# Foundational Theories and Knowledge

# Attachment Practice Paper

## 1. Introduction

This practice paper provides practitioners with a comprehensive understanding of attachment theory as it applies to child protection practice. Considerations for case management are also discussed.

## 2. Understanding attachment

### 2.1 Attachment development

Attachment is the term used to describe the relationship that a child develops with their caregiver/s throughout their first years of life, and beyond.

Infants are born with an innate bias to become attached to a protective caregiver. As an infant experiences how their caregivers respond to their physical and emotional needs and cues, an attachment relationship develops.

Attachment does not depend upon biological connections but on the quality of care provided by the caregiver/s. Attuned, responsive and consistent caregiving supports the development of a healthy attachment relationship. Conversely, poorly attuned, unresponsive and inconsistent (or unpredictable) care can harm a child's ability to form a healthy attachment relationship with their caregiver/s.

Children and young people form attachment relationships with caregiver/s who consistently provide them with safe care. This means that in addition to parents (who are often referred to as primary attachment figures), grandparents or other family members who regularly care for a child or young person become (secondary) attachment figures.

Any person who is a reliable presence in the child or young person's life, provides care consistently and has an emotional investment in the child or young person, could be considered an attachment figure. A child or young person's attachment relationships may be referred to as their attachment 'network' or 'hierarchy'.

In the absence of primary attachment figures, children and young people can seek comfort and care from secondary or other attachment figures. The primary attachment figures will always be the child or young person's preferred caregiver/s, particularly in times of distress.

In many Aboriginal and Torres Strait Islander families, infants, children and young people are raised by multiple caregivers, each of whom may perform different yet equally important caregiving tasks. Those caregivers may be the child's parents or other significant relatives within the child's broader family and kinship network and community. In this way, Aboriginal and Torres Strait Islander infants, children and young people may develop a network of attachment relationships with multiple caregivers who are committed to them and provide them with attachment relationships that support their development. For further guidance, refer to the Aboriginal and Torres Strait Islander Child Placement Principle Practice Paper.

While attachment theory originated within a Western, individualistic social context, attachment theory valuably contributes to our understanding of child development more broadly. Forming attachment relationships is a developmental necessity for human beings (and many other species), but the nature and network of these relationships can look different depending on the culture in which the child or young person is raised.

Differences in cultural and parenting practices can lead to differences in the attachment behaviours children and young people display. Cultural consultation is recommended when practitioners are working with families from cultural backgrounds different to their own. Refer to the Aboriginal and Torres Strait Islander Child Placement Principle Practice Paper, the Practice and cultural consideration Practice Paper and the Working with cultural diversity Practice Paper for further guidance.

Attachment relationships are described as developing through a series of phases. These phases are based on typical developmental trajectories of infants and young children. These phases can be affected by trauma, instability and the child's developmental abilities; for example, infants and young children with developmental delays or disability may develop attachments more slowly.

| **The phases of attachment development include:** | |
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| Indiscriminate orienting and signalling (First few months of life): | During this phase, an infant will initially orient and signal indiscriminately to people around them. Infants will smile reflexively and will not generally show a strong preference for any particular caregiver during their first few months of life. As the infant develops, they will begin to react to the sound of their main caregiver/s voice and will reflexively reach to be held by and visually track their main caregiver/s. Infants will, smile reflexively and indiscriminately, and will not generally show a strong preference for any particular caregiver during their first few months of life. |
| Recognising and discriminating (*Approximately* 3 to 8 months): | During this phase, an infant will begin to recognise their main caregiver/s, and will begin to clearly differentiate between those caregivers and other people. As they age, they will start to show a preference for their main caregiver/s in that they will more often and more consistently look to or seek to interact with them. |

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| Demonstrating active attachment behaviour (*Approximately* 8 to 36 months): | During this phase, the infant will show a clear preference for their main caregiver/s. They will seek proximity to reach more frequently for and visually track their caregiver/s. Infants in the active attachment phase will also be more quickly soothed by the main caregiver/s than by others, and will show distress at or protest separation from the main caregiver/s. |
| Goal-oriented partnership (*Approximately* 36 months onwards): | During this phase, the attachment relationship is strengthened and consolidated. As the infant moves into toddlerhood and their language develops, they will begin to verbalise their needs and attempt to negotiate differences with their caregiver/s. If the attachment relationship is healthy, the toddler will imagine the caregiver's plans and perceptions and fit their own plans and activities according to these. The toddler will also be better able to tolerate (brief) separations from their attachment figures and may accept comfort and caregiving from other significant people in their lives, but will still find the greatest comfort and reassurance from their main attachment figures. |

It is important to note that attachment refers to the unique relationship that children develop with their caregiver/s rather than a caregiver's relationship with a child.

## 2.2 The importance of attachment

Attachment relationships form the foundation for a child or young person's development, across all developmental domains. Practitioners should give careful consideration to the quality of the attachment relationship a child or young person has with their caregiver/s.

Healthy attachment relationships offer infants and young children the safety to confidently explore their world, their emotions and relationships. This then contributes to their physical, emotional, social and cognitive development. For example, infants and young children who believe that their caregiver/s will support and delight in their play, and who offer them comfort and encouragement when they encounter obstacles, will be more likely to want to continue exploring their world. This in turn facilitates healthy learning and development. In the absence of healthy attachment relationships, infants and young children may not feel safe enough to explore their world, which can impede their development. For example, infants and young children who do not trust that their caregiver/s will support or delight in their exploration of their

world, or be available to offer them comfort or assistance when they encounter obstacles, will be less likely to continue exploring. This limits the infant or young child's opportunities to learn and can impact on their developmental progress.

Attachment relationships are critical to children and young people's emotional development. Within a healthy attachment relationship, a child or young person will experience their caregiver/s as emotionally attuned, empathic, responsive and available to help with their emotions. This helps children and young people to better understand and verbalise their emotions, and to develop the capacity for empathy.

When caregiver/s assist children or young people to manage their emotions, children or young people can also develop the capacity for emotional regulation, which then helps with behaviour regulation. Infants and children who do not learn to regulate their emotions and behaviours often have regulatory difficulties throughout their lifespan. Such regulatory difficulties often undermine mental health and can contribute to issues such as substance misuse.

Attachment relationships also influence the way a child or young person views themselves, relationships and the world. The healthier the attachment relationship is and the safer the child or young person feels with their caregiver/s, the more likely the child or young person will develop healthy internal working models of themselves, relationships and the world.

Conversely, the less healthy the attachment relationship is and the more the child or young person has been harmed by their attachment figure/s, the more their internal working models are going to reflect feelings of insecurity, rejection and negativity. Internal working models of children and young people are discussed further in the Trauma Practice Paper.

## 2.3 Attachment and trauma

The quality of the attachment relationship/s the child or young person develops with their caregiver/s is affected by experiences of trauma.

*Trauma experiences*

Children and young people are less likely to develop a healthy attachment relationship with caregivers who harm or neglect them, or expose them to traumatic experiences. For example, caregivers who physically harm their children can be viewed by their children as frightening, dangerous, and unavailable to meet their emotional needs. Children may then see themselves as unsafe and unworthy of care and protection.

Similarly, caregivers who sexually harm their children can be viewed by children as dangerous, unsafe and unpredictable. Children who are sexually harmed may learn to believe they are only valuable to the caregiver when they meet the caregiver's needs, and otherwise see themselves as unlovable and unworthy of protection.

Caregivers who emotionally harm their children can be viewed by children as hurtful and emotionally unsafe, and children subject to emotional harm can view themselves as unlovable. Caregivers who neglect their children can be viewed as unavailable, unresponsive, and unpredictable, and their children may believe themselves to be unimportant and unworthy of care.

Harm perpetrated by someone outside of the child or young person's family or kinship network (extra-familial) can still impact on the child or young person's attachment relationship/s with their caregiver/s if the caregiver/s are seen to be unprotective or unresponsive to the child or young person's needs during or following the trauma.

*Parental alcohol and other drug use*

Issues such as parental alcohol and other drug use, mental health difficulties and domestic and family violence can also impact on the attachment relationships their children develop with them. For example, caregivers who misuse alcohol and other drugs may be preoccupied with seeking substances and demonstrate changes in affect and behaviour when intoxicated or withdrawing. Children may perceive these caregivers as unavailable, unresponsive, inconsistent and frightening, each of which adversely affects attachment. Refer to the Trauma lens Practice Paper, Trauma Practice Paper and Alcohol and other drugs (AOD) in child protection Practice Paper for further guidance.

*Mental health difficulties*

Caregivers who experience poor mental health can be vulnerable to neglecting the needs of their children. For example, caregivers with depression may not have the motivation to respond to their children's needs or may not be able to show delight in their children. Caregivers with anxiety may struggle to support their children's exploration and caregivers with psychotic symptoms may be frightening to their children. Children may then perceive their caregiver as unavailable, unresponsive, or frightening. If the caregiver's mental health fluctuates, children can see their caregiver as unpredictable and inconsistent. Refer to the Understanding mental health difficulties in a child protection context Practice Paper for further guidance.

*Family violence*

Caregivers who are the victims of domestic and family violence may be vigilant to threats of harm and preoccupied with ensuring their safety, which may compromise their ability to respond to their children's needs. Caregivers who perpetrate domestic and family violence can be threatening and frightening to children. Perpetrators who use coercive control may also deliberately prevent their partner from nurturing and showing affection to their child/children. Experiencing domestic and family violence can lead children to view their caregiver/s as unavailable and inconsistently responsive to their needs, adversely affecting attachment. Refer to the Domestic and family violence Practice Paper for further information.

## 2.4 Attachment patterns

The quality of a child or young person's attachment relationship reflects the quality of care they have received from their caregiver/s. While there are patterns or styles of attachment that have been identified in the research literature, formal classification of an attachment relationship requires specialist training and supervision.

Rather than seeking to classify attachment relationship, practitioners are encouraged to consider whether a child or young person's attachment relationship is healthy or unhealthy.

| **Healthy attachment** | **Unhealthy attachment** |
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| Relationships are those that reflect the child or young person's feelings of security and safety within the relationship with their caregiver/s. Children and young people with healthy attachment relationships will show behaviours towards their caregiver/s that suggest they perceive their caregiver/s as person/s who delights in them, can help them and will keep | Relationships are those that reflect the child or young person's feelings of insecurity or fear within the relationship with their caregiver/s. Children and young people with unhealthy attachment relationships will show behaviours towards their caregiver/s that indicate a preference to avoid their caregiver/s or to either inhibit or exaggerate the communication |

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| them safe. In turn, children and young people with healthy attachment relationships are more likely to perceive both themselves and relationships in general positively (that is, healthy attachment relationship support the formation of positive internal working models). Healthy attachment relationships support the child or young person's development and are associated with better life outcomes. | of their needs. At times, the behaviour of the child or young person with an unhealthy attachment relationship will appear confused or difficult to make sense of. Unhealthy attachment relationships impact on the child or young person's internal working model, meaning that they may see themselves as bad or unworthy and may see relationships as unsatisfying, unreliable and as sources of fear. Unhealthy attachment relationships undermine the child or young person's development and are associated with poorer life outcomes. |

## 2.5 Assessing attachment

Assessing attachment requires practitioners to observe the attachment behaviours children and young people display when interacting with their caregiver/s. Attachment behaviours are those that help the child or young person to achieve or maintain proximity to their caregiver/s, so the caregiver/s can be available to meet their needs. These might be 'attractive' behaviours (for example, making eye contact, smiling, greeting, verbalising and vocalising with their caregiver/s), 'aversive' behaviours (for example, protesting separation from the caregiver/s by crying or clinging), or 'active' behaviours (for example, following, reaching for, searching for or calling to the caregiver/s and seeking to be held).

Information about the child or young person's experiences with the caregiver/s, including harm or neglect, is essential to assess the quality of the attachment relationship. This knowledge assists the assessor to contextualise observations and other assessment information. For further information in relation to assessment, refer to the DCP Assessment framework.

The child or young person's behaviours with their caregiver/s will give practitioners an idea as to how they view the caregiver/s. Observing the child or young person in different settings will help practitioners to understand if the child or young person is able to develop healthier relationships with others.

Interviewing the child or young person (where developmentally possible) about their views of their relationship with their caregiver/s is also important. Similarly, interviewing the caregiver/s about their views of the relationship with the child or young person is necessary. Practitioners should also seek information from other sources, such as the child or young person's:

- childcare workers
- teachers
- significant family or kin.

| **Observations of the child or young person with their caregiver/s** | |
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| **Healthy attachment indicators** | **Unhealthy attachment indicators** |

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| • on reunion: excited, smiling, approaching the caregiver/s and seeking affection<br>• generally happy, relaxed and playful in presentation<br>• comforted easily by the caregiver when upset or hurt<br>• seeks the caregiver/s to meet their basic care needs (for example, for food) and emotional needs (for example, for comfort)<br>• engages in eye contact happily and seeks eye contact often<br>• communicates verbally and readily<br>• seeks engagement with the caregiver/s (to watch them, delight in their play, or join in their play)<br>• uses the caregiver/s as a secure base from which they explore their environment (including toys and other people)<br>• seeks affection easily and is receptive to affection from the caregiver/s<br>• behaviour is coordinated, predictable and responsive to the caregiver/s behaviour<br>• protests separation, but can be somewhat consoled and calmed by the caregiver/s. | • on reunion: avoidant or, withdrawn or angry towards the caregiver/s OR clings to the caregiver/s and refuses to separate<br>• generally withdrawn, anxious or angry in presentation<br>• unable to be comforted by the caregiver/s when upset or hurt<br>• does not seek the caregiver/s to meet their needs or is not responsive when the caregiver/s tries to meet their needs<br>• avoids eye contact with the caregiver/s<br>• is largely non-communicative with the caregiver/s<br>• does not often seek to engage the caregiver/s and almost seems to expect the caregiver/s will not respond to them<br>• either clings to the caregiver/s anxiously and fails to explore or ignores the caregiver/s and does not rely on their support to play and explore<br>• rarely seeks affection except when the caregiver/s requests it and may seem rigid or unresponsive in response<br>• behaviour is difficult to understand, unusual and unpredictable<br>• protests separation and cannot be calmed by the caregiver/s, or leaves without any distress and/or asks to go with others<br>• shows preference for others (such as the DCP practitioner) over the caregiver/s. |

A referral for a specialist assessment with a DCP psychologist may be required if the practitioner observes maladaptive behaviour related to attachment. Practitioners should consult with DCP Psychological Services in these instances (refer to Identify and respond to the psychological and emotional needs of the child or young person in the Supporting children and young people in care chapter of the Manual of Practice). For Aboriginal and Torres Strait Islander families consideration should be given to culturally safe psychological services.

## 2.6 Siblings and attachment

Siblings do not generally form attachment relationships with one another. Children develop attachment relationships with the people who primarily meet their basic care and emotional needs. Siblings should not be expected to consistently or independently perform this caregiving role for one another. Siblings can develop significant bonds based on their shared lived experiences.

Some exceptions do occur. For example, sometimes older Aboriginal and Torres Strait Islander children are expected to contribute to the care of their younger siblings and can become attachment figures within the attachment network.

In neglectful homes where adults do not meet children's needs, older siblings may care for their younger siblings. In the absence of a stable adult caregiver/s to meet their needs, the child may form an attachment with an older sibling who offers them some care. Given their experiences of neglect, the quality of these attachment relationships is usually unhealthy. Children and young people who assume the caregiving role can become parentified, which is problematic for their development.

Where attachment relationships between siblings have developed, practitioners must conduct a thorough assessment to understand the sibling relationship. This assessment should inform decisions about the placement of siblings that take into account their individual developmental needs, including both siblings need to develop attachment relationships to the adult caregiver/s.

## 2.7 Building new attachments

Attachment relationships cannot be simply transferred between caregivers. The attachment relationship that develops between an infant/child or young person and a caregiver is unique.

Children and young people removed from their parents and placed in care can develop new attachment relationships. Even older children and young people can develop new attachment relationships with support and persistence.

New attachments rely on the new caregiver/s being attuned, responsive and consistently available to meet the child or young person's needs. New attachment relationships are influenced by previous attachments the child or young person has had, and their expectations of relationships. Children and young people who have had some positive experiences of attachment relationships may find it easier to develop new attachment relationships with carers. Children and young people who have experienced significant harm and neglect have associated unhealthy attachment relationships.

The development of new attachment relationships can be undermined if children and young people are living with uncertainty about their future care arrangements. Children and young people living with this uncertainty who will be staying with a carer in the longer-term, ~~they~~ will be less inclined to let themselves be vulnerable and invest in building a new relationship with their caregiver/s.

It cannot be assumed that an infant, child or young person with healthy attachment relationships in one placement will develop similarly healthy attachments in another.

It can be argued that once the child has formed a template for healthy attachment relationships, they can apply that template to new relationships. However, forming new attachments often requires the cessation of the previous attachments. This experience of loss and grief can seriously undermine the child or young person's willingness to form a new attachment relationship.

When considering placement changes, the child or young person's attachment needs must be carefully considered and weighed against other benefits that the new placement may offer. Healthy attachment relationships must be considered highly valuable, and the risks associated with rupturing such relationships acknowledged as part of the decision making process.

When considering moving the child or young people with a healthy attachment with their current carers to a new placement, it is strongly recommended that practitioners consult with:

- practice leaders
- Principal Aboriginal Consultants
- psychologists.

Should it be decided to move the child or young person, a transition plan should be developed and implemented to attempt to minimise the harm experienced by the child or young person. Refer to Support the child or young person to transition between placements in the Supporting children and young people in care chapter of the Manual of Practice for further guidance.

# 3. Therapeutic care

Children and young people who are assessed as having unhealthy attachment relationships with their caregiver/s or with their carers require therapeutic intervention prior to their removal.

Children and young people with unhealthy attachment relationships benefit from caregiving practices that are attachment-based and trauma-informed. These children and young people need opportunities to experience corrective attachment relationships with carers who:

- are attuned, responsive and available
- will give the child or young person the experience of being cared for and valued
- will challenge and slowly replace the child and young person's negative internal working models of themselves and relationships.

The relationships children and young people develop with their carers can help to reorganise the negative internal working models that they developed in the unsafe environment. Within these safe relationships, children and young people can also develop better emotional and behavioural regulation.

In the absence of this quality of care, children and young people are at risk of ongoing emotional and behavioural disturbances and difficulties into their adolescence and adulthood. Many carers will require therapeutic supports to assist them to meet the needs of a child or young person with attachment-related difficulties.

## 3.1 Reactive Attachment Disorder and Disinhibited Social Engagement Disorder

Children and young people who have not developed secure attachments are at risk of developing Reactive Attachment Disorder (RAD) or Disinhibited Social Engagement Disorder (DSED). These children or young people have also often experienced significant developmental trauma (refer to Trauma Practice Paper for further guidance).

As RAD, DSED or developmental trauma can present very similarly to developmental disorders/neurodiversities such as Autism and Attention Deficit Hyperactivity Disorder, it is important that practitioners consult with a psychologist when considering referring a child or young person for a diagnostic assessment.

# 4. Attachment and case management

At every stage of work with families, practitioners must consider the attachment relationships that children and young people have with their caregiver/s. The child or young person's attachment relationships must be given significant weight when practitioners are determining their assessment, case conceptualisation and case direction. Failure to consider the child or young person's attachment relationships could lead to decisions being made which are not in the child or young person's best interests or that cause them significant emotional harm.

## 4.1 Intake phase

During the intake phase, practitioners should consider whether the notification received offers any information about the child or young person's relationships within the household or family. Consideration should be given to the possible impacts of the reported harm and neglect on the child or young person's relationships.

Practitioners should also consider if the notification relates to concerns that the child or young person's attachment needs are not being met and the child or young person's development is being impaired as a result.

## 4.2 Investigation and assessment phase

During the investigation and assessment phase and as part of assessing whether or not a child or young person is at risk of future psychological harm, practitioners should assess the quality of the relationship/s that the child or young person has with their caregiver/s, noting that safety is paramount.

It is important to understand that separation from primary attachment figures, especially when that attachment is healthy, can have detrimental effects on children and young people. Separation from primary attachment figures can result in feelings of confusion, distress and grief for children and young people. This can constitute a traumatic experience if their capacity to cope with emotional distress is overwhelmed.

Even when an attachment relationship has been disrupted due to harm and neglect, separation from a primary attachment figure can still be distressing for children and young people.

While separation is often necessary to ensure the child or young person's safety, practitioners should be mindful of the impacts of separation. Practitioners should consider how to best support children and young people as they move into care.

When developing genograms, practitioners should include information about the child or young person's attachment figures and significant relationships. This will be useful in helping to identify alternative carers if it is assessed that the child or young person needs to be placed into care.

## 4.3 Protective intervention phase: family preservation

When the decision is made to keep the child or young person at home with their parents whilst work occurs to address risk factors, practitioners should identify sources of support for the child or young person.

Attachment relationships that the child or young person has developed in their broader family and kinship network, or community can be significant source of support. Ensuring the child or young person has regular opportunities to connect with safe attachment figures can promote the child or young person's sense of safety, resilience and wellbeing.

Knowing who the child or young person may have formed an attachment relationship with in their broader networks can also be helpful to practitioners if it is assessed that removal is required to ensure the child or young person's safety.

## 4.4 Protective intervention phase: reunification

Decisions regarding the viability of reunification should be informed by the child or young person's attachment relationships. This includes both the attachment relationship/s the child or young person has

with the person with whom reunification is being considered, as well as the attachment the child or young person has developed with their carers.

For reunification to be successful and in the child or young person's best interests:

- parents need to have adequately addressed the child protection concerns
- children and young people need to feel safe within their relationship with their parents
- children and young people need to trust that their parents will be available, attuned and responsive
- children and young people need to have maintained or developed a reasonably healthy attachment relationship with their parent/s.

If the attachment relationship is unhealthy or attachment difficulties are not addressed, this could undermine reunification efforts. This may lead to the child or young person experiencing further trauma. Attempts must be made to improve the quality of attachment relationships before reunification is pursued further.

Practitioners should also consider the attachment relationships that the child or young person has developed with their carer/s in care. Carers can offer children and young people therapeutic experiences that help them to recover from their experiences of maltreatment.

The relationships children and young people develop with their carers can help them to re-organise the negative internal working models that they developed in the unsafe environment. Within these safe relationships, children and young people can also develop better emotional and behavioural regulation.

Separating children and young people from carers with whom they have developed attachment relationships can be distressing and confusing and can constitute a traumatic event for children and young people. Given that the child or young person has already experienced an attachment disruption through being removed from their parents, separating them from a carer with whom they have developed an attachment can be significantly damaging. It can overwhelm the child or young person's capacity to cope and cause emotional harm. It can also confirm the child or young person's negative internal working model that they are unlovable, that relationships cannot be trusted, and that the world is unpredictable and therefore unsafe.

For infants and young children who are in the critical phases of attachment development, separating them from a carer with whom they are starting to develop or have developed a healthy attachment relationship can cause the child immense harm. The primary developmental tasks for infants and young children are to develop feelings of trust and security with others, develop a template for how they understand themselves and the world (for example, an internal working model), and develop their capacity for emotional regulation and empathy. All of these developmental tasks can be seriously undermined when infants and young children are separated from healthy attachment figures. Most importantly, the distress, grief and confusion that children and young people can experience on separation from an attachment figure is intensified for infants and young children given their lack of verbal and cognitive skills to make sense of and cope with what is happening to them. Aboriginal and Torres Strait Islander infants, children and young people should be linked with an Aboriginal Community Controlled Organisation to support them in participation to their culture and maintaining relationships with their Aboriginal and Torres Strait Islander families, community and Country.

For guidance about the need for early decisions to be made about children or young people's long-term care arrangements and reflects their developmental needs, particularly their attachment needs, refer to the Permanency Planning Practice Paper. For guidance about undertaking family reunification, refer to Undertake family reunification in the Ongoing intervention chapter of the Manual of Practice.

### 4.5 Long-term care

Practitioners must ensure that children and young people in long-term care have every opportunity to develop healthy attachment relationships with carers. Having a healthy attachment relationship with a carer will help children to recover from their experiences of trauma and facilitate optimal development.

It is imperative that every effort is made to identify the most suitable long-term, family based placement for a child or young person as soon as possible. This requires thorough scoping of long-term placement options to occur as a matter of urgency.

Identifying the most suitable placement for children and young people as early as possible prevents them from experiencing damaging placement changes later. For Aboriginal and Torres Strait Islander infants, children and young people, placement decisions must adhere to the Aboriginal Child Placement Principle (refer to the Aboriginal and Torres Strait Islander Child Placement Principle Practice Paper for further information). For culturally and linguistically diverse children and young people, refer to the Culturally and linguistically diverse child placement Policy for guidance about placement decisions.

Practitioners can support carers by engaging them in appropriate training and therapeutic interventions to develop trauma-informed and attachment-focussed skills. Practitioners can also support carers by being attuned, responsive and available to the carers themselves.

If relatives or kin have expressed an interest in caring for the child or young person who has been in a long-term placement with carers with whom they have formed healthy attachment relationships, practitioners must give careful consideration to the impact that separation from attachment figures will have on the child or young person. Practitioners must also consider whether or not the benefits that might be offered in the relative or kinship placement outweigh the risks posed to the child or young person's psychological wellbeing and development by removing them from an attachment figure with whom they have a healthy attachment relationship.

### 4.6 Attachment and family contact

For further guidance, refer to Support the child or young person to develop and maintain family and community connections through contact arrangements in the Supporting children and young people in care chapter of the Manual of Practice.

## 5. The importance of reflective practice

Practitioners are better able to develop skills when they engage in reflective practice. Practitioners are encouraged to discuss with their supervisor how they are taking children and young people's attachment needs into consideration in their case conceptualisation, and how well children and young people's attachment needs are being reflected in case direction decisions.

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