**Ealing Fostering Service**

**Guidance for Making your**

**Family Safer Caring Plan**

**Guiding principles**

Creating family life that feels physically, socially and emotionally safe for all household members is a key responsibility of parents. When ‘ordinary’ families become fostering families, doing this becomes that bit more complicated. In considering your ‘Family Safer Caring Plan’, it is important that the needs of ALL household members are considered and talked about.

It is impossible to eliminate all risk and not infrequently attempts to do this lead to unintended negative outcomes. The approach taken to risks should be to identify them and then think through what would be a ‘sensible’ and ‘proportionate’ response, either to minimise the risk or to cope with potential problems that could result.

Children in your care, be they your own birth children or children in care, need to feel cared for and secure. Meeting their attachment needs is fundamental to providing safer care. Enabling children to learn self-regulation and the ability to manage life’s risks is an important parental and foster caring responsibility.

There is no ‘one size fits all’ for family safer caring. There are, however, aspects of family life that need to be tailored to the needs and situation of children in care and the consequent risks that can come from opening your home to someone else’s child.

What follows are comments on some of the key areas to consider. For each, decisions need to take into account the child’s age and development, their history, how long they have been in your care and their care plan.

**Affection, love, touch, and trauma**

Like all other children, children and young people in care should not be deprived of physical touch. Touch is a normal, healthy part of all parent-child interactions. There is a growing body of literature demonstrating the positive impact of healthy physical contact on people of all ages. Physical touch can relieve stress, decrease anxiety and depression and increase comfort (Barnard & Brazelton, 1990, Field, 1993). *“Loving touch [produces] oxytocin a ‘feel good’ hormone, which is known to solidify infant-mother bonds.* (Panksepp, 2001, p.151).

Sadly we know that many of our children looked after could have experienced trauma through unsafe, hurtful or intrusive touch or physical violations. This does not however mean we automatically exclude touch for these young people but we need to be even more vigilant to monitoring and managing the child’s perception and experience of being touched. Each child’s needs, experiences and complexities need to be held in mind; blanket decisions about avoiding, touch hugging, kissing, wrestling, tickling etc are not helpful. All of these are ‘normal’ family activities, but for some children you may want to exercise caution and not engage in these activities until you have a good sense of the child’s history and have agreed an approach around touch with your supervising social worker. In particular whilst the child is still settling in.

For children who have experienced developmental trauma (See Foster Carers Health Handbook) they may ‘enact’ or play out aspects of this early trauma in your care. For example, a child may have experienced inappropriate or sexual touch and may think this is how adults expect them to respond, they may indiscriminately climb on laps, hug strangers or try to kiss adults. Other developmentally traumatised children whom may have experienced something like neglect, may dislike or avoid physical contact, each child’s response to touch and contact needs to be understood in context of their particular experiences.

It is extremely important that you know as much of your child’s history and experience as reasonable and appropriate. Even when a child has not experienced healthy or safe touch; touch is a vital part of healing from this trauma. You and the team around your young person will need to be vigilant not to re-traumatise a child and understand that the child, in order to heal, may need to experience safe, healthy and positive touch.

**Think this through with your supervising social worker and/or the child’s social worker and clinical psychologist in the team so that you consider a range of perspectives beyond what you would do with your own child, trauma history and experiences of the child in your care.**

Remember as well that it is right to be respectful of the child’s verbal and non-verbal messages whether or not s/he is happy to receive a reassuring hug or a kiss. Children need to learn that they can say no, as well as learn how enjoyable ‘safe and healing touch’ can be.

In thinking about physical touch, be most cautious when you are new to a child and s/he is to you. Think about how you can convey affection and comfort in a manner that gives the child or young person room to communicate to you (often non-verbally) how they feel about your touches. If there is reason for the child or you to feel insecure about touches, think about where best to do this – in public may be better than in private, on the shoulder may be better than on the face, and brief touches may be better than sustained or longer ones.

Also consider what looked after children will be seeing you do with other children you are fond of; looked after children are very alert to ways in which they are treated differently. If areas of life need to be different, talk to them in a reassuring manner about why this is. Lastly, you will need to consider and be sensitive to how the looked after child’s birth parents will feel about witnessing affectionate touches between you and their child. You may need to consider how to minimise tension around this whilst also meeting the needs of the child.

*Touch and sensory processing difficulties*

Touch is one of our sensory systems, known as the tactile system and is vital in enabling a child to develop not only awareness of objects around them but to develop a sense of self in relation to others. A child with poor tactile awareness will drop things and lack finer coordination. They may also struggle to know where to put their feet and trip easily. Tactile sensitivities will affect a child's ability to engage with the world and to tolerate clothing or a toothbrush in their mouth.

A child with a lack of good touch or inappropriate touch in early life may well develop tactile defensiveness or tactile seeking behaviour. This means that they will pull back from some touch sensations or in contrast may seek out fidgeting or touching things constantly.

This will need to be considered within the touch and care you provide for your child. If you are concerned about sensory processing or your child’s response to physical events/ stimulation such as teeth brushing or play please speak to your child’s social worker, SSW or clinical psychologist for further support and advice.

*Developmental age versus chronological age*

It is common for children who have experienced early trauma to display a developmental age different from their chronological age. Traumatic events and neglect can interrupt their psychological stages of development, or lack of stimulation, may delay their development. There are many factors, which can impact differences in milestone achievements. A child’s chronological age is their age based on their date of birth. Their developmental age is the age at which they function emotionally, physically, cognitively and socially. A child may be seven years old at the time of coming into care, but developmentally they may display behaviors that make them seem much younger.

Understanding that there is often a difference between a child’s chronological and developmental age will help you as caregivers to have more realistic expectations for the child in your care and a better understanding of their needs for and responses to touch.

**Key message: physical touch and affection is important for all children to receive from caring adults. Although, it may need more careful consideration with the network, children who have experienced inappropriate/rough touch rely on their carers to give them a new experience of healthy/safe touch, and to help them be able to receive this.**

**Privacy and personal care**

Bedrooms provide private space, for all family members. Because of this, the unobserved nature of life in bedrooms can present unwanted risks. It can be useful to have a family expectation that bedroom doors are open when children are playing inside and that visitors are entertained in communal areas of the house.

When you plan to go on holiday in a caravan, tent or other accommodation in which children in your care will be sharing with others, think about what precautions may be helpful in reducing any foreseeable risks. Talk this through with your supervising social worker before making your arrangements.

Almost without exception bed-sharing between children should not be allowed and adults should not allow children to join them in their bed. For children living with you over a long period or for very young children this may be appropriate – talk about this with relevant social workers before making a change and also report and record accurately

For bedtime stories, adults and older children reading to little ones should ideally sit reasonably upright and if reading in the bedroom it’s best not to sit on the bed itself; perhaps have a chair next to the bed. The adult/older child should be dressed in daytime clothes, not in nightwear. Many families decide that ‘bedrooms are for sleeping,’ so that bedtime stories are read downstairs and the child knows that once in their bedroom they are expected to go to sleep. As with all of this guidance it is important to know the child’s history well, talk to the social worker and supervising social worker if you intend/ feel you should be responding in a different way to your child’s needs around bedtimes and reading.

Children who come to your bedroom in the night should be reassured and settled back into their own bed, to ensure they are not confused about the expectation not to join the adults in their bedroom.

When children and/or adults in your home are in their nightclothes be aware of whether they are adequately covered, giving consideration to the ages and genders of others in the household.

Some children and young people feel unsafe and vulnerable during bath times. If you don’t know the child’s feelings about this or know there is reason to be especially careful with a particular child, leave the door ajar, talk to the child about what you are doing and why, and encourage them to cope as independently as their age, developmental age and ability allows. Be alert for signs from the child of any unease.

When cleaning very young children’s bodies, use a flannel or sponge rather than your hand. Once children are about four years of age, cleaning of their ‘private’ areas normally should be done by the child her/himself but this may depend on their developmental stage of development. You may need to seek specific advice around this. It can be advisable at around this age for an adult of the same gender as the child to take responsibility for their bath time attention. When the child becomes shy about their developing body, it is important to respect this and to ensure they have privacy in the bath or when changing their clothes.

Don’t take photos or video recordings of children or young people in a state of undress.

**Behaviour, discipline and consequences**

Within Ealing we promote a therapeutic approach to understanding and responding to challenging behaviour and engaging with children based on the work of psychologists specialising in work with looked after and adopted children, Dan Hughes and Kim Golding. If you have attended one of our courses you will familiar with some of the key ideas.

Children who have experienced early trauma tend to respond less well to traditional behavioral management strategies such as rewards, sanctions and time out as they rely on small doses of shame to correct behavior. Many developmentally traumatised children experience overwhelming shame (sense of being ‘bad’, unlovable, unwanted) and so these techniques can confirm their beliefs about themselves as ‘bad’, flood them with shameful feelings leaving them unable to make use of and learn from consequences. These traditional behaviour management strategies therefore do not tend to lead to behavioral change.

These children benefit more from regulatory and relationship-based parenting. This is parenting that focuses on helping the children to regulate their emotional experience through the emotional connection between carer and child *before* attention is given to the behavior. Developmentally traumatised children can have a foundation of mistrust of carers and adults and so can experience management of behavior as signs that they are going to be hurt or rejected again.

These children need carers who can connect with the child's experience before, or when appropriate instead of, discipline. This is described here as ‘connection before correction’. This approach requires carers to *first* ‘connect’ with the child (through an attitude known as PACE-see below) *then* offer ‘correction’. Correction in this sense means helping children to develop positive socially acceptable behaviors and to find safe ways to express intense emotional experience. We call this connect then correct approach the ‘two hands of parenting’.

*Hand One-Connection*

Carers need to successfully connect to the emotional experience, thoughts and feelings behind the behaviour the child is displaying. One way to achieve this connection is through adopting an attitude or style of communication known as PACE.

PACE stands for Playfulness, Acceptance, Curiosity and Empathy. Being PACE-ful doesn’t mean being playful all of the time, different elements of this attitude will be more important at different times.

Playfulness= A light hearted, relaxed and playful attitude can help the child feels connected within the relationship. Helps the child to experience fun and connection

Acceptance= Understanding the reasons why a child behaves or experiences something in a way. Carers can convey this understanding through acceptance.

Curiosity= Figuring out what is going on. Understanding the meaning behind the behaviour, wondering about the child, wondering with the child and making best guesses about the inner experience of the child

Empathy= Enter imaginatively into the experience of the child. Convey acceptance of inner experience to the child.

Adopting this an attitude of PACE provides warmth and nurture and means that they will be open to receiving your care. They will feel connected to, trusted and liked and they in turn can connect with other, trust and love.

*Hand Two -Correction*

Correction in the sense described above provides structure, and boundaries for developmentally traumatised children. Connection should happen *before* correction. There should be no ‘correction’ without understanding the behaviour and the child’s mind/ response to the correction.

Offering good ‘corrective’ experiences to children means avoiding lectures and delaying problem solving until the child is in a more open reflective state.

Correction should always avoid punishing the with the relationship e.g. we do not recommend time out or ignoring a distressed child.

After boundaries, structure or discipline, carers need to be the ones to take responsibility for relationship repair. Modelling this for the child.

The Two Hands working together:

PACE empowers discipline and behaviour management, as the discipline is provided with understanding. The Two Hands guides and teaches the child, whilst keeping the child’s level of shame low, meaning they can make use of the carers guidance. With the two hands approach a child experiences discipline in a more open and trusting manner.

PACE is a way of expressing unconditional regard and care for the child which they may not have experienced in early life. With PACE the child can be confident of the carers good intentions and belief in him/her.

Using these techniques and discussions with the Clinical Psychologist where necessary, will help inform you about the best and the acceptable approaches to behaviour management. There also are courses available to build knowledge and skills in managing challenging behaviour.

An example of a PACE response to concerns around a child being overly and inappropriately physical;

*“I wonder if you want lots of cuddles and kisses because that’s what grown-ups have wanted from you in the past (curiosity and acceptance). I know it must be confusing to do things differently (empathy), but that way of cuddling and kissing wasn’t always safe and I want to make sure that you are safe right now (boundary). We don’t touch each other in that way in our family (boundary,) but we will hold hands and have lovely hugs on the sofa when we all sit down together and watch your favourite show! (light, playful tone)”*

**Safety in the community**

Carers need to be safety conscious about physical risks and hazards for children when they are out and about, for instance by ensuring seat belts are used in cars and that use of challenging playground equipment is supervised.

Additionally, carers need to consider how best to manage the risks for children who may have poor impulse control, indiscriminate approaches to others, provocative behaviours or poor awareness of their environment. Such children will need structure, routine and clear guidance to help them manage social expectations. Crucially, alongside this, they will also need to regulate with an adult before they develop and to build their own skills in self-regulation.

**Bullying**

Bullying has to be tackled assertively wherever it occurs and whatever its form. You may need to work collaboratively with schools and/or other agencies to deal with issues and reassure affected children that the adults caring for them are committed to trying to keep them safe.

**Digital and internet technologies**

Given that internet access is so important to children and young people, it is important to agree with all concerned what access they will have to items such as mobile phones, laptops and internet-connected gaming devices.

All computers in the home should be fitted with age-based filters. Access to computers should be in communal areas of the household, when possible.

Communication and involvement with children and young people about what they are accessing via the internet are keys to improving their safety. For instance, setting up your own Facebook account will help you monitor what a young person is receiving and communicating to others.

Make sure children and young people in your home feel they can come to you or someone they trust if they are worried about anything they encounter online.

**Overnight stays, play dates, going out with friends, using babysitters**

Foster carers are given delegated authority to make ‘everyday decisions about children in their care.’ Unless you have been informed that a person or household is not an allowed arrangement, you can exercise your own judgment, as you would as a ‘good parent.’

It is important to record how and why you made each decision.

**Sex and sexual health**

Planning around how to handle issues of sex and sexual health for a placed child or young person should be shared with your supervising social worker and the child’s social worker, who can consider whether and if so how to include the child’s parent/s in any decisions that have to be made.

For foster carers who have an under two sharing their bedroom, thought is needed about where and when the adults’ sexual relationship can take place, so that the child does not witness sexual activity.

 If other members of the household (including a fostered child or young person) also are sexually active (including masturbation) it needs to be understood that all sexual activity is kept private.

*Sexual development and sexualised behaviour*

Sexualised behaviour of children in as incredibly difficult issue for adults to think about. It can end up being dealt with in a superficial way or avoided. The reasons for this are complex, but usually centre on cultural and societal difficulties in being open about sexuality in general, but in particular our reticence about the sexuality of young people.

A difficulty in considering sexualised behaviour in children traumatised by abuse and/neglect when they direct their sexual attention to adults or other children, is the conversations that consider at times the identities of the child as both ‘victim’ and ‘perpetrator’ and that there is often not a clear either/or. Equally challenging is the need to consider ‘typical’ sexual development in children and teenagers. We have already seen that developmentally traumatised children can present with a mismatch between their chronological and developmental ‘age’ so what is considered ‘typical’ sexual development may change in context of knowing the child’s history.

If you are concerned about the sexual development of the children in your care or are concerned about sexualised behaviour in your home it is crucial that you speak with your supervising social worker and the child’s social worker who may seek advice from the clinical psychologist.

**Working with other agencies and services**

Creating a safer caring plan that responds effectively to the individual needs of each child in the household may well require coordinated work with other colleagues/agencies, such as schools, Clinical Psychologists or other significant agencies. Ask your supervising social worker to help ensure you have support from other agencies as needed, and make sure you are clear about the roles and commitments made by others.

**Planning for who can take what decisions**

When drawing up the Placement Plan for any particular child or children, completion of the ‘*Delegated Authority Decision Support Tool*’ is very helpful in clarifying who has authority to give consent / agreement or to undertake tasks related to ensuring and promoting the wellbeing of the child being placed with you. Consulting this when unsure of your authority is an important safer caring action.

**Blanket bans and exceptions to the rules**

For children in care, we all need to be alert to statutory guidance that must be followed. You can access this at http://www.legislation.gov.uk/uksi/2011/581/contents/made

Beyond statutory guidance, Ealing, as all fostering agencies, has policies that provide guidance; most of these will be available in your Fostering Handbook.

All policies should be followed unless it is agreed and recorded that an exception is being made. If a decision or position does not seem to fit the needs of the child or young person you are caring for, say so and debate its appropriateness.

**Reducing the risk of allegations**

Thinking through your Family Safer Caring Plan, keeping it ‘alive’ and under review as family members and family circumstances change is key to being robust in reducing risk of allegations.

Building and maintaining positive relationships and regular communication with those who are important to any child in your care is very important. Talking through your dilemmas, taking advice, sharing responsibilities and recording fully the rationale for decisions and actions you take also are very important, as is reporting incidents and allegations promptly to your supervising social worker.

In the face of allegations carers know to be false, there can be a range of strong emotional responses. Allegations can feel like a ‘betrayal’ of trust but can also feel vindictive or rejecting to carers. The typical responses that may occur when a child has made an allegation about their carers can invariably be driven by strong and entirely understandable emotional reactions. Carer’s, in the face of allegations may be pulled to argue their point, defend themselves and state that the allegation is false.

Carers can then be at risk of withdrawing emotionally and physically from the child as a result. Carers may find themselves caring in more defensive ways, for example withholding touch of any kind or no longer being playful in their interactions to protect themselves from further allegations, this can result in difficulties in the relationship and risks destabilising placements. It will be important to use all of the support, processes and structures available to you in the event of an allegation. In the event of an allegation, as well as support to understand your own emotional reaction to the allegation, it may be helpful to have support to help you understand what function making the allegation may have serve for the child and how to retain empathy for the child’s emotional experience (See PACE- above).

There is a one day course all foster carers should attend, entitled ‘*Safer Caring: Minimising the Risk of Allegations.’*

**Further guidance**

A good book to read about safer caring is *Safer Caring: A New Approach*, by Jacky Slade, published by Fostering Network, 2012.

Also see the *Guidance for Safer Working Practice for Adults you Work with Children and Young People,* published by the Department for Children, Schools and Families in November 2007

**Family Safer Caring Plan**

This Plan should reflect the understanding of all members of the household and the assessing / supervising social worker. It should be reviewed at the beginning of each placement and before each annual carer review, and revised if necessary.

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| **For all applicants or fostering families:** |
| Applicants’ / Foster carers’ names |  |
| Names and ages of children or other adults who are permanent members of the household |  |
| Names and ages of regular visitors to the household |  |
| Who has helped to complete the plan? | Assessor / SSW:Child’s SW:Other: |
| Has Safer Caring training been completed? | [ ]  Yes Date:[ ]  No |
| Are there any on-going or current safer caring issues about which a written agreement has been made with the Service? [[1]](#footnote-1) If so, include detail in the ‘any other issues’ section of this plan. | [ ]  Yes Date:[ ]  No |
| Were there any safer caring issues that have been agreed for deletion in the making of this plan? | [ ]  Yes Date:[ ]  No |
| Date this form as been completed |  |
| **For fostering families with children in placement:** |
| Names of children in placement |  |
| Risk Assessment completed? | [ ]  Yes  [ ]  No |
| If so, please give detail of any risk(s) identified*[This may be from a member of the child’s family or an aspect of the child’s behaviour]* |  |
| Rate the level of overall risk | [ ]  High Risk [ ]  Medium Risk[ ]  Low Risk |
| Has all relevant information been shared with carers?*[if not, what information needs to be accessed?]* | [ ]  Yes [ ]  No |

We have drawn up these ‘home rules’ in order to help make our family safe for any child or young person placed with us, for our own children, for ourselves, for other members of our extended family and for other people who share our life.

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| 1. **The names we use**  |
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| 2. **Showing affection** |
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| 3. **Playing and leisure activities** |
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| 4.**The way we dress** |
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| 5. **Adult/s’ bedrooms** |
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| 6. **Child/ren’s bedrooms** |
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| 7.**Bedtime routines** |
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| 8. **In the toilet / bathroom** |
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| 9. **In the kitchen** |
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| 10.**Travelling by car** |
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| 11.**When children or young people go out (with or without us)** |
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| 13. **Staying overnight with friends** |
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| 10. **Babysitters**  |
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| 12. **When we have visitors** |
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| 14. **Education about sex and sexuality** |
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| 15.**Sexual activity within the home** |
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| 16. **Taking photos and videos** |
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| 16.**Computers and internet access** |
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| 17.**Our pets** |
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**ANY OTHER ISSUES – add additional boxes, as above**

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| **Name/s[[2]](#footnote-2)** | **Signature** | **Date** |
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1. If any such agreement is judged to no longer be relevant, SSW should seek advice and agreement from the Team Manager and the Family Safer Caring Plan should be updated. It is important that an update on progress on this practice area is discussed at the Annual Foster Carer Review. [↑](#footnote-ref-1)
2. To be signed by all members of the fostering household who are over the age of 18 [↑](#footnote-ref-2)