaviour listed in the Main and Solomon indices in any setting, nor a classification by a reliable coder of infant disorganised attachment in the Strange Situation, can be used in any valid way to assess a child for maltreatment. What can be said is that careful attention to the behaviours shown in the Strange Situation, described and classified by a trained and reliable coder, may give clinicians important information. The Strange Situation may help a clinician learn about how an infant has learnt to manage distress in the context of the history of their attachment relationship. However, although correlated with it, maltreatment cannot be inferred from infant disorganised attachment."<br><br>• Abrams, K. Y., Rifkin, A., & Hesse, E. (2006) Examining the role of parental frightened/frightening subtypes in predicting disorganized attachment within a brief observational procedure, *Development and Psychopathology*, 18, 345–361.<br>• Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. J., & Van IJzendoorn, M. H. (2010) Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses, *Development and Psychopathology*, 22, 87–108.<br>• Hazen, N., Allen, S., Umemura, T., Heaton, C., & Jacobvitz, D. (in press) Very extensive non-maternal care predicts mother- | |

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| | | | | infant attachment disorganization: Convergent evidence from two samples. *Development and Psychopathology*.<br>• Hesse, E., & Main, M. (1999) Second-generation effects of unresolved trauma in nonmaltreating parents: Dissociated, frightened, and threatening parental behavior, *Psychoanalytic Inquiry*, 19(4): 481-540.<br>• Hesse, E. & Main, M. (2006) Frightened, threatening, and dissociative parental behaviour, *Development and Psychopathology*, 18(2): 309-343.<br>• Lyons-Ruth, K., Bureau, J. F., Easterbrooks, M. A., Obsuth, I., Hennighausen, K., & Vulliez-Coady, L. (2013) Parsing the construct of maternal insensitivity: Distinct longitudinal pathways associated with early maternal withdrawal, *Attachment & Human Development*, 15, 562–582.<br>• Madigan, S., Bakermans-Kranenburg, M., van IJzendoorn, M., Moran, G., Peterson, D. & Benoit, D. (2006) Unresolved states of mind, anomalous parental behavior, and disorganized attachment, *Attachment & Human Development*, 8: 89–111.<br>• Manassis, K., Bradley, S., Goldberg, S., Hood, J., & Swinson, R. P. (1994) Attachment in mothers with anxiety disorders and their children, *Journal of the American Academy of Child & Adolescent Psychiatry*, 33, 1106 –1113.<br>• Solomon, J., & George, C. (1996) Defining the caregiving systems: Toward a theory of caregiving, *Infant Mental Health Journal*, 17, 183–197.<br>• Solomon, J. & George, C. (2011) The Disorganised | |

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| | | | | Attachment-Caregiving System. In Judith Solomon & Carol George (Eds) *Disorganized Attachment & Caregiving* (pp.25-51), NY: Guilford Press. | |
| Northumbria University | Full | 20 | 25 - 26 | *"these behaviours may only last for a few seconds – hence, the term disorganised attachment behaviour, to emphasise its fleeting nature"*<br><br>This statement is incorrect; we strongly suggest that it be cut. As noted in our comment regarding page 19, lines 4-7, not all behaviours in the Main and Solomon indices are fleeting. The term "disorganised" was not intended to emphasise the fleeting nature of some of the behaviours. It was used, together with "disoriented", as characterisations of the disruption of the attachment system. Such disruptions are inferred with greater confidence from behaviours listed in the Main and Solomon indices which are intense, pervasive, abrupt and/or occurring immediately on reunion. | Thank you for your comment, this sentence has been deleted. |
| Northumbria University | Full | 20 | 29 - 31 | *"many researchers believe the more accurate figure is around 80%, because DAB so closely reflects the 'fear without solution' that abused children experience"*<br><br>The idea that researchers conclude that the more accurate figure is 80% because disorganisation is really fear is to disregard empirical data based on a reification of the disorganised concept. This is both unscientific and highly misleading. As explained in more detail in the comments on p.20, line 22-24, | Thank you for your comment. The Guideline Committee agree and have amended the figure to suggest it is around 48% rather than 80% and included the reference to van Ijzendoorn. |

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| | | | | the behaviours listed in the Main and Solomon indices cannot be reduced all in the same way to fear without solution, and certainly cannot be reduced to experiences of abuse.<br><br>On p.239 of the proposal it is stated that "Physical and emotional abuse and neglect are strongly associated with insecure and disorganised attachment (Cicchetti and Barnett 1991)." Perhaps these are the 'researchers' being discussed on p.20. But Cicchetti and Barnett, though eminent, were writing when there was only one study of the relationship between disorganisation and maltreatment, which indeed had a strong effect. To use the authority of such early discussions to disregard the 48% figure from later meta-analysis (van IJzendoorn et al. 1999) is scientifically unsound. We recommend that this sentence is removed.<br><br>• van IJzendoorn, M. H., Schuengel, C., & Bakermans-Kranenburg, M. J. (1999). Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae, *Development and Psychopathology*, 11, 225–249. | |
| Northumbria University | Full | 27 | 9 - 10 | *"Disorganised attachment has also been observed at very high rates in samples of infants and young children who have been exposed to maltreatment (Cyr et al., 2010b; van IJzendoorn et al., 1999a) and among children who have been adopted or are in foster care."* | Thank you for your comment. The Guideline Committee agree that the wording may be a little strong, however 48% the meta-analytic average is a high rate and less than half seems to suggest this not very much, and imply an exaggeration in the opposite direction. The Guideline Committee therefore do not |

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| | | | | This statement leads to the appearance of exaggeration, for the reasons stated in the comment on page 20, lines 22-24. We recommend the wording is amended and suggest the following: "disorganised attachment has been observed in less than half of infants who have been exposed to maltreatment according to meta-analytic work, though the incidence is somewhat higher than the 34% seen in general low-income samples (van IJzendoorn et al., 1999). Cyr et al. (2010) found no difference in the incidence of the disorganised attachment classification between infants known to have been abused, and infants in families suffering from five socio-economic risks."<br><br>(Zeanah et al. (2005) report disorganization (65%) and unclassifiable attachment behaviour (13%) among institutionalized children in Romania (mean age 24 months). But it is questionable whether this extreme institutionalisation is comparable to what clinicians and social workers will see in Britain.) | think the wording needs to be changed, however agree that the term 'very' is subjective, and have removed this term in light of your comment.<br><br>The Guideline Committee agree with your point about institutionalised care, and have changed the wording in this sentence to acknowledge that disorganisation is 'to a lesser extent' observed among children who have been adopted or are in foster care. |
| Northumbria University | Full | 31 | 28 - 46 | *"In a recent HTA report (Wrigth et al., unpublished) estimated the expected budget impact of screening strategies and treatment for disorganised patterns of attachment within the context of a Clinical Commissioning Group (CCG). The authors assessed budget impact of screening and treating disorganised patterns of attachment by various target populations (for example, screening general population, middle class children, born into poverty, alternative caregiver, and maltreated). … However, if the target population was maltreated children the* | Thank you for your comment. The Author name has been corrected. The aim of this section is to illustrate what are the potential costs associated with screening and treating attachment problems, and how these costs would vary according to the target population. This section is not recommending anything, it simply summarizes research conducted by Wright et al. For clarity and to avoid misunderstanding sensitivity analysis reporting costs for maltreated population has |

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| | | | | *cost of identification and subsequent treatment would be £15,223 to the average CCG (assuming that 0.42% of the general population would be maltreated and the prevalence of attachment problems is 48%)."*<br><br>i) Wrigth should be Wright?<br><br>ii) Note: disorganisation is not a pattern. See remarks on line 28 of page 18.<br><br>iii) The prospect of using disorganised attachment as a screening tool for the general population should be considered with caution in light of the issues raised in the comments on page 20, line 22-24<br><br>iv) Perhaps this is the result of an unclear formulation, but presently the last sentence of the section cited above implies the prospect of screening children known to be maltreated using the criterion of disorganised attachment and only offering services to those who are both maltreated and classified as disorganised. If this is what is intended, it is highly problematic and surely based on a misunderstanding. What justification could there be for excluding infants known to being maltreated from services, on the basis that they do not receive a disorganised attachment classification? We assume that this logic is guided by a misunderstanding that disorganisation is immediate fear without solution, and hence any child who does not show disorganised | been removed from the text. |

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| | | | | attachment is therefore not experiencing fear of their caregiver, and so not "really" maltreated. If this is not the intention, then we suggest that the discussion is revised and elaborated for full clarity. | |
| Northumbria University | Full | 82 | 15 - 17 | *"risk factors are generally assumed to have their effects on attachment through the impact they have on the sensitivity of care provided to the child by the carer (Belsky & Fearon, 2008)."*<br><br>This statement is not sufficiently precise. See especially Raikes. & Thompson (2005): "Results of this study of 63 low income mothers and their 24–36-month-old children indicated that the influence of multiple economic risks on children's security is mediated through an associated effect on maternal behavior, while emotional risks – those directly affecting the emotional climate of the home – exert direct influences on child security not mediated by maternal behavior.". Also, Owen & Cox (1997) found disorganised attachment associated with marital conflict.<br><br>• Raikes, H.A. & Thompson, R. (2005) Links between risk and attachment security: Models of influence, *Applied Developmental Psychology*, 26: 440–455.<br>• Owen, M. T., & Cox, M. J. (1997) Marital conflict and the development of infant–parent attachment relationships, *Journal of Family Psychology*, 11, 152-164.<br><br>(In addition, the proposals themselves note on p.27 that "A | Thank you for your comment. The Guideline Committee think that the original statement in the guideline is broadly correct and do not wish to make a general statement based on the results of one small study, such as the reference you suggest. Very little research has actually looked at family climate at the same time as parenting and teased their separate effects apart, therefore we have added a sentence stating "exposure to some stressors (e.g. marital conflict, domestic violence, may have direct effects on the child's attachment, although relatively little work has examined this systematically". We have also adjusted the sentence so that it says 'quality of care' not sensitivity of care. |

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| | | | | substantial number of studies have found that standard assessments of sensitivity do not reliably predict disorganised attachment (van IJzendoorn et al., 1999b)." This is in clear contradiction to the statement above.)<br><br>We recommend the wording is amended and suggest the following: "risk factors are generally assumed to have their effects on attachment through the impact they have on the behaviour of the carer towards their child (especially when the latter is distressed) and through the wider emotional climate of the home (Owen & Cox, 1997; Raikes & Thompson, 2005; Belsky & Fearon, 2008; Cyr et al., 2010)." | |
| Northumbria University | Full | 97 | 15 - 18 | *"The term 'frightened, threatening and dissociative' behaviour was term coined by Main and Hesse (1990), who proposed it is a determinant of disorganised attachment and is measured using the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) scale."*<br><br>The Main and Hesse system for identifying parental behaviour (the 'FR system') is different from the AMBIANCE, which was developed by Lyons-Ruth and colleagues.<br><br>We recommend the wording is amended and suggest the following: "The term 'frightened, threatening and dissociative' behaviour was a term coined by Main and Hesse (1990), who proposed these behaviours shown by a caregiver as one contributor to disorganised attachment. A focused assessment of | Thank you for your comment. The Guideline Committee agree that the distinction between the two coding systems was unclear. The text has been amended in line with your comment to make the distinction between the FR and the AMBIANCE coding system and have referenced Lyons-Ruth in relation to the latter. The Guideline Committee have also noted that the meta-analysis by Madigan 2006 found no difference between studies using these two different systems and the association with disorganised attachment. |

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| | | | | frightened, threatening, and dissociative parental behaviour was developed by Main and Hesse (1991, 2006).<br><br>The AMBIANCE assessment (Atypical Maternal Behavior Instrument for Assessment and Classification (Bronfman, Parsons, & Lyons-Ruth, 1992; Bronfman, Madigan, & Lyons-Ruth, 2007) is somewhat broader than the Main and Hesse assessment of frightened, threatening, and dissociative parental behaviour in that it includes (with permission from the authors) the Main and Hesse (1991) frightened, threatening, and dissociative behaviours , but also assesses withdrawing parental behaviours and contradictory parental communications, as well as a broader spectrum of role-confused behaviours.<br><br>More extensive descriptions of both measures and their associated evidence base is available in Madigan et al. (2006), Hesse & Main (2006) and Lyons-Ruth & Jacobvitz (in press)."<br><br>• Main, M., & Hesse, E. (1990) Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. T.Greenberg, D.Cicchetti, & E. M.Cummings (Eds.), *Attachment in the preschool years: Theory, research and intervention* (pp. 161–182). Chicago, IL: University of Chicago Press.<br>• Main, M., & Hesse, E. (1991, 2006) *Frightened, threatening,* | |

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| | | | | *dissociative, timid-deferential, sexualized, and disorganized parental behavior: A coding system for frightened/frightening (FR) parent-infant interactions.* Unpublished Manuscript, University of California, Berkeley.<br>• Bronfman, E., Parsons, E., & Lyons-Ruth, K. (1992) *Atypical maternal behavior instrument for assessment and classification (AMBIANCE): Manual for coding disrupted affective communication. Version 1.0.* Unpublished manuscript, Harvard Medical School.<br>• Bronfman, E., Madigan, S., & Lyons-Ruth, K. (2007) *Atypical maternal behavior instrument for assessment and classification (AMBIANCE): Manual for coding disrupted affective communication. Version 2.0.* Unpublished manuscript, Harvard Medical School.<br>• Madigan, S., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Moran, G., Pederson, D. R., & Benoit, D. (2006). Unresolved states of mind, anomalous parental behavior, and disorganized attachment: A review and meta-analysis of a transmission gap, *Attachment and Human Development,* 8, 89-111.<br>• Hesse, E., & Main, M. (2006) Frightened, threatening and dissociative behavior in low-risk samples: Description, discussion and interpretations, *Development and Psychopathology*, 18, 309–343.<br>• Lyons-Ruth, K., & Jacobvitz, D. ( in press) Attachment disorganization from infancy to adulthood: Neurobiological | |

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| | | | | correlates, parenting contexts, and pathways to disorder. In Cassidy, J. & Shaver, P., editors. *Handbook of Attachment: Theory, Research, and Clinical Applications*. 3nd Edition. New York: Guilford.<br><br>In the draft Guideline, the empirical research of Lyons-Ruth on disorganised attachment appears to have been confused with that of Main and Hesse. Lyons-Ruth's work is not currently directly referenced, which is a serious omission, especially as the Guideline directs the reader towards the AMBIANCE measure. Particularly pertinent works that it may well be useful for this Guideline to draw upon are:<br>• Lyons-Ruth, K., Bronfman, E. & Parsons, E. (1999) Maternal Frightened, Frightening, or Atypical Behavior and Disorganized Infant Attachment Patterns, *Monographs of the Society for Research in Child Development*, 64(3): 67-96.<br>• Lyons-Ruth, K., Bureau, J.-F., Easterbrooks, M., Obsuth, I., Hennighausen, K. & Vulliez-Coady, L. (2013) Parsing the construct of maternal insensitivity: distinct longitudinal pathways associated with early maternal withdrawal, *Attachment & Human Development*, 15(5-6): 562-582.<br><br>Clear distinctions should be drawn between the work of Main and Hesse and the work of Lyons-Ruth. Wang et al. (2015) provides a notable recent discussion of, and addition to, the work of Main and Hesse and Lyons-Ruth. | |

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| | | | | • Wang, F., Cox, M.J., Mills-Koonce, R., & Snyder, P. (2015) Parental Behaviors and Beliefs, Child Temperament, and Attachment Disorganization, *Family Relations*, 64(2): 191-204. | |
| Northumbria University | Full | 228 | 13 (Table 133) | *"Crittendon 1984"*<br><br>Should be Crittend**e**n 198**8**. Also needs correcting in tables 135 and 137 on p.229. | Thank you for your comment, this has been corrected. |
| Northumbria University | Full | 234 | | *"To predict children and young people at risk of developing attachment difficulties, the GUIDELINE COMMITTEE agreed that maternal insensitivity is a strong predisposing risk factor for the development of attachment difficulties."*<br><br>Earlier in the document there is acknowledgement that, whilst parental sensitivity predicts attachment security (p.26, lines 29-30), it does not predict disorganised attachment (p.27, lines 7-9). As the guideline has highlighted the import of focusing on children who have or are at risk of developing a disorganised attachment or an attachment disorder and not those with organised insecure attachment (p.20, lines 18-21) it is unclear why measurements/tools of a parenting factor that predicts attachment security-insecurity but not disorganisation and/or disorders have been reviewed.<br><br>van IJzendoorn et al.'s (1999) meta-analysis of disorganised attachment found a combined effect size of the association | Thank you for your comment. The Guideline Committee agree with your point, however it was felt that measuring sensitivity is important since it is predictive of secure attachment and it was agreed that promoting secure attachment is a helpful goal for children in foster care or on the edge of care.<br><br>The Guideline Committee also agree that it is correct that reducing frightening/frightening parenting, and helping the child development an organised, if not necessarily secure, attachment is also a sound goal clinically. It is important to note also that although sensitivity does not strongly predict disorganised attachment sensitivity based-interventions (i.e., designed to improve sensitivity) do reduce disorganised attachment rates. So, promoting sensitivity is clearly helpful; but attention to frightened/frightening or highly atypical parenting is also important. |

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| | | | | between infant disorganisation and parental insensitivity of just r = .10, compared with a combined effect size of the association between infant disorganisation and parental unresolved/disorganised/disoriented states of mind in the Adult Attachment Interview of r = .31. Parental hostile-helpless states of mind in the Adult Attachment Interview have also been significantly related to infant disorganization (and ambivalent/resistant attachment) in two studies (Lyons-Ruth et al., 2005; Melnick et al., 2008). Anomalous parental behaviour has also been found predictive; Madigan et al.'s (2006a) meta-analysis found a combined effect size of the association between infant disorganisation and parental frightened, frightening or disruptive behaviour of r = .34. These findings suggest that measures/tools that classify parental states of mind during the Adult Attachment Interview (notably Main, Goldwyn and Hesse's unresolved states of mind, or Lyons-Ruth et al.'s hostile-helpless states of mind) or anomalous parental behaviours (notably Main and Hesse's FR coding system, or Bronfman et al.'s AMBIANCE coding system) will be substantially more predictive of attachment disorganisation than measures of parental sensitivity.<br><br>In light of this, we strongly suggest this statement and the related recommendation be revisited.<br><br>• Lyons-Ruth, K., Yellin, C., Melnick, S., Atwood, G. (2005) Expanding the concept of unresolved mental states: | The Guideline Committee highlighted the above points in the Linking Evidence to Recommendations relating to measuring maternal sensitivity.<br><br>The Guideline Committee agree with your point that AAI assessments are useful, although even more complex to use in practice and they do not suggest a helpful clinical strategy.<br><br>Focusing on parental states of mind are less effective than those promoting sensitivity –and we ought to assume that until we have better evidence that the same applies to children in foster care or on the edge of care ( although Cicchetti study includes some parental psychotherapy). |

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| | | | | Hostile/helpless states of mind on the adult attachment interview are associated with atypical maternal behavior and infant disorganization, *Development and Psychopathology*, 17: 1-23.<br>• Melnick, S., Finger, B., Hans, S., Patrick, M., Lyons-Ruth, K. (2008) Hostile-helpless states of mind in the AAI: A proposed additional AAI category with implications for identifying disorganized infant attachment in high-risk samples. In H. Steele & M. Steele (Eds.), *Clinical applications of the adult attachment interview* (pp. 399-423). New York: Guilford.<br>• Main, M., Goldwyn, R., & Hesse, E. (2003) *Adult attachment scoring and classification system. Version 7.2.* Unpublished manuscript, University of California at Berkeley.<br>• Main, M., & Hesse, E. (1991, 2006) *Frightened, threatening, dissociative, timid-deferential, sexualized, and disorganized parental behavior: A coding system for frightened/frightening (FR) parent-infant interactions.* Unpublished Manuscript, University of California, Berkeley.<br>• Bronfman, E., Parsons, E., & Lyons-Ruth, K. (1992) *Atypical maternal behavior instrument for assessment and classification (AMBIANCE): Manual for coding disrupted affective communication. Version 1.0.* Unpublished manuscript, Harvard Medical School.<br>• Bronfman, E., Madigan, S., & Lyons-Ruth, K. (2007) *Atypical maternal behavior instrument for assessment and classification (AMBIANCE): Manual for coding disrupted* | |

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| | | | | *affective communication. Version 2.0.* Unpublished manuscript, Harvard Medical School. | |
| Northumbria University | Full | 241 | 25 - 27 | *"A forth category for disorganised attachment (type D) was later added to describe diverse behaviour patterns that were disorganised or disorientated."*<br><br>Not only is this statement is circular, but additionally disorganisation is also neither a pattern nor a summary of diverse "patterns" (in the Ainsworth sense of the term used by the field).<br><br>We recommend the wording is amended and suggest the following: "A fourth, disorganised/disoriented classification was later added by Main and Solomon (1990). This classification, running orthogonal to Ainsworth's three, is used for infants whose behaviour suggests a substantial or pervasive disruption of the attachment system. There are seven different indices of behaviours which can be used to code disorganised/disoriented attachment, and it is assessed on a 1-9 scale where 5 or more is sufficient for assignment of the classification as an addition to a best-fit Ainsworth classification." | Thank you for your comment. The Guideline Committee agree that the suggested re-wording provides a more accurate description of the classification system and have amended this in the document. |
| Northumbria University | Full | 243 | 24 | *"George, Kaplan and Amin, 1985"*<br><br>Should be George, Kaplan and **Ma**in. The date also needs amending. The first edition of the AAI interviewing protocol was1984, the second edition was 1985 and the third (and most | Thank you for your comment. The Guideline Committee have amended the text. The year has been kept since it is what was used as their reference. |

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| | | | | recent) edition was 1996. | |
| Northumbria University | Full | 283 | | *"because the AQS does not measure disorganisation and the standard SSP is only used up to the age of 2, the GC felt that the modified versions of the SSP should be recommended."*<br><br>Caution is warranted here: the Cassidy-Marvin modified procedure has problems of predictive validity and stability of the disorganised classification, as noted by Solomon and George (2008) in the Handbook of Attachment edited by Cassidy and Shaver. | Thank you for your comment. Whilst the Guideline Committee acknowledge that the Cassidy-Marvin modified procedure has limitations (although the predictive validity in the largest study, the NICHD SECC was high), it is the best measure available therefore the Guideline Committee wish to retain this recommendation. |
| Northumbria University | Full | 283 | | *"For adolescents over the age of 15, there was no evidence covered by the HTA report. Therefore the GUIDELINE COMMITTEE drew on their expert clinical experience and judgement to evaluate and recommend the use of the Adult Attachment Interview."*<br><br>A mother's Adult Attachment Interview classification predicts the Strange Situation classification of her infant, with unresolved parental states predicting disorganised infant behaviour. However, the two longitudinal studies that have examined continuity found that disorganised infants were no more likely to be classified unresolved in the Adult Attachment Interview in adolescence (Main, Hesse, & Kaplan, 2005; Weinfeld, Whaley, & Egeland, 2004). In light of this, a number of researchers suggest that the value of the Adult Attachment Interview is as a measure of parental caregiving behaviour, and that its value as a measure | Thank you for your comment. Although the Guideline Committee acknowledged that there are problems, conceptually, with the Adult Attachment Interview (particularly the lack of a meaningful disorganised category), they viewed the AAI to be the most well-validated tool to identify attachment status in late adolescents, and as a measure of attachment, including disorganized states of mind, is not really contested.<br><br>Although the Goal-Corrected Partnership in Adolescence Coding System is an interesting measure, it is a largely un-validated instrument and the Guideline Committee did not think there was enough evidence to warrant recommending it as a solid instrument.<br><br>The Goal-Corrected Partnership in Adolescence Coding System has been discussed in the introduction. |

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| | | | | of adolescent disorganised attachment is therefore likely to be limited (Allen & Manning, 2007; Mikulincer & Shaver, 2007; Allen & Miga, 2010; Lyons-Ruth and Jacobvitz, in press). We therefore suggest this recommendation be revisited.<br><br>• Main, M., Hesse, E., & Kaplan, N. (2005) Predictability of attachment behavior and representational processes at 1, 6, and 18 years of age: The Berkeley Longitudinal Study. In K. E. Grossmann, K. Grossmann, & E. Waters (Eds.), 'Attachment from infancy to adulthood' (pp. 245-304). New York: Guilford.<br>• Weinfeld, N., Whaley, G., & Egeland, B. (2004) Continuity, discontinuity, and coherence in attachment from infancy to late adolescence: Sequelae of organization and disorganization, *Attachment & Human Development*, 6: 73-97.<br>• Allen, J. P.,& Manning, N. (2007). From safety to affect regulation: Attachment from the vantage point of adolescence, *New Directions in Child and Adolescent Development*, 117: 23–39.<br>• Mikulincer, M., & Shaver, P. R. (2007) Attachment in adulthood: Structure, dynamics, and change. New York: Guilford Press.<br>• Allen, J.P., & Miga, E.M. (2010) Attachment in adolescence: A move to the level of emotion regulation, *Journal of Social and Personal Relationships*, 27(2): 181-190.<br>• Lyons-Ruth, K., & Jacobvitz, D. (in press) Attachment | |

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| | | | | disorganization from infancy to adulthood: Neurobiological correlates, parenting contexts, and pathways to disorder. In J. Cassidy & P. Shaver (Eds.), 'Handbook of Attachment: Theory, Research, and Clinical Applications'. 3nd Edition. New York: Guilford.<br><br>A recent observational measure of attachment disorganization has been introduced that is coded from a 15 minute interaction between parent and adolescent (Goal-Corrected Partnership in Adolescence Coding System (GPACS); Obsuth, Brumariu, & Lyons-Ruth, 2014). The GPACS has shown promise as a measure of attachment among at-risk adolescents, in that it is related to disorganization in infancy, as well as to current unresolved AAI states of mind. The GPACS has also been robustly related to current maladaptation in adolescence, including increased depressive symptoms, dissociative symptoms, borderline personality disorder features, suicidality, and overall psychopathology on a standard psychiatric diagnostic interview (Obsuth, Brumariu & Lyons-Ruth, 2014; Lyons-Ruth et al., 2014; Vulliez-Coady et al., 2013). It also relates significantly to abusive behaviour in romantic relationships. Training is available on this measure through Lyons-Ruth's lab. However, further work is needed in other samples to be sure these results will replicate broadly.<br><br>• Obsuth, I., Brumariu, L., Lyons-Ruth, K. (2014) Disorganized behavior in adolescent-parent interactions: Relations to | |

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| | | | | attachment state of mind, partner abuse, and psychopathology, *Child Development*, 85: 370-387.<br>• Lyons-Ruth, K., Brumariu, L., Bureau, J., Hennighausen, K., & Holmes, J. (2014). Role confusion and disorientation in young adult-parent interaction among individuals with borderline symptomatology, *Journal of Personality Disorders*, 28.<br>• Vulliez-Coady, L., Obsuth, I., Torreiro Casal, M., Ellertsdottir, L., & Lyons-Ruth, K. (2013) Maternal role-confusion: Relations to maternal attachment and mother-child interaction from infancy to adolescence, *Infant Mental Health Journal*, 34: 117-131. | |
| Northumbria University | Full | General | General | Overall, there may be value in further theoretical qualifications regarding disorganisation. As it stands, the discussions of disorganisation are too general and too vague, often implying that it is a single "thing" occurring through a unitary process. This is an unwarranted assumption. For instance it may be helpful to reference Lyons-Ruth et al.'s (2013) and/or Padron et al.'s (2014) findings on differences among disorganised infants.<br><br>• Padrón, E., Carlson, E.A. & Sroufe, L.A. (2014) Frightened Versus Not Frightened Disorganized Infant Attachment, *American Journal of Orthopsychiatry*, 84(2): 201–208. | Thank you for your comment, however, the Guideline Committee looks for evidence to best inform the review questions. The smaller evidence base that you refer to is scientifically interesting, however, it is still limited to a small number of studies coming from a small number of research groups. Moreover, the Guideline Committee has a duty to summarise pragmatically the research on attachment so that the key clinical messages can be taken up and used appropriately, therefore the Guideline Committee does not view it as helpful, overall, to complicate the picture in this way. |
| Northumbria University | Full | General | General | It may also be useful to highlight that already by age three behaviour can be seen in the Strange Situation which is *not* disorganisation at a behavioural level, but which *is* associated | Thank you for your comment. The Guideline Committee agree that this needs to be highlighted and have added to the section linking evidence to |

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| | | | | with risk e.g. caregiving by the child to the parent, as a response which can be mustered with the developmental possibilities opened up after infancy (Main & Cassidy 1988; Crittenden 1988; Moss et al. 2005; Macfie et al. 2008). For example, Main and Cassidy (1988) found that disorganised behaviour in infancy predicted controlling behaviour towards the parent at age six.<br><br>When they introduced the procedures for coding disorganisation, Main and Solomon (1990) specified that the indices should not be used with children under 11 months – or above the age of 20 months, since with development children can be expected to elaborate organised behavioural responses to situations which had previously been experienced as causing conflict they could not solve.<br><br>After 20 months of age, disorganised behaviour can still be coded, but caution is needed. Cicchetti and Barnett (1991) found that maltreated young children were particularly likely to continue to show disorganised behaviour later into the preschool period compared to non-maltreated controls. Among three-year-olds in the large NICHD SECCYD sample, disorganised behaviour was more strongly related to maladaptation than controlling behaviour at that age (O'Connor, Bureau, McCartney, & Lyons-Ruth, 2011), again suggesting that it is important to be aware of disorganised behavioural manifestations well into the preschool period, especially among young children at severe risk. | recommendations the following:<br><br>The Guideline Committee acknowledged that after approximately 2 years of age the focus of coding in the realm of disorganization is on punitive caregiving, where the child tends to harshly order the parent around or on compulsive caregiving where the child will do anything to make his/her caregiver feel better so that he/she feels safe. These forms of behaviour appear to arise from disorganised attachment during infancy (Main and Cassidy (1988). |

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| | | | | • Main, M. & Cassidy, J. (1988) Categories of response to reunion with the parent at age six: Predicted from infant attachment classifications and stable over a one-month period, *Developmental Psychology*, 24(3): 415-426.<br>• Macfie, et al. (2008) Independent influences upon mother–toddler role reversal: infant–mother, Attachment disorganization and role reversal in mother's childhood, *Attachment & Human Development*, 10(1): 29-39.<br>• Cicchetti, D., & Barnett, D. (1991) Attachment organization in maltreated pre-schoolers, *Development and Psychopathology*, 3, 397-411.<br>• O'Connor, E., Bureau, J-F., McCartney, K., & Lyons-Ruth, K. (2011) Risks and outcomes associated with disorganized/controlling patterns of attachment at age three in the NICHD Study of Early Child Care and Youth Development, *Infant Mental Health Journal*, 32, 450-472. | |
| Northumbria University | Full | General | General | Given that there is a focus on changing the caregiving behaviours which increase the likelihood of a disorganised attachment classification, it would be useful to acknowledge in the Guideline that randomised controlled trials now provide strong evidence that disorganised attachment is amenable to change through interventions that focus on the mother-infant relationship (Bernard et al., 2012; Cicchetti, Rogosch, & Toth, 2006; Heinicke et al., 1999; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2005; Moss, Bureau, St-Laurent, & Tarabulsy, 2011; Smyke et al., 2010; Tereno et al., 2014; Toth et al., 2006). | Thank you for your comment and highlighting this. In chapters 9 and 10 the Guideline Committee reviewed the quality of randomised controlled trials that aimed to improve attachment in children on the edge of care, foster care or are adopted.<br>The Guideline Committee agree this could be highlighted early on in the guideline. A comment relating to this in the linking evidence to recommendation section for assessing attachment difficulties in children has been added**.** |

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| | | | | • Bernard, K., Dozier, M., Bick, J., Lewis-Morrarty, E., Lindhiem, O., & Carlson, E. (2012) Enhancing attachment organization among maltreated children: Results of a randomized clinical trial, *Child Development*, 83, 623-636.<br>• Cicchetti, D., Rogosch, F., & Toth, S. (2006) Fostering secure attachment in infants in maltreating families through preventative interventions, *Development and Psychopathology*, 18, 623-649.<br>• Heinicke, C. M., Fineman, N. R., Ruth, G., Recchia, S. L., Guthrie, D., & Rodning, C. (1999) Relationship-based intervention with at-risk mothers: Outcome in the first year of life, *Infant Mental Health Journal*, 20, 349-374.<br>• Juffer, F., Bakermans-Kranenburg, M., & van IJzendoorn, M. (2005) The importance of parenting in the development of disorganized attachment: evidence from a preventive intervention study in adoptive families, *Journal of Child Psychology and Psychiatry*, 46, 263-274.<br>• Moss, E., Bureau, J-F., St-Laurent, D., & Tarabulsy, G. M. (2011). Understanding disorganized attachment at preschool and school age: Examining divergent pathways of disorganized and controlling children. In J. Solomon & C. George (Eds.), *Attachment disorganization* (2nd ed.). Guilford.<br>• Smyke, A., Zeanah, C., Fox, N., Nelson, C., & Guthrie, D. (2010) Placement in foster care enhances quality of | The Guideline Committee discussed that RCTs that target the mother-child relationship show they reduce the risk of children from having disorganised attachment. The results of these interventions and subsequent recommendations can be found in Chapters 9 and 10 of this guideline<br><br>The Guideline Committee have also added to the Linking Evidence to Recommendations sections on interventions to improve maternal sensitivity that "Although the evidence on the effectiveness of parental sensitivity and behavioural training on disorganised attachment in children was unclear, evidence from a review in Chapter 7 showed maternal sensitivity measured at one point in time is associated with the likelihood of a child developing disorganised attachment 5 to 24 months later. Thus, it is important that maternal sensitivity is improved where needed since it may prevent on the development of disorganised attachment.<br><br>In the review, the Guideline Committee found the maternal sensitivity measured by the Ainsworth Sensitivity Scale and CARE-Index were able to predict disorganised attachment 6 to 24 months later. Maternal Sensitivity Q sort predicted attachment security but not necessarily disorganised attachment. |

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| | | | | attachment among young institutionalized children, *Child Development*, 81, 212-223.<br>• Tereno, S., Guédeney, N., Wendland, J., Lyons- Ruth, K., Tubach, F., Lamas, C., Guédeney, A. & and the CAPEDP Study Group. (2014) Impact of a home-visiting program on maternal atypical behavior: The role of cumulative risk factors. Submitted for publication.<br>• Toth, S., Rogosch, F., Manly, J., & Cicchetti, D. (2006) The efficacy of toddler-parent<br>• psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial, *Journal of Consulting and Clinical Psychology*, 74, 1006-1016.<br><br>Other randomized studies have targeted other problematic aspects of infant behaviour and stress response, for example, Bernard et al. (2014), Lind et al. (2014), and Bernard et al. (2015).<br><br>• Bernard, K., Dozier, M., Bick, J. & Gordon, M.K. (2014) Intervening to enhance cortisol regulation among children at risk for neglect: Results of a randomized clinical trial, *Development and Psychopathology*: 1-13.<br>• Lind, T., Bernard, K., Ross, E. & Dozier, M. (2014) Intervention effects on negative affect of CPS-referred children: Results of a randomized clinical trial, *Child Abuse & Neglect*, 38(9): 1459-1467. | Thank you for the references. The Guideline Committee has already included:<br><br>Bernard 2012<br>Cicchetti 2006<br>Heinicke 1999<br>Juffer 2005<br>Smyke 2010<br>Toth 2005<br><br>The following were not included (with reason):<br>Moss 2011: was not included since it was a book with no primary research reported that we could meta-analyse.<br>Tereno: not yet published.<br>Bernard 2014: no critical outcomes reported.<br>Lind 2014: no critical outcomes reported.<br>Bernard 2015: no critical outcomes reported.<br>Tereno: thank you for the suggestion to contact the authors. |

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| | | | | • Bernard, K., Hostinar, C.E., & Dozier, M. (2015) Intervention Effects on Diurnal Cortisol Rhythms of Child Protective Services–Referred Infants in Early Childhood: Preschool Follow-up Results of a Randomized Clinical Trial, *JAMA Pediatrics*, 169(2): 112-119.<br><br>The authors may also consider contacting the Tereno, Guédeney & CAPEDP Study Group in Paris. They are reporting results from an attachment-based intervention, which has been found to reduce rates of disorganised attachment e.g. Guédeney, A. et al. (2014) 'Fraiberg in Paris – early prevention through a mental health programme' in Early Parenting and Prevention of Disorder, eds. Robert N. Emde & Marianne Leuzinger-Bohleber, London: Karnac, pp.73-89. | |
| Nottingham shire County Council | Short | 4 | 79 | From our experience it is important to consider the effect of the traumatic experiences the child may have had, both from the actual experience of coming into care and from the possible traumatic events (eg domestic violence) that led to the move into care. This is different from but needs to be considered alongside the attachment difficulties the child may have. (Kate Cairns "Attachment, trauma and resilience" (2002)) | Thank you for your comment, however the Guideline Committee feels that this issue is amply covered elsewhere in the guideline, for example, 1.3.2 and 1.4.12-1.4.13. |
| Nottingham shire County Council | Full | 22<br>-23 | 48<br>-6 | We welcome this comment that it is more likely that the disturbed parenting has had effects on several systems. We would like this to go further, as we would like it to state that it is possible that a child may have been misdiagnosed (with conditions such as ADHD) before the extent of the attachment | Thank you for your comment. The Guideline Committee have added to section 2.7.<br>"The apparent overlap in the behaviour of a child with attachment difficulties and a child with a different neurological condition, may lead to a child being |

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| | | | | and trauma issues was recognised. Once attachment issues have been recognised (even if there is no firm diagnosis of disorder) we would recommend that intervention for the attachment issues proceeds and is evaluated before further diagnoses are considered and that previous diagnoses are reconsidered. | misdiagnosed (with conditions such as ADHD or the Williams syndrome), before the extent of the attachment and trauma issues have been recognised. Thus it is important that health care professionals take into account all manner of explanations and causes during an assessment, that may lead to a single or dual-diagnosis."<br><br>Without the Guideline Committee reviewing any evidence on the sequence of treatments, a recommendation relating to this specifically could be made. |
| Nottingham shire County Council | Full | 29 | 43 -45 | We welcome these lines. | Thank you for your comment. |
| Nottingham shire County Council | Full | 29 | 46 | We are concerned that there is even a mild suggestion that medication could be helpful. We are worried about the word "benign" it implies that the caregiver would be justified in not behaving in a benign way if the child's behaviour is understandably challenging. We believe that the intervention needed here is to provide intensive, nurturing support for the caregiver, recognising the emotional impact on them. | Thank you for your comment. The sentence to which you refer has been deleted, however the point the Guideline Committee is making later in the paragraph is that there may be a role for medication for children with attachment difficulties, but only to treat a physical or mental health problem. |
| Nottingham shire County Council | Short | 17 | 398 | The attachment issues should be understood and addressed first before any other diagnosis is considered as the presenting behaviours for other conditions may look the same. (eg see The Coventry Grid, Heather Moran for guidance on differential | Thank you for your comment. The Guideline Committee agree that it is important to distinguish between attachment and other conditions, that is why we recommend "Health and social care professionals |

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| | | | | diagnosis between ASD and attachment disorder) | should offer a child or young person who may have attachment difficulties, and their parents or carers, a comprehensive assessment before any intervention" 1.3.2. This assessment includes a long list of factors that will help to distinguish between attachment issues and any other diagnosis. The Guideline Committee did not review the Coventry Grid as this was beyond the remit of the guideline and therefore did not wish to make a recommendation on this. |
| Nottingham shire County Council | Short | 22 | 521 | Some children's needs may not be severe enough to warrant a diagnosis of attachment disorder using DSM V but they and their families may still benefit from structured and supportive interventions to prevent coming into the care system. | Thank you for your comment. The Guideline Committee fully agrees – the guideline covers the full range of attachment problems, including those that are not categorised as attachment disorders. |
| Nottingham shire County Council | Short | 23 | 548 -591 | We welcome this section. | Thank you for your comment. |
| Nottingham shire County Council | Short | 27 | 663 | We are concerned at the emphasis on "behavioural management techniques". The priority must be to build a healing, nurturing relationship between the child and carers or adoptive parents with the adults having a solid understanding of attachment and trauma. (The PACE model can be really helpful, "Creating loving attachments" Golding and Hughes 2014). In our experience many "traditional" reward and consequence systems are often ineffective and sometimes damaging because they can increase | Thank you for your comment. The Guideline Committee has changed recommendation 1.5.5 to say '*positive* behavioural management methods'. |

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| | | | | the child's sense of shame and the parent's frustration. | |
| Nottingham shire County Council | Short | 28 | 695 | See point 8, the term "behavioural reinforcement system" sounds like a traditional positive reinforcement method which is likely to be unhelpful at best and damaging at worst. | The recommendation you are referring to was based on the positive findings from the study by Kim 2011 Substance Use and Delinquency Among Middle School Girls in Foster Care: A Three-Year Follow-Up of a Randomized Controlled Trial. |
| Nottingham shire County Council | Short | 35 | Sec 2.5 | In our experience school staff (teachers and teaching assistants, midday supervisors, caretakers) can be a valuable resource for the child. We have devised and delivered training packages around attachment and trauma that have been well received and have had a significant impact on the wellbeing of children. Our training begins with the premise that negative behaviours are a sign of unmet needs. Please contact us for further information. Given the prevalence of children with insecure attachments we would also recommend that this should be included in initial teacher training. | Thank you for this comment. It was for the reasons that you give that we used the wording 'Schools and other education providers should ensure that all staff who may come into contact with children with attachment difficulties receive appropriate training' as this would include those on ITT, midday supervisors, caretakers etc (1.2.1). |
| Nottingham shire County Council | Short | 3 | 50 -56 | We are concerned that the emphasis here is only on parents' neglectful and maltreating behaviour. Some attachment difficulties arise from circumstances beyond a parent's control, eg post natal depression. | Thank you for your comment. Whilst the Guideline Committee acknowledge there are myriad of reasons why the primary caregiver has difficulties in forming a healthy attachment with their child the most common reasons (as we stated) are neglectful and maltreating behaviour from primary caregivers |
| Nottingham shire County | Full | 109 | 2nd para | We are deeply concerned that practitioners are not being encouraged to look at the child holistically but are being | Thank you for your comment, however the Guideline Committee judged that it was important to be aware of |

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| Council | | | | encouraged to symptom check for other mental health problems which could better be explained by a single diagnosis of attachment difficulties. ((see point 2 above) | common comorbidities, which may significantly inhibit the effective delivery of interventions for attachment difficulties. |
| Nottinghamshire County Council | Short | 17 | 405 | We welcome the mention of the work of educational psychologists in schools. We have a significant role in supporting teachers with their work around individual children and in delivering training to the wider school. We subscribe to a social model of disability which would include children with attachment difficulties, our approach, therefore, would be in working with the adults around the child. | Thank you for your comments. |
| Nottinghamshire Healthcare NHSFT | Full | 195 -196 | | Q1 - The recommendation that attachment interventions be implemented if on the edge of care, have a disability or mental health problems or are form a minority ethnic group, will be a significant challenge as only a very small number of the CAMHS workforce outside of Looked after Services, have specific training in attachment interventions<br>Q2 – ensure all CAMHS at least specialist level have specific attachment training in Theraplay and an attachment intervention such as DDP at least to level 1 and ensure robust supervision arrangements around attachment issues. More Theraplay and DDP trainers so that more in-house training can help sustain skilling up the workforce | Thank you for your comment. The Guideline Committee has amended the recommendation to not specifically lay the responsibility with CAMHS. |
| Nottinghamshire Healthcare NHSFT | Full | 197 | General | Q1 – assessment of all unaccompanied YP for mental health issues particularly PTSD will be a challenge to resource: It will be additional case work; require more staff to be trained in trauma assessment and intervention and requires establishing a closer | Thank you for your comment.<br>The recommendations are based on the best available effectiveness and cost effectiveness evidence but the Guideline Committee recognises the challenges of |

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| | | | | interface with partner agencies we are not routinely worked with currently. Also more awareness of cultural issues will be an essential part of the work<br>Q2 – in the past, we had a good practice of ring fenced resources and dedicated members of the team who interfaced and worked with people with 'refugee' status and this worked well as people became more familiar with cultural and political issues in areas where children had travelled from, and were skilled in working with trauma. This model worked well. | implementation<br><br>It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| Nottingham shire Healthcare NHSFT | Full | 198 | General | Q1 – may be a challenge to identify and agree amongst agencies what the threshold for 'edge of care' is particularly if the recommendations from NICE re consistency of caseworkers and different type of case management are then to be put in place. There will need to be thought given to which agency provides this or whether it will be decided on a case by case basis (however, this might make it harder to provide consistency). However, in principle the consistency of case worker for all children in care or edge of care will be beneficial and many service users who need to use services over a long period of time voice this need across many different 'care groups' | Thank you for your comment. The Guideline Committee are glad you agree that consistency of case workers for all children in care or on the edge of care will be beneficial.<br><br>The recommendations are based on the best available effectiveness and cost effectiveness evidence but the Guideline Committee acknowledges the challenges of implementation.<br><br>It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. Practical resources will accompany the guideline and be provided by the NICE implementation team. |
| Nottingham shire | Full | 386 | General | Q1 – Challenge to implement within YP mental health services with separate 'looked after' teams. Children of the edge of care | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by |

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| Healthcare NHSFT | | | | more likely to be supported by general YP mental health services, where locally there are few clinicians with attachment-specific training | service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Nottingham shire Healthcare NHSFT | Full | 392 | General | Q1 – It is problematic to recommend sole focus on the NICE guidelines for PTSD in YP who have experienced maltreatment. The impact of maltreatment may manifest in different presentations, not consistent with PTSD. | Thank you for your comment. Whilst the Guideline Committee recognise that the impact of maltreatment may manifest in different presentations, the only available evidence for school aged children came from one trial which found trauma-focused CBT for children who had been sexually abused to be effective. In the absence of any other evidence, the Guideline Committee extrapolated this to all children who had been maltreated and showed signs of trauma. |
| Nottingham shire Healthcare NHSFT | Full | 13 | 36 | The use of the term 'attachment difficulties' is welcome and inclusive of the many perspectives taken by professionals. It would be preferable if this was a term consistently used throughout the document rather than becoming overly focused on 'attachment disorder' (except where the specific diagnosis is being referred to). By referring to difficulties/disorder in our experience causes significant confusion for other professionals and families – who will often seek a diagnosis to support their applications for additional support/understanding particularly in education | Thank you for your comment. The Guideline Committee has been very careful in how it has used the term 'attachment difficulties' as an overarching terms, and has checked the guideline thoroughly to ensure it has been used consistently. The Guideline Committee (which included service users, foster carers and adoptive parents as well as representatives from education), had detailed discussions about terminology and decided that 'attachment difficulty' was the most appropriate term |
| Nottingham shire | Full | 13 | 42 | We are concerned that Occupational Therapy Services are not covered by this guidance given that increasingly we identify a | Thank you for your comment. The guideline is limited to how much of the care pathway for children with |

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| Healthcare NHSFT | | | | need for OT sensory assessment and intervention within our work and as such this guidance is highly relevant for our OT colleagues who increasingly pay attention to Sensory Attachment Integration – we are seeking to encourage recognition of the need to regulate over- aroused nervous systems in children and young people and would hope to integrate Occupational Therapy support into the provision of our service. | attachment difficulties can be covered. Generally speaking, NICE do not make recommendations targeting specific health care professionals. Thus, occupational therapists may be able to implement our recommendations where possible.<br><br>The Guideline Committee state in chapter 1, the guideline will also be relevant to the work, but will not cover the practice, of those in:<br>• occupational health services<br>• social services<br>• the independent sector. |
| Nottinghamshire Healthcare NHSFT | Full | 17 | 5 and 28 | We wonder if it would be more inclusive and helpful to reference other researchers in the area rather than relying on referencing Fonaghy et al – this may suggest a limited review of attachment theory | Thank you for your comment. There are approximately 390 references in the guideline. Various members of the Guideline Committee group wrote the introduction to each chapter. A wide range of authors in this field are referenced in the guideline and we have added more still in response to stakeholder comments. In any instance, the selection of papers for the reviews is systematic and unbiased. And it is those that are used to generate NICE recommendations. |
| Nottinghamshire Healthcare NHSFT | Full | 17 | 18 | 'as we have developed an increasingly sophisticated understanding of the relationship between early brain development, early psychosocial experiences and developmental psychopathology' would benefit from referencing researchers who have helped to develop this | Thank you for your comment. The Guideline Committee have added your suggested references. |

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| | | | | sophisticated understanding – for example Crittenden; Perry; Seigel; Van der Kolk | |
| Nottinghamshire Healthcare NHSFT | Full | General | | There is a need to recognise trauma and the impact of these experiences on attachment and therefore on understanding and intervention and this appears to be lacking within the guidance – too simplistic a view can prove a barrier to ensuring that specialist services and staff with expertise are recruited to services. | Thank you for your comment. Although maltreatment and trauma are not the focus of this guideline, the Guideline Committee nevertheless looked at the data on providing support for children with attachment difficulties who have been maltreated (please see recommendations 1.3.1, 1.3.2, 1.4.9, 1.4.12 and 1.4.13).<br>The Guideline Committee also make general recommendations on the principles of care to ensure that professionals pay due attention to trauma amongst this group. Beyond this is outside of the scope of the guideline. |
| Nottinghamshire Healthcare NHSFT | Full | 19 | 3<br>- 4 | We are concerned that this description does not pay attention to other models of attachment theory (Dynamic Maturational Model) where an ABC model is the focus rather than ABCD for evidenced reasons. The 'are' in this statement is actually a 'may be' – At this time many professionals working in the field of attachment are well informed about the DMM of Attachment and Assimilation and we would feel that this should be referred to in the guidance as an increasingly welcome understanding of attachment (before page 20 where it is referred to in relation to assessment). This model also holds a developmental approach which fits well with CAMHS service provision. | Thank you for your comment. The Guideline Committee have mentioned in chapter 2 that there are other models of describing attachment, other than the ABCD model. |
| Nottingham | Full | 20 | 2.5 | Here the focus on attachment difficulties shifts to emphasise | Thank you for your comment and for highlighting this |

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| shire Healthcare NHSFT | | | | disorganised attachment or attachment disorder which appears out of keeping with the initial premise of guidance relating to attachment difficulties – which was so welcome in the earlier part of the document. It seems that the guidance has moved to a diagnostic understanding of attachment rather than continuing to hold in mind the strategic functioning of the child to maintain safety. Too often services are asked to diagnosis attachment disorder rather than develop understanding of attachment difficulties which points towards intervention and support. | apparent contradiction to what the Guideline Committee hoped to achieve in this guideline. We were hoping to avoid a diagnostic definition of attachment rather than a behavioural response to their environment.<br>To avoid confusion the Guideline Committee have deleted the opening paragraph in section 2.5. |
| Nottingham shire Healthcare NHSFT | Full | 20 | 43 onward s | Attachment is a framework within which to understand, and indeed to helpfully understand, aggression; risk taking; lying stealing and manipulation. These behaviours are often about managing fear, exercising control or seeking proximity or distance with others. There is ambivalence therefore between saying that these behaviours are commonly experienced by children in the care system and trying to separate such behaviours from an attachment understanding. We face a consistent challenge of ensuring that an attachment understanding is not a diagnosis but a framework | Thank you for your comment. The Guideline Committee agree, and hope your point has been captured, that attachment is a framework within which to describe a series of behaviours rather than a diagnosis. |
| Nottingham shire Healthcare NHSFT | Full | 26 | 31 | In referring to the Strange Situation as a means of assessing attachment we are concerned that reference is not also made to the fact that this method actively induces negative response within a child who utilises insecure attachment strategies and as clinicians and researchers we need to consider if this is an attuned methodology of assessing a child who is overwhelmed by fear when facing separation. We would not want to use this | Thank you for your comment. The Guideline Committee agree that the clinician has to decide whether it is helpful to conduct the assessment in terms of the overall needs of the child, however many clinicians in the field have found the strange situation to be very useful clinically. The procedure is always curtailed if the child is distressed, so in many instances |

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| | | | | methodology routinely to assess a child's needs. | (where there is upset) the two episodes of separation are often no more than 30 seconds each (up to 3 minutes if little or no distress).<br><br>The Guideline Committee also acknowledge that there are broader issues about the feasibility of using this procedure and its cost, which in turn will affect individual practitioner's decisions about under what circumstances proceeding with an assessment of this nature would be in the net best interests of the child- these issues are discussed elsewhere in the guideline. |
| Nottingham shire Healthcare NHSFT | Full | 24 | 1 | There is no reference made to trauma bonds or to the real challenges which can exist for some children within their sibling relationships when they have experienced significant trauma, neglect or abuse. This means that careful and reflective sibling assessment is required and needs also to pay attention to the challenges faced by adoptive parents who adopt more than one sibling, especially if they are adopting a sibling group. | Thank you for your comment. The Guideline Committee agree, that careful consideration needs to be made when deciding to place siblings together in-care. The evidence showed keeping siblings together resulted in either a better outcome or it had no effect on the following: being reunited with their parents, entering adoption, number of placements or re-entry into care. Nevertheless, the Guideline Committee acknowledged there are cases when placing siblings together in care, when they have attachment difficulties, may make it more difficult for one or both of them to form an attachment to their primary caregiver, since they may use their sibling as a crutch. In such cases, it may be better to wait until one of them forms a healthy attachment to a primary career before reuniting them with their sibling. |

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| | | | | | A comment relating to this, when considering placing sibling together has been added to the the Linking Evidence to Recommendations section. |
| Nottinghamshire Healthcare NHSFT | Full | 27 | 20 | **'Attachment disorders** are observed almost exclusively in conditions that represent extreme departures from normative care, including extreme neglect and institutional care.' This helpfully makes clear that attachment disorder is an extreme departure but throughout the document RAD and DSED are not consistently referred to as extreme, as attachment difficulties/attachment disorders are interchanged and the focus becomes RAD particularly. The guidance appears to struggle to maintain the idea of attachment strategies being developmental strategies to manage relationships and more importantly anxiety/fear which will prove a challenge to implement the guidance if there is no consistent understanding of what we are describing. | Thank you for your comment. The Guideline Committee agree that attachment disorders are an extreme departure from normative care, as you quoted from our guideline. They have addressed any inconsistencies when they have made reference to attachment difficulties and disorder throughout the guideline and only referred to specific categories when the evidence allowed us to.<br><br>Given the paucity of the evidence, the Guideline Committee included any relevant study that addressed any attachment difficulty, that they defined as insecure or disorganised attachment or an attachment disorder. The Guideline Committee acknowleged the problems of diagnosing a child with attachment disorder and feel this was captured in the Linking Evidence to Recommendations and the introduction where it was made clear that it was attachment disorders. For example in Section 2.3, "Although particular types of attachment pattern (especially disorganised attachment) may indicate a risk for later problems, these classifications do not represent a disorder." |
| Nottingham | Full | 28 | 32 | This sentence about relationship based therapies needs to be | Thank you for your comment. The Guideline |

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| shire Healthcare NHSFT | | | | stand alone. By linking it to the sensationalised next sentence suggests that relationship based therapies are all exotic and bizarre which could cause considerable anxiety and inappropriately stand in the way of the development of relationship focused interventions which are yet to be fully researched. | Committee have made a better distinction between those that are considered therapeutic versus not. |
| Nottingham shire Healthcare NHSFT | Full | 28 | 32 | DDP and Theraplay are well established interventions which are relationship focused. Practice based evidence suggests they are theoretically consistent with many practitioners practice and are sought by foster carers, local authorities and adoptive parents alike. It would be helpful to specify that relationship based therapies including DDP and Theraplay have not yet been subject to RCT. | Thank you for your comment. The Guideline Committee agree that there are interventions currently being used that have not been scrutinised via an RCT that may be important to consider. However, the Guideline Ccommittee identified this as a key area of uncertainty which is why they generated a research recommendation to: "Evaluate currently unevaluated but extensively used interventions for attachment difficulties." |
| Nottingham shire Healthcare NHSFT | Full | 28 | 33 | This sentence about exotic and bizarre therapies is sensationalist and journalistic and very out of keeping with the remainder of the document. A footnote seems unnecessary – let us be clear in a stand alone paragraph that any therapy which involves those things listed is abusive and not therapeutic. | Thank you for your comment. The Guideline Committee have edited the language to say "some are abusive and not therapeutic and make unsubstantiated claims about improving brain function". The Guideline Committee have left the information in the footnote but joined a latter paragraph that summarises these interventions to give better insight into what is being referred to without the detail that is given in the footnote. |
| Nottingham shire | Full | 29 | 1 -11 | This sounds like DDP – why not specify that? This could prove very helpful for securing funding around research | Thank you for your comment. Unfortunately no high quality RCT evidence was identified in this area. |

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| Healthcare NHSFT | | | | | However, the Guideline Committee agreed that this is a key area of uncertainty which is why they generated a research recommendation to: "Evaluate currently unevaluated but extensively used interventions for attachment difficulties." |
| Nottinghamshire Healthcare NHSFT | Full | 29 | | There is no mention here about responding to trauma within psychological intervention or to sensory regulation both of which would seem to be significant omissions. | Thank you for your comment and highlighting this omission. The Guideline Committee have now commented on the evidence to address to trauma in Section 2.11. "The evidence available shows dyadic parent-child psychotherapy or trauma-focused cognitive therapy for both the child and parent may improve parental sensitivity or attachment security in children and young people who have been maltreated with related trauma {Cicchetti, 2006,Cohen, 2004}. |
| Nottinghamshire Healthcare NHSFT | Full | 29 | 43 onwards | This section is very clear and helpful | Thank you for your comment. |
| Nottinghamshire Healthcare NHSFT | Full | 105 | Rec 5 | The use of the term 'integrated' is ambiguous and probably will lead to many unhelpful discussions about what integrated means – this doesn't necessarily fit with the previous point about specialist expertise – many services will see that the service needs to be integrated and in many cases as has happened already this will lead to specialist expertise being diluted (eg the CAMHS CLA service being located in community CAMHS rather than a specific resource). Do we want specialist expertise? – if so | Thank you for your comment. The recommendation has been changed to say 'works with' rather than 'integrated with'. |

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| | | | | we need to highlight this and use terminology which expects that all services will link together to ensure care planning is joined up and responsive to the young person's needs | |
| Nottinghamshire Healthcare NHSFT | Full | | Rec 6 and 7 | These recommendations are very helpful and important but will also demand in some areas significant investment in specialist CAMHS CLA therapeutic services. Therapy focused on supporting attachment need is already a scant resource in many areas and needs to be sought independently with little integration. | Thank you for this comment. The Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Nottinghamshire Healthcare NHSFT | Full | 239 | 13 | A opportunity here to reference the work of Crittenden who has made a significant contribution to our understanding of controlling and compulsive caregiving | Thank you for your comment. The Guideline Committee has added an additional sentence to explain "coercive, controlling or compulsive caregiving" and referenced the work of Crittenden. |
| Nottinghamshire Healthcare NHSFT | Full | 282 | Rec 29 | We are concerned that in recommending the Strange Situation as an assessment tool that this will be inexpertly utilised as an assessment tool which actively induces anxiety responses in young children for no other reason that meeting the clinician need. Through observing the child and their discourse one can assess attachment style without purposefully dysregulating a child given that this loss, separation and experience of fear is at the core of the child's difficulties. | Thank you for your comment. The Guideline Committee agree that the clinician has to decide whether it is helpful to conduct the assessment in terms of the overall needs of the child, however many clinicians in the field have found the strange situation to be very useful clinically. The procedure is always curtailed if the child is distressed, so in many instances (where there is upset) the two episodes of separation are often no more than 30 seconds each (up to 3 minutes if little or no distress). |
| Nottinghamshire | Full | 285 | Rec 30 | Great recommendation if we are able to remember that according to the guidance: **'Attachment disorders** are observed | Thank you for your comment, however the Guideline Committee felt that it was clear from the context and |

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| Healthcare NHSFT | | | | almost exclusively in conditions that represent extreme departures from normative care, including extreme neglect and institutional care.' Perhaps we need a definition of 'extreme neglect' | following text what was meant by 'extreme neglect'. |
| Nottinghamshire Healthcare NHSFT | Full | | Rec 31 onwards | We are concerned that recommendations are made about intervention when there is recognition that interventions used broadly at present are not researched adequately nor within an RCT format. It would seem that the most appropriate recommendation would be that purported to within the text – page 29 lines 1-11. This would seem to be a more helpful recommendation than 15 recommendations which reflect ways of working embedded in other interventions such as consultation, foster care training (eg Nurturing Attachments), DDP, Theraplay, Sensory Integration but which have limited evidence bases and are very restrictive on the basis of lack of evidence for anything else. Of course DDP therapists and researchers have been seeking to try to gain support for an RCT of DDP for some years now with apparently little success. A research recommendation would be of value. | Thank you for your comment. The Guideline Committee acknowledged there are therapies being used that currently lack RCT evidence. **Unfortunately no RCT evidence was identified in this area. Thus, this area was identified as a key uncertainty by the** Guidleine C**ommittee which is why they generated a research recommendation to** "Evaluate currently unevaluated but extensively used interventions for attachment difficulties". |
| PAC-UK | Full | General | General | The Guideline provides a very impressive and interesting overview of all research findings data with regard to attachment issues in children adopted from care, children in care or at risk of going into care. A surprising number of recommendations though, seem to be made on the findings in studies that have a 'low' or even 'very low' mark for 'quality of evidence'? | Thank you for this comment. The Guideline Committee agree that in some reviews only low quality evidence was available, and they went as far as they could in terms of offering guidance given this situation. |
| PAC-UK | Full | General | General | We appreciate that the Guideline is based on quantitative | Thank you for your comment. Whilst the Guideline |

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| | | | | research as this tallies with the NHS's medical model of research; we wondered whether there are any qualitative studies that could be included as these capture some of the 'experience' (with regard to attachment) of adopted/LAC children, their foster/SG/Kinship carers and adoptive parents, and their therapists, social workers, other professionals – this would add important dimension to the data (the combination of experimental and phenomenological approaches to research being the most interesting and helpful when studying humans?) | Committee agree that additional information could be obtained from qualitative papers, a review of this nature was beyond the scope of this guideline. Where evidence was lacking, the expertise of the Guideline Committee was referred to, that included service users and care leavers, for insight into their experience in care and made recommendations where possible to improve the delivery of care and to minimise the risk of attachment difficulties. |
| PAC-UK | Short<br><br>Short<br><br>Full<br><br><br><br>Full<br>Full<br><br>Full | 4<br><br><br><br>392<br><br><br><br>394<br>20<br><br><br>436 | 78-80<br><br>316/17<br><br>rec. 42<br><br><br><br>3rd para<br>43<br><br><br>20 and onwards | '*Children and young people in these situations have many needs, including those resulting from maltreatment':* we think this is an essential comment and one that is made in other parts of the Guideline. We were unsure though why 'unaccompanied immigrants' were specifically mentioned as 'highly likely to have been traumatised, especially coming from war zones' whilst the combination of previous maltreatment, (complex) trauma and the effects of these in addition to attachment difficulties in LAC/adopted from care children is made explicit only in the full guidance?<br><br>Although we appreciate the necessity and much needed distinction between attachment issues and (other) issues resulting from maltreatment and other early life traumas (as indeed there can be '*misunderstanding re what the origins are of attachment difficulties*' and whether a child can be diagnosed with having all three, two or one of these conditions: attachment difficulties, RAD and complex trauma). From our experience the | Thank you for your comment and for the reference. Maltreatment and complex trauma are covered in later recommendations in the short guideline – see 1.3.1, 1.3.2, 1.4.9, 1.4.10 and 1.4.12.<br><br>In response to your second point, as you say, this guideline is specifically about attachment difficulties. There are no plans as yet for 'guidance on the combination and integration of interventions', but the guideline does advise on the assessment and management of comorbid problems, including trauma – see, for example, recommendations 1.1.20, 1.3.1 and 1.3.3. |

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| | | | | co-morbid nature of the children and young people that we see more often than not requires us to combine/integrate interventions so that not only the child's attachment issues can be addressed but also some of their trauma related and other difficulties (and the same for the parents: they need support to parent a child with a multitude of difficulties). Will there, at some future date, be guidance on the combination and integration of interventions? (In the mean time we find the concept developed by *Blaustein, M. & Kinniburgh, K.M., (2010) - Treating Traumatic Stress in Children and Adolescents: how to foster resilience through Attachment, Self-Regulation, and Competency. Guildford Press* very helpful in this respect). | |
| PAC-UK | Short | 8 | 171 | We think it positive that the short guidance refers in some detail to what schools (and Educational psychologists in particular together with CAMHS, virtual schools and others) can do to help children (with attachment difficulties) and their teachers.<br><br>*'Developing and providing training courses on attachment for teachers of all levels'* is an important aspect of what can be done for and with schools. However, we would again like to see the issue of 'attachment' being addressed and supported in schools in combination and integrated with other issues children in care/adopted from care struggle with (whereby the effects of early trauma would very much be included, but also issues around life story and identity). It can be argued that teachers also need to be given assistance in understanding their own counter-transference reactions when teaching challenging | Thank you for your comment. The Guideline Committee envisages that attachment becomes ONE part of the training that teaching staff undertake as a core part of their training. This should include the impact of young people with attachment difficulties on professionals and how they should respond to this. The link between developmental needs (including attachment), managing challenging behaviour and the need to provide a safe and secure learning environment are already recognised in such programmes as Team Teach. Managing challenging behaviour to achieve positive outcomes in the light of informed understanding are the principles of Positive Behaviour Management and this is reflected in the Department of Education document Learning |

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| | | | | students such as some LAC/Adopted children, and how they can be supported in untangling the many projections they will have to absorb as the child seek to project all of their demise into the teacher/teaching staff. This requires more than just training, as it is also about training teachers to manage themselves when educating LAC/Adopted children and having time to think with assistance. | Behaviour Principles and Practice – What Works in Schools. Understanding how the adult reacts and responds to the child and the impact on the situation is part of the training. Learning from the teaching and application of such specialist training approaches for teaching staff provides valuable information that should be used to inform improved support to teaching staff (including the use of additional support resources such as educational psychologists).<br><br>However the Guideline Committee agrees that understanding trauma and how adults can understand and manage their responses to trauma are very important, and has changed recommendation 1.2.2 accordingly. |
| PAC-UK | Full | 24 | 21<br>-32 | We think the key stage 2 data for children who left care into adoption and special guardianship need to be included, to highlight that early life experiences continue to have an impact even once children are in permanent placements. https://www.gov.uk/government/publications/key-stage-2-attainment-for-children-recorded-as-adopted-from-care | The Guideline Committee agree that children who are adopted may still continue to have problems adapting to their new surroundings, not just in foster care. For this reason, we have added a point that behaviours observed in different placements include those who are adopted. |
| PAC-UK | Full | 213 | Item 25 | A helpful table summarising the educational support needed. Item 25 on that table lists several helpful interventions. The item is titled: 'children in the care system who have attachment difficulties'. However, the first bullet point then highlights | Thank you for your comment. The Guideline Committee has amended the recommendation so that it is clear that each bullet point applies to all the groups specified. |

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| | | | | 'adopted children and those who 'have attachment difficulties'. The next bullet point refers to 'all the above groups.' The next two bullet points (having a safe person and a safe space) could be understood to refer only to children in care because that is the title of the item. It would be very helpful to clearly state that this also applies to children who are adopted and children with attachment difficulties too. | |
| PAC-UK | Full | 30 | 33<br>-35 | In section 2.12 adoption services are described as having a high cost. An explicit acknowledgement of the money (per year, per child) that adoptive parents save the state by taking the child out of care would put the 'high cost of adoption' into perspective<br>Also: '*The average cost per day across all adoption services (including the private and 34 voluntary sector) is £230 (2013/14 prices)*'. What does this average cost per day exactly refer to: is this is a cost per day that starts form the moment an adoptive home is sought for a child until the adoption order is finalised? | Thank you for your comment. The Guideline Committee could not find publications reporting 'the money that adoptive parents save the state'. The reported 'average cost per day' gives an indication of potential savings. The estimate includes 'adoption allowances paid and other staff and overhead costs associated with adoption including the costs of social workers seeking new and supporting existing adoptive parents' (This was calculated by dividing total local authority expenditure for own-provision and other provision adoption services by the total number of days of care for both own provision and other local authority provision). This has been clarified in the text. |
| PAC-UK | General<br><br><br><br>Full | General<br><br><br><br>429 | General<br><br><br><br>49 | With regard to the assessment (of attachment issues) and intervention for children and young people in care and adopted from care: there some very interesting findings in the Guidance that we will considered to inform aspects of our practice.<br><br>With regard to intervention we welcome the emphasis the use of | The Guideline Committee agree with your point that it is important that the recommendations are not delivered in a way that sound like it is the carers fault when a child is very challenging, or presents 'miscues' about their attachment needs.<br><br>The Guideline Committee agree, the short version of |

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| | Short | 10 | 207 | video feedback (or parent-child observation without videoing) and on parent/carer intensive training and support.<br><br>In the short version we think that the emphasis on parental sensitivity training and behaviour management training (without further explanation) could be understood as if the parents are 'at fault'. It may need to be emphasised that for older adopted children, parents have to fine tune their sensitivity and their behaviour management well beyond the norm, due to their child struggling with attachment difficulties (and early life trauma) that are also outside the norm. It is our experience that the parent's own attachment and trauma issues will have an effect on their capacity to take sensitivity training in and 'implement what they learnt with very difficult, older children – further study re this issue might be interesting.<br><br>With regard to the interventions for children/young people: the recommendation of group cognitive and interpersonal skills sessions for children after placement seem to be made on the basis of a study that focused on supporting children to make a good transition from primary to secondary school? We were unsure how the leap to a recommendation for all older children with attachment issues was made? It seems positive though that this intervention can be 'adjusted' for young people, adolescents (without exact prescriptions). From our experience children and young people need therapeutic time to truly | the NICE guideline does not provide much context for the recommendations.<br><br>A point has been added relating to your concerns about the carers appearing "at fault" in the full guideline in section 2.11.<br><br>With regard to the use of the study that focused on children making a transition between primary to secondary school, there was very little other evidence available to help develop a recommendation for this age group. The Guideline Committee felt this study was important since it intervened at a vulnerable time for children in care, and when children are placed into a new foster care home they often have to change schools. Thus, the Guideline Committee felt this study was very important. |

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| | | | | It is our view (and experience) that children need to make sense of their adoption and pre-adoption life, and this includes some therapeutic work involves emotional processing of sad, traumatic events and of previous broken attachments. We think that a future research study (RCT or other) might consider comparing children who are helped to make sense of their past and grieve their losses before being supported to 'develop a positive outlook', with children who have 'cognitive and interpersonal skills sessions' only. | |
| PAC-UK | General | General | General | *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.* Yes. There are a number of interventions that exist already that need to be tested comparing to other interventions and controls; see below). | Thank you for your comment. The Guideline Committee reviewed what RCT evidence there was available on this topic. However there were limited studies available; for this reason the committee also identified this as a key area of uncertainty and included the following research recommendation to: "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" |
| PAC-UK | Full | 28 | 32 -34a | In the meantime *There is a wide range of other relationship-based therapies available, but none appear to have been subject to a randomised controlled trial. Some are exotic or verging on the bizarre, others make unsubstantiated claims about improving brain function. (E.g. practises involving re-birthing, lying on top of the child and licking their face or pinching their ribcage, making the child sit still and stare at the wall for long periods of time,* | Thank you for your comment. The Guideline Committee agree that there are interventions currently being used that have not been scrutinised via an RCT that may be important to consider. However, this area was identified as a key uncertainty by the Guideline Committee which is why they generated a research recommendation to "Evaluate currently unevaluated |

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| | | 29 | 1-9 | *being told to leave dried pasta in the child's shoes while they are out at school, punitive consequences such as scrubbing the floor or having to sleep in the shed that are intended to make young people grateful for normal care, lying down and screaming back at a child having a tantrum so they know what it feels like, not to mention the six or so deaths from wrapping up children in blankets and leaving them exposed all night in the US)* These types of interventions were extreme, not main stream and they have now receded well into the past for serious therapists in the US? Having travelled to the US on at least 7 occasions over the last 20 years to attend conferences on Attachment (and related issues) my overriding sense of what was developed in the US is related to the therapies referred to in the following paragraph: *In the absence of trial data, if non-evidence-based interventions are to be chosen, it would seem sensible to choose therapies that are based in empirically supported theory of how secure attachments develop, and on established psychological therapies which address related issues such as self-esteem, emotional regulation, enhancing communication and family functioning, as well as psycho-educational interventions that help to explain the impact of maltreatment and the nature of attachment relationships to parents/carers either individually, or in groups. Much of the work is dyadic – working with the parent and child together – which makes sense given the nature of attachment relationships and the challenges of building a trusting relationship with a therapist. Work that relates to reducing shame, experiencing empathy, to co-regulate 10 emotional and* | but extensively used interventions for attachment difficulties."<br><br>The text has been clarified so that there is a distinction between those that are potentially beneficial versus those that are abusive and not therapeutic. |

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| | | | | *physiological arousal is a promising area for this dyadic and family work.* We agree and welcome the inclusion of these therapies as possible intervention options. The descriptions of these non-evidence-based interventions seem to refer to interventions such as DDP (Daniel Hughes) and Theraplay (which have indeed been endorsed by the Adoption Support Fund as worthy therapeutic approaches for adopted children; the evidence for the decision to include these therapies seems to have come from parents' and therapists' positive 'experience' with these therapies rather than from an RCT.) | |
| PAC-UK | Full | 29 | 26 | *There is no evidence of "suppressed rage" in this population*. Considering Julie Selwyn's research (2014), which highlights levels of violence in a significant number of adoptive families, one may wonder whether anger does feature (and clearly not always suppressed) in these children: not necessarily because of their attachment issues, but because of the multitude of issues they may have relating to early life trauma, multiple separations, adoptive identity issues, lack of self-regulation, possibly ADHD, CD, ODD, etc. (We certainly encounter high levels of anger in many of the previously maltreated adopted children we work with.) | Thank you for your comment. The Guideline Committee have removed this section to avoid any misunderstanding of whether suppressed rage is found in our population. As the saying goes "absence of evidence is not evidence of absence" |
| PAC-UK | Full | 431 | Bottom of page | *The GUIDELINE COMMITTEE discussed that cognitive behavioural therapy has been shown to be an effective form of therapy for children with other mental health problems. Although there was little evidence identified in our target population, the results from children on the edge of care and from children with other* | Thank you for your comment. The Guideline Committee felt that in the absence of evidence it is better to make a recommendation than not considering they are a vulnerable population. |

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| | | | | *conditions, they felt confident recommending this intervention.* We are not sure how this leap can be made if a strict evidence-based stance is adhered to? | The Guideline Committee agreed that the little evidence available on children in care/adopted from care appeared to complement what was convincingly found in the edge of care population. Therefore they felt confident translating the findings from the edge of care population to children in-care and adopted from care.<br><br>To address the gaps in the evidence the Guideline Committee made a research recommendation that more studies need to be conducted in these populations, especially in children older than 5 years. |
| PAC-UK | General | General | | The guideline needs to be commended for the significant amount of work that it must have involved and which has resulted in very interesting results that will no doubt be of interest to colleagues in the USA too. | Thank you for your comment. |
| Parent Infant Partnership UK | Full | 18 | 3 plus | There are also some therapeutic group interventions that have the capacity to improve parent-infant relationships and thus attachment quality in the early years; e.g. Mellow Babies, Circle of Security (mentioned on p. 28, 6. | Thank you for your comment. The Guideline Committee generated recommendations where the best evidence was available. Because other interventions, such as Theraplay, are being used in the absence of high quality RCT evidence the Guideline Ccommittee identified it as a key area of uncertainty which is why they generated a research recommendation to<br>"Evaluate currently unevaluated but extensively used interventions for attachment difficulties." |

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| Parent Infant Partnership UK | Full | 22 | 34 plus | It could be said that the behaviours that lead to an assessment of very insecure attachment, especially disorganised, are markers for the presence of some form of maltreatment within the family and that these behaviours are survival responses that if left untreated will become 'hardwired' stress reactions; i.e. attachment category / disorder is an indicator not an end point diagnosis. | Thank you for your comment. The Guideline Committee agree with you and have added your point in Section 2.8.2 |
| Parent Infant Partnership UK | Full | 23 | 33 | The disruptive behaviour within the classroom has negative effects others, the collateral damage such children inadvertently cause has a large cost. | Thank you for your comment. The Guideline Committee have added the following to the Linking Evidence to Recommendations section for the education-related recommendations.<br>"The Guideline Committee discussed the difficulty of managing a child with an attachment difficulty who displays disruptive behaviour in the classroom. Their behaviour can interrupt teaching and have negative effects on other students. The Guideline Committee highlighted how important behaviour support and management is in such cases, however the group recognised this is a challenge in the education system." |
| Parent Infant Partnership UK | Full | 24 | 2 plus | No mention of the direct health consequences of insecure attachment. These children, especially disorganised, have a compromised auto immune system (caused by excess secretion of adrenaline and cortisol mainly) that leads to more frequent infectious illnesses. Long term this has been linked to serious physical illnesses, as seen in the ACE Study (which may get a mention later). | Thank you for your comment, the Guideline Committee agree this is an important issue, however it is outside the scope of the guideline. |

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| Parent Infant Partnership UK | Full | 28 | 15 plus | No mention of the use of therapeutic communities for older children. | Thank you for comment. The Guideline Committee agree, as mentioned one paragraph earlier "There is much less evidence for later developmental periods, including middle childhood and adolescence." |
| Parent Infant Partnership UK | Full | 30 | 9 plus | Another long-term, high, cost is the interventions that may be needed when these children become parents in turn as without intervention the pattern of parenting that in implicit may be repeated, including the likelihood of maltreatment. Though it should be stressed that few, if any, parents set out knowingly to cause harm to their child. | Thank you for this comment. The issues you raise are outside of the scope of the guideline. |
| Psychology Associates | Full | General | General | Question 1: The guidelines are unlikely to hold face validity with many working within the field of Attachment, due primarily to the lack of acknowledgement of large swathes of research and practice in this area. In particular the exclusion of neurobiological research and the work of significant authors such as Hughes, Van der Kolk, Porges, Cozolino and Seigel. | Thank you for your comment. We have added the following:<br><br>The Guideline Committee acknowledged that there is a body of work relating to neurobiological research that suggests maturation of the infant's brain is experience dependent, and that these experiences are embedded in the attachment relationship. Thus, if the child experiences early trauma this may have a negative impact on the neurobiological structures that are maturing during the brain growth- spurt and this may lead to disorganised attachment.<br><br>Exploring this area of research was beyond the scope of the guideline. Most of the evidence to date is in animal since it is difficult to carry out in children for ethical |

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| | | | | | reasons and because of the brain scanning equipment needed. Hence, we only included studies that measured attachment using standard measures in children.<br><br>A comment about this was inserted into the guideline in Chapter 9 where interventions for children who have been maltreated were reviewed. |
| Psychology Associates | Full | General | General | Question 2: Whilst acknowledging the limitations of the NICE remit in terms of the research that will be considered, these guidelines would be easier to implement and better respected within the field if there were at least an acknowledgement of the work of the authors mentioned above. Without this, the guidelines appear incomplete and could lack clinical validity. | Thank you for your comment. The Guideline Committee have added a number of these references to the introduction of the guideline. |
| Psychology Associates | Full | General | General | We are concerned that the focus on RCT research excludes some areas of attachment interventions i.e. where it is unethical to implement such large scale studies with significantly traumatised children and young people. Thus the advances in the knowledge and evidence base with corroboration from practice based evidence should be better represented in this specialist service area especially where RCT and other evidence is so limited and potentially skewed. | Thank you for your comment. The aim of the reviews for NICE guidelines is to preferentially include the highest quality evidence where available. When investigating the effectiveness of interventions, randomised controlled trials offer us the best quality evidence. Whilst we agree, there are other study designs, such as observational studies, that may provide additional evidence, we are less confident in the quality of these studies and would only include such studies if RCT evidence is not available. Alternatively, we will refer to the Guideline Committee |

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| | | | | | to make recommendations based on their expertise and experience (including service users). |
| Psychology Associates | Full | 23 | General | Question 1: The guidelines highlight the positive influence a teacher can have on learning, but suggest a lack of experience and training. Our experience is that we offer Attachment based training using the principles of PACE (PLAYFULNESS, ACCEPTANCE, CURIOUSITY & EMPATHY), based on the work of Bomber and Hughes ('Settling Troubled Pupils to Learn, 2013). At Psychology Associates we have found PACE to be an extremely useful tool in improving the relationship between teachers and pupils. Unfortunately to date there is no published empirical evidence supporting our experiences of PACE, however we have much practice based evidence. | Thank you for your comment. The Guideline Committee recognised that there is need for further research and empirical evidence to explore the efficacy of a number of interventions and training approaches for which there is practice based evidence. |
| Psychology Associates | Full | 2.8 | General | Question 1 As mentioned, the large evidence base around Neuropsychology and brain development among children and young people with attachment difficulties has not been considered sufficiently within the guideline. There is some inconsistency here, as although these are not mentioned, several aspects of neurobiological functioning are referred to. For example, in section 2.8.1 on education the introduction focuses on the challenges to learning and references the flight, fight, freeze response, but the neurobiological basis of this is not acknowledged. | Thank you for your comment. We have added the following:<br><br>"The Guideline Committee acknowledged that there is a body of work relating to neurobiological research that suggests maturation of the infant's brain is experience dependent, and that these experiences are embedded in the attachment relationship. Thus, if the child experiences early trauma this may have a negative impact on the neurobiological structures that are maturing during the brain growth spurt and this may lead to disorganised attachment." |

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| | | | | | Exploring this area of research was beyond the scope of the guideline. Most of the evidence to date is with animals since it is difficult to carry out in children for ethical reasons and because of the brain scanning equipment needed. Hence, only studies that measured attachment using standard measures in children were included.<br><br>The Guideline Committee inserted a comment about this in the guideline in Chapter 9 where the interventions for children who have been maltreated were reviewed. |
| Psychology Associates | Full | 1.4 | General | Question 1 Similarly, in section 1.4 it is suggested that giving Oxytocin to mothers may aid attachment. This seems to assume an acknowledgement of the importance of neurobiological functioning, which is in conflict with it being totally excluded from the guideline. It also ignores the other mechanisms by which Oxytocin is naturally released and those therapeutic strategies designed to affect these processes. | Thank you for your comment. After reviewing the evidence the Guideline Committee decided not to recommend oxytocin. Whilst some positive effects were detected, there were a number of limitations, including attachment was not measured in any of the studies. Given the lack of clinical evidence on efficacy, the Guideline Committee judged that pharmacological treatment is not likely to be cost effective in the management of attachment difficulties in children and young people. |
| Psychology Associates | Full | General | General | Question 2: It is likely that taking into account the neurobiological and the practice based evidence of PACE within schools would better support those in practice in their work to | Thank you for your comment. Unfortunately there is insufficient quality evidence for the Guideline Committee to make any recommendations relating to |

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| | | | | improve relationships between pupils their parents and teachers. It would also support our work in helping teachers to develop skills to cope with behaviour related to difficulties in attachment in the school environment. | PACE. However, the Guideline Committee identified this area as a key uncertainty which is why they generated a research recommendation to "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." |
| Psychology Associates | Full | General | General | Question 1: In response to the group work recommendations, we are concerned that "compliance" in group work is misconstrued as active engagement. For clients with shame based schemas this compliance is a survival mechanism that may be activated in group contexts but can so easily be mistranslated as engagement unless very sensitively monitored by a therapist. For the most troubled child we strongly believe group work is not beneficial unless significant family and individual work has preceded it. | Thank you for your comment. Whilst the Guideline Committee acknowledge that group therapy may not be preferable to everyone, the recommendations for group therapy was based on the RCT evidence that suggests children and young people respond well in groups. |
| Psychology Associates | Full | General | General | Question 2: Whilst acknowledging that NICE are not well placed to do this, we would ideally like to see an acknowledgement of the usefulness of rich and detailed qualitative research in this field. This is particularly pertinent in this area where standardised RCT research will present significant ethical challenges. | Thank you for your comment. The Guideline Committee agree that qualitative research is helpful for understanding service user experience and for when standardised RCT research presents ethical challenges. However, there was no question in the scope that required a review of qualitative research. In instances where evidence was lacking Guideline Committee members were relied upon, particularly service users or care leavers, to offer insight. A number of recommendations were made based on their |

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| | | | | | experience and expertise. |
| Psychology Associates | Full | General | General | Question 2: Accepting and acknowledging that individual therapy might need to be offered first as opposed to group work. However, in all cases we as professionals should provide person centred care and make decisions about group vs. individual work based on an individual's presenting difficulties. For example, someone experiencing feelings of shame would not necessarily benefit from group work, whereas someone with mild levels of depression might do. The guideline does not currently adequately acknowledge this level of sensitivity and complexity. | Thank you for your comment. Whilst the Guideline Committee acknowledge that group therapy may not be preferable to everyone, the recommendations for group therapy were based on the RCT evidence that suggests children and young people respond well in groups.<br><br>For example, primary school aged children in care group therapy improved placement stability.<br><br>For children in care who are late primary and secondary school aged, group therapy followed up with individual therapy was recommended as described in a published RCT that showed it also improved placement stability.<br><br>Moreover, there are instances where recommend individual therapy. For example, for primary school aged children who have been abused, individual trauma-focused cognitive behavioural therapy was recommended in line with the NICE PTSD guideline.<br><br>Thus, a range of interventions for children who have attachment difficulties was recommended, depending on their age and the RCT evidence available. |
| Psychology | Full | General | General | Question 1: Those of us who work in the field have long | Thank you for your comment. NICE are in the process |

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| Associates | | | | experience that 'behavioural' and psychoeducational interventions do not work effectively with severely traumatised children and young people who have no trust in other people; feel shame when disciplined; and emotionally dysregulate when challenged. Such presentations typically present with attachment problems, especially disorganised attachment and complex developmental trauma. The guideline does not appear to offer the expertise<br>required by the most troubled children who require the most complex interventions. | of developing a guideline on Child Abuse and Neglect. This is due for publication in 2017. Because of the potential overlap in work, the Guideline Committee focused the review and subsequent recommendations using the evidence specifically relating to child abuse/trauma and attachment difficulties. |
| Psychology Associates | Full | 17 | 2.2:42 | Question 1: Through good practice and clinical experience we acknowledge the need to consider significant neglect as well, as this will provide a rich and more detailed account around a child's history. Therefore, this additional information will influence what the most appropriate treatment will be. | Thank you for your comment. |
| Psychology Associates | Full | 20<br>& 21 | 47<br>48, 1, 2<br>& 3 | Question 1: Through clinical practice we believe that there is a need to acknowledge that developmental<br>behaviours are often related to the child's attachment experience and can be conceptualised as an<br>attachment strategy – e.g. lying to keep safe/avoid proximity in avoidant attachment relationship or<br>aggressive behaviour in an ambivalent relationship to keep the attachment figure close. Not taking this<br>information into consideration will potentially have a huge impact on the treatment among children who are primarily in the care system. | Thank you for your comment. The key issue in the paragraph you refer to is to ensure the people understand that not all behaviours that a child shows are necessarily as a result of attention difficulties. However, the guideline is quite clear in stating the other differences whether stemming from attention problems or not and which need to be addressed in the treatment plan. |

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| Psychology Associates | Full | 22<br>23 | 51<br>& 1 | Question 1: Several interlinked systems – isn't the attachment system relevant to the symptoms specified here? | Thank you for your comment. Yes, the attachment system is relevant to the symptoms specified here. This sentence has been edited to make it clearer. |
| Psychology Associates | Full | 24 | 11<br>-16 | Question 1: Aren't these types of behaviours when in placement representing ambivalent and avoidant attachment strategies? | Thank you for your comment. The Guideline Committee felt there is no evidence to evaluate that question that they know of. These types of behaviours that you are referring to could represent ambivalent and avoidant attachment strategies, but what we know empirically is that they are correlated with early childhood attachment insecurity and/or disorganization. |
| Psychology Associates | Full | 28 | 10<br>& 11 | Question 2: It may be helpful to specify which therapies are designed specifically to address these issues taking a dyadic approach – e.g. Dyadic Developmental Psychotherapy. Whilst a word of caution is needed around evidence base there is a good face validity for this and other models that have been highlighted (below) are not well evidenced within this population | Thank you for your comment. The study referred to in the introduction of the guideline refers to a naturalistic longitudinal study, so no intervention was introduced per se to improve attachment. The evidence-based recommendations provided in the guideline do address insecure attachment in children and young people. So the Guideline Committee do not feel they need to provide the references in the background literature. |
| Psychology Associates | Full | 29 | 18 | Question 1: We need to consider how to adapt these therapies for children with attachment difficulties and consider that the research on their efficacy is primarily based upon children without attachment difficulties. We consider there is an inherent skew in this evidence, given the lack of specific and targeted research with those most troubled by attachment problems. | Thank you for your comment. The Guideline Committee agree and have amended the text to highlight "that these interventions have primarily been assessed in children without attachment difficulties. Thus, future research should focus on how to better adapt these interventions for this population" |

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| Psychology Associates | Full | 105 | 3 | Question 1: *"However, because mental health problems that commonly coexist with attachment difficulties might also be identified during an assessment, the GUIDELINE COMMITTEE made a separate recommendation that problems such as antisocial behaviour and conduct disorder, autism, ADHD, PTSD, social anxiety disorder, depression and alcohol misuse should be treated according to NICE guidelines."* Do we not need to consider making adaptations to these (often individual) therapeutic approaches when children have co-morbid attachment difficulties? It is extremely common for co-morbid presentation to occur. | Thank you for your comment. The Guideline Committee considered that it was not appropriate to state that adaptations to interventions for comorbid mental health problems would be needed as there was no evidence to suggest that this should be the case. |
| Psychology Associates | Full | 238 | No number | Question 2: We are interested in why the researchers did not consider the Parent Development Interview here (this may relate to time taken to interview and score?) or the ASI, VASQ, CECA (Bifulco) | Thank you for your comment. The Parent Development Interview (nor the other tools listed) is not a measure of parental sensitivity so it was not included in the review. |
| Psychology Associates | Full | 282 | 29 | Question 2: Why did you not include the Story Stem Assessment Procedure? (only the McArthur) | Thank you for your comment. We assume you are referring to the Story Stem Assessment Profile (Hodges and Hillman, 2004). The Guideline Committee re-considered this tool and agreed that this is a useful tool for measuring attachment and therefore should be listed in addition to the other story stem tools in recommendation 2.3.4. This change has been made; thank you for drawing this to our attention. |
| Psychology Associates | Full | 389 | 41 | Question 2: Recommendation that parent–child psychotherapy is based on the Cicchetti and Toth model does not allow | Thank you for your comment. In making recommendations, the Guideline Committee noted |

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| | | | | consideration of other models which are designed to address attachment difficulties (e.g. DDP). This would be understandable if there was a moderate grade of evidence on the Cicchetti & Toth model but this does not seem to be the case and we wonder why the review has not discussed other models of attachment focused psychotherapy. This causes some concern that there has been an unnecessary bias towards certain approaches in the absence of a weight of evidence that those approaches are more effective. | that the only evidence available for parent–child psychotherapy was from the studies using the Cicchetti and Toth model. Therefore, the recommendation was based on their study design.<br><br>The Guideline Committee took into account the quality of evidence when making recommendations, and this is reflected in their recommendation to 'consider' using parent-child psychotherapy. In reviewing this recommendation the Guideline Committee considered this point and agreed not to change the recommendation based on this comment. |
| Research in Practice | Short | | 57<br>-61 | The definitions of secure, insecure, organised and disorganized attachment should be included here as on lines 18 – 22 on page 18 and lines 3-12 of page 19 of the full guideline. The guideline must be clear that insecure attachment affects a large minority of the population and is **not** 'often' associated with abuse and neglect. The distinctions between attachment problems and attachment difficulties needs to be made clearer throughout both documents. Further comment on this issue is offered in relation to specific lines below. | Thank you for your comment. Attachment difficulties and insecure and disorganised attachment are defined in the introduction to the short guideline. The Guideline Committee discussed the use of terminology at some length and opted to use the 'attachment difficulties' as an overarching term to include insecure and disorganised attachment as well as attachment disorders. The term 'attachment problem' has not been used.<br><br>The text in the full guideline to which you refer has been amended. |
| Research in Practice | Short | General | | The distinctions between attachment problems and attachment difficulties needs to be made clearer throughout both documents. There needs to be clarity about the different | Thank you for your comment. The Guideline Committee opted to use the term 'attachment difficulties' rather than 'attachment problems' because |

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| | | | | negative outcomes associated with insecure and disorganised attachment, and whether interventions are appropriate for either or both sets of behaviours (insecure and/or disorganised).<br><br>Lines 18-21 of page 20 of the full guideline read as follows: "*Given that 30-35% of representative populations have an insecure attachment, it is arguably unhelpful to view insecure attachment as an 'attachment problem'. Thus in this guidance we have used the term 'attachment problem' to refer to children who have a disorganised attachment or an attachment disorder.*"<br><br>This is a helpful distinction as it allows for clear demarcation between behaviours that indicate neglect or abuse, and those that indicate risk of emotional immaturity and self-control. However, this distinction is not used consistently in the guideline and risks causing confusion. | they deemed it be less stigmatising towards the child. They have made sure the terminology is consistent throughout, where appropriate. The term attachment difficulties is defined as covering insecure attachment patterns, disorganised attachment and attachment disorders, as stated in the introduction. As such the recommended interventions are suitable for all presentations. |
| Research in Practice | Short | | 58 | The use of the phrase *"develop into coercive caregiving*" is unclear here. This may be a reference to parental responses to already insecure attachment responses in children, thus increasing risks to the child, or it may be the long-term results of poor attachment in childhood on parenting later in life. either way, clarity is required. Given the phrase only occurs once in the full guideline, we suggest it should be removed entirely from the summary document. | Thank you for your comment. The Guideline Committee feels it is important to stress how attachment difficulties may develop into coercive caregiving, but the sentence has been amended to clarify that the Guideline Committee is referring to coercive caregiving patterns in preschool children and older. |
| Research in | Short | | 58 | We suggest that it would be helpful to set out the negative | Thank you for your comment, a sentence based on |

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| Practice | | | | outcomes, short of abuse or neglect, that are associated with insecure attachment here, to clarify the different impact compared to disorganised or secure attachment. The statement on lines 33-35 on page 17 of the full guideline could be included: "*Early attachment relations are thought to be crucial for their later social relationships, the acquisition of capacities for emotional and stress regulation, self-control, mentalisation and emotional maturity. Children who have experienced insecure attachments are more likely to struggle in these areas and to experience emotional and behavioural difficulties.*" | your suggested text has been added to the introduction. |
| Research in Practice | Short | | 70 -74 | While the scope may have included children living under Special Guardianship Orders, this group only gets one specific mention in the full guideline, and that is to compare it negatively to adoption in terms of breakdown. Either the lack of consideration of special guardianship should be rectified in the full guideline, or the lack of evidence for this group should be noted and explained. | The Guideline Committee agree and have added reference to special guardians, where relevant, throughout the recommendations. |
| Research in Practice | Short | | General | We suggest that there is some benefit to including a fuller introduction to attachment in the summary guideline. This should cover:<br>• the role of early experiences in shaping later relationships (Page 17, Lines 16-36 of the full guideline)<br>• the relationship between disorganized attachment **only** and neglect or abuse (Lines 22 – 37 of page 20 of the full guideline)<br>• the relationship between care givers and changes in | Thank you for your comment. The purpose of the short guideline introduction is to provide a very brief summary of the scope of the guideline. The Guideline Committee feels that it has covered most of the points you raise in adequate detail but has added a sentence about the role of early experiences shaping later relationships. |

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| | | | | care giver on attachment difficulties (Lines 25 -36 of page 21 of the guideline)<br>• the different manifestations of attachment according to age of the child (Lines 25 – 47 of page 21 of the full guideline)<br>• the difficulties that professionals may face in working with children and young people with attachment difficulties, particularly in adolescence (Lines 7-26 on page 25 of the full guideline).<br><br>This should make it clear that attachment difficulties are not "stable" and can be changed with changes in care giver or the quality of care particularly for younger children. The additional support required for adolescnts who have experienced poor attachment should also be highlighted. | |
| Research in Practice | Short | | 96 -98 | This should include a caveat about involving parents and carers in decision-making where there are safeguarding concerns. | Thank you for your comment. This is standard text within the NICE template. NICE are in the process of replacing the standard text with links to information on the NICE website, including to Department of Health consent information |
| Research in Practice | Short | | 151 -158 | *"children on the edge of care and adopted from care"* should be an option in the type of placement in the main text, alongside fostering and special guardianship, not one of the bullet points. | Thank you for your comment. The Guideline Committee agrees and has moved the bullet point 'children on the edge of care and adopted from care' into the stem of the recommendation. |
| Research in Practice | Short | | 163 | Care planning is a legal duty for children in care, those with a child protection plan or in need under section 17 (as all children | Thank you for your comment. The Guideline Committee agrees that it is important that health and |

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| | | | | on the edge of care should be). This should be noted in the guideline to give the correct legal context. | social care practitioners are aware of their legal duties, but the recommendation to which you are referring is about ensuring stable and consistent care. |
| Research in Practice | Short | | 167 -169 | While commendable, this is a very difficult recommendation for children's social care to implement. It would require significant service redesign and a much more stable workforce than is currently available in many areas. A number of projects funded by the Department for Education Innovation Programme are investigating models that support stable and ongoing relationships between professionals and young people and their families, but these are at a very early stage. The challenges should be acknowledged or we risk the spirit of the recommendation being overlooked. | Thank you for this comment – the Guideline Committee agree this will need to be carefully considered by service managers and commissioners. It is the role of NICE guidelines to set the standard of what should be available nationally, and for the NHS to ensure these services are delivered. |
| Research in Practice | Short | | 247 -251 | This term 'edge of care' needs to be better defined. While commonly used, there is no standard accepted definition of the term "edge of care". It is often used to describe adolescents experiencing family breakdown, homelessness or who are involved in offending, and less commonly in relation to infants and young children in the child protection system. The guideline clearly covers both of these groups and so a clearer definition should be used. | Thank you for your comment. It was necessary for the purposes of this guideline to define the parameters of edge of care. The examples that are given in this definition (maltreatment, parental mental health and parental substance misuse) account for the vast majority of children and young people being considered to be at high risk of going into care. The Guideline Committee has however adjusted the definitions to make it clear that edge of care requires awareness by a social care worker that the child is 'at risk'. |
| Research in Practice | Short | | 332 -334 | This is a crucial recommendation and should be included in the key recommendations at the beginning of this document, at line | Thank you for your comment. The Guideline Committee made a judgement, based on which |

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| | | | | 151 onwards. | recommendations were auditable, that other recommendations were more suitable to be key priorities for implementation. |
| Research in Practice | Short | | 340 -341 | Recommendation 1.1.6 includes willingness to be a long-term foster carer. This is not always possible. Short-term and emergency foster carers play a crucial part in provision of care and the fulfilment of statutory duties, particularly when children are at risk of immediate harm. While the need to find stable and long-term placements quickly is clearly important in support for children with attachment difficulties, it is not within the power of children's social care or fostering services to "ensure" that this is always the case. | Thank you for your comment. The Guideline Committee appreciates your concerns and has reworded this recommendation to say "Ensure that carers are ready to accept the child or young person's need to be in a loving relationship and, *whenever possible,* are able and willing to consider longer-term care or involvement if needed." (1.1.7) |
| Research in Practice | Short | | 379 -389 | The full guideline makes clear that this is based on consensus of the committee, rather than any direct evidence for effect on attachment difficulties, or even proxies like placement disruption. This should be made clear in the guideline. The benefit of well-organised and assessed contact with birth families, former carers and siblings should have a similar emphasis as life story work, in order to support those children for whom the plan is reunification with their birth families (See Biehal, 2006). As, such, social workers should not only consider keeping a list of significant people, but consider how to safely maintain contact, if appropriate. This should be a recommendation on its own, rather than as an addition to interventions (Line 233, 718 and 747) | Thank you for your comment, but it is not the purpose of the short guideline to explain the evidence base of recommendations. Regarding your point about maintaining contact with significant people, the Guideline Committee considers that this point is amply covered in other sections of the guideline (1.5.11 and 1.6.3), and has made a new recommendation about maintaining contact with adoptive parents if such placements break down (1.1.12). |
| Research in | Short | | 500 | The summary guideline should make clear the different levels of | Thank you for your comment. It is NICE policy not to |

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| Practice | | | -513 | evidence of validity and reliability for the different assessment tools recommended here. The full guideline clarifies that MacArthur Story Stem is recommended based on clinical expertise of the committee, rather than extensive evidence. Similarly the lack of evidence for the use of the adult assessment tool with adolescents should be made clear in the short version of the guideline (See the box in section 8.4 on page 283 of the full guideline). | include details about the quality or strength of the evidence in the short version of the guideline. Readers who are interested in these details should refer to the full version of the guideline and the 'linking evidence to recommendations' table which you refer to. Therefore, these details cannot be added to the short guideline, however the Guideline Committee felt that the recommendations reflected the best evidence available to them. |
| Research in Practice | Short | | 597 -600 | Care should be taken when extrapolating from findings of evaluations of the Nurse-Family partnership in the United States. This recommendation should be clear about the level of qualification needed for the Family Nurse Partnership model in the UK. The recommendation should not imply that any home visiting programme will be effective | Thank you for your comment. Home visiting had the highest number of published studies available. Whilst the majority of which were published in the USA, some were also from Australia, Canada and the UK. The details of the recommendation for home visiting was generated from an amalgamation of all the different studies that contributed to this recommendation. The Guideline Committee were also aware of what the home visiting programme entails in the UK and made sure the recommendations complemented that. |
| Research in Practice | Short | | 682 -688 | Recommendations should be clear where the evidence is for reduced placement moves / improved placement stability rather than directly for attachment**,** as in this example. Recommending these interventions for attachment may mean some looked after children whose attachment difficulties are not apparent do not benefit from the intervention. | Thank you for your comment. For the studies used to generate recommendations on interventions, the Guideline Committee only included studies in the review that either measured attachment difficulties, secure attachment or parental sensitivity.<br><br>The only time placement stability was used as a surrogate for attachment was for the review where the |

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| | | | | This recommendation should also be clearer about the extrapolation from evidence for young adolescents to older young people.<br><br>This recommendation only applies to those in long-term stable placements, as noted in comments on the full guideline. This would be difficult and costly to implement, with less long term benefit, for those children, and adolescents who will be reunified with their parents. Work with the birth family along the lines proposed for edge of care could be recommended for this group. As noted in comments on the full guideline, the needs of this substantial proportion of the population of looked after children should be given more prominence throughout. | Guideline Committee looked at what factors influence the positive or negative experience of children in care. |
| Research in Practice | Short | | 711 -715 | These modifications to existing interventions do not sufficiently recognize the changes experienced by adolescents and the different responses that they need to their changing needs, including their changing response to attachment difficulties. The lack of evidence for treating attachment difficulties in adolescents noted in the full guideline, should be made clear in the summary. The challenging behaviour that these young people can express suggests more intensive interventions, such as specialist foster care, and additional counseling may be appropriate. Considerations of contact should be given greater prominence. | Thank you for your comment. The summary is kept brief, so details about lack of evidence is described in the full guideline. The Guideline Committee agreed that data on adolescents with attachment difficulties is an area of uncertainty and more data are needed. Hence the Guideline Committee generated a research recommendation to address this. |
| Research in Practice | Short | | 720 -739 | The nature of the population and workforce in children's residential homes needs to be acknowledged. Young people in | Thank you for your comment. The Guideline Committee acknowledge the difficulties caused by staff |

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| | | | | residential care have very high levels of additional needs, including emotional and behavioural difficulties and often experienced numerous changes of placement before and during their stay in residential care. Their attachment difficulties are entrenched and may require specialist intervention. However, staffing in children's residential care is often erratic, making identifying individuals to act as key attachment figures difficult. Staff do not always receive the high quality CPD and supervision needed to play this role. Children in residential care are often in care for short periods. These factors undermine the efficacy of training for the workforce, and the delivery of child-carer interventions. See for example Berridge et al, 2012) | turnover, however, the guideline needs to ensure that best possible and appropriate care in residential settings, and staff who have an understanding of attachment/difficulties should be more able to provide this. This does NOT mean that more specialist input cannot be provided if indicated but reflects the need for basic skills in those caring for young people in residential care settings. |
| Research in Practice | Full | 20 | 18 -21 | This is a useful distinction to make, however, it is not consistently applied in the evidence review sections, due to the lack of specific measures of disorganised attachment or attachment disorders in available studies. As a result, the recommendations and evidence cover both insecure attachments and more serious attachment problems. There needs to be more clarity about how these terms are used to be helpful in practice in deciding on eligibility for interventions. The cost of treating insecure attachment in all children on the edge of ,or in, care would be substantial. | Thank you for highlighting this point. In response to your comment and another stakeholder's comment, the Guideline Committee have deleted the opening paragraph in section 2.5 to avoid misinterpretation. |
| Research in Practice | Full | 13 | 41 -44 | This guideline definitely does make recommendations for practice for social services, both commissioners and frontline social workers working with children and families on the edge of or in care or who have left care. The majority of | Thank you for your comment, the Guideline Committee agree that a collaborative approach is needed. This is covered in the recommendations on 'Principles of care in all contexts' where collaborative decision making |

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| | | | | recommendations will need the co-operation of schools, local authority children's services and other agencies in order to be implemented. | among all health, education and social care professionals is addressed (recommendations 6-22, 30, 61 in the full guideline, 1.1.1-1.1.20 in the short version). |
| Research in Practice | Full | 110 | 8 -44 | It is unhelpful for the start of the chapter on process and and arrangement features for children in care to only cover research into adoption. Adoption is the permanency outcome for only a very small percentage of the population of looked after children and young people, and their experiences within the care system are the focus of many of the recommendations in the rest of the chapter. Research on the effect of placement moves, reunification with the family and kinship care are all relevant here. 37% of children who leave care as children return home to their families (DfE, 2013). Wade et al 2011 found that these returns are often short, and poorly planned, yet these children and young people will need to form or reform attachments to their parents if they are to return home. Much more focus should be given to these children in the rest of this chapter, and relevant evidence is set out in subsequent comments.<br><br>Further, any evaluation of the benefits of adoption need to be balanced with the findings from Selwyn 2014 on adoption breakdown, and in particular the increased rates of breakdown as children who have been adopted reach adolescence. | Thank you for highlighting this. The Guideline Committee has amended the introduction to address this. |
| Research in Practice | Full | 196 | 38 | This statement shows the risks in using international evidence to understand entry to and experiences in care. Different | Thank you for your comment. Whilst the Guideline Committee agree that data from the UK is preferable, |

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| | | | | experiences based on ethnicity may not apply across different cultures and legal systems for accommodating children at risk. Using culturally specific terms like African-American and Hispanic underlines the possible lack of transferability of these findings to the British care system. | we feel that the difficulties that ethnic minorities experience in access to care or experiences when in care are likely to be similar and thus the findings should translate to the UK. Even if they don't directly, we are being over-inclusive to ensure they receive the care they need. |
| Research in Practice | Full | 196 | 38 | By disregarding evidence for reunification with parents, or other permanence options, the guideline fails to consider the needs of a large proportion of the looked after population who will return home or find permanence with kinship carers or through Special Guardianship Orders. Not considering this evidence leads to a lack of recommendations on contact with birth families, interventions with birth families to prepare for a return home, or managing the particular needs of kinship carers to maintain stable placements and safe contact with the wider kinship network (see for example Farmer and Lutman, 2010; Wade et al, 2011; Davis and Ward, 2012; Farmer 2010). | Thank you for your comment. The Guideline Committee acknowledge there is a body of evidence that would inform us on the factors associated with an increased or decreased likelihood of the child being reunited with their biological parents. However, it was felt to be too difficult to make recommendations on this when it may not be the optimal outcome for the child, if for instance they were abused or neglected. The Guideline Committee had to accept that this is a limitation with our review and recommendations. |
| Research in Practice | Full | 239 | 12 -16 | This uses the phrase "attachment difficulties" to be both insecure and disorganized attachment, contrary to the definitions given at the beginning of the document. The use of "coercive controlling or compulsive caregiving is unclear, and not fully explained, This is its only use in the full guideline. | Thank you for your comment. The definition 'attachment difficulties" given at the beginning of the document has been changed to refer to both secure and disorganised attachment which is consistent with the definition given in the NICE guideline. Therefore the use of the phrase here is now consistent with the rest of the document. We have added a sentence to explain the use of the term "coercive controlling caregiving" and provided references to make this clearer. |

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| Research in Practice | Full | 239 | 20 -22 | Again this confuses the close relationship between disorganised attachment and neglect and abuse with broader insecure attachment. This must be absolutely clear throughout the document. | Thank you for your comment. The Guideline Committee has amended this sentence to refer to the relationship between 'disorganised attachment' and deleted have deleted 'insecure attachment' to make this explicit. |
| Research in Practice | Full | 425 | In box, no line number | We acknowledge the importance of placement stability in supporting children and young people to form attachments and stable relationships with their carers. It is tempting therefore to use it as a proxy outcome for attachment. However, it should also be acknowledged that placement moves are sometimes necessary to respond to the wishes and feelings of the child, or to remedy problems posed by the current placement (Sinclair, 2005; Sinclair et al 2005; Schofield et al, 2012; Neil 2012). | Thank you for your comment. We agree with you and have commented on this in the Linking Evidence to Recommendations that relate to minimising placement disruption. |
| Royal College of General Practitioners | Full | General | General | It is not clear which member of the multi-professional guideline development group is a current practising GP and there are no recommendations or references to primary care or general practice in the document. | Thank you for your comment. The Guideline Committee is indeed a multi-disciplinary group. However, a GP was not recruited to be on the committee.<br>The Guideline Committee felt that 'healthcare professionals' was broad enough a term to encompass both primary and secondary care healthcare professionals.<br><br>The recommendations apply in all settings unless stated otherwise.<br>The Guideline Committee are not concerned with |

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| | | | | | professional roles per se, but with interventions and care being delivered by healthcare professionals with the relevant competencies and experience. |
| Royal College of Nursing | General | General | General | The Royal College of Nursing welcomes proposals to develop this this guideline. This consultation was circulated to RCN members who are involved in the care of looked after children for their views. The comments below are the views of the respondents. | Thank you for your comments. |
| Royal College of Nursing | Full | General | Section 2.8 educati on | Our members expressed concern that the guideline does not seem to mention the problem around children who internalise their issues and so in the classroom might appear as the good child, keep quiet and not engage. Often these children have attachment issues but as they are not showing aggressive behaviour they could be missed. They could also have learned to cope with issues at home by taking themselves off somewhere internally. | Thank you for your comment. The Guideline Committee have added the following to section 2.8 on education:<br>"Other children may be quiet and not engage because they are internalising their issues, and because they appear okay they could be overlooked." |
| Royal College of Nursing | Full | General | General | In general it is thought that the guideline is well written, easy to read and interesting. | Thank you for your comment. |
| Royal College of Paediatrics and Child Health | Full | General | General | This is an incredibly comprehensive guideline—a vast review of the subject of attachment.<br><br>There remains a problem in separating attachment as described by Ainsworth, secure, disorganised etc. and attachment disorders as defined by DSM and ICD and the guideline switches between the two. From the NHS services viewpoint, which should resource be spent on? | Thank you for your comment.<br>In the guideline the Guideline Committee have defined 'attachment difficulties' as an insecure or disorganised attachment pattern or a diagnosed attachment disorder. The latter may be an inhibited/reactive attachment disorder or a disinhibited attachment disorder, now termed 'disinhibited social engagement disorder' in the *Diagnostic and Statistical Manual of* |

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| | | | | We welcome the emphasis—which could be greater—on diagnosing and treating coexisting mental health problems in attachment disorders. | *Mental Disorders*, fifth edition (DSM-5) (American Psychiatric Association, 2013).<br><br>The Guideline Committee have referred to specific categories of attachment difficulties when the literature allows (or dictates) us to do so.<br><br>The Guideline Committee did not feel one category of attachment difficulty should be given priority for funding. They only agreed that attachment disorganisation and attachment disorder may best reflect the long-term prospects of the child and results on these outcomes were particularly important for decision making.<br><br>To help with funding, NICE provides costing and implementation tools for services to prepare for guideline implementation that are separate from the guideline. |
| Royal College of Psychiatrists | Full | General | General | In the present format the document is very long (nearly 500 pages). There is a well written introduction however the rest of the document is a bit too raw. The algorithm-driven approach to selecting the research evidence, grading the quality and presenting the effect sizes means the narrative is often hard or impossible to find. | Thank you for your comment. It is unavoidable that the full guideline is a long document as it details all the evidence reviewed to make the recommendations. All NICE full guidelines follow the same processes and are presented this way. NICE will also publish a short version of the guideline as well as a document for the public and service users. |
| Royal | Full | General | General | It may have been better to have concentrated on 'attachment | Thank you for your comment. The Guideline |

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| College of Psychiatrists | | | | disorders' and possibly 'disorganised attachment' which are of much greater interest in terms of interventions/ outcomes for children/ value for money than insecure attachment, which is really a research concept with little or no clinical application. | Committee agree with this, and this was what motivated the focus on attachment problems as including disorganized attachment and attachment disorders. They have added to the Linking Evidence to Recommendations section of each (relevant) chapter that: The Guideline Committee agreed that in terms of decision making disorganised attachment and attachment disorder are the most important outcomes since they best reflect the poor long-term outcome of the child. |
| Royal College of Psychiatrists | Full | General | General | The approach to measures straddles research and practice. | Thank you for your comment. The Guideline Committee agree, and acknowledged the limitation of certain assessment tools in the section "linking evidence to recommendations".<br><br>For example in Chapter 8, on assessing attachment difficulties, the following has been included: "Based on this evidence, the Guideline Committee agreed that both the SSP and the AQS were good tools to identify attachment difficulties infants and children for the recommended age ranges. However, based on their clinical experience, the Guideline Committee noted that these tools can be time consuming to administer (up to 3 hours for the AQS). Therefore, in order to avoid putting burden on services and to ensure the access threshold was not too high, the Guideline Committee stressed that tools should only be |

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| | | | | | considered where there was concern about attachment difficulties, and where there was reason to believe the infant might benefit from an attachment focused intervention." |
| Royal College of Psychiatrists | Full | General | General | Most of the findings are as we would expect. What stands out as new is the emergence of video interaction techniques as effective and good value for time and money with a wide range of clinically relevant populations. | Thank you for your comment. |
| Royal College of Surgeons | General | General | General | No comments. | |
| Surrey & Borders Partnership NHSFT | Short | 3 | General | It is helpful to include a clarification of how attachment difficulties are seen within DS5 and ICD-10. The initial comments under the heading ' Strength of recommendations, is helpful and recognises the difficulty in providing sufficient evidence based research but this also gives the document the potential for a wider consideration of interventions than reflected by the draft However it is disappointing that there is no consideration of Developmental trauma: Van de Kolk, ( 2005), Perry (2006).. Eg role of sensory motor psychotherapy, sensory integration, theraplay. Dyadic psychotherapy. | Thank you for your comment. Please refer to the introductory chapter (section 2.3) for an explanation of attachment disorders. |
| Surrey & Borders Partnership NHSFT | Short | 14 | 321 -389 | These principles are helpful. In particular 1.1.3 careful case management is critical when there is always a danger of the [professional network reflecting the fragmentation | Thank you for your comment. Regarding 1.1.5, the Guideline Committee recognises that managing reactive situations it important, but it is beyond the scope of this guideline. |

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| | | | | in the family.<br>1.1.5 There is no question about the importance that admission in to care should be planned , however it would be helpful to have some suggestions about how removal into care should be managed when it is reactive as this isn usually the case.<br>1.1.14. Preserving the personal history of a child or young person is critical in helping them to develop a coherent narrative. This needs to include ongoing updates facilitated by foster carers. | Regarding your point about recommendation 1.1.14, the Guideline Committee agrees and has changed the recommendation to say that personal histories should be kept up to date. |
| Surrey & Borders Partnership NHSFT | Short | 423 | | 1.2.3: Schools need to prioritise training for staff working with these children and young people. There is no reference to the work by Louise Bombier, Heather Geddes or in the 'Calmer Classrooms.'<br>Bomber, L. Inside I'm Hurting ( 2007)<br>Education.qld.gov.au/schools/healthy/pdfs/**calmer-classrooms**-guide.pdf | Thank you for your comment. Though the Guideline Committee have recommended training, we have not recommended any specific trainer's work but believe the outline provided gives room for approaches such as those of Louise Bomber |
| Surrey & Borders Partnership NHSFT | Short | 469<br>-491 | | 1.3.2 The components for a comprehensive assessment given in the document are limited and omit any assessment for level of dysregulation or sensory processing. | Thank you for your comment. The recommendation on comprehensive assessment outlines the broad areas that need to be covered by any assessment, therefore the Guideline Committee did not consider it appropriate to add sensory processing to the list of factors; it has, however, added emotional dysregulation to the list of coexisting mental health problems and neurodevelopmental conditions that should be assessed. |

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| Surrey & Borders Partnership NHSFT | Short | 492 | | 1.3.3. Recognition of co morbid mental health or neuro developmental difficulties. However sometimes these symptoms have considerable overlap with attachment difficulties and therefore the need to hold these possible diagnoses in mind needs to be highlighted | Thank you for your comment, however the Guideline Committee did not consider that the recommendation needed to change because the challenges you highlight would already have been considered as part of the comprehensive assessment in recommendation 1.3.2. |
| Surrey & Borders Partnership NHSFT | Short | 540 -747 | | • Trauma CBT is often not accessible for these children and young people due to their executive functioning.<br>• There is an absence of the role or a specialist occupational therapist specialising in sensory integration.<br>• No recognition in the entire re document of working with a neuro sequential model which recognises the importance of brain development in the light of developmental trauma. This has fundamental implications about what treatment can be accessed by many children and young people with attachment difficulties.<br><br>Koomar, J. (2009). 'Trauma- and attachment-informed sensory integration assessment and intervention.' in: *The American Occupational Therapy Association.* Vol. 32. No.4.<br>Ogden, P., Minton, K. & Pain, C. (2006). *Trauma and the Body: A Sensorimotor approach to psychotherapy.* W.W. Norton.<br>Perry, B.D. & Hambrick, E.P. (2008). "The Neuro sequential | Thank you for your comment. Regarding children with trauma the Guideline Committee reviewed the evidence for trauma focused interventions that also addressed their attachment difficulties. There was very little evidence on this, however the Guideline Committee did make recommendations using the evidence available and referred to the NICE PTSD guideline. NICE are currently in the process of developing a guideline on children who have been maltreated.<br><br>The cited studies were not included as they did not meet the inclusion criteria for any of the reviews. |

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| | | | | Model of Therapeutics" in: *Reclaiming Children and Youth*. Vol. 17, No. 3. | |
| Tavistock Centre for Couple Relationships | Full | General | | We think that the guidance should draw on a wider number of research studies which demonstrate the links between marital discord and insecure attachment (see following point). | Thank you for your comment. Whilst the Guideline Committee agree that additional information could be obtained from qualitative papers, a review of this nature was beyond the scope of this guideline. Instead, high quality prospective studies that had adjusted for potential confounders were included.<br><br>The Guideline Committee acknowledged that although the evidence on marital discord was limited, they wanted to include conflict between parents (including domestic violence and abuse) as a factor to be taken into account when doing an assessment of whether children have (or likely to have) attachment difficulties. |
| Tavistock Centre for Couple Relationships | Full | 96 | 18 | We would like to draw the GDG's attention to the following papers:<br><br>Goldberg, W. (1984). Role of Marital Quality in Toddler Development. *Developmental Psychology*. 20 (3), 504-514 – in which researchers looked at seventy-five families with one 20-month old child to investigate the significance of the husband-wife relationship for early child development. They concluded that secure child-mother and child-father attachments were most likely to occur in families in which husbands and wives were highly satisfied with their marriages, whereas insecure | Thank you for your comment and for drawing the Guideline Committee attention to these papers. However, the two studies do not meet the inclusion criteria for the guideline review. Marital discord is defined by studies which use observed measures of marital conflict. Both the studies you cite use self-reported questionnaires and therefore do not meet the inclusion criteria. The meta-analysis by Van Ijzendoorn (1999) on the association between marital discord and attachment difficulties also used this inclusion criteria and not include these studies. |

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| | | | | child-parent attachments were most likely to occur when marital adjustment was poor.<br><br>Das Eiden, R., Teti, D. M., & Corns, K. M. (1995). Maternal Working Models of Attachment, Marital Adjustment, and the Parent-Child Relationship. *Child Development*. 66, 1504-1518 – in which researchers found that among the children of insecure mothers, those whose mothers reported high marital adjustment were significantly more secure than those whose mothers reported low marital adjustment, while no such association was evident among children of secure mothers. | |
| Tavistock Centre for Couple Relationships | Full | 96 | 18 | We feel that an important section has been omitted from the summary presented of the van Ijzendoorn . The study *did* find a statistically significant association on the studies using the Main and Solomon coding systems (see excerpt below), and yet this finding is not included in the guidance. The current guidance gives the impression that there is no question regarding whether or not there is a statistically significant association between marital discord and disorganised attachment; when the study actually presents a nuanced position. We believe that the guidance should include this omitted section in order to give a more accurate picture of the evidence.<br><br>*"*Owen and Cox (1997) suggested that children witnessing marital discord may experience disorganizing fright from their attachment figure, and they proposed marital discord as one of the alternative pathways to disorganization of attachment. In | Thank you for your comment. The Guideline Committee agree that the Van Ijzenroorn meta-analysis presents a more nuanced position regarding the association between marital discord and attachment problems than we have in our reporting of the results from the meta-analysis. The Guideline Committee have therefore included this detail in clinical evidence descriptions. The clinical evidence summary states that the evidence from this review was inconclusive as to whether marital discord is associated with disorganised attachment which they feel reflects this literature. |

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| | | | | their study on 38 mothers and 33 fathers, Owen and Cox (1997) found impressive effect sizes (*r* =.40 and *r* ?.45, respectively), but in by Radke–Yarrow, Cummings, Kuczynski, and Chapman (1985), Shaw, Owens, Vondra, Keenan, and Winslow (1996), and Moss, Rousseau, Parent, St-Laurent, and Saintonge (1998) this outcome was not replicated at *r* =?.04, *n* =?95; *r* =?.07, *n* =?77; and *r* =.19, *n* =?121, respectively. In the four studies on *n* =?364 participants, the combined effect size was *r* =?.05 (n.s.). In the studies using the Main and Solomon (1990) coding system (Owen & Cox, 1997; Shaw et al., 1996), the combined effect size was *r* =?.25 (*p* =?.007)." (van Ijzendoorn, 1999). | |
| Tavistock Centre for Couple Relationships | Full | 104 | | In light of the fact that the guidance notes that "There was some evidence that marital discord showed an association with insecure attachment' and 'that it was an important factor to consider as part of a comprehensive assessment for children or young people who may have attachment difficulties', we suggest that the list of recommendations on page 104 include:<br>• sensitising practitioners to the significance of the relationship between parents (not just each parent's relationship with their child), as a significant part of the child's emotional environment, for a child's attachment security | Thank you for your comment. Whilst the Guideline Committee decided to include marital discord in the list of factors to be covered in a comprehensive assessment they did not think that there was enough evidence to warrant including it in the recommendation on training practitioners. |
| The Potato group | Full | 14 | 12 -15 | Parenting children with attachment disorders is extremely tough and we would like to see it made explicit that CAMHS and other professionals must support and work with adopters for the best outcome for child and family. "Child attachment related | Thank you for your comment. The Guideline Committee agree CAMHs and other health care professional should support and work with adopters. |

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| | | | | difficulties, parental mental health and levels of mindfulness were significant predictors of adoptive parenting stress." Guerney-Smith, Ben et al 2011 | However, since NICE prefer not to state exactly who is responsible for each recommendation, the following are most relevant for CAMHS:<br><br>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:<br>• has specialist expertise in attachment difficulties in children and young people and their parents or carers<br>• works with other services, including mental health services for children and young people, education and social care<br>• actively involves children and young people with attachment difficulties in staff training programmes (recommendation 5).<br><br>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:<br>• can access mental health services for children and young people and education psychology services for interventions<br>• are supported at school while they are taking part in interventions following advice from |

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| | | | | | mental health services for children and young people and education psychology services (recommendation 25). |
| The Potato group | Full | 19 | 11 &12 | We appreciate the guideline highlighting that up to 80% of children and young people (C&YP) with disorganised attachment have been maltreated. We would appreciate you making it clear that the vast majority of adopted C &YP adopted from care have been maltreated. | Thank you for your comment. The figures state that up to 80% of maltreated children have disorganised attachment (or attachment disorder) not the other way around. The Guideline Committee has confirmed this**.** This statistic has now been referenced. |
| The Potato group | Full | 19 | 13 &14 | 'Risk for later problems' What problems ? For traumatised adopted teens the problems are significant. Those problems can and do result in C & YP re - entering the care system under S20/ permanent exclusion /placement in residential care settings & residential Emotional, Social and Mental Health schools/ in patient tier 4 CAMHS and returning to unsafe birth homes. | Thank you for your comment, The Guideline Committee have made changes to the full guideline to better explain what problems we are referring to, in Section 2.8 |
| The Potato group | Full | 20 | 46 | This applies equally to adopted C&YP. Please add in '.....care system & adopted from care' | Thank you for your comment, this change has been made. |
| The Potato group | Full | 20 | 49 (3) | This also applies to adopted C & YP . Please addi in adopted from care. | Thank you for your comment, this change has been made. |
| The Potato group | Full | 21 | 2 & 3 | Attachment disorder diagnosis gives families no access to support through care pathways and often misses the complex picture that underpins poor attachment. "Although more common diagnosis, such as ADHD, Conduct Disorder, PTSD or adjustment disorder. may be less exciting, they should be considered as the first line diagnosis before contemplating any more rare condition such as RAD or an unspecified attachment | Thank you for your comment. Whilst the Guideline Committee agree that reactive attachment disorder is a rare condition, they have not reviewed any evidence that would allow them to make a recommendation of whether RAD should be considered before or after any other common diagnosis. |

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| | | | | disorder" Chaffin et al, 2006 | |
| The Potato group | Full | 22 | 23 -30 | While we agree with this – we would appreciate the link being clearly expressed re previously maltreated (by birth families) adopted adolescents | Thank you for your comment. The paragraph you refer to establishes the link between RAD and DSED with a range of mental health problems. |
| The Potato group | Full | 22 | 48 -51 | Agree | Thank you for your comment. |
| The Potato group | Full | 22 | 51 | Please distinguish between birth parents and adoptive parents - 'disturbed parenting' we hope refers to the maltreating birth parents. | Thank you for your comment. This comment applies to any carer, we kept it non-specific to capture this. |
| The Potato group | Full | 22 | 51 (4,5,6) | We agree – please be clear that the affect on neurological configuration can and does continue into adolescence - for adopted, looked after and C 7YP on the edge of care. | Thank you for your comment, the Guideline Committee has now made this clear. |
| The Potato group | Full | 23 | 12 -15 | Even with adoptive parents or foster carers "remaining sensitive to childs needs" many children still go on to have troubles. | Thank you for your comment, this has now been made clear. |
| The Potato group | Full | 23 | 21 -32 | It is our understanding that the DfE is trying to obtain data for adopted children and that the data is showing that adopted C & YP experience very similar difficulties in education as Looked After Children. | Thank you for your comment; further data in this area would be useful. |
| The Potato group | Full | 23 | 44 -46 | Equally true of adopted C & YP – especially previously maltreated adopted teenagers. | Thank you for your comment. |
| The Potato group | Full | 24 | 27 | Please add in adopted children - they too will react in the same way to their adoptive placements. | Thank you for your comment, but this section is specifically about children in care. |
| The Potato group | Full | 25 | 46 -50 | Please state what evidence has been used to say contact is beneficial, to whom and in which circumstances? is this supposition or measured? | Thank you for your comment. The Guideline Committee have now provided a reference to evidence the statement that contact is beneficial (Sinclair, 2005- Fostering now: Messages from research) and have |

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| | | | | | provided a reference to evidence whom contact may be beneficial for and in which circumstances (Selwyn, 2004- Placing older children in new families: changing patterns of contact). |
| The Potato group | Full | 26 | 36 -40 | Agree BUT disappointed that text does not clearly link lack of literature and consensus on practice | Thank you for your comment. The Guideline Committee are glad that you agree but please note this is an introduction to the subject area and the evidence can be found in chapters 4 - 6. |
| The Potato group | Full | 28 | 13 & 14 | This is very true of adoptive parenting of traumatised adopted adolescents - could you specify please | Thank you for your comment, however the Guideline Committee did not consider this needed to be specified as the paragraph is about all children with attachment difficulties regardless of their placement. |
| The Potato group | Full | 28 | 23 -25 | Please add in especially when transitioning from late childhood to adolescence | Thank you for your comment. This phrase has been added. |
| The Potato group | Full | 29 | 1 -9 | Agree - | Thank you for your comment. |
| The Potato group | Full | 29 | 7 -9 | Dyadic work is overwhelmingly helpful in adoptive parenting. Parent and child treatment is essential in adoption. | Thank you for your comment. The evidence towards Dyadic work is insufficient to recommend although the Guideline Committee appreciate how Dyadic work may be of value for adoptive parents. |
| The Potato group | Full | 29 | 13 | `...tried with this population`. We feel very strongly that traumatised adopted teens do not have time for treatments to be `tried`. If `tried` and no positive outcome - what then ? | Thank you for your comment. The Guideline Committee have changed this to "offered". |
| The Potato group | Full | 29 | 28 -31 | We are very concerned by the concept of ` judiciously` using time outs. Our members are concerned that foster carers/adopters may not use time out with the required amount | Thank you for comment. The Guideline Committee felt that many Foster carers may not have had their children long but may find it |

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| | | | | of care to avoid the feeling of rejection on the part of the child - we would be interested to know where the evidence is that time outs are effective in children with attachment difficulties. Our shared experience is that time in's are much more effective with this population. | useful to use time out, as long as it is in the context of a loving relationship. There is no reason to suggest that they find it traumatising or triggering attachment/abandonment issues. A number of studies have shown respite from fostering, which provides temporary relief for<br>foster parents to rejuvenate from the stress of fostering and has been identified by foster parents as an important form of support (Hudson and Levasseur, 2002;<br>Rhodes et al., 2001, Redding 2000, Mac Greggor 2006). Conversely, lack of respite care has been related to foster parents quitting (Triseliotis et al., 1998).<br><br>These references have been added to section 2.11. |
| The Potato group | Full | 110 | 15<br>16 &17 | No, "the earlier and more prolonged the trauma, the more severe and lasting effect." pub. Journal Molecular Psychiatry 2011, Anja Kriegeskotten, She goes onto suggest the earlier the intervention the better due to greater plasticity of brains. | Thank you for your comment. The Guideline Committee feel the introduction to this chapter captures your point. |
| The Potato group | Full | 288 | 1st para | Re Section 20 – please remove `birth ` parent. Adopted children are on the edge of care and 3 -9% of adopted C & YP will re enter care for the second time under section 20. Their adoptive parents will voluntarily agree to their child going into care - PLEASE CHANGE TO PARENT. | Thank you for your comment, this has been changed to 'parent'. |
| The Potato group | Full | General | General | We represent the views of over 300 adoptive parents of traumatised (previously maltreated ) adopted adolescents. We | Thank you for your comment. Please see NICE recommendations in section 1.4 where the possibility |

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| | | | | feel that the guideline does not make it clear that previously maltreated C & YP are by the very nature of their attachment difficulties ( mostly disorganised) on the edge of care. Where those young people re enter the care system they are entering the care system for the second time – albeit with a different name and not due to present maltreatment but due to the long term effects of previous maltreatment within their birth families /foster care. It is of concern that the large bulk of the evidence presented refers to children not taken through the UK looked after system and having judicially lead adoption. We would argue that this system is different to that of other countries especially when considering the epigenetics of birth families in the UK that have their children removed and adopted. | of entering and re-entering the care system has been added. This section also includes how to help children and young people who have been maltreated or who are at high risk of maltreatment (see recommendations 1.4.9, 1.4.10 and 1.4.12).<br><br>The Guideline Committee agree there are concerns regarding the evidence which is international when translating this into a specific nation (UK context). However, if we restricted the evidence used to that generated in the UK we'd have very little to say. The Guideline Committee have therefore opted to interpret the international evidence for the UK context. |
| The Potato group | Short | 16 | 365 -366 | If adopted C & YP re enter care under Section 20 - the adoptive parent retains parental responsibility . Therefore it is vital that adoptive parents are able to maintain contact with their adopted child or young person - not just until the Young Person want it. | Thank you for your comment, however the Guideline Committee does not think that Section 20 is relevant to this passage in the Guideline. Birth parents also retain parental responsibility when children are accommodated under Section 20. In fact, birth parents and adoptive parents retain parental responsibility if a child is committed to care under a care order or emergency protection order, although in these circumstances parental responsibility is shared with the local authority, which can override their wishes if this is in the interests of the child.<br><br>The Guideline Committee does however recognise that the wording of this recommendation might be |

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| | | | | | misleading and has revised it (1.1.11). |
| The Potato group | Short | 18 | 424 | Please remove `care system` This applies equally to adopted children. | Thank you for your comment, this has been removed. |
| The Potato group | Short | 19 | 461 | Please add in – knowledge of effect of previous maltreatment in adopted children | Thank you for your comment, however the Guideline Committee judges that trauma and maltreatment are adequately covered in recommendation 1.3.1 in the third bullet point. |
| The Potato group | Short | 26 | 633 | Please add - in brackets – after `been maltreated` - (including adopted children on the edge of care ) or similar. | Thank you for your comment. The definition for 'edge of care' includes adopted children on the edge of care therefore the Guideline Committee does not think this is necessary. |
| The Potato group | Short | 29 | 744 | Please add - retaining relationships with adoptive families | Thank you for your comment. The Guideline Committee has created a new recommendation about retaining relationships with adoptive families (see 1.1.11). |
| The Potato group | Short | 29 | 747 | Please add – Discuss making contact with birth parents with C & YP together with their adoptive parents. Adoptive parents retain legal parental responsibility of C & YP when they are in residential care under a Section 20. | Thank you for your comment, however the recommendation is about the therapeutic relationship rather than the legal requirements to consult adults with parental responsibility. If children and young people are not adopted and are placed in residential care under section 20 or indeed under a care order, birth parents retain parental responsibility. |
| The Potato group | Short | General | General | Adoptive parents would appreciate clarity in the short guideline that adopted, previously maltreated C & YP who have disorganised attachment are on the edge of care and can be looked after. | Thank you for your comment, the Guideline Committee think that that is reasonably clear, but have made some adjustments to the introductions to sections 1.4 and 1.5 to define the groups covered. |

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| The Potato group | Full | General | General | Adoptive parents would like to see the role of the Virtual School extended to cover adopted C & YP within education. | Thank you for your comment. The needs of all children and young people and their parents and carers who are on the edge of care, looked after, who are under special guardianship, adopted from care or in residential care (see recommendation 1.1.2). Nevertheless, the Guideline Committee are unable to change current legislation which gives Virtual Heads a statutory role for looked after children and young people but not adopted children. The Guideline Committee hope this guideline will encourage Virtual Heads to pay due attention to the needs of adopted children. |
| University of Glasgow | Full | General | | Excellent overview of the field – very grateful for this massive effort, thanks. The document combines erudition with pragmatism and highlights clearly the gaps in the evidence base that need to be filled. | Thank you for your comment. |
| University of Glasgow | Full | 20 | 40 | Agree that the prevalence in the population is not well established but two prevalence studies should be included:<br>• The prevalence of mental health problems in children 1½ years of age – the Copenhagen Child Cohort 2000 Anne Mette Skovgaard et al DOI: 10.1111/j.1469-7610.2006.01659.x<br>• Minnis H, Macmillan S, Pritchett R, Young D, Wallace B, Butcher J, Sim F, Baynham K, Davidson C, Gillberg C (2013). Prevalence of reactive attachment disorder in a deprived population. The British Journal of Psychiatry, | Thank you for your comment and the references, these have been included in the document. |

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| | | | | 202, 342-346. DOI: 10.1192/bjp.hp.112.114074. | |
| University of Glasgow | Full | 24 | 13 -16 | Particularly grateful to you for making this important point. | Thank you for your comment. |
| University of Glasgow | Full | 27 | 20 -35 | You may wish to cite our paper on heritability of RAD and DSED behaviours here.<br>• Minnis H, Reekie J, Young D, O'Connor T (2007). Genetic, environmental and gender influences on attachment disorder behaviour. British Journal of Psychiatry, 190, 490-495. | Thank you, the Guideline Committee have acknowledged your findings about the genetic link to RAD in the introduction. |
| University of Glasgow | Full | 53 -67 | Table 8 | It seemed odd to me that you included our behavioural genetics paper (cited in the row above) here as the Relationship Problems Questionnaire is a measure of RAD and DSED behaviour, not of attachment, so does not really fit with papers using attachment measures such as the Strange Situation Procedure | Thank you for your comment. The review protocol allowed us to include any paper that looked at the association between gene expression and attachment difficulties, including RAD. Your paper (Minnis 2007) is the only study that looked at the association between gene expression and RAD. We agree that the Relationships Problems Questionnaire doesn't necessarily fit in with papers that used attachment measures such as the SSP. The Relationships Problems Questionnaire clearly needs to be further validated, but the Guideline Committee thought it was worth including since it was based on the ICD-10 and DSM-V criteria for RAD. |
| University of Glasgow | Full | 269 | 8 | The correct name is the Relationship Problems Questionnaire (not Reported Difficulties Questionnaire) | Thank you for your comment, this has been corrected. |
| University of | Full | 401 | Table | This study did not measure any psychiatric disorder (certainly not | Thank you for your comment. The Guideline |

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| Glasgow | | | 250, 2nd column, row 5 | "Disorganised disorder") but instead measured symptoms of mental health problems and RAD/DSED | Committee has corrected this. |
| University of Glasgow | Full | 420 | 42 and 45 | In both these lines, there seems to be a typo – should say "decreases" not "increases" | Thank you for your comment. The results as they are reported are correct. Please refer to Minnis 2001. |
| University of Glasgow | Full | 424 | Third para of second box | The statement "the definition does not extend beyond the age of 5…" is incorrect. Symptoms have to be present before the age of 5. | Thank you for your comment. The Guideline Committee have the correct definition of attachment disorders in the introduction and have excluded it from the Linking Evidence to Recommendations to avoid any confusion. |
| University of Glasgow | Full | 430 | 5th para in box | I am absolutely delighted to see school issues being highlighted. | Thank you for your comment. |
| University of Glasgow | Full | 431 | Second section of box, first line | There is a tiny bit of economic information that came from our 2001 Foster Carers Training Project RCT.<br><br>Minnis H, Pelosi AJ, Knapp M, Dunn, J. (2001) Mental Health and Foster Carer Training. Archives of Disease in Childhood, 84, 302-306.<br><br>Minnis H, Everett K, Pelosi A, Dunn J, Knapp M (2006). Children in foster care: Mental health, service use and costs. European Child and Adolescent Psychiatry, 15(2), 63-70. | Thank you for your comment. The study Minnis 2001 is included in the guideline. However, Minnis 2006 did not provide the exact number of children with attachment problems so the health economist could not use the results. |

**Registered stakeholders:** http://www.nice.org.uk/guidance/indevelopment/gid-cgwave0675/documents

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