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Attachment disorders versus more common problems in looked after and adopted children:  
comparing community and expert assessments

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## Abstract

**Background:** Attachment disorders in adopted and fostered children may be overdiagnosed and could obscure more common disorders.

**Methods:** A case note review of 100 referrals to a specialist adoption and fostering service compared community referrals with the specialist assessments of attachment disorders.

**Results:** Attachment disorders were identified four times more often in community referrals versus the specialist service, but this only partly explained the significant under-identification of more common disorders in the community, especially for neurodevelopmental factors and conduct disorder by up to tenfold.

**Conclusions:** The relevant practice parameters are discussed and implications for service models for adopted and fostered children reviewed.

**Keywords:**

Reactive attachment disorder; disinhibited attachment disorder; adoption; fostering

## Introduction

The ICD-10 diagnoses of Reactive and Disinhibited Attachment Disorders of infancy and early childhood (RAD/DAD; F94.1/F94.2) occur when infants and young children have not had the opportunity to form attachments to primary caregivers, usually because of ‘grossly inadequate childcare’ or ‘extremely frequent changes in caregivers’ (WHO, 1992). Disruptions to early caregiving are almost always present for adopted and looked after children, but are not sufficient to indicate a diagnosis of either RAD or DAD. Indeed, although the prevalence of these attachment disorders is not well-established, they are thought to be **uncommon** (Haugaard & Hazan, 2004; Zeanah & Smyke, 2009), even in populations experiencing significant social and familial risks (Zeanah, Berlin & Boris, 2011). Nonetheless, there has been a wide dissemination of attachment disorder constructs that are unrelated either to the ICD-10 or DSM-IV diagnostic classifications, or indeed to attachment theory and research (Prior & Glaser, 2006) and many carers of adopted and fostered children request attachment-based diagnoses and treatments (Barth, Crea, John, Thoburn & Quinton, 2005). The problem of the over-diagnosis of attachment disorders and generic attachment problems is reflected in the practice parameters for the assessment and treatment of maltreated children (Chaffin et al, 2006), which emphasise the importance of avoiding the ‘allure of rare disorders’ (Haugaard, 2004, p.127) especially attachment disorders and attachment problems: “Although more common diagnoses, such as ADHD, conduct disorder, PTSD, or adjustment disorder, may be less exciting, they should be considered as first line diagnoses *before contemplating any rare condition, such as RAD or an unspecified attachment disorder*” (Chaffin et al, 2006, p.82, italics added). The practice parameter also stresses the importance of neurodevelopmental assessments, especially important in the light of accumulating evidence about the impact of early maltreatment and neglect on

neurobiological development (e.g., McCrory, De Brito & Viding, 2010; Gunnar & Fisher, 2006).

Identifying common disorders such as ADHD and conduct disorder facilitates access to evidence based treatments. Similarly, identifying neurodevelopmental problems can clarify complex behaviour and maximise educational opportunities. Unspecified attachment problem constructs, on the other hand, can lead to treatments that are not well grounded in evidence or theory and may even be dangerous (Chaffin et al, 2006). Other guidelines recommend attachment disorders should be assessed by suitably skilled and experienced clinicians, able to consider the full range of possible disorders (American Academy of Child and Adolescent Psychiatry (AACAP), 2005).

Little is currently known about the prevalence of mental health problems in adopted children in the UK. However, most are adopted from local authority care and will have been a looked after child at some stage (BAAF, 2011). Fortunately we have good evidence about the mental health of looked after children within the UK (Meltzer, Gatward, Corbin, Goodman & Ford, 2003; Ford, Vostanis, Meltzer & Goodman, 2007) which also provides our best current estimate for the prevalence of psychiatric disorder the UK adopted population. These studies are based upon a large, nationally representative sample of over 1500 looked after children in the UK. Mental health data was assessed using a well-validated, structured clinical interview conducted with all carers, and children over the age of 11, supplemented by teacher reports of an abbreviated version. The data for looked after children was compared with over 10,000 children living in private households, split into socially disadvantaged and non-disadvantaged groups. These data reveal significantly elevated rates of common disorders such as conduct problems, ADHD, learning problems and neurodevelopmental disorders compared to children in birth families including those in high levels of social and economic adversity. Interestingly, attachment problems in the same sample were low at around 2%, using an

operationalisation broadly consistent with ICD-10 definitions for RAD/DAD (Meltzer et al, 2003), although this excluded criteria relating to the onset of problems before the age of five and evidence of pathogenic care.

The current study explored the hypothesis that there is a tendency to overdiagnose attachment disorders and attachment problems in the populations of looked after and adopted children, at the expense of identifying more common disorders for which there are well-evidenced treatment or management options. We present a case note review of 100 consecutive attendees to a National Child and Adolescent Mental Health Service (CAMHS) service for looked after and adopted children. First we present an analysis of the diagnoses and concerns raised in the referral letters. We then present the rates of psychiatric disorders identified within the specialist service, on the basis of ICD-10 diagnoses and a comprehensive multidisciplinary assessment. Finally we compared these with the rates of psychiatric disorders reported in a large UK sample of looked after children (Ford et al, 2007). Our predictions were as follows. Higher rates of attachment disorders and attachment problems would be identified in the referral letters than in the specialist multidisciplinary assessment. Secondly, the identification of higher rates of generic attachment problems in the referrals, would have impeded the identification of more common diagnoses. Therefore it was predicted that for cases identified with attachment problems in the referral letters, there would be fewer problems in total identified in the referral compared with the specialist assessment and, further, that this would be specifically evident for common disorders such as conduct problems and ADHD. Finally, in the light of the recommendation that experienced clinicians should assess these complex presentations, it was predicted that the rates of attachment problems would be lowest amongst professionals with the greatest levels of professional training in child psychiatric diagnosis. That is, the rate would be lowest in the referrals from CAMHS psychiatrists compared with those from GPs, social care and paediatricians.

## Method

### Sample

The files of a consecutive series of 100 cases (49 adopted children and 51 looked after children) referred to a specialist, Tier 4 CAMHS Adoption and Fostering Service across a 4 year-period were accessed and reviewed. A Tier 4 outpatient service offers a specialist multidisciplinary service with capacity for national referrals for specific populations of children and adolescents, in this case adopted and fostered children, with severe and/or complex problems who require highly specialist expertise and/or newly developed ways of working not commonly available across the country.

The study design was approved by the Clinical Audit Office for the South London & Maudsley NHS Foundation Trust. The mean age at referral was 8.6 years (sd=3.57, range 2 to 17). Sixty one were boys and 66 were white European. Sixteen were black British, black Caribbean or Latin American and 18 were of dual heritage (a total of 34 from black and minority ethnic groups). Although the gender mix is similar to that reported in Ford et al, the cases in the current paper represent a younger and more ethnically diverse sample. Thirty one of the cases were referred by CAMHS psychiatrists and 69 from non-CAMHS sources (10 by paediatricians, 25 by GPs and 34 from social services).

### Data coding

The referral letters and assessment summaries were coded for information regarding diagnoses and problem areas using a standardised and anonymised assessment sheet. The clinic's diagnoses were always made according to ICD-10 multi-axial criteria as part of an assessment conducted by a multidisciplinary team, comprised of consultant child and adolescent psychiatrists, clinical psychologists and mental health social workers. The

assessment considered data from previous mental health assessments, school and/or daycare, and social care reports. The intake assessment itself consisted of interviews with the child, carers and the professional network, standardised questionnaires and observations of the child's behaviour with their carers and with strangers (clinic staff). Eighty six children over the age of three were assessed with age-appropriate standardised IQ and literacy assessments. While a primary diagnosis was assigned, as many diagnoses were given as needed to complete the clinical presentation and all identified disorders were recorded.

Although there was variability in the length of referral letters, they all had to be sufficiently detailed about the child's presentation to have met the threshold for commissioning a specialist assessment. All referrals requested a mental health assessment, except for five in which the referral question was about either placement planning or potential breakdown. In three of these five, subsidiary questions were raised about mental health issues such as withdrawn mood or aggressive behaviour.

Referral letters were inspected for the presence of specific diagnoses of attachment disorder, depression, anxiety, conduct disorder, hyperkinetic disorder, autism and related disorders, other neurodevelopmental disorders (e.g., epilepsy, motor/co-ordination problems, tics etc.) and learning disability. Other disorders such as encopresis, sleep disorders, dyspraxia and adjustment disorder were noted but are not presented in Table 1 as no comparable data was presented in Ford et al.

Referral letters were also inspected for problematic behaviour suggestive of symptoms of psychiatric disorders, e.g., a description of "fighting, stealing and impulsivity" was coded as evidence of conduct disorder and ADHD symptoms.

The presence of attachment disorders in the referral letters was more complicated. Although described 16 times, only 5 of these specified a recognised attachment disorder diagnosis, all of which were RAD. The remaining eleven instances were of a generic



‘attachment disorder’. In contrast, a more general description of ‘attachment problems’ was used 26 times in the referral letters. In all 31 children were described as having a recognised attachment disorder, an unspecified attachment disorder and/or attachment problems.

Following the terminology used by Chaffin et al, we refer to this broad conceptualisation of attachment difficulties as ‘attachment problems’. Notably, only one child, not part of the 31 with attachment problems, was described with a possible attachment disorder symptom of ‘indiscriminate in affections’.

#### Attachment Disorder diagnoses within the clinical assessment

The identification of attachment disorders is not straightforward and indeed Meltzer and colleagues specifically excluded attachment disorders from the main body of the ONS report concerned that it would be “seriously misleading to provide readers with a single ‘bottom line’ estimate of the prevalence of attachment disorders” (Meltzer et al, 2003, p.139) based only upon a structured interview and the clinical rating of supplementary open-ended questions.

New assessment methodologies and guidelines are emerging for the assessment of attachment disorder (AACAP, 2005; McLaughlin, Espie & Minnis, 2010; Gleason, et al, 2011) and they share in common the principle of observing interactions between the child with their carers and with strangers. The clinical assessment of attachment disorder presented here is based upon observations of the child with adult strangers (clinic staff) and with their carers, including separations and reunions – situations which would normally activate the attachment system. Information about the child’s social behaviours was also collected from school and any other relevant settings outside of the family home to assess pervasiveness. The diagnosis of either RAD or DAD followed ICD-10 guidelines, and so required evidence of the relevant behaviours in the caregiving history before the age of five years and clear

evidence of pathology within the attachment system that could not be accounted for by more common disorders such as autism spectrum disorders. In total 4 children in the clinical assessment were identified with RAD and none with DAD.

#### Any Axis-I disorder

A summary score was also constructed that summed all the occurrences of diagnosed Axis I disorders for both the referral letters and those resulting from the clinic assessment.

#### Data analysis

Agreement between the diagnoses mentioned in the referral letters and those made in the clinic was assessed with kappa values. Similarly, kappa values were used to test whether the identification of an attachment problem obscured the identification of common disorders. Thus, agreement between diagnoses in the referral letters and the clinic for both conduct disorder and ADHD were obtained for the subgroups of referrals which did or did not mention attachment problems. This question was further explored by testing whether referrers who identified attachment problems compared with those who did not were seeing more complex cases, indicated by the number of disorders identified either by referrers or in the clinic. Finally, to test whether CAMHS referrers were identifying fewer attachment problems than other referrers, the proportion of attachment problems identified for each were compared.

### Results

Table 1 presents the data from Ford et al, the comparable diagnoses and symptom-level problem behaviours for the referral letters and the clinic assessment diagnoses. For information, the clinic assessment data is also presented according to adopted and looked

after cases. The adoption cases were a slightly older and less diverse sample, and because of these sample differences, no formal testing of the differences between the rates of diagnoses was performed.

#### Comparison of psychiatric diagnoses in referrals, clinic, and ONS data

Even though this sample had been identified as requiring a specialist Tier 4 mental health assessment the rate of psychiatric disorder in the referral letters was a third lower than the ONS figures for looked after children. Whereas, the proportion of cases with any psychiatric disorder from the clinic assessment is just over a third higher than the ONS rates. Mostly the rates of individual disorder identified in the clinic are comparable with the ONS data, except for ADHD and conduct disorder. Very few referrals to the clinic (4%) considered the possibility of conduct disorders. Referrers were three times more likely to have identified hyperkinetic problems than they were to have considered conduct disorder.

Ford et al did not present data specifically about encopresis or enuresis. However, at 6% in this sample, this was a more common clinical diagnosis than RAD/DAD. It was not possible to present comparable data for the literacy or numeracy problems in Ford et al (34.3%) because the clinic used a more conservative discrepancy analysis for literacy problems rather than absolute levels of functioning. Eighty six cases had complete psychometric data, and of these 19.7% were identified as having specific literacy disorders in the clinic assessment (the expected base rate would be less than 2.5%).

#### Attachment problems and more common disorders

Attachment disorder and attachment problems were far more often cited in the referral letters than were diagnosed in the clinic assessment.

Of the 16 cases with an attachment disorder diagnosis in the referral letter, only one of these met criteria in the clinic assessment ( $\kappa = .04$ ), but this was not one of the five cases referred with a specific RAD diagnosis. In total, 31 cases were referred with attachment problems in the referral letter, of whom only three were diagnosed in the clinic assessment ( $\kappa = .10$ ). The mean age of the 28 children for whom the referral letter and clinic diagnosis were in disagreement for RAD/DAD was 9.04 ( $sd=2.96$ ), whereas the mean age of the three children for whom there was agreement was 5.33 ( $sd=4.92$ ).

To assess whether attachment problems in the referral letter obscured the diagnosis of more common disorders, rates of conduct disorder and ADHD were examined within the subsample of 31 cases identified with either attachment disorder or attachment problems at referral.

Fifty eight percent of these 31 cases were diagnosed with a conduct disorder in the clinic assessment compared with only 3.2% in the referral letter ( $\kappa = .04$ ). In contrast, the clinic assessment identified 35% of the 31 cases as having ADHD, compared to 19% in the referral ( $\kappa = .60$ ). To test whether the reduced identification of conduct disorder could be attributed to an over identification of attachment problems, similar analyses were conducted with the remaining 69 cases who were not identified with attachment problems in the referral letter. Contrary to expectations rates of agreement were also extremely low ( $\kappa = .08$ ), suggesting identifying attachment problems were insufficient to explain the low levels of conduct disorders in the referrals.

To test whether identifying attachment problems obscured the number of domains affected, the total number of disorders identified in the referral letters of the 31 cases referred with attachment problems were compared with the total number of disorders identified in the clinic assessment. The mean number of Axis I diagnoses (excluding attachment problems) in the referral letter for the 31 cases was .38 ( $sd=.66$ ), compared with 1.45 ( $sd=1.17$ ) in the

clinic (Wilcoxon  $Z= 3.69$ ,  $p<.001$ ). However, as above, more problems were identified in the clinic assessment versus the referral letter for the 69 cases with no attachment problems identified in the referral (Wilcoxon  $Z=5.24$ ,  $p<.001$ ).

While this suggests that attachment problems did not obscure more common disorders, the possibility arises that cases referred with attachment problems were in fact more complex. One index of complexity may be the presence of comorbidity. The total number of identified disorders in the referral letter were not significantly higher in the 31 cases identified with attachment problems compared with the 69 cases without (Mann-Whitney  $Z = 1.35$ ,  $p=.17$ ,  $.38$  ( $sd=.66$ ) and  $.21$  ( $sd=.51$ ) for those identified with and without attachment problems, respectively). When this comparison was re-run for the number of diagnoses identified in the clinic assessment, the slightly higher number of diagnoses in the 31 cases identified by referrers with attachment problems was not significant (Mann Whitney  $Z = 1.80$ ,  $p=.07$ ,  $1.45$  ( $sd=1.17$ ) and  $1.01$  ( $sd=.89$ )).

#### Proportion of attachment problems according to referral source

It was predicted that CAMHS services would identify the lowest number of attachment problems in their referrals. However, this was not the case. Eleven CAMHS referrals (35.5%), compared with five non-CAMHS referrals (7%) mentioned attachment disorder in the referral letter ( $\chi^2 = 12.69$ ,  $df=1$ ,  $p<.001$ ). The pattern was similar for attachment problems, with over half the CAMHS referrals (51%) identifying attachment problems compared with less than a quarter (21%) from non-CAMHS referrers ( $\chi^2 = 8.94$ ,  $df=1$ ,  $p<.01$ ).

The elevated rate of attachment problems found in referrals from CAMHS psychiatrists might be explained by case complexity as indexed by increased comorbidity. This was partly supported as there were more mental health problems identified in the referral

letters from CAMHS (Mann-Whitney  $Z = 2.45$ ,  $df=1$ ,  $p < .05$ ). However, this complexity was not borne out by the clinical assessment, which found similar numbers of problems for either referral source (Mann-Whitney  $Z = 1.31$ ,  $df=1$ ,  $p = .18$ ). Thus, although there was a similar number of mental health issues in the cases referred from CAMHS and non-CAMHS sources, the former were more likely to identify a range of problems, even if that complexity was at least in part attributed to attachment problems.

## Discussion

Attachment disorders were construed differently to other disorders in the referral letters. Few referrers who identified an attachment disorder used one of the appropriate terms of either RAD or DAD (five out of sixteen) and unlike other disorders these were not supported by descriptions at the symptom level. Indeed many referrers described a generic but unelaborated presentation of attachment problems in addition to attachment disorders. In total attachment problems, i.e., specific and non-specific attachment disorders and/or generic attachment problems, were mentioned in 31% of the referrals, yet only one potential attachment-specific symptom was described and this was for a child in the 69% not identified with attachment problems.

There was some support for a tendency to over-diagnose attachment disorder in adopted and fostered children. In the specialist clinic assessment many common disorders were diagnosed more frequently than RAD/DAD including conduct problems, ADHD, anxiety, autism, encopresis/enuresis, neurodevelopmental problems, learning disability and specific learning disability. Indeed conduct problems were diagnosed thirteen times more frequently than RAD/DAD. Yet in each case, an attachment disorder (16%) or attachment problem (31%) was more frequently identified by referrers than one of these more common disorders (between 0% and 12%) in referral letters. Yet the low rates of attachment disorder

and higher rates of more common disorders identified in the clinic assessment is consistent with both the practice parameters for maltreated children with attachment problems and also the ONS data for looked after children.

While there was support for the main hypothesis that attachment disorders would be over-identified by referrers, the related hypothesis that this would obscure the identification of more common problems was not well supported. There was only weak evidence for a difference in terms of the total number of diagnoses identified in the clinic between the cases referred with attachment problems and those who were not. Similarly, there was a marked under identification of conduct problems in referral letters compared with the ONS data, regardless of attachment problems. Thus it was not diagnosing attachment problems that obscured the rates of more common disorders but more worryingly, a tendency to under-identify common disorders more generally. Only 4% of referrals identified conduct disorder compared to almost ten times that amount being identified in the ONS data, and even more in the specialist clinic assessment. Interestingly, the number of symptoms of common disorders in the referral letters was much greater than the number of disorders diagnosed in the referral letters and much more similar to the rates of disorders diagnosed in the clinic. The notable exception being for attachment problems, for which referrers almost never considered symptoms in the referral letters.

Finally, the practice parameters recommend expert assessments by experienced clinicians, but the hypothesis that CAMHS referrers would be less susceptible to over-diagnosing attachment problems was not supported. Indeed CAMHS referrals were the most likely to identify an attachment problem, even in the absence of evidence that they were referring cases with the most comorbidity. This raises a number of issues, including what constitutes an expert assessment. In particular no referrers indicated concerns about neurodevelopmental problems, even though these are relatively common in the ONS data; the

practice parameters suggest paying particular attention to this area; there is converging evidence of the impact of early maltreatment upon neurodevelopment (McCrary et al, 2010); these problems were relatively common in the clinic assessment and there is a collection of studies that demonstrate the specific neuropsychological consequences of extreme neglect in post-institutionalised children (Pollak et al, 2010; Bos, Fox, Zeanah & Nelson, 2009). These latter studies may not be directly compatible with the population of adopted and fostered children from non-institutional backgrounds but, along with the research outlined above, they do emphasise the importance of considering neurodevelopmental factors in adopted and looked after children's assessments. To some extent neurodevelopmental issues may be clarified in the new ICD-11, in which the draft framework currently proposes replacing DAD with disinhibited social engagement disorder, effectively removing the attachment construct from the diagnosis (WHO, 2012).

The data in this study contribute to the growing concern that the current diagnostic system for attachment problems is inadequate to meet the needs of clinicians working with looked after and adopted children (Minnis, Marwick, Arthur & McLaughlin, 2006; DeJong, 2010). There is confusion about the appropriate diagnostic framework, and an absence of agreed standards for assessing attachment disorders. The ONS data used a narrow and broader definition, and the latter increased the rate almost tenfold (Meltzer et al, 2003).

The emerging assessment guidelines may help but are time and labour intensive, and also particularly suited to young children (AACAP, 2005; McLaughlin et al, 2010). Indeed the presentation of attachment disorder in children older than five years is unclear, yet some referrers identified attachment problems in teenagers and the diagnostic disagreements between the referrals and the clinic were more apparent for older children. Observations of separations and reunions are unlikely to be clinically useful for children beyond infancy and early childhood because the attachment system undergoes significant developmental



transitions from infancy through childhood and adolescence into adulthood, moving away from observable behaviours to the level of representation (Allen et al, 2003), yet the attachment disorder phenotype currently lacks elaboration of these transitions.

This study has a number of limitations. First, in the light of the conceptual confusion about attachment disorder constructs and their reliable measurement, the assessments reported here from the specialist clinic cannot claim to be gold standard. Although a multi-informant approach with direct observations was used, we can only say the observed discrepancies between the specialist assessment and the referral letters indicate differences in approach to assessment and formulation. The clinic's assessment methodology, and in particular observations of attachment-specific behaviours, appeared to be very different from the assessments conducted by the referrers and meant that fewer children with attachment disorders were identified in the clinic than in some other services. However, the children who *were* diagnosed with attachment disorders in the clinic did have evidence of specific pathology within the attachment system and the low rate of attachment disorders is consistent with the expert estimates of the prevalence of attachment disorders. Moreover, the formulation derived from the clinic assessment justifies all diagnoses with a variety of evidence, so another service can review the evidence and argue against a diagnosis based on new assessment information or by taking issue with the evidence presented. This transparent approach stands in contrast to the practices criticised by Zeanah (1996) whereby presentations arising from diverse social problems are ascribed to an attachment disorder without an explicit consideration of the alternative causes, in a manner which blurs aetiological factors with the presenting problems.

Secondly, the coding of the diagnoses and problem areas in the referrals was based only upon the information referrers chose to include in the letters. Referrers were not asked to systematically complete a checklist of diagnoses or problem behaviours, and as such it is

possible that the under-reporting of common disorders, and conduct disorder in particular, may have reflected their choice to foreground other more complex aspects of the child's presentation. Hence it is possible that referrers had identified common disorders but they did not prioritise them as core parts of the presentation in the referral letters to Tier 4.

Finally, the findings from this small study cannot be generalised to estimate the prevalence or even ratio of common disorders and attachment disorders more generally in the looked after and adopted populations in the UK, not least because the referral patterns in a small cohort within a specialist service are likely to be biased in unsystematic ways. Moreover the use of clinical assessments based on ICD-10, supplemented by observations recommended for DSM-IV RAD-I/II, rather than standardised research measures potentially confounds systematic comparison with existing research findings. Indeed, other types of research are needed to clarify not just the criteria, operationalisation and prevalence of RAD/DAD, but also how these diagnoses fit with other commonly occurring disorders. Probably no single research approach will be adequate to address all these issues. For example, large studies such as that carried out in the UK for looked after children (Meltzer et al, 2003) would help greatly with planning for the needs of adopted children, to identify the rates of common and rare disorders. In contrast, specific DAD/RAD studies require more intensive observational assessments upon smaller samples, but such studies should be thorough in their identification of more common (but 'less exciting') disorders to relate back to larger prevalence studies and help clarify overlapping phenotypes.

These are interesting research questions we hope to see answered to clarify clinical practice, but in the meantime, based on the practice parameter guidelines for children with attachment problems, it is probably unhelpful to think of disorders such as attachment disorder as being first line diagnoses or as routinely trumping more common disorders in looked after or adopted children. The practice parameters recommend identifying common

problems and treating them with evidence based approaches. Mental health interventions specifically for attachment disorders in looked after or adopted children remain in the earliest stages of development (Buckner, Lopez, Dunkel & Joiner, 2008) and the best evidence is to promote stable placements with sensitive carers (Zeanah et al, 2011; Rutter, Kreppner & Sonuga-Barke, 2009). In contrast to the recommendations within the practice parameters, many services working with looked after and adopted children continue to have an overriding belief in attachment issues as the primary explanatory factor for their clients' problems (Barth et al, 2005; Prior & Glaser, 2006). This has the potential to lead to conflict between different service models, in part fuelled by the confusion in diagnostic categories and the competing treatment plans that follow from these. The victims of this confusion are likely to be the looked after and adopted children who miss out on access to the evidence based treatments and educational support that could help them (Woolgar & Scott, 2013).

#### Practice Points

- Consistent with the practice parameters (Chaffin et al, 2006) assessments of looked after and adopted children should prioritise the identification of common disorders to open up evidence-based care pathways
- Services for looked after and adopted children should offer multidisciplinary assessments by specialist teams, with expertise in the wide range of problems likely to present, including assessment of neurodevelopmental and neuropsychological problems.
- Attachment disorders should always be specified as RAD and/or DAD and not as generic attachment problems. Diagnosis requires significantly more than either disruptions to attachment relationships or a history of pathogenic care. Assessment should always include evidence of pathology within the attachment system, e.g., using

observational assessments with primary caregivers in contexts likely to activate the attachment system.

- RAD and/or DAD formulations should describe in detail the evidence for and against **these disorders** versus more common disorders, considering evidence of attachment-specific symptoms, as well as any broader attachment-related issues not part of the RAD/DAD phenotype.

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Attachment disorder versus more common problems in adopted and fostered children

Table 1: Percentage of Psychiatric disorders in ONS data; diagnoses and symptoms in referral letters; and clinic diagnoses (N=100)

	ONS figures (N=1253)	Referral letters (N=100)		Clinic Assessment Disorders (N=100)			Agreement between referral and clinic disorders (kappa)
		Disorders	Symptoms	All (N=100)	Fostering (N=51)	Adoption (N=49)	
<b>Male</b>	<b>57.1%</b>			<b>61.0%</b>	<b>58.8%</b>	<b>63.3%</b>	
<b>Older (11 or above)</b>	<b>59.0%</b>			<b>33.0%</b>	<b>23.5%</b>	<b>42.9%</b>	
<b>White</b>	<b>91.6%</b>			<b>66.0%</b>	<b>56.9%</b>	<b>75.5%</b>	
<b>Any Disorder</b>	<b>46.4%</b>	<b>30.0%</b>	<b>82.0%</b>	<b>64.0%</b>	<b>60.8%</b>	<b>67.3%</b>	<b>.26**</b>
<b>Anxiety</b>	<b>11.1%</b>	<b>5.0%</b>	<b>14.0%</b>	<b>8.0%</b>	<b>5.9%</b>	<b>10.2%</b>	<b>.26**</b>
- PTSD	1.9%	1.0%	1.0%	2.0%	2.0%	2.0%	-.01
<b>Depression</b>	<b>3.4%</b>	<b>1.0%</b>	<b>4.0%</b>	<b>3.0%</b>	<b>3.9%</b>	<b>2.0%</b>	<b>-.01</b>
<b>Conduct Disorders</b>	<b>38.9%</b>	<b>4.0%</b>	<b>51.0%</b>	<b>53.0%</b>	<b>45.1%</b>	<b>61.2%</b>	<b>.07</b>
- ODD	12.2%	4.0%	28.0%	19.0%	15.7%	22.4%	.11
- Conduct Disorder	26.7%	0%	33.0%	35.0%	31.4%	38.8%	-
<b>Hyperkinetic Disorders</b>	<b>8.7%</b>	<b>12.0%</b>	<b>23.0%</b>	<b>31.0%</b>	<b>27.5%</b>	<b>34.7%</b>	<b>.29***</b>
<b>Autistic Spectrum Disorders</b>	<b>2.6%</b>	<b>4.0%</b>	<b>11.0%</b>	<b>6.0%</b>	<b>3.9%</b>	<b>8.2%</b>	<b>.58***</b>
<b>Attachment Disorders</b>	<b>2.5%<sup>a</sup></b>	<b>16.0%</b>	<b>1.0%</b>	<b>4.0%</b>	<b>5.8%</b>	<b>2.0%</b>	<b>.04</b>
<b>Other Neurodevelopmental Disorders</b>	<b>12.8%</b>	<b>0%</b>	<b>6.0%</b>	<b>12.0%</b>	<b>11.8%</b>	<b>12.2%</b>	<b>-</b>
<b>Learning Disability<sup>b</sup></b>	<b>10.7%</b>	<b>3.0%</b>	<b>5.0%</b>	<b>10.0%</b>	<b>13.7%</b>	<b>6.1%</b>	<b>.27**</b>

<sup>a</sup> N=523, in Meltzer et al

<sup>b</sup> Learning Disability as mental age 60% of chronological age in ONS, as stated in the referral letters and as IQ <70 in the clinic assessment

\*\* p<.01; \*\*\* p<.001