CHAPTER 3
THE WELFARE OF THE CHILD

PREPARING THE GROUND

1. Parents should be encouraged to share as much information as possible about the child and his needs before placement so that the prospective foster carers can measure the task they will take on.

2. Information which will help the foster carer to help the child settle into his or her new home includes:
    a. the child's history and needs,
    b. his or her routines, capabilities, habits, fears, likes and dislikes, and
    c. his or her understanding of the reasons for and duration of the placement.

See also the section on Well Being – p.25

3. At the same time, the child should be told as much about the prospective foster carers and their home as she or he is able to understand, about the location for instance, and the interests of any other children.

4. A process of introduction should be arranged to minimise the pain of separation, and to promote the child's sense of security and capacity to accept change.

5. The foster carers need to be prepared for some disturbed behaviour to begin with.

6. As noted later, to secure the child's welfare the parents and foster carer will also need a clear, written agreement on the expected length of the placement, contact between them, and payment.

See Chapter 4 - Information for Private Foster Carers

CHILD DEVELOPMENT

7. A foster carer should expect to promote the child's physical, intellectual, emotional, social and behavioural development using some of the following means:
    a. appropriate and sufficient diet,
    b. exercise and play,
    c. intellectual stimulation,
    d. identification of disabilities,
    e. help (where necessary) with the development of language, identity, self esteem, and relationships,

f. the development of social skills and behaviour, and

g. ensuring that his or her needs are appropriately assessed and satisfactorily met and his or her views heard.

8. The Department can give advice on appropriate play, nursery school or playgroup experience, leisure activities and experiences

9. If the child has special needs, or is "in need" within the definition of the Act, he or she should receive the appropriate services.

See CYPA 2001 s.23(5) and Children in Need p.6 above

WELL BEING

10. Foster carers need to be aware of the factors which promote emotional well-being, such as:

a. the quality and permanence of previous care and relationships,

b. how separation and loss are handled (parents and private foster carers may both need advice),

c. the amount of continuity in the child's life, i.e. whether only part of his or her life has changed or his or her total environment,

See also Preparing the Ground above on the passing on of information about likes, habits, experiences and history

d. his or her sense of self worth, which comes from being loved, respected and accepted as an individual in one's own right, a sense of belonging to his or her new family and social setting, and not being discriminated against,

e. his or her self image and sense of identity, including ethnicity; knowing who his or her parents are and having a consistent name,

11. The parents should be encouraged to give the foster carers as much information about the child, his family and his needs as possible: what he or she is normally called, photos of themselves and their family, keeping the child up to date with family events.

12. The foster carers should maintain consistency for the child, not attempting to alter his or her name for example. They should encourage the parents to provide family news, contact with any siblings and the rest of the natural family, and with significant people from the past.

13. The following indicators are signs that all is not well and an assessment of the problems is needed, advice sought, and action taken if necessary:

a. the happiness of the child,

b. quality and comfort of relationships,

c. disturbed behaviour, whether the child is insecure or confused,

d. the reaction and attitudes of the foster family to the foster child and his or her needs.

These matters are discussed more fully on pages 14 and 15.

HEALTH

14. One of the key principles of working together is that health and social services should work in partnership to safeguard and promote the welfare of children.

15. A child who happens to move around a lot should have the same opportunities for diagnosis and treatment available to other children. To ensure good continuity of care the foster carer should be given:

    a. information about the child's medical background, health checks and vaccinations, and

    b. sufficient information about the implications of any disability or learning difficulty.

16. Children aged under five should benefit from the child health surveillance programme. Health checks are usually offered at intervals up to 24 months and are more frequent for first time mothers.

17. Appropriate arrangements should also be made between the Department, the foster carer and the child's parent for the child's personal health record to be held by the person who has care ('actual custody') of the child.

Children of school age are included in health care provided under the School Health Service.

18. All foster carers should have basic First Aid skills or be encouraged to obtain develop them. The local branch of the Red Cross or St. Johns Ambulance may be a useful source of advice and training.

Health care

19. Health care is an essential part of a parent's responsibility in safeguarding and promoting the welfare of the child. If a child is well and active special screening may not be needed over and above the routine screening and surveillance offered to all children in the Isle of Man. If, however, the child is unwell, his or her circumstances should be taken into account as they may be the key to the ill health.

20. The parents of the child to be privately fostered should make the child's medical history known to the prospective foster carers and the

Department. If possible, the child's personal health record (PCHR) should be given to the foster carer.

21. Children of certain ethnic origin or from certain parts of the world may have particular health care needs and full consideration should be given to this aspect of their care. They may, for example, be at risk of sickle cell disease, thalassaemia, tuberculosis, hepatitis B, or tropical diseases such as malaria.

22. A child with a disability may have been receiving medical attention from a specialist unit and special arrangements may be necessary to ensure continuity of care and treatment. The Department should check if the health service is aware of these arrangements so as to ensure continuity of treatment.

Child's medical history

23. Giving proper attention to the child's medical history is an integral part of safeguarding and promoting his or her welfare.

24. In addition to the child's basic details - height, weight - the medical history should include:

    a. the immunisations given and when,

    b. the results of any neo-natal screening tests,

    c. infectious diseases, with dates,

    d. any episodes of in-patient or out-patient hospital treatment, the reasons why, the dates, and as much detail as possible,

    e. whether the child is known to have any congenital condition, its medical implications, and/or the need for any continuing health care,

    f. whether the child is known to have any allergies, including allergies to medication,

    g. current short term or long term medication and other treatments, including consultants involved in the treatments, and

    h. any special dietary requirements or restrictions.

Medical examinations

25. It is recommended good practice that for a privately fostered child should be examined medically at the beginning of the placement, or as soon as possible afterwards.

26. When a child's medical history is incomplete further examinations may be required. The medical officer may charge the natural parent for these examinations.

Consent to medical examination or treatment

27. General medical consent, for any everyday treatment for which the child him or herself is not capable of giving consent, should be given in writing to the private foster carer by the child's parent, or person with parental responsibility, at the beginning of the placement.

28. It may be appropriate for the Department and the health authority to have copies of the consent.

29. Children of sixteen and over give their own consent to medical treatment**.**

30. Children under sixteen may also be able to give or refuse consent depending on their capacity to understand the nature of the treatment. It is for the doctor to decide this. Children who are judged able to give consent cannot be medically examined or treated without their consent.

31. The child's attention should be drawn to his or her rights to give or refuse consent to examination or treatment if:

    a. he or she is 16 or over, or

    b. under 16 and the doctor considers him or her to have sufficient understanding to give or withhold consent.

32. Young people should be encouraged to take responsibility for their own health. If a child refuses consent, and parents or others with parental responsibility wish to contest this, they should seek legal advice about applying to the court to exercise its inherent jurisdiction, requiring that the child should be made party to such proceedings.

Registration with a General Practitioner

33. Wherever possible, a child to be privately fostered should remain with his or her present GP. The Department and health services should in any case ensure that all privately fostered children are registered.

34. The child's parent should be given the name and address of the general medical practitioner with whom the child is registered.

35. Regular visits to the dentist for checks and treatment should also form an integral part of the general health care of the child.

EDUCATION

36. When children of school age are privately fostered they should remaining at the same school, if at all possible, so as to avoid the additional disruption of a move.

37. Good practice requires the Department to satisfy itself about arrangements for the child's education and that the Department of Education is informed of the fostering arrangements.

PHYSICAL CARE

YPA 2001
.3(3)
23(3)

YPA 2001
23(6)

38. Expectations about the physical care of the child should be agreed between the parents and foster carers at the time of their first contact. Discussion should be based on achieving the best interests of the child through co-operation, encouragement, with advice and mediation available if necessary.

39. The Department can give advice on all aspects of child care and set requirements if necessary. If the overall standard of care is unsatisfactory then appropriate action, involving the natural parents, should be taken.

CONTACT WITH THE CHILD'S FAMILY

40. The Department will encourage the private foster carer to promote contact between the child and his or her immediate and wider family.

See The Role of the Department, p.19.

41. Arrangements should be agreed with the parents at the outset and written down.

SERVICES FOR CHILDREN WITH DISABILITIES

42. A child with a disability is a child in need.

43. Disablement is defined in the Act as:
"A child is disabled if he is blind, deaf, dumb, suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed."

44. The only specific requirement imposed by the Act in relation to children with disabilities is to secure that accommodation the Department provides is not unsuitable for his or her needs. This provides a guide to be followed where possible for children with disabilities who are privately fostered.

45. The Department intends to have a register of disabled children. The register should help in accessing appropriate services.

46. The Department will need to consider the overall development needs of a child with a disability who is privately fostered, in co-operation with the relevant agencies.

More detailed guidance is contained in Volume F: 'Children with Disablities'.

FEMALE CIRCUMCISION

47. The Act requires the Department to give due regard to the child's religious persuasion in making decisions about a child it is looking after. Occasionally, where children from a particular ethnic minority

YPA 2001
46(1)

and cultural backgrounds are privately fostered, the Department, in co-operation with the health services, will need to concern itself with religious or cultural practices which are generally unacceptable and often prohibited within the United Kingdom.

48. In circumstances where the Department has reason to believe that a child is likely to suffer significant harm as a result of female circumcision it should pursue its duty to investigate under the Act and consider the need to take action, for example by applying for e.g. an Emergency Protection Order.

MALE CIRCUMCISION

49. Male circumcision is simple and straight forward and should, under appropriate conditions, pose no harm or danger to the health and welfare of the child. It used as a religious, social and cultural practice among many groups in Great Britain, and also for therapeutic purposes.

50. If a parent requests a private foster carer to arrange circumcision, the social worker should advise that the operation be carried out by a properly qualified medical practitioner at a hospital or clinic.

ETHNIC, CULTURE, RELIGION AND LINGUISTIC NEEDS

51. When a family from an ethnic minority community chooses to place their child in a private foster home of a different ethnic origin and culture to themselves, the Department will aim to establish the prospective foster carer's understanding of the child's culture, and the extent of his or her willingness to do so.

52. The fact that the foster placement is a private arrangement means that the Department cannot seek to prevent it unless other considerations justify the imposition of requirements or a prohibition, e.g. the premises are unsuitable.

53. In seeking to satisfy themselves that a child's welfare is being satisfactorily safeguarded and promoted in a private foster home, the Department's social worker will aim to ensure that the foster carer is aware of the differences between minority ethnic groups, and the significance of religion and culture in relation to racial origin.

54. The private foster carer and the Department will need to be aware of the practical difficulties which such placements can present and be prepared to deal with them at an early stage to avoid problems in the future. The Department will give advice on the resources and facilities available.

YPA 2001 s.25

EQUAL OPPORTUNITIES

55. The Department aims to promote good race relations. A private foster carer caring for a child from a minority ethnic or cultural group should be encouraged to value and respect the child's ethnic origin, religion, culture and language.

56. The Department will consider how advice and knowledge on equal opportunities, cultural issues, child care and health matters can be shared with private foster carers.

CONTINUITY AND CHANGE

57. Advice to private foster carers and natural parents should include the importance of planning the ending to fostering arrangements and preparing the child for the change. These changes may include:
    a. a move to new foster carers. The Department may decide to support a short term placement if a child is in need, to allow for adequate preparation for the move and introductory visits,
    b. returning to his or her own family.

58. When a child is changing foster home, as much continuity as possible should be maintained, e.g. continuing at the same school, remaining with the same G.P. The previous foster carer should provide information on the child's background, habits, interests, routines and needs.

59. The current private foster carer should always obtain the agreement of the natural parent before any move to another private foster carer.

60. Depending on the circumstances, the Department may need to contact, consult or advise the natural parent directly. This could be necessary if an "emergency" move is required because of difficulties between the natural parent and foster carer, or disturbed behaviour on the part of the child.

61. The need for continuity is as important at the end of the placement as at the beginning. A child's return to his or her family also needs careful preparation by both the foster carer and the natural parent - depending on the length of time the child has been away and the extent of change which has occurred.

62. For example, children from some ethnic minority communities who are intentionally placed in private foster care on a long term basis in the belief that it is good to grow up in a white family, may return to a different address, an unfamiliar culture and new family members.

63. The former foster carers should pass on information to the parent on the habits, food preferences, interests, routines and connections developed by the child. Ideally, parents should also be prepared for

these changes, and the possibility of disturbed behaviour while the child re-establishes him or herself in the family.

RECORDING THE CHILD'S DEVELOPMENT

64. Private foster carers should keep information about the child's development, and share it with the parents, and where appropriate, the social services, health and education services.

65. Such information should cover:

- maintaining and updating the child's medical history, including input from health staff, and a record of visits to the GP, etc.,
- keeping a file of school reports,
- noting the dates and means of contact with the parents and other significant people and events in the child's life (visits, letters, phone calls),
- maintaining a financial record of monies received on behalf of the child's upkeep,
- noting the dates and nature of Social Services contact,
- keeping a photograph album of significant events/people in the child's life.