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Quality standards and indicators

Briefing paper

Quality standard topic: Children's attachment

Output: Prioritised quality improvement areas for development.

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for children's attachment. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. NICE guideline NG26 (2015).

2 Overview

2.1 Focus of quality standard

This quality standard will cover identification, assessment and treatment of attachment difficulties in children and young people up to age 18 who are adopted from care, in special guardianship, looked after by local authorities in foster homes (including kinship foster care), residential units and other accommodation, or on the edge of care .

A glossary of terms can be found in appendix 3.

2.2 Definition

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

Children whose caregivers respond sensitively to the child's needs at times of distress and fear in infancy and early childhood develop secure attachments to their primary caregivers. They have better outcomes than non-securely attached children in social and emotional development, educational achievement and mental health. Early attachment relations are thought to be crucial for later social relationships and for the development of capacities for emotional and stress regulation, self-control and mentalisation. Children and young people who have experienced insecure attachments are more likely to struggle in these areas and to experience emotional and behavioural difficulties.

Attachment difficulties include insecure attachment patterns and disorganised attachments, which can often evolve into coercive controlling or compulsive caregiving patterns in children of preschool age or older.

The term 'attachment difficulties' also covers attachment disorders in the Diagnostic and statistical manual of mental disorders, 5th edition (DSM-5; reactive attachment disorder and disinhibited social engagement disorder) and the International classification of diseases and related health problems, 10th revision (ICD-10; reactive attachment disorder and disinhibited attachment disorder).

Four attachment behavioural patterns have been defined in young children:

- Secure
- Insecure avoidant
- Insecure resistant (also called ambivalent)
- Disorganised.

These patterns are relatively stable over time in the absence of changes to caregiving. This stability is underpinned by continuities in a child’s ‘internal working models of attachment’ that develop as a result of early interactions between the parent and child. The insecure avoidant and resistant patterns, while less optimal, are organised attachment patterns for retaining some proximity to the attachment figure and adapted to the anticipated response of the attachment figure. In contrast,

children who are classified as disorganised, appear to lack an organised strategy for achieving closeness with their attachment figure when distressed.

2.3 Incidence and prevalence

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

Children and young people in the care system, or on the edge of care, are at particular risk of attachment difficulties. The number of children and young people in the care system has risen in recent years. On 31 March 2014, there were approximately 69,000 looked‑after children and young people in England.

The prevalence of attachment disorders in the general population is not well established, but is likely to be low.

2.4 Management

Assessment

The assessment of patterns of attachment is complex. Attachment is assessed for its quality or pattern, not quantitatively for its intensity and there are different ways of assessing attachment that are appropriate to different ages on the basis of observed behaviour, representation of attachment relationships and coherence of the child’s account regarding their attachment relationships.

Attachment can also be assessed indirectly by examining the primary caregiver’s sensitivity to the child, particularly in response to the child’s distress or fear, because a significant association has been found between maternal sensitivity and child security of attachment.

Attachment disorders are typically assessed using structured interviews with carers, and may be supplemented by questionnaires and direct observation of the child or young person's behaviour.

Interventions

Psychological interventions for children with attachment difficulties can either directly address child attachment security or address associated problems. For those that address attachment security where children are still living in the family where the attachment difficulty has arisen, the first line of treatment is to improve the relationship between carer and child. There are a number of approaches with looked-after children that aim to improve parenting, and which may also improve attachment security.

In addition to specific interventions it is also important that there is also understanding of the child's psychological needs and a consistent, empathic and containing environment within school.

Because it is a relatively small population group whose needs are highly complex, services often span health and social care, and the priority is normally to find and support stable placements for looked-after children, which should be within a family wherever possible. It is often hard for families and carers to access therapeutic support due to limits on CAMHS to work with diagnosed mental health problems, rather than conditions that arise from maltreatment. Evidence-based interventions are often very hard to access for adopters as provision is low, and where they are available, they are not offered to children on the edge of care and fostered and adopted children.

Attachment difficulties and associated mental health problems during childhood place a considerable financial burden on health and social care services, the criminal justice system and society.

2.5 National Outcome Frameworks

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers**
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** ***Improvement areas*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures *ii Psychological therapies* *iii Recovery in quality of life for patients with mental illness*
4 Ensuring that people have a positive experience of care	***Overarching indicators*** ***Improvement areas*** **Improving people's experience of integrated care** *4.9 People's experience of integrated care***
Alignment with Public Health Outcomes Framework ** Indicator is complementary Indicators in italics in development	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.1 Children in poverty 1.2 School readiness 1.3 Pupil absence 1.4 First time entrants to the youth justice system 1.5 16–18 year olds not in education, employment or training
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.5 Child development at 2–2$^{1}/_{2}$ years 2.8 Emotional well-being of looked after children 2.10 Self-harm 2.23 Self-reported well-being
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.10 Suicide rate

3 Summary of suggestions

3.1 Responses

In total 12 stakeholders responded to the 2-week engagement exercise 15/01/2016-29/01/2016.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 4 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Assessment of attachment difficulties • Assessing attachment • Assessment of asylum seeking children	CBAAF SCMs MU ADMP UK Chroma
Supporting children in schools	SCMs
Interventions for parents and carers	PIP UK CBAAF SCMs RCPsych
Interventions for children	CBAAF SCMs Chroma ADMT UK
Access to mental health services	iHV SCM
Additional areas • Staff training and supervision • Equalities • Dissociative identify disorder recognition • EPAC forms	SCMs iHV ADMP UK RCPsych
PIP UK – Parent Infant Partnership UK RCPCH – Royal College of Paediatrics and Child Health MU - Middlesex University	

Suggested area for improvement	Stakeholders
SCMs – Specialist committee members CBAAF - CoramBAAF Adoption and Fostering Academy and Coram Adoption Services RCPsych - Royal College of Psychiatrists iHV - Institute of Health Visiting Chroma - Chroma (Therapies) Ltd ADMP UK - The Association for Dance Movement Psychotherapy UK	

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 365 papers were identified for Children's attachment. In addition, 101 papers were suggested by stakeholders at topic and 65 papers internally at project scoping.

Of these papers, 6 have been included in this report and are included in the current practice sections where relevant. Appendix 2 outlines the search process.

4 Suggested improvement areas

4.1 Assessment of attachment difficulties

4.1.1 Summary of suggestions

Assessing attachment

Stakeholders highlighted completion of a comprehensive high quality assessment is a fundamental initial step in being able to offer an effective intervention based on the needs of the individual child. A stakeholder acknowledged that the results of assessments must be identified explicitly in the child's care plan.

They highlighted that there is a lack of capacity within services such as social care, health and CAMHS to carry out the assessments.

A number of stakeholders highlighted assessment tools such as the Attachment style Interview for adolescents, the Vulnerable attachment style questionnaire (VASQ) and the Child attachment style interview (ASI) for children aged 7-10 yrs, that have been recently developed for screening for attachment difficulties.

Assessment of asylum seeking children

Stakeholders suggested that when asylum seeking children undergo an assessment it is important that the carer is present at the assessment with the practitioner to give their first-hand view and ensure the assessment is fully informed.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Assessing attachment	**Assessing attachment difficulties in children and young people in all health and social care settings**

	NICE NG26 Recommendation 1.3.2 NICE NG26 Recommendation 1.3.4 NICE NG26 Research Recommendation 1
Assessment of asylum seeking children	**Not directly covered in NICE NG26 and no recommendations are presented**

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

NICE Recommendation 1.3.2

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

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

NICE NG26 Recommendation 1.3.4

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

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

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

NICE NG26 Research Recommendation 1: Screening assessment tools

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

4.1.3 Current UK practice

Assessing attachment

No published studies on current practice were identified for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Assessment of asylum seeking children

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.2 Supporting children in schools

4.2.1 Summary of suggestions

Stakeholders report that children and young people with attachment difficulties struggle to concentrate in school. Problems with behaviour, learning and peer relationships can make the environment challenging and frightening. It is essential that parents and teachers understand the factors that cause children difficulties and identify ways of supporting them in school. They report that improving children's experience in school not only provides them with opportunity to better reach their potential, it also provides opportunity to practice peer relationships and can contribute to family placement stability.

Stakeholders also report that school behaviour policies are not written to include the needs of this group of children and staff are not supported to build relationships with their pupils in a way that supports their attachment needs. Stakeholders commented that inconsistent approaches in schools lead to children being too quickly punished and excluded.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	**Selected source guidance recommendations**
Supporting children in schools	**Supporting children and young people with attachment difficulties in schools and other education settings (including early years)** NICE NG26 Recommendation 1.2.3 NICE NG26 Recommendation 1.2.4

NICE NG26 Recommendation 1.2.3

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

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

NICE NG26 Recommendation 1.2.4

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

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

4.2.3 Current UK practice

The 2010 knowledge review by The Centre for Excellence and Outcomes in Children and Young People's Services (C4EO) reported that there were a disproportionate number of looked after children and young people experiencing exclusion from school or time out of school for other reasons. Few progress to higher education.

They reported that the level of achievement has serious implications for their future life opportunities.[1]

In the October 2015 Children's Well-being publication it was reported that children being bullied was strongly related to mental ill-health, they found that children who were bullied frequently were 4 times more likely to report a high or very high score of mental ill health [2]

The 2014 report by the New Economics Foundation on the relationships of children in care reported that the rate of permanent exclusions from school of looked-after children (0.15%) is over twice that of the general school-age population (0.07%). The rate of fixed-term exclusions from school of looked-after children (11.36%) is nearly three times that of the general school-age population (4.05%). They also reported that 15.3% of looked-after children achieve five or more A*–C GCSEs including English and Maths, versus 58% of non-looked-after children. [3]

[1] Centre for Excellence and Outcomes in Children and Young People's Services (2010) Vulnerable children: knowledge review 1: Improving educational outcomes for looked after children and young people

[2] Office for National Statistics Reports (2015) Measuring National Well-being, Children and Young People's Well-being in the UK

[3] New economics foundation (2014) Relationships for children in care

4.3 Interventions for parents and carers

4.3.1 Summary of suggestions

Provision

Stakeholders commented that looked after and adopted children will have had very insecure, often disorganised attachment as a result of a stressful caregiving experience. They highlighted that adults who have had such experiences as children may pass their own negative experiences onto their own babies. Specialised infant parent psychotherapeutic intervention, aligned with other provision such as children's centres, may help break the cycle.

Stakeholders commented that it is essential that services are designed to meet the holistic needs of families, taking into account parental mental health needs as well as parenting needs so that the numbers of children coming into care can be reduced. They report that current services for edge of care populations are fragmentary, limited in scope with short term packages of support and often delivered too late.

Foster and special guardianship order parents require access to training and therapeutic support to assist in understanding their child's emotional needs and how their response can develop trust and promote the attachment relationship. This support needs to be flexible so it's available at different times as the child grows and develops into adulthood. Support also needs to focus on prevention and early intervention.

Stakeholders report a lack of capacity to deliver video feedback training programmes.

Intervention types

One stakeholder commented that interventions should be a combination of group and individual support including emotional support alongside parenting advice and support. They report that interventions are often symptom rather than relationship focused, despite attachment difficulties being a failure of relationships and do not meet the needs of the family.

Stakeholders also noted that when parents decline to use of video feedback interventions they should be offered sensitivity and behaviour training models instead. Stakeholders report that there is an absence of recommended models for sensitivity and behavior training and have suggested the 'Circle of Security' as a suggested model.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Provision	**Ensuring equal access to consistent care** NICE NG26 Recommendation 1.1.4 (KPI) **Improving the stability of placements** NICE NG26 Recommendation 1.1.9
Intervention types	**Interventions for attachment difficulties in children and young people on the edge of care** NICE NG26 Recommendation 1.4.1 (KPI) NICE NG26 Recommendation 1.4.2 NICE NG26 Recommendation 1.4.4 NICE NG26 Recommendation 1.4.5 NICE NG26 Recommendation 1.4.6 **Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care** NICE NG26 Recommendation 1.5.1 (KPI) NICE NG26 Recommendation 1.5.3 NICE NG26 Research Recommendation 3

Ensuring equal access to consistent care

NICE NG26 Recommendation 1.1.4 (key priority for implementation)

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

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

Improving the stability of placements

NICE NG26 Recommendation 1.1.9

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

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

NICE NG26 Recommendation 1.4.1 (key priority for implementation)

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

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

NICE NG26 Recommendation 1.4.2

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

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

NICE NG26 Recommendation 1.4.4

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

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

NICE NG26 Recommendation 1.4.5

Ensure parental sensitivity and behaviour training:

- first consists of a single session with the parents followed by at least 5 (and up to 15) weekly or fortnightly parent–child sessions (lasting 60 minutes) over a 6-month period
- is delivered by a trained health or social care professional
  - includes:
  - coaching the parents in behavioural management (not applicable for children aged 0–18 months) and limit setting
  - reinforcing sensitive responsiveness
- ways to improve parenting quality
- homework to practise applying new skills.

NICE 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.

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

NICE NG26 Recommendation 1.5.1(key priority for implementation)

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

NICE NG26 Recommendation 1.5.3

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

NICE NG26 Research Recommendation 3: Evaluation of extensively used interventions

Evaluate currently unevaluated but extensively used interventions for attachment difficulties.

4.3.3 Current UK practice

Provision

The 2015 Early Intervention Foundations report into the range of early intervention programmes provided in the UK found nearly a fifth (19%) of 1,533 mothers with a child aged 0-5 years old who sought help on social, emotional, communication or language skills for their child said that they did not find it easy to access information on the range of help available and although 81% of mothers did find it easy to access help when they attempted.[4]

[4] Early intervention Foundation (2015) The best start at home: a report on what works to improve the quality of parent child interactions from conception to age 5.

No additional studies on current practice were highlighted for the provision of services available for this suggested area for quality improvement.

Intervention types

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.4 Interventions for children

4.4.1 Summary of suggestions

Stakeholders commented on the need for access to therapeutic interventions to support the mental health and emotional wellbeing of children. They highlighted that sometimes children do not meet the thresholds for interventions unless they also have diagnosed co-morbid difficulties.

Stakeholders suggested that there should be an emphasis on children having a clear plan for when their therapeutic interventions will begin. They commented that there are inconsistencies in when interventions are begun when children are moving between independent foster care providers and local authorities and this can cause a breakdown in the foster care placements.

Stakeholders reported that there was a need for a research programme to evaluate the effectiveness of extensively used therapeutic interventions for children with attachment difficulties. They comment that the number of evidence based interventions recommended in the guidance is limited and insufficient. Stakeholders suggested a number of arts, music, dance and drama based therapeutic interventions and assessments which could be used to improve parent child attachment. They commented that awareness of such therapies should be raised among parents.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Interventions for children	**Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care** NICE NG26 Recommendation 1.5.7 NICE NG26 Recommendation 1.5.10 NICE NG26 Research Recommendation 3 NICE NG26 Research Recommendation 4

<u>NICE NG26 Recommendation 1.5.7</u>

Ensure group therapeutic play sessions for primary school-age children after placement:

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

<u>NICE NG26 Recommendation 1.5.10</u>

Ensure training and education programmes for late primary and early secondary school-age children and young people in the care system, subject to special guardianship orders and adopted from care:

- consist of twice-weekly sessions (lasting 60–90 minutes) in a group for the first 3 weeks, then individual weekly sessions over the remaining school year
- are delivered by trained mentors, which may include graduate level workers, at a time that ensures schooling is not disrupted
- teach skills to help reduce involvement with peers who may encourage misbehaviour, and to increase their levels of self-confidence
- encourage them to get involved in a range of educational, social, cultural and recreational activities
- help them develop a positive outlook.

<u>NICE NG26 Research Recommendation 3: Evaluation of extensively used interventions</u>

Evaluate currently unevaluated but extensively used interventions for attachment difficulties.

NICE NG26 Research Recommendation 4: Interventions in a school setting

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

4.4.3 Current UK practice

The 2015 Early Intervention Foundation's report into the range of early intervention programmes provided in the UK found over 100 such programmes in existence across the UK, and reviewed 32 for the ways they impacting on the child's attachment, social and emotional development, and language and communication skills. Information was not presented on the geographic availability of these interventions or the numbers of each type of intervention available in the UK.[5]

No additional studies on current practice were highlighted for this suggested area of quality improvement services.

[5] Early intervention Foundation (2015) The best start at home: a report on what works to improve the quality of parent child interactions from conception to age 5.

4.5 Access to mental health services

4.5.1 Summary of suggestions

A stakeholder commented that foster and adoptive parents need to have prioritised access to an infant mental health team. Identifying that there needs to be local infant mental health pathways in place to promote attachment and infant mental health as well as provide interventions, they comment that uncoordinated services make it hard for referring and signposting.

One stakeholder highlighted that children with attachment difficulties often have high levels of mental health difficulties that cannot be met by traditional services and need to be understood in the context of family experiences such as trauma or loss and separation. They report that dedicated services can provide higher quality services tailored to their specific needs. It was suggested there should be research done into the relationship between attachment difficulties and complex trauma, commenting that little is known about the prevalence of such cases.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Access to mental health services	**Supporting children and young people with attachment difficulties in schools and other education settings (including early years)** NICE NG26 Recommendation 1.2.3 **Assessing attachment difficulties in children and young people in all health and social care settings** NICE NG26 Recommendation 1.3.8 NICE NG26 Research Recommendation 5

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

NICE NG26 Recommendation 1.2.3

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

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

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

NICE NG26 Recommendation 1.3.8

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

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

NICE Research Recommendation 5: Relationship between attachment difficulties and complex trauma

This research recommendation is composed of 2 parts:

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

4.5.3 Current UK practice

Office of National Statistics figures show 1 in 8 children aged 10 to 15 reported symptoms of mental ill-health in 2011 to 2012, as measured by a high or very high total difficulties score [6]

No additional studies on current practice were highlighted for this suggested area of quality improvement services.

[6] Office for National Statistics Reports (2015) Measuring National Well-being, Children and Young People's Well-being in the UK

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 10 March 2016

Staff training and supervision

Stakeholders suggested that social workers, health visitors, children's centre staff and child protection specialist community paediatricians involved with children under the age of 2 should have access to reflective supervision to deal with the consequences of being involved in traumatic and complex cases.

Stakeholders commented that training needs to be provided for health visitors in the promotion of infant mental health and assessment of attachment. The highlight that these professionals provide universal services during pregnancy and in the first year of life and in a prime place to promote these issues. They comment that provision of training has been low and investment inconsistent. Stakeholders also report that there should be health visitor infant mental health specialists or champions in all areas to lead, coordinate services and provide training and support.

They also report that there should be national standards for health visitor pre-registration training and continuing professional development to include theories of attachment and infant mental health, and assessment and interventions.

Stakeholders reported that teachers and care staff should be upskilled through the use of attachment workshops provided in schools and care settings where attachment theory is explained in relation to child development. They also suggested that head teachers should have mandated training in attachment theory.

Quality standards do not prioritise the training and development of staff within services as an area for quality improvement; however the quality standard should be read in the context of national and local guidelines on training and competencies.

Equalities considerations

Stakeholders highlighted the need for the quality standard to cover children and young people of all levels of intellectual ability and to identify those with communication needs as being a particularly vulnerable group. Equality groups will

be considered within the equality impact assessments for the topic and the equality and diversity sections within the individual statements developed.

Dissociative identify disorder (DID) recognition

A stakeholder reported that the consequences of DID not being universally recognised causes far reaching problems for children with the disorder, as well as impacting on parents and carers looking after the children, the comment that there are inconsistent approaches across the UK.

This area of care is not included in the underpinning guidance and is not within the scope of this quality standard.

EPAC forms

A stakeholder highlighted educational plans for adopted children (EPAC) forms as an additional area of emergent practice, commenting that these forms should be used and that awareness of them was important.

This area of care is not included in the underpinning guidance and is not within the scope of this quality standard.

Appendix 1: Key priorities for implementation (NG26)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

Principles of care in all contexts

- Ensure that all children, young people and their parents or carers get equal access to interventions for attachment difficulties regardless of whether they:
  - are on the edge of care, accommodated under Section 20 of the Children Act 1989, subject to a care order, under special guardianship or adopted from care
  - are placed with birth parents, foster carers (including kinship carers), special guardians or in residential care
  - are from a minority ethnic group
  - have a disability or a mental health problem
  - are from the UK or overseas. [1.1.2]

- Ensure that the health, education and social care processes and structures surrounding children and young people with attachment difficulties are stable and consistent. This should include:
  - using a case management system to coordinate care and treatment
  - collaborative decision making among all health, education and social care professionals, the child or young person if possible and their parents and carers
  - having the same key worker, social worker or personal adviser or key person in school throughout the period the child or young person is in the care system or on the edge of care. [1.1.4]

Supporting children with attachment difficulties in schools

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

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

- Health and social care provider organisations should train key workers, social care workers, personal advisers and post-adoption support social workers in the care system, as well as workers involved with children and young people on the edge of care, in:
    - recognising and assessing attachment difficulties and parenting quality, including parental sensitivity
    - recognising and assessing multiple socioeconomic factors (for example, low income, single or teenage parents) that together are associated with an increased risk of attachment difficulties
    - recognising and assessing other difficulties, including coexisting mental health problems and the consequences of maltreatment, including trauma
    - knowing when and how to refer for evidence-based interventions for attachment difficulties (see sections 1.4, 1.5 and 1.6). [1.3.1]

Interventions for children and young people on the edge of care

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

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

Preschool-age children

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

Primary school-age children

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

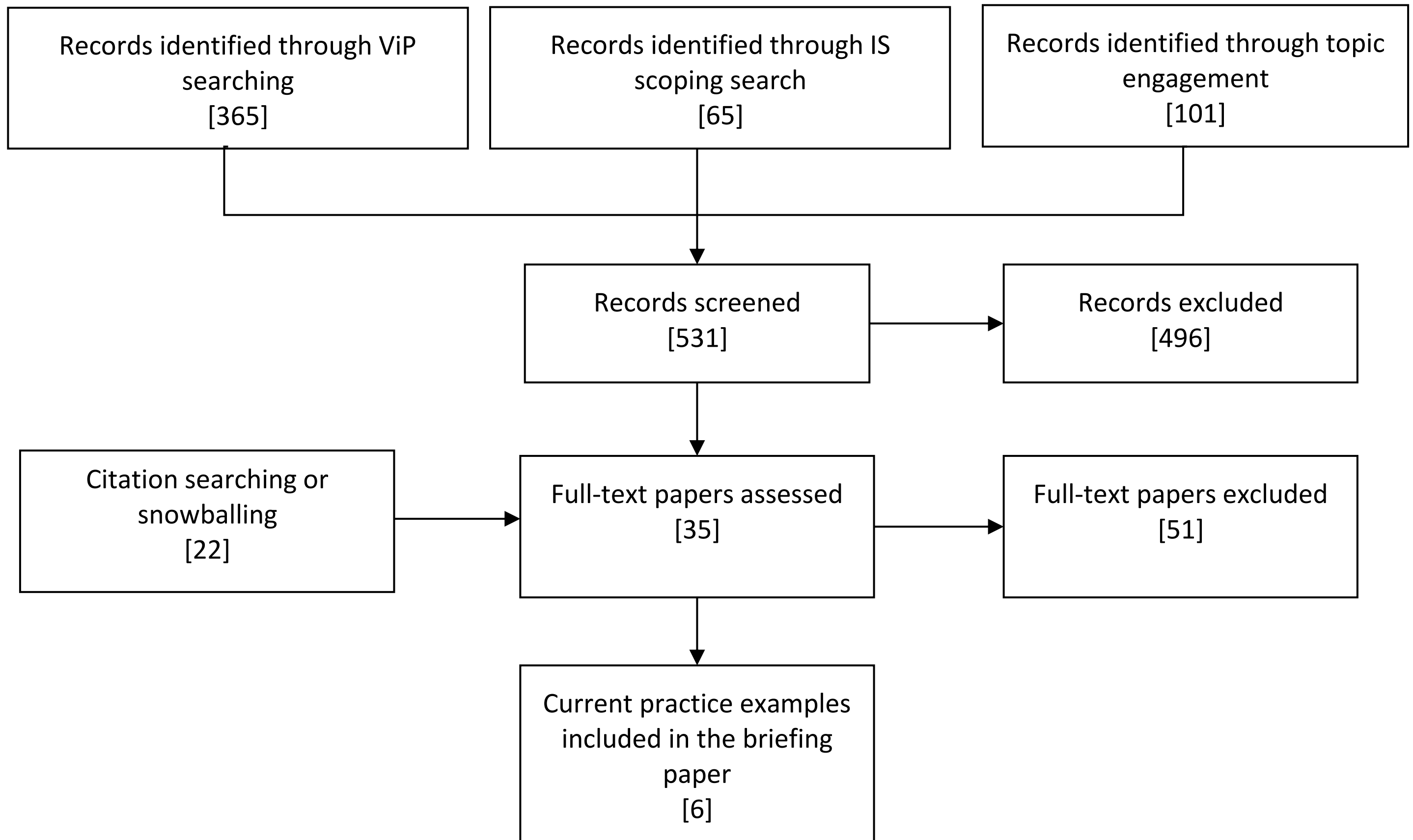
Late primary and secondary school-age children

- Consider a group-based training and education programme for foster carers, special guardians and adoptive parents to maintain stability in the home and help transition to a new school environment (see recommendation 1.5.9), combined with a group-based training and education programme for late primary and early secondary school-age children and young people in the care system, subject to special guardianship orders and adopted from care to improve social skills and maintain positive peer relationships (see recommendation 1.5.10). [1.5.8]

- Modify interventions for young people in the care system, subject to special guardianship orders and adopted from care when needed to allow for:
    - physical and sexual development
    - transition to adolescence
    - re-awakening of emotions about their birth parents or original family.

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

Appendix 2: Review flowchart



Appendix 3: Glossary

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

Children Aged 0–12 years

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

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

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

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

Special guardianship Under the Children Act 1989, amended by the Adoption and Children Act 2002, special guardianship is a legally secure placement for children and young people who cannot live with their birth parents that confers parental responsibility on the special guardian.

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

Young people Aged 13–17 years.

Appendix 4: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Assessment of attachment difficulties					
1	CoramBAAF Adoption and Fostering Academy and Coram Adoption Services	Robust, high quality, evidence based assessments	Overall we agree with the key priorities for implementation outlined in NG 26 Children's attachment. Our first priority would be the actions specified as part of assessing attachment difficulties in children and young people in all health and social care settings.	Completion of a comprehensive high quality assessment is a fundamental initial step in being able to offer an effective intervention based on the needs of the individual child. Recognising these issues from early childhood through to late adolescence and adulthood are core aspects of implementation. However it needs to be recognised that many of the assessment tools recommended require professionals who are appropriately trained and supervised in order to ensure validity and reliability of the administration and interpretation of the results.	See below
2	SCM1	Assessment of attachment difficulties	If a child or Young Person is not assessed as having attachment difficulties , access to therapeutic interventions is impossible.	That opportunity for assessment is easily accessible by trained professionals and a clear pathway for therapeutic intervention where required	
3	SCM2	Unaccompanied asylum –seeking children who enter U.K – To have a more integrated assessment which includes either report from Foster Carer or presence of Carer at	Crucial to have view of carer first hand by practitioners assessing unaccompanied asylum seeking child. Behaviours could be mis-communicated or therapist questions could be answered inadequately by someone who doesn't undertake the day to day care.	It is an ever growing area in Social Services and can have far reaching effects for the child if the assessment is only part informed before they make their conclusion.	Evidenced effects of this in Fostering Community.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		assessment			
4	Middlesex University	NICE report 2015: *Key priorities for implementation: Assessing attachment difficulties in children and young people in all health and social care settings.* The Attachment Style Interview for adolescents age10-18 has been effectively tested in care settings.	Attachment measures need to be embedded for children/young people in care. Ideally these need to be administered by the staff involved to aid with assessment and inform care planning. The ASI for adolescents provides a standardised, reliable and valid interview for assessing a young person's attachment style. Sections include assessing behaviour in relationships with peers and caregivers and ability to access support. In addition their cognitive-affective characteristics in a range of attachment related dimensions are measured (eg mistrust, fear of rejection, anger etc). Overall classification of Secure, Enmeshed, Fearful, Angry-dismissive, Withdrawn or Disorganised style assessed. Degree of such style also assessed.	Standardised, semi-structured interviews form a 'gold standard' for collecting contextualised information on psychosocial risk and resilience factors. Utilising interview measures like the ASI on site in care homes, enables the collection of narrative (the child's 'voice') to capture interpersonal context and quality of relationships, overall categorisation of attachment style. These tailored assessments determine individual risks and resilience around attachment style. This can be used as a basis for care planning for children in care. ASI for adolescents has been used in both residential and foster care settings to inform care planning. The measure can be used by selected care workers following a 4-day training course run by the Centre for Abuse and Trauma Studies at Middlesex University The measure has now been used fairly extensively in St Christopher's Fellowship for use in residential care homes in the UK and Isle of Man.	www.attachmentstyleinterview.com http://www.cats-rp.org.uk/projects.htm http://www.stchris.org.uk/services/residential-childrens-homes/st-christophers-approach.aspx Antonia Bifulco and Geraldine Thomas (Routledge, 2012) *Understanding Adult Attachment in Family Relationships: Research, Assessment and Intervention* *Caring about attachment in young people in residential care: the use of the attachment style interview. Report of a voluntary sector and university partnership.* Jacobs, Catherine; Ilan-Clarke, Yael & Bifulco, Antonia (2012) Community Care Inform Adolescent attachment style in residential care: The Attachment Style Interview and

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Vulnerable Attachment Style 5Questionnaire. Bifulco, A, Jacobs, C, Ilan-Clarke Y, Spence R, Oskis A (submitted)
5	Middlesex University	Screening assessment tools for attachment style in adolescence – using the Vulnerable Attachment Style Questionnaire	A self-report attachment scale (the VASQ) can be used to monitor change in attachment insecurity over time. This 22 item scale is used in residential and foster care by two voluntary organisations (St Christopher's Fellowship and Action for Children) on a prospective basis. It is completed by young person, carer and social worker/teacher to provide different perspectives on the child's attachment style. Dimensions of anxious (proximity-seeking); mistrustful avoidance and disorganised style are determined.	Preliminary work using the VASQ as part of the Q pack which also assesses life events and SDQ psychological disorder shows baseline risk/resilience and charts change over time. There is evidence of positive change in 6 months in foster care and 18 months in residential care. The change is mainly around Disorganised style moving to a single insecure style. This is paralleled by positive change in psychological disorder.	The Vulnerable Attachment Style Questionnaire (VASQ): an interview-based measure of attachment styles that predict depressive disorder (2003) A. Bifulco, J. Mahon, J.-H. Kwon, P. M. Moran & C. Jacobs Psychological Medicine, 33, 1099–1110. Adolescent attachment style in residential care: The Attachment style interview and Vulnerable Attachment Style Questionnaire. Bifulco, A, Jacobs, C, Ilan-Clarke Y, Spence R, Oskis A (submitted) *(Available from first author on request)* Internal reports of evaluation to St Christopher's Fellowship and Action for Children, available on request.
6	Middlesex	Assessing	A new version of the ASI for	This has been tested in schools and with a	The Child Attachment Style

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	University	attachment style in younger children: The Child ASI (aged 7-10)	children has been developed. It enables the same categorisation as the adolescent ASI. It is more child friendly however, shorter with more involvement of the child in producing self-rated items. It assesses relationship with parents or carers; friendships and close family and attitudes around autonomy, closeness, fear and anger in relating. It shows good reliability and validity.	small group of children in fostering. It is being rolled out further to services. The measure captures attachment difficulties in both normative and in-care settings.	Interview (Child-ASI): Reliability, Validity and Practice Application (submitted) A Bifulco, Y Ilan-Clarke, S. West* A. Bunn, R. Spence, C. Jacobs, R. Damiani & A. Oskis *(Available from first author on request)*
7	The Association for Dance Movement Psychotherapy UK (ADMP UK)		Assessing and identifying attachment difficulties. Dance movement psychotherapist are routinely involved in initial assessment, ongoing and outcome evaluation of the therapeutic process.	Appropriate assessment can offer support to children with attachment issues. Given that these issues are often expressed non-verbally, the input of a movement specialist can be particularly useful.	Movement analysis systems in assessment: Kestenberg Movement Profile http://link.springer.com.edgehill.idm.oclc.org/article/10.1007%2Fs10465-011-9112-8 The Kestenberg Movement Profile (KMP) is also based on LMA but also strongly influenced by attachment theory next to Freudian psychosexual development and object relationship theory. It is a comprehensive movement assessment tool that has been developed by

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Judith Kestenberg, and can be used to describe client's personality as well as relational and psychological domains. Due to the fact that it combines both movement consideration along with psychological thinking, it makes it very relevant to using it both for assessment ad ongoing evaluation but also as a useful tool to understand non-verbal relationships. This tool may be ideal to use as part of identifying the attachment difficulties of children but also, and more importantly, relational issues within dyads and families. Other movement analysis tools include Laban Movement Analysis, Bartenieff Fundamentals, Body-Mind Centering © For more information about these and additional tool, see Payne (1992; 2005), Wengrower (2016).
8	Chroma (Therapies) Ltd	The need to strengthen assessment skills and	In order to successfully treat families with attachment difficulties	With an objective baseline retests can be conducted to examine how attachment patterns	www.apci.dk/En/aboutAPCI

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		processes in adoption support services.	there needs to be an objective assessment of their fundamental interaction patterns.	have altered through the therapy process. For example, Chroma has been working with researchers at Aalborg University in Denmark on their music therapy based, APCI (assessment of parent-child interactions) tool. This is statistically valid and reliable assessment reporting on attachment types, child autonomy and a number of other key areas of attachment. It has also been shown to be an enjoyable assessment for parent-child dyads to take part in.	Jacobsen, S. L. & Killén, K. (2015). Clinical Application of Music Therapy Assessment within the Field of Child Protection Nordic Journal of Music Therapy, 24(2), 148-166 Jacobsen, S. L. & McKinney, C. H. (2014) A Music Therapy Tool for Assessing Parent-Child Interaction in Cases of Emotional Neglect Journal of Child and Family Studies
Supporting children in schools					
9	SCM3	Supporting children with attachment difficulties in schools	Children and young people with attachment difficulties struggles to concentrate in the school setting and can find the environment both challenging and frightening. These pupils often have problems with behaviour, learning and peer relationships. It's essential that parents and teachers understand the factors that cause children difficulties and identify ways of addressing them.	Improving children's experience in school not only provides them with opportunity to better reach their potential, it also provides opportunity to practice peer relationships and can contribute to family placement stability. Many adoptive parents highlight that school is a key area of stress on the adoptive placement and exclusion can be contributory factor towards placement disruption. Training teachers and school staff on understanding attachment has the potential to improve the quality of the school experience for children with attachment difficulties.	Bombèr L. M. (2007) Inside I'm hurting. Practical strategies for supporting children with attachment difficulties in schools. London: Worth Publishing Ltd. Bombèr L. M (2011) What about me? Inclusive strategies to support pupils with attachment difficulties make it through the school day. London: Worth Publishing Ltd. Bomber, L. M. & Hughes, D. A. (2013) *Settling to learn. Settling troubled pupils to learn: why relationships matter*

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					in school. London: Worth Publishing Ltd. Cairns K. & Stanway A (2004) Learn the Child. Helping looked after children to learn, London: BAAF Forbes, H. T. (2012) Help for Billy. A beyond consequences approach to helping challenging children in the classroom. Boulder, Colarado: BCI Golding, K. S. (2014) Bringing Attachment Theory into the classroom: An observation checklist to support education staff to meet the relationship needs of emotionally troubled children. The Child & Family Clinical Psychology Review, 2, Summer, 37 – 43
10	SCM2	Meaningful Support at beginning	At the start of child coming into care more emphasis needs to be on clear plan for therapeutic intervention, to help the child while the trauma unravels	Inconsistency between (independent Fostering Agency) IFA and Local Authority. Often IFA confirm that therapeutic intervention will be available at the beginning where local authority waits till child is in stable home.	What we see in practice is that when there is a breakdown and the child is moved to another foster home, often the support that the foster carer had required to continue is implemented straight away in

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					new home. The support going in at the beginning could have prevented another breakdown and further trauma being inflicted on the child.
11	SCM4	Supporting pupils with attachment difficulties in schools	Children and young people with attachment difficulties do not respond well to the typical behaviour management in school. These pupils subsequently fail to learn, fail in their social relationships and have too many moves and/or exclusions from school. Understanding the social and emotional needs of these pupils is key to supporting their learning. Therefore, parents and education staff need to have a good understanding of the nature and course of attachment difficulties and how to support these vulnerable pupils emotionally, socially and with their learning.	Too few education staff understand the impact of poor early attachment experience on their pupils or how this impacts on their functioning in school. Whole school behaviour policies are not written to include the needs of this population of pupils. Key staff are not supported to build relationships with their pupils in a way that supports their attachment needs.	Bombèr L. M. (2007) Inside I'm Practical strategies for supportir children with attachment difficult schools. London: Worth Publish Bombèr L. M (2011) What abou Inclusive strategies to support p with attachment difficulties make through the school day. London Publishing Ltd. Bomber, L. M. & Hughes, D. A. (2013) *Settling to learn. Settling troubled pupils to learn: why relationships matter in school.* London: Worth Publishing Ltd. Cairns K. & Stanway A (2004) L Child. Helping looked after child learn, London: BAAF Forbes, H. T. (2012) Help for Bi beyond consequences approacl helping challenging children in t classroom. Boulder, Colarado: E Golding, K. S. (2014) Bringing Attachment Theory into the

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					classroom: An observation checklist to support education staff to meet the relationship needs of emotionally troubled children. The Child & Family Clinical Psychology Review, 2, Summer, 37 – 43
Interventions for parents and carers					
12	PIP UK	Specialised help with parenting should be available as a matter of course for all new parents who were once looked after or adopted.	In many (not all) instances of maltreatment within the family in the first 2 or 3 years of life this ‘taken for granted’ way of parenting is carried forward to the next generation. One third of maltreated children go on to become maltreating parents.	All looked after and adopted children will have had very insecure (often ‘disorganized’) attachment as a result of a stressful caregiving experience. As adults these ‘ghosts in the nursery’ may negatively impact their own babies. Specialised infant parent psychotherapeutic intervention, aligned with other provision such as children’s centres, may help break the cycle. Local authorities are in loco parentis; grandparents do not usually abandon their grandchildren.	See the report from the DoE and WAVE Trust ‘Conception to age 2: the age of opportunity’ http://www.wavetrust.org/our-work/publications/reports/conception-age-2-age-opportunity and the APPG report ‘Building Greater Britons’ http://www.wavetrust.org/our-work/publications/reports/building-great-britons
13	PIP UK	Foster and adoptive parents who have offered a home to a child under the age of two should have ready and prioritised access to an infant mental health team.	These parents may find themselves having to deal with complex issues that stem from the quality of care the child has had since conception.	Experiences in utero can negatively affect the foetus and lead to an infant who is intrinsically hard to parent. Children who are maltreated within the birth family suffer overwhelming (some call this toxic) stress which affects both their attachment responses and their neuro-biological stress responses. Without specialised intervention both may remain ‘hard-wired’.	http://www.beginbeforebirth.org http://developingchild.harvard.edu

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
14	SCM3	Increasing support interventions for adoptive, foster and SGO parents of children with attachment difficulties	Where children have suffered abuse from their birth parents, it clearly impacts on their subsequent ability to trust their new parents and develop healthy attachment relationships. Adoptive, Foster and SGO parents require access to training and therapeutic support to assist them in better understanding their child's emotional needs and how they can best respond in order to develop trust and promote the attachment relationship. This support needs to be flexible in that it is available whenever it is needed at different times as the child grows and develops into adulthood. Support needs to focus on prevention and early intervention.	Relationship based therapeutic interventions that recognise the impact of the child on the parent and the parent on the child are key in promoting improved attachment relationships. Parents need access to effective timely support in order to avoid relationship breakdown and provide children with the opportunity to experience positive attuned parenting. Relationships are central to the development of healthy adults, and providing abused children with the opportunity to experience positive relationship can create a foundation for positive mental health into adulthood.	To understand the impact of parenting these children on the parent Hughes, D. & Baylin, J. (2012) *Brain-Based Parenting: The Neuroscience of Caregiving for Healthy Attachment* New York: W.W. Norton Alper, J. & Howe, D. (2015) Assessing adoptive and foster parents. Improving analysis and understanding of parenting capacity. London: Jessica Kingsley Publishers Chapters 6 & 7 To understand the support needs of the parents Rahilly T. & Hendry, E. (2014) Promoting the wellbeing of children in care Messages from research NSPCC Tarren-Sweeney M. & Vetere, A. (2014) Mental health services for vulnerable children and young people. Routledge.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Alper & Howe (2015) Chapter 5
15	SCM3	A research programme to evaluate the relationship between attachment difficulties and complex trauma	Little is known about the prevalence of attachment difficulties, complex trauma or both in children and young people in the care system and on the edge of care in the UK. This information is essential in understanding the needs of these children and will highlight how complex trauma contributes to our understanding of a child's behaviour and their attachment difficulties.	The vast majority of children in the care system have experienced significant trauma from their birth parent/s. In order to ascertain what therapeutic attachment interventions could be most helpful for them it is essential to understand the relationship between trauma and attachment. If a child has been traumatised by their primary attachment figure, future attachment figures will appear frightening. Where a child remains with their birth family, interventions that try and promote the attachment relationship with an abusive or neglectful birth parent need to consider, both the impact on the child of the trauma in relation to the attachment relationship, as well as the capacity of the parent.	Nice guidelines, November 25 2015 Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care
16	CoramBAAF Adoption and Fostering Academy and Coram Adoption Services	Assessments that directly lead to identified issues that must be addressed in the child's care plan that directly and immediately impact of the quality of care provided by the carer whatever their status.	Building capacity within health and social care is essential to implementation of these recommendations.	The recommendations cannot be implemented unless there is sufficient capacity both in terms of expertise and numbers of professionals who can offer these services, as well as services which facilitate delivering the recommendations. There are critical issues in the early stages of a child's planning and decision making in ensuring that a child's attachment status is the focus of the preparation and support of carers whether they are temporary or intended to be permanent. It is also essential that these	In the experience of our members, in most regions there is a lack of capacity within social care, health and CAMHS to provide assessment services, as well as to offer training to birth parents and foster carers, special guardians and adopters and within education/schools. Some regions have had skilled

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				issues are addressed when children are moved from one carer to another. Some of these issues must be embedded in the preparation and training of carers and others in the focus on the detail of the child's current adjustment to adverse circumstances and the messages they convey about their needs in relation to their adult carers. The results of such assessments must be identified explicitly in the child's care plan and other related reports and delivered through supportive exploration of any proposed intervention. Implementing these recommendations will require a cultural change in addition to significant planned and ongoing investment in training and building capacity within social care, health and education over an extended period. In particular it is recommended that certain NHS CAMHS clinics are identified as resources for LAC and adopted children where professionals and carers can receive consultation and advice on how to respond to issues which have been identified.	expertise but with financial restraints many of these services have been reduced.
17	CoramBAAF Adoption and Fostering Academy and Coram Adoption	A strategic, fully resourced programme to implement the recommended interventions that		Currently there a wide range of interventions being delivered with attachment as a focus. Some combine attachment with a range of other parenting concepts and these range for the poorly informed with extravagant claims to well balanced, appropriate interventions that	The video feedback programmes offer an opportunity to maximise the adopters' or carers' capacity to strengthen the child's positive attachment to them as carers.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	Services	also recognises the very limited availability of those programmes in the current structure of services.		are properly child and parent focussed. There is a particular lack of capacity to deliver the video feedback programmes recommended, with very few professionals currently trained in this intervention. Additionally, investment will be required to develop services to offer new interventions such as video feedback programmes, and to extend training to a hugely increased number of individuals such as teachers and foster carers.	However, the engagement with the adopters or carers, the videoing and then the interpretation of passages which are identified for discussion requires a highly trained workforce with access to appropriate professional supervision. Again it is recommended that professionals who are engaged in this work need to be located in and/or supervised by clinical professionals in NHS CAHMS clinics who can ensure that the intervention is conducted in accordance with the protocols and with the necessary sensitivity to the complex relationships involved.
18	CoramBAAF Adoption and Fostering Academy and Coram Adoption Services	Parenting needs to be emphasised as the key component in attachment		It is essential that *parenting* is identified as the key component in attachment. Attachment is a relationship with parenting figures that the child has come to identify as their parents. Whatever their legal status it need to be the driver in the implementation at the heart of the quality standards as they are agreed and published	Key research studies have identified that adoption is itself a powerful transformational intervention which increases the child's capacity to form secure attachments over time. Any attachment intervention needs to recognise the power of this relationship, and aim to support the adopters' (or other

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					carers') ability to understand the impact of past experiences on their child's behaviour.
19	SCM4	Increase support interventions for parents parenting children with attachment difficulties	Parenting children and young people with attachment difficulties is a challenging and ongoing task. This is especially complex when the parent has not parented the children from birth. In a similar way to parenting children with learning difficulties or complex needs, parents benefit from support, when they need it, from practitioners who are familiar to them and who they already have a relationship with. A combination of group and individual support is needed which provides emotional support as well as parenting advice and guidance.	Too often these families do not get this kind of support until they are at crisis point. By this point parents are often blocked in their capacity to care and experiencing secondary trauma. It is then too little, too late. CAMHS interventions can be focused individually on the child, or are provided for very time limited periods. Interventions are often symptom rather than relationship focused, despite attachment difficulties being a failure of relationships. This does not meet the needs of the family and therefore does not build resilience to continue to parent challenging children and young people, with challenges that are long term, even when symptoms are addressed in the short term. Social care interventions such as Family Support services are also often time limited, and with staff who are not always sufficiently trained in understanding Attachment Theory and the impact of attachment difficulties. Recognising the long term difficulties and ongoing impact on family members of parenting children and young people with attachment difficulties means that ongoing support needs are recognised.	To understand the impact of parenting these children on the parent Hughes, D. & Baylin, J. (2012) *Brain-Based Parenting: The Neuroscience of Caregiving for Healthy Attachment* New York: W.W. Norton Alper, J. & Howe, D. (2015) Assessing adoptive and foster parents. Improving analysis and understanding of parenting capacity. London: Jessica Kingsley Publishers Chapters 6 & 7 To understand the support needs of the parents Rahilly T. & Hendry, E. (2014) Promoting the wellbeing of children in care Messages from research NSPCC Tarren-Sweeney M. & Vetere, A. (2014) Mental health services for vulnerable

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					children and young people. Routledge. Alper & Howe (2015) Chapter 5
20	SCM4	Ensure that intensive support interventions are available for families on the edge of care that includes help for the parents and support for parenting	Removing children from their birth families is a drastic and damaging intervention. Therefore, it is essential that services are designed which can meet the holistic needs of families, taking into account parental mental health needs as well as parenting needs so that the numbers of children coming into care can be reduced.	Current services for edge of care populations are fragmentary, limited in scope with short term packages of support and often delivered too late by relatively low skilled staff. The mental health needs of the parents are often considered separately from the parenting needs of the children. Integrated, holistic services with a focus on prevention and early intervention are needed if more children are going to successfully remain with their birth families. Adult mental health services and child and family service need to be integrated in a way which is rarely seen currently.	Silver, M.; Golding, K.S. & Roberts, C. (2015) Delivering psychological services for children, young people and families with complex social care needs. In: Julia Faulconbridge, Duncan Law & Amanda Laffan (Eds) What good looks like in psychological services for children, young people and their families. Child & Family Psychology Review, Summer, 3, 119 – 129.
21	Royal College of Psychiatrists	Offering video feedback	Offering video feedback as a tool for young children at the edge of care and their families as well as with foster carers and adoptive families is excellent.		VIG and VIPP are both mentioned in the NICE guideline. Both good programmes.
22	Royal College of Psychiatrists	'Circle of Security'	If parents do not wish to engage with video feedback, the recommendation in the guidance is to offer 'sensitivity and		It is already recommended for improving secure attachment and attunement (alongside VIPP and 'Watch, wait and

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			behavior training'- I cannot see a reference to which model(s) is/are suggested for this process. I suggest that the committee consider recommending 'Circle of Security (COS-P)' for this. It is an accessible, evidence based programme aimed at shifting emphasis from behaviour to relationship development in an 8 week group programme.		wonder') by this report: http://www.wavetrust.org/sites/default/files/reports/conception-to-age-2-full-report_0.pdf
23	SCM1	Treatment/ Therapeutic intervention for attachment difficulties	Going forward, an evidence base needs to be established (in England and Wales, better if UK wide) to reference scant availability of data on efficacy. The research evidence used to inform NG26 was international and paid little regard to the differences in Child Protection/Care systems in the UK.	We don't know what we don't know. Many treatment and therapeutic interventions that are commonly used in the UK , but do not, as yet, have any `NICE` validation, but are overwhelmingly helpful, particularly to adopters of traumatised children with attachment difficulties are not mentioned in NG26. Therefore, professionals carrying out treatment and interventions as recommended by NG26 SHOULD in my view, use a country wide system to record efficacy.	
24	SCM1	Emerging Practice ,	DDP, Theraplay, Non Violent resistance, Creative therapy and Therapeutic re parenting are all emerging practice to aid the parental sensitivity aspects	This is a key area of emerging practices which was a research recommendation in NG26. As stated above, over whelming useful,	

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			alluded to in NG26	particularly or adoptive parents, foster carers and RC workers of c&yp with attachment difficulties who have been previously maltreated.	
Interventions for children					
25	SCM3	A research programme evaluating the effectiveness of extensively used interventions for children with attachment difficulties	There is currently only a limited evidence base relating to therapeutic interventions for children with attachment difficulties. Adoptive families report that they experience certain interventions as helpful and it would assist therapy services and commissioners if these interventions could be properly researched.	At a time when the Adoption Support Fund is available many local authorities are commissioning therapies for adoptive children with attachment difficulties without information to assist them in identifying which interventions could be most helpful. It is important that local authorities are able to make informed decisions about utilising limited resources to help children with considerable need. Additionally both the Adoption Support Fund and Regionalisation are encouraging the development of the adoption support market. It is essential that therapy services are provided with information at this key time in order to help them develop a range of provision that is proven to be effective. It is important to recognise that families are all different and have different needs and that services need to have access to a range of interventions that would enable them to be most helpful.	Su Casswell, G.; Golding, K. S.; Grant, E.; Hudson, J. & Tower P. (2014) Dyadic Developmental Practice (DDP): A framework for Therapeutic intervention and Parenting. The Child & Family Clinical Psychology Review, No 2, 19 - 27 Hughes, D. (2014) Dyadic Developmental Psychotherapy: Toward a comprehensive trauma-informed treatment for developmental trauma disorder. The Child & Family Clinical Psychology Review, No 2, 13 – 18 Boyer, N. R. S.; Boyd, K. A.; Turner-Halliday, F.; Watson, N.; & Minnis H. (2014) Examining the feasibility of an economic analysis of dyadic developmental psychotherapy for children with maltreatment

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					associated psychiatric problems in the United Kingdom. BMC Psychiatry 14:346 Turner-Halliday, F.; Watson, N.; Boyer, N. R. S.; Boyd, K. A. & Minnis H. (2014) The feasibility of a randomised controlled trial of Dyadic Developmental Psychotherapy. BMC Psychiatry, 14:347
26	Chroma (Therapies) Ltd	The increased use of arts therapies as an intervention to improve parent-child attachment within post-adoption support services.	There is good evidence that improved parent-child attachment and bonding can drive significant improvements in resilience and self-regulation for adopted children. This can positively impact their career opportunities, self-esteem and quality of life. The threshold for referral would usually be based on the local authority assessment of needs.	There are a wide range of case studies and clinical guidelines in the literature reflecting the established use of the arts therapies in this field. In the case of Music Therapy empirical studies compliment an evolving understanding and assessment of the efficacy of the Arts Therapies in this field. For example research indicates that music therapy can be effective in improving social functioning in adolescents with social deficits, often caused as a result of trauma from early family breakdown.	'Art Therapy for Children: How It Leads to Change' at http://ccp.sagepub.com/content/11/2/271.short). Music therapy reference: http://jmt.oxfordjournals.org.zorac.aub.aau.dk/content/48/4/440) There are published papers highlighting the effectiveness of music therapy working with children with emotional difficulties caused by insecure attachment: (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3095989/
27	Chroma	Raising awareness	Raising awareness of family	Families need to know what support services	The recent report from the

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	(Therapies) Ltd	among parents of therapy services.	based and/or parent-child interventions enables families with attachment-based issues to access high quality evidence-based therapy services, provided by HCPC registered Allied Health Professionals.	are available and which have a strong evidence-base to positively impact attachment issues as a result of adoption/attachment.	Colebrooke Centre for Evidence and Implementation and the Dept for Education on the Adoption Support Fund clearly shows the positive impact of increased therapeutic intervention for post adoption families. http://www.gov.uk/government/publications
28	The Association for Dance Movement Psychotherapy UK (ADMP UK)	Key area for quality improvement 1	There is growing evidence for the value of using dance movement psychotherapy (one of the arts psychotherapies next to art, psychotherapy, music therapy and drama therapy) with children and adolescents who are faced with emotional challenges. The evidence so far suggests that dance movement psychotherapy may contribute to quality of life, reduction of depression and anxiety and interpersonal skills. NICE guidelines on schizophrenia and dementia have already included dance movement psychotherapy (and the ‘therapeutic uses of dance’)	Dance movement psychotherapy (also known as dance movement therapy or dance therapy) is used in different settings including foster services, CAMHs, schools, residential care settings, charities working with children and children’s hospitals as a way of engaging children creatively and non-verbally, working through and addressing relational issues that can be difficult to be thought about and verbalised at a young age.	There are general systematic reviews, which include studies on the effectiveness of dance movement (psycho)therapy for children and adolescents: Cochrane Systematic Review: Meekums B, Karkou V, Nelson EA. Dance movement therapy for depression. Cochrane Database of Systematic Reviews 2015, Issue 2. Art. No.: CD009895. DOI: 10.1002/14651858.CD009895.pub2. One study with adolescents with depression was included (40 participants). The review recommended the need for

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			as a recommended psychological intervention next to other arts psychotherapies.		further research. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009895.pub2/abstract Meta-analyses: Koch S, Kunz T, Lykou S and Cruz R (2014) Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis, The Arts in Psychotherapy, 41, 46-64. http://www.sciencedirect.com/science/article/pii/S0197455613001676 This meta-analysis looked at the effectiveness of dance movement therapy and dance from 23 primary trials (N = 1078) including studies with children and adolescents on variables of quality of life, body image, well-being, and clinical outcomes, with sub-analysis of depression, anxiety, and interpersonal competence. Results suggest that these interventions are effective for

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					increasing quality of life and decreasing clinical symptoms such as depression and anxiety. Positive effects were also found on the increase of subjective well-being, positive mood, affect, and body image. Effects for interpersonal competence were encouraging, but due to the heterogeneity of the data remained inconclusive. Cruz, R., & Sabers, D. (1998). Dance/movement therapy is more effective than previously reported. The Arts in Psychotherapy, 25(2), 101–104. http://link.springer.com/article/10.1023/A%3A1013041723005 Cruz and Sabers (1998) report on their recalculation of Ritter and Low's (1996) meta-analysis and argue that dance/movement therapy is more effective than reported before due to an error on calculating effect sizes for repeated measures. They also

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					argue that the effect of dance/movement therapy is comparable with other psychological interventions and especially effective for children/adults faced with anxiety. Ritter, M. & Low, K. G. (1996). Effects of dance/movement therapy: A meta-analysis. Arts in Psychotherapy, 23, 249–260. http://www.sciencedirect.com.edgehill.idm.oclc.org/science/article/pii/0197455696000275 Ritter and Low (1996) report on a meta-analysis of 23 studies on dance/movement therapy for a number of different client groups. 781 clients were included in total including children. An array of benefits from dance/movement therapy were reported in these studies including improvements in motor skills, body awareness, muscle control and balance, special awareness, attention, participation and relaxation, as

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					well as expressivity. The meta-analysis reports effective outcomes when working with children who have a developmental difficulty with a modest positive effect. Systematic Literature Reviews: Randomised controlled trials are also included in narrative systematic reviews in the field, some of which refer to children and adolescents with attachment issues: Kiepe, M.-S., Stöckigt, B., & Keil, T. (2012). Effects of dance therapy and ballroom dances on physical and mental illnesses: A systematic review. The Arts in Psychotherapy, 39(5), 404–411. http://www.sciencedirect.com/science/article/pii/S0197455612000998 Strassel,J.K., Cherkin, D. C., Steuten, L., Sherman,K.J., & Vrijhoef, H.J.M.(2011). A systematic review of the evidence for the effectiveness

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					of dance therapy. Alternative Therapies in Health & Medicine, 17(3), 50–59.
29	The Association for Dance Movement Psychotherapy UK (ADMP UK)	Key area for quality improvement 2	Dance movement psychotherapy can be used in all levels of care for children with attachment issues. Dance movement psychotherapists are qualified practitioners, trained for a minimum of two years at a Masters' level and experienced in contributing to multidisciplinary teams on assessment, formulation of treatment plans, delivery and evaluation of treatment and supervision	Qualified dance movement psychotherapists emphasise the non-verbal and creative aspects of relating within agreed and safe relationships. As such they are able to work with issues formed in early development. Any difficulties in these relationships can often be acted out when anxiety is high as can be the case with fostering and adoption processes. The evidence on the input and value of non-verbal relationships is currently receiving a lot of attention from neuroscience. Some studies are available in dance movement psychotherapy that incorporate evidence from brain scans, primarily as the results of non-verbal interactions such as mirroring and kinaesthetic empathy. Most evidence relating to working within the adoption system remains qualitative stemming from single case studies. All argue for the potential contribution of this field within the adoption process and offer rich descriptions of how this could take place. There is also qualitative evidence for the value of dance movement psychotherapy with children with learning disabilities. When	Neuroscientific research, dance movement psychotherapy and relationships The role of embodiment within psychotherapy is currently receiving renewed attention from neuroscientists. For example, research studies in neuroscience provide evidence for the biological basis of emotion and the links between body and feelings (Damasio 1994, 2000); the plasticity of the brain and thus a life-long ability for humans to make new synaptic connections (Edelman 1987); the role of mirror neurons in the brain and their links with empathy (Rizzolatti et al 1996; Gallese 2003; Gazzola et al 2006). Within dance movement psychotherapy, the following empirical studies offer evidence on the impact of kinaesthetic empathy on the

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				these children are considered for adoption, their disability adds a further complexity in the process, both for the children, the parents and the services around them.	brain: Rova, M. (2012-2015) Embodying Kinaesthetic Empathy as an Intersubjective Phenomenon and Clinical Intervention: a practice-based interdisciplinary study combining Dance Movement Psychotherapy, Phenomenology and Cognitive Neuroscience. London: University of Roehampton (PhD research) Fischman, D. (2009) Therapeutic Relationships and Kinesthetic Empathy in Chaiklin, S. & Wengrower, H. (Eds.). The Art and Science of Dance/Movement Therapy: Life is Dance. New York/London: Routledge http://www.torontopubliclibrary.ca/detail.jsp?R=2681347 McGarry, M. L. & Russo, F.A. (2011) Mirroring in dance/movement therapy: Potential mechanisms behind

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					empathy enhancement. *The Arts in Psychotherapy*, *38*, 178-184 http://www.sciencedirect.com/science/article/pii/S0197455611000426 Case studies on dance movement psychotherapy and adoption Harvey, S. (1995) Sandra: The Case of an Adopted Sexually Abused Child. Levy, F (1995) Dance and Other Expressive Arts Therapies: When Words are Not Enough. Routledge: USA. Chapter 12 p. 167- 180 Blau, B and Reicher, D (1995) Early Intervention with Children at Risk for Attachment Disorders. In Levy, F (1995) Dance and Other Expressive Arts Therapies: When Words are Not Enough. Routledge: USA. Chapter 13 p.181 - 189 Studies with people with learning disabilities: Berrol, C. F. (1984). The effects of two movement

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					therapy approaches on selected academic, physical and socio-behavioral measures of first grade children with learning and perceptual motor problems. American Journal of Dance Therapy, 7, 32–48. Couper, J. L. (1981). Effects on motor performance of children with learning disabilities. Physical Therapy, 61(1), 23–26 Edwards, J. 2015, "Exploring sensory sensitivities and relationships during group dance movement psychotherapy for adults with autism", Body, Movement and Dance in Psychotherapy, vol. 10, no. 1, pp. 5-20. http://www.tandfonline.com/doi/abs/10.1080/17432979.2014.978894?journalCode=tbmd20
30	The	Key area for quality	Support in school.	For children with attachment issues, specialist	Dance Movement

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	Association for Dance Movement Psychotherapy UK (ADMP UK)	improvement 4	Dance movement psychotherapists work in schools within mainstream education with children who may be at risk of developing mental health issues as well as those who remain at school while receiving further support from CAMHs. In the latter case, the work may be part of a multidisciplinary provision.	intervention within schools can support children from being moved to care. Dance movement psychotherapy can provide an alternative option for children with attachment issues.	Psychotherapy schools Karkou, V. Fullarton, A. and Scarth, S. (2010) Finding a Way out of the Labyrinth through Dance Movement Psychotherapy: Collaborative Work in a Mental Health Promotion Programme for Secondary Schools. In V Karkou (ed) Arts Therapies in Schools: Research and Practice. London: Jessica Kingsley, 59-84. Twelve adolescents (11-13-year-olds) were randomly allocated to a 10-week Dance Movement Psychotherapy (DMP) group and a waiting list. The study took place within a mainstream school as part of a wider mental health promotion project called the Labyrinth and drew upon attachment theory. Pre- post-measures (ASEBA questionnaires) showed significant positive differences for the Dance Movement Psychotherapy group in relation to internalising and depressive symptoms. Qualitative comments from the

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					therapist, the participating students and their teachers suggest that the group made a significant difference to the way they thought about relating to each other and themselves. The participants became more capable in expressing themselves in the group, while built self-confidence and a stronger sense of self-worth. Evaluation forms completed by the end of the group highlighted the value of non-verbal aspects of the work and having an opportunity to share these experiences with others. Jeong Y J and Hong, S C (2005) Dance Movement Therapy Improves Emotional Responses and Modulates Neurohormones in Adolescents with Mild Depression, International Journal of Neuroscience, 115:1711–1720 Joeng and Hong (2005) completed an RCT that assessed changes in psychological health and

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					neurohormones of adolescents with mild depression who took part in the 12 week dance movement therapy group. Forty middle school seniors (mean age: 16 years old) volunteered to participate in this study and were randomly assigned into either a dance movement group (n = 20) or a control group (n = 20). The study reported that scored relating to psychological distress from the 20 adolescents attending dance movement therapy sessions significantly decreased, plasma serotonin concentration increased and dopamine concentration decreased. It is suggested that dance movement therapy may be effective in mild depression through stabilising the sympathetic nervous system. Dance Movement Psychotherapy with Children with emotional and/or behavioural difficulties: Tortora S (2005) The dancing

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Dialogue: Using the Communicative Power of Movement with Young Children. MN: Redleaf Press and Tortora, S (2010) From the Dance Studio to the Classroom: Translating the Clinical Dance Movement Psychotherapy Experience into a School Context. In V Karkou (ed) *Arts Therapies in School: Research and Practice*. London: Jessica Kingsley, 27-43. Several case study evaluations of practice have been completed by Tortora (2005). Particular references to evaluating practice with children with emotional and/behavioural difficulties are made in a more recent publication (Tortora 2010). Koshland, L (2010) Peace through Dance Movement Therapy: The Development and Evaluation of a Violence Prevention Programme in an Elementary School. In V

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Karkou (ed) *Arts Therapies in Schools: Research and Practice*. London: Jessica Kingsley, 43-58. and Kosland, L and Whittaker, J B (2004) Peace through Dance/Movement Therapy: A violence prevention programme for elementary school, *American Journal pf Dance Therapy*, 26, 2, 69-90. Koshland (2004, 2010) reports on a mixed methods evaluation of a particular programme developed as part of a violence prevention programme. Based on evaluation reports from teachers students and researchers, there was a significant decrease in aggressive behaviour in several identified areas and an increased ability for children to control disruptive behaviour and instigate fights. Meekums B (2008) Developing emotional literacy through individual Dance Movement Therapy: a pilot study,

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Emotional and Behavioural Difficulties Vol. 13, No. 2, 95–110 Meekums (2008) reports on a mixed methods pilot study on the contribution of Dance Movement Therapy towards emotional literacy for six children (4-7) in a primary school. The study is primarily based on teacher perceptions relating to teacher-identified goals and on movement metaphors reported in therapist notes. Results suggest a link between metaphors identified and positive teacher-rated outcomes in the following areas relating to emotional literacy: self-esteem; emotional expression and regulation; and social function. Causal links cannot be identified with certainty due to the pragmatic uncontrolled design, but are inferred through qualitative teacher feedback. Recommendations for further research are made. Payne, H (1987) The

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					perceptions of male adolescents labelled delinquent towards a programme of dance movement therapy, MPhil thesis, University of Manchester. and Payne, H. (1992) 'Shut in, Shut out: Dance Movement Therapy with Children and Adolescents.' In H. Payne (ed.) *Dance Movement Therapy: Theory and Practice*. London: Routledge, 39–80. Adolescents with behavioural problems were the focus of the study completed by Payne (1987, 1992) in which a comprehensive evaluation of process and outcomes took place. The participants' perceptions were the main focus of the evaluation. Based on these and the therapist/researcher's clinical notes, guidelines for good practice have been proposed that address adolescent defences.

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					Other case studies with children in schools: Eke, L. & Gent, A.M. 2010, "Working with withdrawn adolescents as a moving experience: A community resourced project exploring the usefulness of group dance movement psychotherapy within a school setting", Body, Movement and Dance in Psychotherapy, vol. 5, no. 1, pp. 45-57. Ylönen, M.E. & Cantell, M.H. 2009, "Kinaesthetic narratives: Interpretations for children's dance movement therapy process", *Body, Movement and Dance in Psychotherapy,* vol. 4, no. 3, pp. 215-230.
31	SCM4	Ensure that children and young people with attachment difficulties have access to therapeutic interventions	Children and young people with attachment difficulties are vulnerable to mental health and emotional well-being difficulties throughout their lives. They need interventions which can support their mental health and emotional wellbeing and thus allow them to develop into health adults.	These children and young people frequently do not meet the thresholds for interventions, unless they have diagnosable co-morbid difficulties. Whilst the adoption support fund is now providing a means for accessing interventions for more of this population this still leaves a large number of children and young people not able to access timely and appropriate interventions.	Tarren-Sweeney M. & Vetere, A. (2014) Mental health services for vulnerable children and young people. Routledge Vostanis, P (2007) Mental health interventions and services for vulnerable children and young people JKP

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32	SCM4	A research programme to explore a range of therapeutic interventions for the children and their families; with CAMHS and other intervention services supported to implement promising interventions as part of this research programme.	The number of evidence based interventions recommended for children and young people with attachment difficulties is very limited and insufficient for practitioners to meet the complex needs of the children, young people and their families. Practitioners need to be supported to provide a range of promising interventions and to contribute to the developing evidence base.	The range of evidence based interventions for use with this population of children and young people is extremely limited. Practitioners working with this population need to be enabled to provide a range of interventions based on sound theory and research evidence which can be used flexibly and creatively to meet the needs of the individual child and family in front of them. One size will not fit all!	Casswell, G.; Golding, K. S.; Grant, E.; Hudson, J. & Tower P. (2014) Dyadic Developmental Practice (DDP): A framework for Therapeutic intervention and Parenting. The Child & Family Clinical Psychology Review, No 2, 19 - 27 Hughes, D. (2014) Dyadic Developmental Psychotherapy: Toward a comprehensive trauma-informed treatment for developmental trauma disorder. The Child & Family Clinical Psychology Review, No 2, 13 – 18 Boyer, N. R. S.; Boyd, K. A.; Turner-Halliday, F.; Watson, N.; & Minnis H. (2014) Examining the feasibility of an economic analysis of dyadic developmental psychotherapy for children with maltreatment associated psychiatric problems in the United Kingdom. BMC Psychiatry 14:346 Turner-Halliday, F.; Watson,

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					N.; Boyer, N. R. S.; Boyd, K. A. & Minnis H. (2014) The feasibility of a randomised controlled trial of Dyadic Developmental Psychotherapy. BMC Psychiatry, 14:347
Access to mental health services					
33	Institute of Health Visiting (iHV)	The development of local Infant Mental Health pathways to ensure that appropriate, evidence based health and social care services are in place and working together to promote infant mental health and attachment, and to assess and provide therapeutic interventions for children and families where there are attachment difficulties.	If there are no pathways in place services are not co-ordinated and it becomes harder for professionals to refer and signpost women and families to appropriate services	Without a clear infant mental health pathway in place that is developed and underpinned by evidence, services evolve in an adhoc way rather than through a systematic process. It also becomes difficult to measure the effectiveness of the service and planning and use of future resources when there is no clear joined up structures in place.	Warwickshire Infant Mental Health pathway
34	Institute of Health Visiting	Provision of specialist	Whilst health visitor's work to prevent perinatal and infant	Quality assurance is predicated on providing safe high quality care to clients and patients.	

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	(iHV)	(psychotherapy) services for referral and also for advice, support and supervision	mental health illness, it is imperative that those individuals requiring specialist services receive prompt effective treatment. In order for this to happen health visitors require appropriate services to refer on to and work with to support them in the work that they are undertaking with women, children and families.	To identify women and children in need of services and then not to have services to refer onto can have a detrimental impact on those individuals who require the service. It is also important for health professionals and health visitors specifically to be aware when to refer and have benchmark statements in place to adhere to so that the service delivered is measurable and equitable and delivers the highest standard of care.	
35	SCM4	Ensure that dedicated mental health services are available to children and families which are delivered by practitioners knowledgeable about this population of children and young people and the attachment difficulties that they experience.	Children and young people with attachment difficulties, especially those in care or adopted from care, are known to have high levels of mental health difficulties which are not always best met by traditional mental health services.	The mental health needs of children and young people with attachment difficulties do not fit neatly into the diagnostic categories typically used in mental health services. In addition, these mental health needs must be understood in the context of family experience. Eg trauma, loss and separation are important contextual experiences which need to be taken into account when delivering mental health services. Dedicated mental health services can substantially increase the relevance and quality of services tailored to the specific needs of the population.	Rahilly T. & Hendry, E. (2014) Promoting the wellbeing of children in care Messages from research NSPCC Chapter Four Tarren-Sweeney M. & Vetere, A. (2014) Mental health services for vulnerable children and young people. Routledge Rahilly T. & Hendry, E. (2014) Promoting the wellbeing of children in care Messages from research NSPCC
Additional areas					
36	Institute of Health (iHV)	Training for all Health Visitors in the	Health Visitors provide a universal service to families	Training for Health Visitors in this area has been variable as investment has not been	Healthy Child Programme: Pregnancy and the first 5 years

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		promotion of infant mental health and assessment of attachment in pre school children, and also to provide therapeutic interventions for attachment difficulties such as video feedback (eg VIG and Watch Wait and Wonder) and parental sensitivity and behaviour training programmes.	during pregnancy and the first years of children's lives and are therefore in a prime position to promote infant mental health and attachment. They are also able to assess and identify attachment difficulties early so that appropriate interventions and services can be put in place to support children and families. This is a key public health issue that needs to be addressed by appropriate training of the health visitor workforce Marmot (2010)	consistent across provider organisations. There are some excellent examples where health visitors have been trained (for example using the Institute of Health Visiting Champions Training Model) which could be used as benchmarks for quality improvement.	of Life. Dept of Health 2009 Health Visitor Infant Mental Health Training pack. Institute of Health Visiting 2014 Early Intervention Foundation, 2015 Statistics demonstrate the cost of Perinatal Mental Health problems if they are not managed appropriately.
37	Institute of Health Visiting (iHV)	Health Visitor Infant mental health specialists / champions to be established in all areas to lead and coordinate services and provide training and support.	In order to co-ordinate the direction of integrated services in this area and provide a systematic approach to service improvement through leadership, the development and training of infant mental health specialists is imperative.	The provision of high quality, coordinated and accessible Perinatal and Infant Mental Health Services varies widely across England. There are some excellent examples where health visitors are leading service developments in infant mental health which could be used as benchmarks for quality improvement.	
38	Institute of Health Visiting (iHV)	National Standards for Health Visitor pre-registration training and CPD – to include theories of	In order to provide consistent evidence based practice, standards are required that all Higher Education Institutions offering Health Visitor education	At present the delivery of health visitor education is variable across the UK. Whilst all programmes meet the NMC (2004) Standards for Specialist Community Public Health Nursing requirements. The curriculum	A National Framework for Continuing Professional Development. Institute of Health Visiting 2015

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		attachment and infant mental health, and assessment and interventions.	adheres to. This will ensure all health visitors have been assessed at an agreed level of competence in this area.	delivered across the UK in response to these standards is variable. Which results in an adhoc approach to the delivery of perinatal and infant mental health. What is required is a standardised approach that ensures that all health visitors wherever they train have the skills and knowledge required.	Why Health Visiting? Cowley et al , 2013
39	The Association for Dance Movement Psychotherapy UK (ADMP UK)	Key area for quality improvement 3	Training of carers, teachers and health and social care staff: Dance movement psychotherapists often offer training to members of staff on understanding non-verbal communication and becoming aware of non-verbal relationships	Children and adolescents faced with attachment issues cannot be seen in isolation. Significant adults in their lives, carers, teachers, health and social care workers make an important contribution in the degree to which healthy attachments can be formed.	Working with teaching staff: Karkou, V. Fullarton, A. and Scarth, S. (2010) Finding a Way out of the Labyrinth through Dance Movement Psychotherapy: Collaborative Work in a Mental Health Promotion Programme for Secondary Schools. In V Karkou (ed) Arts Therapies in Schools: Research and Practice. London: Jessica Kingsley, 59-84. This programme in the first instance, offered training to teaching staff on identifying and understanding signs of emotional distress. This is just one example available in the published literature. Working with families: Loman, S. (1998) Employing a

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Developmental Model of Movement Patterns in Dance/Movement Therapy with Young Children and Their Families. American Journal of Dance Therapy. Vol 20. No 2,Fall/Winter1998 Weston, C. (2015) Becoming bonded through Developmental Movement Play: review of a parent and child movement group incorporating the theory, practice and philosophy of Sherborne Developmental Movement. Body, Movement and Dance in Psychotherapy. Volume 10, Issue 4, pages 189-193 Desmarais, S. (2006) `A space to float with someone`: recovering play as a field of repair in work with parents of late-adopted children. Journal of Child Psychotherapy. Vol. 32 No. 3 2006 349 - 364
40	SCM4	Additional evidence sources for consideration	I would recommend that Louise Bomber is called as an expert on meeting the attachment needs		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			of children in schools. She has a great deal of expertise in this area. She has extensive experience supporting schools and has been called as an expert to advise parliament on improving teacher training in understanding attachment difficulties.		
41	SCM2	Dissociative Identity Disorder (DID) recognition	Consequences of DID not being universally recognised causes far reaching problems for Children with this, as well as impacting on parents/carers looking after the children.	Inconsistent approach across U.K	Norfolk, Yorkshire, Leicester recognise DID and Health & Social care refer in from local authority. However if you are not in these areas you have to self fund for correct therapy. MIND has a clear definition on their website.
42	SCM2	Training in Schools	Children and Parents/Carers need to have confidence and feel supported by the school, knowledge of attachment and coping mechanisms are crucial.	Inconsistent approaches in school means that thousands of children are too quickly punished and talk of exclusions is happening still too much. I believe the Head Teacher should be the one that all attachment training is mandatory for. It is not enough to just have a designated teacher as this teacher could have good understanding of attachment and want to implement change but be stopped by a head teacher who is not as informed.	Recently attending a conference purely on Educational attainment for children in care, it was clear the courses are out there but are not being tapped into by schools
43	SCM2	Compulsory training for Foster Carers	Thinking and practice around this evolves and as well as first aid and safeguarding training being compulsory every three	Attachment effects the majority of our children and once understood can help you to parent more to the needs of that child.	Already in place the importance of First Aid due to updating and changing information, this would be next

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			years, I feel this is just as important.		natural step accepting that practice also changes around the brain.
44	SCM2	Additional developmental areas of emergent practice	EPAC forms - Educational Plans for Adopted Children. The awareness of these forms is important.	PEP's are widely known and commented on in guidelines, including this form, would be next logical step	More awareness of this is growing, so to include it would be in line with other practices.
45	SCM2	Additional evidence sources for consideration	Fostering Community & MIND guidelines		
46	Royal College of Psychiatrists	To start early and prioritise the pre-school age group.	Because attachment takes place particularly in first 18 months and becomes more difficult after the age of three to reduce permanent impairment.		
47	Royal College of Psychiatrists	Some children pass through the period when attachments most naturally form (6-18 months) without finding a satisfactory 'attachment figure'.	If these children's circumstances improve in the next year or so they can still form an attachment, however the quality of these relationships is likely to be impaired and after the child reaches 3 years in age the risk of developing an attachment disorder rises swiftly. This is a developmental emergency for children on the edge of care. Equally children with established attachment disorders who are looked after,		

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			subject to SGOs or adopted have substantially increased emotional and behavioural problems and needs and their life chances will be greatly impaired if they don't receive the right help. In particular these children do less well in education, are more prone to bullying and exploitation, have more problems with intimate relationships and less chance of stable and rewarding employment.		
48	SCM1	Recognition and awareness of attachment difficulties in children on the edge of care, in care and adopted from care	Despite a good knowledge base in some services in England and Wales about the prevalence of attachment difficulties there is no unified definition of what attachment difficulties are, how they manifest themselves in the everyday life of children and what to do about these difficulties.	Professionals (in CAMHS, Children's social care and education) who don't know what they don't know need to be given a clear, unambiguous definition of attachment difficulties.	
49	SCM1	Education and training for parents(birth and adoptive) ,Foster carer's and RC workers on	As carers of children and young people with attachment difficulties, parental (& carer) sensitivity can be the greatest skill to counteract the very real day to day issues for children	As carers to this vulnerable group of c & yp, the biggest single factor in a child's life is parental sensitivity and an understanding of how that can impact on the attachment relationship.	

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		Attachment	with attachment difficulties . Carers need access to well planned and effective training and development to understand the importance of parental sensitivity		
50	SCM1	Education, training and support for staff of Children and Young people in Schools and post 16 education with attachment difficulties	Children and young people spend a great deal of time in school. A general understanding of staff in schools and post 16 provision of attachment difficulties and how that can impact on learning and attainment is essential. While the needs of Children in Care are managed by the statutory provision of Virtual School Head teachers', children on the edge of care,nor those adopted from care have that luxury.	There is growing evidence that children on the edge of care and those adopted from Care are not making the progress that peers in Care are making. It is possible that staff in schools are not being given clear enough information about the causes of attachment difficulties in these grps of children and young people , together with the tools required to assist all students with attachment difficulties	