NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

SCOPE

1 Guideline title

Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care

1.1 Short title

Children's attachment

2 The remit

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

3 Need for the guideline

3.1 Epidemiology and background

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

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

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

d) Over 75% of looked-after children are classified as white, with black and black British (7%), mixed (9%) and Asian and Asian British (4%) accounting for most of the rest. About 60% of looked-after children are placed under either interim or full care orders; a further 29% are subject to voluntary agreements under section 20 of the Children Act 1989. Importantly, just over 3% of all looked-after children in England are unaccompanied and seeking asylum; the vast majority of these being boys aged 16 or over.

e) Of the 67,000 children and young people in care on 31 March 2012, 75% were in foster care, 4% were placed for adoption, 5% were in placements with their parents, 9% were in secure units, children's homes and hostels, and 1% were in a residential school. Two-thirds had been subject to a single placement in the preceding year, 22% had 2 placements and 11% had 3 or more.

f) In the same year, just over 28,000 children started to be looked after and about the same number stopped being looked after; with 37% returning to live with their parents or relatives, 13%

being adopted and the rest living independently or under a variety of different circumstances, such as guardianship orders for foster parents or with other carers.

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

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

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

j) Children who receive responsive and attuned caregiving during the first 18 months of life develop secure attachments to their primary caregiver. These children can be comforted by their caregivers and use their caregiver as a secure base from which to explore their environment. It is estimated from population samples that around two-thirds of children are securely attached. These children have better outcomes than non-securely attached

children across all domains, including social and emotional development, educational achievement and mental health.

k) Children who receive caregiving that is erratic or intrusive typically develop ‘insecure anxious-ambivalent’ attachments. These children maintain proximity to their caregiver by ‘up-regulating’ their emotional states: they become anxious and clingy and cannot be calmed when comfort is offered.

l) Children who receive caregiving that is rejecting or punitive typically develop ‘insecure anxious-avoidant’ attachment. These children maintain proximity to their caregiver by ‘down-regulating’ their emotional state: they appear to manage their own distress and not to need comfort.

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

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

o) In addition to the classification of attachment as secure, insecure or disorganised, a number of types of ‘attachment disorders’ have been defined. Reactive attachment disorder includes 2 types: inhibited and disinhibited (as defined in DSM-IV-TR and ICD-10).

Both types of disorder, which can coexist, include markedly disturbed and developmentally inappropriate behaviours.

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

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

r) The limited evidence available about the attachment classification and/or prevalence of attachment disorders in looked-after children and young people and those adopted from care suggests that only 10% are securely attached to their biological parents. Many have experienced significant levels of abuse and neglect, which are strong predictors of both disorganised attachment and attachment disorder. The prevalence of mental health problems is significantly higher in looked-after children and young people and those adopted from care. About 42% of children aged 5–10 years who have been in care develop mental health problems compared with 8% who have not been in care; the figures for young people aged 11–15 years are 49% and 11% respectively.

3.2 Current practice

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

- the needs of children and young people with identified insecure or disorganised attachment or an attachment disorder, and
- the needs of looked-after children and young people and those adopted from care.

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

- family drug and alcohol courts, which comprise a new approach to care proceedings when drug dependency in a parent is the major problem
- family group conferencing, which is being used by 60 local authorities to plan care for children at high risk, and
- multisystemic therapy for young people (aged 11–17 years) and their families, when there is a risk of out-of-home placement (care or custody) and there has been poor engagement with services.

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

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

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

- behavioural approaches, such as video interaction guidance
- psychotherapeutic approaches
- combined behavioural and psychotherapeutic approaches, such as Watch, Wait and Wonder, and
- programmes based on mentalisation, such as Minding the Baby and the Infant and Toddler Program.

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

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

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

4 The guideline

4.1 Population

4.1.1 Groups that will be covered

a) Children and young people (aged 0–18 years) who are:

- adopted, including those adopted in England from abroad
- looked after children in the care system
- at high risk of being taken into care.

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

4.1.2 Groups that will not be covered

a) Children and young people with attachment problems or disorders who are not looked after, or who are not at risk of being looked after, or who have not been adopted from the care system

(for example, children who are adopted by a relative or step-parent and children who are adopted abroad).

b) Adults over the age of 18 years.

4.2 Setting

a) Any setting in which professionals have contact with children and young people adopted from care, children and young people who are being looked after or those at high risk of being looked after. This will include:

- a range of community settings, including fostering, residential and kinship care settings
- primary care settings
- secondary care settings
- secure settings.

b) All educational settings in which children and young people who are adopted from care, who are being looked after or who are at high risk of being looked after, are educated.

4.3 Management

4.3.1 Key issues that will be covered

Prediction, identification and assessment

a) Identification of the factors (such as biological and environmental) associated with the development of attachment problems and disorders

b) The identification of factors (such as processes and arrangements) and experiences that may be associated with the risk of attachment-related problems and disorders.

c) Instruments, tools and methods used to predict, identify and assess attachment problems and disorders.

Prevention of attachment problems or disorders

d) Interventions aimed at the child or young person, the parents/caregivers or the family for the prevention of attachment problems.

Management of attachment and attachment disorders

e) Psychosocial and pharmacological interventions aimed at the child or young person, the parents/caregivers or the family for the management of attachment problems.

4.4 Main outcomes

a) Disorganised attachment and/or attachment disorders.

b) Behavioural, cognitive, educational and social functioning.

c) Wellbeing and quality of life.

d) Developmental status.

e) Quality of the relationship between the parent or caregiver and child or young person.

f) Quality of parenting and parenting behaviour.

g) Risk factors.

h) Criminal outcomes.

i) Experience of interventions and care processes.

j) The breakdown of fostering and adoption.

4.5 Draft review questions

4.5.1 Prediction, identification and assessment

a) What biological and environmental factors are associated with the later development of insecure/disorganised attachment or an

attachment disorder in children and young people who are adopted from care, who are looked after and those who are at high risk of being looked after?

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

c) What features of arrangements made for children and young people in each looked-after setting and those related to adoption are associated with an increase or decrease in the risk of developing insecure/ disorganised attachment or an attachment disorder?

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

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

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

4.5.2 Prevention of attachment problems or disorders

a) What interventions are effective in the prevention of insecure/disorganised attachment or attachment disorders in children

and young people at high risk of being looked after? What are the risks associated with the each intervention?

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

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

4.5.3 Management of disorganised attachment and attachment disorders

a) What psychosocial interventions are effective for attachment problems and disorders in children and young people who have been adopted from care? What are the risks associated with each intervention?

b) What psychosocial interventions are effective for attachment problems and disorders in children and young people who are looked after in the care system? What are the risks associated with each intervention?

c) What psychosocial interventions are effective for attachment problems and disorders in children and young people who are at risk of being looked after? What are the risks associated with each intervention?

d) What pharmacological interventions are effective for attachment problems and disorders in children and young people? What are the risks associated with each intervention?

4.6 Economic aspects

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

4.7 Status

4.7.1 Scope

This is the final scope.

4.7.2 Timing

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

5 Related guidance

5.1 Published NICE guidance

- Antisocial behaviour and conduct disorders in children and young people. NICE clinical guideline 158 (2013).
- Looked-after children and young people. NICE public health guidance 28 (2010).
- Pregnancy and complex social factors. NICE clinical guideline 110 (2010).

- Alcohol-use disorders – preventing harmful drinking. NICE public health guidance 24 (2010).
- Reducing differences in the uptake of immunisations. NICE public health guidance 21 (2009).
- Social and emotional wellbeing in secondary education. NICE public health guidance 20 (2009).
- When to suspect child maltreatment. NICE clinical guideline 89 (2009).
- Schizophrenia (update). NICE clinical guideline 82 (2009).
- Borderline personality disorder. NICE clinical guideline 78 (2009).
- Antisocial personality disorder. NICE clinical guideline 77 (2009).
- Social and emotional wellbeing in primary education. NICE public health guidance 12 (2008).
- Attention deficit hyperactivity disorder. NICE clinical guideline 72 (2008).
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007).
- Behaviour change. NICE public health guidance 6 (2007).
- Interventions to reduce substance misuse among vulnerable young people. NICE public health guidance 4 (2007).
- Prevention of sexually transmitted infections and under 18 conceptions. NICE public health guidance 3 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Obsessive–compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).
- Depression in children and young people. NICE clinical guideline 28 (2005).
- Post-traumatic stress disorder (PTSD). NICE clinical guideline 26 (2005).
- Violence. NICE clinical guideline 25 (2005).
- Self-harm. NICE clinical guideline 16 (2004).
- Eating disorders. NICE clinical guideline 9 (2004).

5.2 Published SCIE guidance

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

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

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

5.4 NICE Guidance under development

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

- Challenging behaviour and learning disabilities. NICE clinical guideline. Publication date to be confirmed.

6 Further information

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

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

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