

REDUCING THE RISKS OF ENVIRONMENTAL TOBACCO SMOKE FOR LOOKED AFTER CHILDREN AND THEIR CARERS

This Practice Note updates previous guidance in the light of changing scientific information and the improved understanding of the effects on health of exposure to passive or second-hand smoke from cigarettes, cigars and pipe tobacco. Throughout this document, absolute priority has been given to the best interests of children and their carers and the protection of their health. The guidance applies equally to adopters, foster carers, kinship carers and respite carers.

Introduction

BAAF's last Practice Note on children and smoking was published in 1993. In the intervening years, public awareness of the dangers of inhaling second-hand smoke has steadily increased and attitudes to it have radically changed. What used to be seen as a minor irritant, which could ruin a train journey or spoil a meal in a restaurant, is now seen as a serious, potential health problem from which the public needs to be protected. Governments, both nationally and internationally, are beginning to use legislation to ensure that protection is put into place.

This change in attitudes has immediate implications for all local authorities, voluntary agencies and fostering service providers that recruit and train substitute carers. Social care professionals who make placement decisions on behalf of vulnerable children must give a high priority to the present and future health of these children. The rights of substitute carers to smoke must always be balanced against the rights of children to remain healthy. This is especially true for looked after children, who frequently come into the care system with neglected or impaired health. This Practice Note clarifies, for both agencies and prospective carers, the very significant potential harm to a child who lives in an environment where there is daily exposure to tobacco smoke.

We recognise that the risk of placing a child in a smoking household is only one factor in the process of the holistic assessment of a child's needs. However, the scientific evidence supports the recommendations, which is set out later in this Practice Note, is very strong and must be given sufficient weight in any matching process. We also recognise the need for agencies to set in place a longer-term strategic framework to ensure that the acknowledged health risks and consequences of exposure to environmental smoke are incorporated into routine practice and decision-making.

We are mindful of the importance of not disrupting a stable placement which is otherwise meeting the needs of a child. However, it is the responsibility of the placing agency to ensure that any health risks to the child are brought to the attention of their carers. The National Minimum Standards for fostering Services (England) (Department of Health, 2002a) emphasise the importance of health promotion awareness for foster carers both in relation to their own health and that of children in their care.

Adoption agencies are required to take into account the Government view that there should be no “blanket” bans when considering applications from prospective adopters. The issue is therefore not one of banning prospective adopters and new carers, but of engaging with them, providing information and advice and facilitating access to smoking cessation programmes. Stopping smoking is the single most important thing that any adult can do to protect their health and increase their life expectancy.

We would strongly recommend that all substitute carers should be pro-actively encouraged to stop smoking. If they are unable to stop smoking, they should always follow the National Safety Council Guidelines for parents that are listed in the new recommendations at the end of this Practice Note.

What Is In Second-Hand Smoke?

Breathing other people’s smoke is called passive, involuntary or second-hand smoking. Tobacco smoke in the home is an important source of exposure to a large number of dangerous substances. The US Environmental Protection Agency (EPA) (1992) identified tobacco smoke as a major source of indoor air pollution which contains over 4,000 chemicals in the form of particles and gases.

Unlike adults, who can choose whether or not to be in a smoky environment, children have little choice. Outside school, children spend most of their time at home, indoors with their parents or carers. The younger the child, the more likely it is that the child will spend most of the day physically in the same room as his or her smoking parent (s).

A child breathes both the “sidestream” smoke from the burning tip of the cigarette and also the “mainstream” smoke that has been inhaled and then exhaled by the smoker. Fielding and Phenow (1988) estimated that nearly 85% of the smoke in a room results from sidestream smoke. Many potentially toxic gases are present in higher concentrations in sidestream smoke than in mainstream smoke.

The particles in tobacco smoke include tar, nicotine, benzene and benzopyrene. The gases include carbon monoxide, ammonia, dimethylnitrosamine, formaldehyde and hydrogen cyanide. Some of these have marked irritant properties, and 60 are known or suspected carcinogens (substances which cause cancer). The US Environmental Protection Agency has classified environmental tobacco smoke as a Class A human carcinogen.

Cannabis

At the present time, the risks to children of inhaling second-hand smoke from cannabis are not known. In the UK, the most common way to smoke cannabis is to mix it with tobacco and roll the mixture into a cigarette, known as a “joint” or “spliff”. A cannabis joint is smoked with deep and prolonged inhalation and no filter. Cannabis burns at a higher temperature than tobacco.

The scientific evidence that is emerging suggests that smoking cannabis and tobacco together may be more harmful than smoking either alone. The smoke from herbal cannabis preparations contains all the same constituents (apart from nicotine) as tobacco smoke, including carbon monoxide and bronchial irritants (British Medical Association, 1997). Smoking cannabis with or without tobacco, can cause irritation and damage to the respiratory system. Cannabis smoke contains more carcinogens and insoluble particles than that of tobacco and appears to be associated with an increased incidence of cancers

of the mouth and oesophagus. Chronic cannabis smoking is associated with bronchitis and emphysema. It has been calculated that smoking three to four cannabis cigarettes

per day is associated with the same evidence of acute and chronic bronchitis and the same degree of damage to the bronchial mucosa as 20 or more tobacco cigarettes per day (Benson and Bentley, 1995). Therefore, common sense suggests that the health risks to children will be at least the same, if not greater, than smoking tobacco alone.

There is also considerable evidence, reviewed by Hall et al (1994) that performance in heavy, chronic cannabis users remain impaired even when they are not actually intoxicated. These impairments, especially of attention, memory and ability to process complex information, can last for many weeks, months or even years after cessation of cannabis use (Hall and Solowij, 1998). Whether or not there is permanent cognitive impairment in heavy long-term users is not clear. Cannabis use is also associated with an increased risk of road, rail and air traffic accidents.

Adolescents already troubled with poor school performance and with pre-existing mental health problems may be more susceptible to developing a dependence on cannabis. There is also increasing evidence linking regular cannabis use to the worsening of some schizophrenic disorders, and people with a history of mental illness may be vulnerable to cannabis-induced psychosis (Johns, 2001).

Therefore, no placing authority should condone placing a child with any family where it is known that cannabis is smoked; either from a legal point of view or from the point of view of protecting the physical and mental health of children in placement.

The Immediate Effects Of Environmental Tobacco Smoke In Children

Young children are particularly susceptible to the effects of second-hand smoke because their lungs and airways are small and their immune systems are immature. Consequently, when exposed to environmental tobacco smoke they are more likely than adults to develop both respiratory and ear infections. Children also have higher respiratory rates than adults and consequently breathe in more harmful chemicals, per pound of body weight, than an adult would in the same period of time.

There is consistent scientific evidence to support the association of an increased risk of the following conditions in children brought up in smoking households:-

- Sudden Unexpected Death in Infancy (SUDI) or cot death is the most common cause of death in children aged 1-12 months. Compared to those infants whose mothers do not smoke, the infants of smoking mothers have almost five times the risk of dying from SUDI
- Lower respiratory tract infections (pneumonia and bronchitis) in pre-school children occur more frequently if a parent smokes.
- Asthma and respiratory infections in school age children are more common in a smoking household. It is estimated that between 1,600 and 5,400 new cases of asthma occur every year as a result of parental smoking. In addition, established asthma tends to become more severe in smoking households.

- Parental smoking is responsible for a 20-40 per cent increased risk of middle-ear disease in children. This is associated with hearing loss, a need for surgery, secondary speech delay, schooling difficulties and social isolation.
- In the UK, 17,000 children under the age of five are admitted to hospital every year with illnesses resulting from passive smoking.

The evidence for some of these conditions is dose-related – the greater the number of cigarettes smoked by the adults, the greater the risk. The risks to children will also be increased by the frequency of visits of smoking relatives and family friends.

Reducing parental smoking would result in significant reductions in respiratory morbidity and mortality in infants and children. Further detailed information and references are available in *Children Exposed to Parental Substance Misuse Phillips, 2204*, published by BAAF) and in *Smoking and the Young* (Royal College of Physicians, 1992).

The Long-Term Effects Of Environmental Tobacco Smoke In Children

The long-term effects of growing up in a smoking household are not yet fully known, but they are likely to be significant, bearing in mind the recognised risks to adults exposed to passive smoking. The Department of Health's Scientific Committee on Tobacco and Health (2004) issued a report that concluded that exposure to second-hand tobacco smoke can cause both lung cancer and heart disease in adult non-smokers. This report estimated that non-smokers exposed to second-hand smoke increased their risk of developing lung cancer by about 24%. The best estimate for the increased relative risk of heart disease was about 25%.

Charlton and Blair (1989) looked at absenteeism amongst 2,800 young people aged 12 and 13 in the North of England and showed maternal smoking was associated with an increased rate of absence from school. This issue is particularly important for looked after children, who frequently come into the care system with neglected education, are more likely to be excluded from school for other reasons and whose educational achievements in care are poor (Department of Health, 2002b).

The Implications Of Becoming A Smoker Whilst Being Looked After

The World Health Organisation (WHO) (1999) reported that children living with parents who smoke are nearly three times more likely to be smokers than those whose parents do not smoke. Children of smokers are more likely to take up the habit because they copy the behaviour of adults. Growing up in a household where adults smoke often means that children perceive smoking as the "norm". Their parents' approval or disapproval of the habit is a significant factor in determining whether a child will eventually become a smoker.

Many young people come into the care system as smokers. Others only become smokers whilst being looked after. The health implications for all these young smokers are serious and those responsible for their welfare should do everything that they can to help them quit the habit.

The Royal College of Physicians (1992) reported on the significant ill effects of taking up smoking in adolescence. The earlier in life that children start smoking, the greater the risk of developing heart disease and lung cancer in later life. Children who smoke are between two and six times more susceptible to coughs, wheeziness and shortness of breathe than those who do not smoke. Smoking is known to be a cardiac stimulant, which magnifies the effect of stress on the heart. It also increases blood coagulability and adversely affects

blood lipids. Sub-arachnoid brain haemorrhage is six times more common in young smokers than in non smokers.

Young smokers take more time off school than non-smokers. They are less physically fit than other children and are slower at both sprints and endurance running. The performance in a half-marathon of a young smoker of 20 cigarettes per day is the same as that of a non-smoker who is 12 years older. Smoking increases skin ageing and skin wrinkling. Female smokers are two to three times more likely to be infertile than non-smokers.

The International Scene

The UN Convention on the Rights of the Child Article 3 (Office of the United Nations High Commission for Human Rights, 1990) states that:- 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child should be a primary consideration.' It must therefore follow that children have the right to be protected from passive smoking. Most national and international legislation and good practice guidance supports this right.

The World Health Organisation (2001, p6) points out that second hand smoke is a real and substantial threat to child health, causing a variety of adverse health effects. 'Because of the enormous potential harm to children from tobacco use and exposure. States have a duty to take all necessary legislative and regulatory measures to protect children from tobacco and ensure that the interests of children take precedence over those of the tobacco industry.'

National Governments therefore have a duty to inform the public of the hazards of breathing in other people's tobacco smoke and responsible adults should act on that advice to protect the health of children. Parents (or those with parental responsibility) must recognise that passive smoking caused serious ill-health in children and that they have a responsibility not to inflict harm on their children.

In response, Governments across the world have taken action. In 2000, South Africa was the first country in the world to ban smoking in all public areas. Bans followed in Zimbabwe (2002), Thailand (2002), Pakistan (2002), Romania (2002), Iran (2003), India (2004) and Uganda (2004). In 2004 the Republic of Ireland became the first country in the Northern Hemisphere to ban smoking in all enclosed public spaces, followed by Norway (2004), Spain (2005), Sweden (2005) and Italy (2005). In the US most major cities, starting with New York in 2002, have now banned smoking in public places with some cities even extending the smoking ban to beaches, public parks, prisons, sports stadiums and railways stations. Smoking is prohibited within 25 feet (8 metres) of playgrounds throughout the State of California. In the US, anti-discrimination laws do not cover smokers because smoking is not considered an inalienable right under the US Constitution.

The National Scene

There is increasingly widespread public support for smoking restrictions in public places. The Department of Health (2003) found that 86% of respondents, including 70% of smokers, agreed that smoking should be restricted at work and in restaurants.

In January 2004, the Scottish Executive launched *A Breath of Fresh Air for Scotland*, a tobacco action plan designed to offer a programme for action covering prevention and

education, protection and controls and the expansion of smoking cessation services. It also addressed the issue of passive smoking and set out plans for major public consultations which led to the Smoking, Health and Social Care (Scotland) Act 2005. That legislation came into force in March 2006 with a ban on smoking in enclosed public places in Scotland.

In the Public Health White Paper published in November 2004, *Choosing Health, Making Healthy Choices*, the Department of Health set out proposals to ban smoking in most work places and enclosed public places in England, with exemptions for private clubs and pubs not serving food. In 2005 the Welsh Assembly Government also proposed a comprehensive ban.

The Department of Health and the Wales Office issued a joint consultation about the smoke free provisions in the Health Bill in June 2005. The Health Bill was introduced into the Westminster Parliament in October 2005. After a very public debate, the proposal to have the exemptions for private clubs and pubs not serving food was overturned by a free vote in the Commons in February 2006. England will now join Wales with a total smoking ban in all enclosed public places on 1st July 2007.

The National Service Framework For Children

In 2004, the Department of Health published The National Service Framework for Children (NSF). This document sets new standards for children's health and social services and represents a fundamental change in Government thinking about the way health and social care services are delivered. It is intended to lead to a cultural shift, resulting in services being designed and delivered around the needs of children and their families.

The Government's aim is for every child, whatever their background or their circumstances, to have the support they need to be healthy and stay healthy. The NSF is aimed at everyone who comes into contact with, or delivers services to children, young people or pregnant women. A programme for the improvement of services across health, education and social care in England for the next 10 years is proposed.

The suggested health promotion programme is underpinned by the best available evidence. It focuses on priority issues such as healthy eating, physical activity, safety, smoking, sexual health and mental health. It should be delivered by all practitioners who come into contact with children and young people and in all settings used by this age group.

Children, young people and families should be supported and able to make healthy choices in how they live their lives. There are several areas in the lives of children and young people where being able to make healthy choices will make a real difference to their life chances and health, social and economic outcomes. Carers should also be supported in providing an environment which encourages improvements in the health and wellbeing of children and young people in their care (Standard 2).

Given the worldwide shift in attitudes to smoking and the increasing scientific evidence, it will become increasingly difficult for local authorities to justify placing children in environments where they are exposed to the impact of passive smoking. In an ideal world no child for whom "being healthy" was given priority would ever be placed in a smoking household.

Can The Smoking Patterns Of Carers Reduce The Risks To Children?

Cotinine is a metabolite or breakdown product of nicotine as it is “processed” by the human body. It is only produced by nicotine and is therefore a good indicator that nicotine has been inhaled or otherwise introduced into the body. People who do not smoke or who are not exposed to other people’s smoke should not have measurable cotinine in their blood, urine or saliva.

In 1991, nearly 90% of the US population had measurable levels of serum cotinine in their blood. The Centre for Disease Control and Prevention’s Third National Report on Human Exposure to Environmental chemicals (2005) reported a 75% decrease in cotinine levels for adult non-smokers in the US since 1991. This dramatic decline in serum cotinine levels among adult non-smokers, who can choose to avoid environmental cigarette smoke, is a good indication that efforts to ban smoking in public places are working.

The protection that these measures have apparently given to children is, however, far less effective. Although the cotinine levels in US children have decreased by 68% since 1991, worryingly, the levels of cotinine found in children were still double the levels found in adults. Because children have very little choice over the environment in which they live US health officials still consider that the impact of environmental cigarette smoke on children remains a major public health issue.

Spencer et al (2005) studied the cotinine levels in toddlers aged 18-30 months living in 309 smoking households in the Midlands to see if the amount of cotinine in the children’s urine was influenced by their parents’ reported smoking patterns. Most of the parents in this study (88%) reported that they were taking some measures to protect their children from their cigarette smoke. These measures included: smoking fewer cigarettes; not smoking in the same room as the child; not smoking in the child’s bedroom; not smoking in the living room, airing rooms after smoking; and, finally, banning smoking completely in the house.

The last most drastic, option was also the least popular measure with only 14% of households reporting a complete household ban. However, only a total household ban on cigarette smoking was associated with significant reductions in cotinine levels. The other less strict measures adopted by parents appeared to have little impact on the children’s exposure to cigarette smoke in this age group. Even the children from the households where smoking was completely banned indoors still had measurable cotinine in their urine. Their bodies were still metabolising nicotine despite the efforts of their carers to protect them.

The researchers concluded that even this drastic measure was unlikely to fully protect children from the adverse effects of tobacco smoking. The effects of passive smoking are cumulative over time and low levels of exposure might still be harmful. Whilst, it might reassure professionals that some anti-smoking measures are in place, smoking outside will not be sustainable for 52 weeks of the year. In addition, many children in the care system have unpredictable behaviour and leaving a child unsupervised whilst a carer smokes outside will not be an acceptable solution for most young children.

New Recommendations To Protect Children From Environmental Tobacco Smoke

We fully acknowledge that many excellent substitute carers smoke. There is also a national shortage of both foster carers and adopters. Despite this, all who recruit foster or adoptive parents need to give the protection of the health of children in their care a high priority and will, in the future, have to balance the positive elements of any placement

against the negative impact of smoking. This means that, wherever practical, all placement teams should try to protect children from exposure to second-hand smoke at home. Placing authorities also need to be aware of potential legal action in the future if a child develops a smoking-related disorder after being placed in a foster or adoptive home in which family members smoke.

New Recommendations

1. BAAF (1993) advised that children under two years old should not be placed with carers who smoke because of the potential risk to health. This age limit should be increased to **all children less than five years old**. This is because of the particularly high health risks for very young children and toddlers who spend most of their day physically close to their carers.
2. All children with a disability which means they are often physically unable to play outside, all children with respiratory problems such as asthma, and all those with heart disease or glue ear should not be placed with smoking families.
3. In all long-term fostering, kinship and adoptive placements, the additional health risks to the child of being placed in a smoking household needs to be carefully balanced against the available benefits of the placement for the child. This is because the significant risks of exposure to passive smoking increase with time.
4. Children from non-smoking birth families should not be placed with substitute carers who smoke.
5. All older children, who are able to express a view, must be given a choice to be placed with a non-smoking family.
6. All carers should be advised about the risks of buying cigarettes for adolescents. Cigarettes should never be used as a reward for good behaviour in adolescents.
7. The National Safety Council (NSC) (2004) has produced guidelines for parents on what practical steps they can take to minimise children's exposure to tobacco smoke, if they are unable or unwilling to stop smoking. All foster carers, respite carers, adopters and child minders should follow these guidelines, which should also be incorporated into preparation courses. This advice includes:-
 - Don't smoke around children or permit others to do so. Their lungs are particularly susceptible to smoke.
 - Keeping your home smoke free. Because smoke lingers in the air, children may be exposed to smoke even if they are not around while you are smoking.
 - Smoke only outside the house.
 - If you must smoke inside, limit smoking to a room where you can open windows for cross-ventilation. Be sure the room in which you smoke has a working smoke detector to reduce the risk of fire.

- Never smoke in the room where your child sleeps and do not allow anyone else to smoke there.
 - Never smoke while you are washing, dressing, or playing with your child.
 - Never smoke in the car with the windows closed, and never smoke in the car when children are present. The high concentration of smoke in a small, closed space greatly increases the exposure of other passengers.
8. Stopping smoking will protect not only the health of children but also the health of their carers. Agencies have a primary responsibility to ensure that where a relationship is established between a child and a carer that this is maintained for as long as the child needs it. It is a tragedy for a foster carer or adopter to be unable to continue to care for a child who has already experienced significant loss because of preventable illness or premature death. All agencies should therefore encourage all their carers to stop smoking by:-
- Providing information on the effects of passive smoking in children.
 - Providing information on the effects of smoking on adult health.
 - Providing regular training and information for fostering, adoption and permanency panels.
 - Advertising local and national NHS services for stopping smoking.
 - Resourcing nicotine patches for carers, if necessary.
 - Discussing smoking risks as a routine part of the recruitment process and at every review for all foster carers.
 - Giving consideration to the smoking habits of other family members and friends who visit regularly, e.g. grandparents or older children who no longer live at home should also be part of these discussions.
9. Carers who have successfully given up smoking should not be allowed to adopt or foster high-risk groups (children under five, children with a disability, chest problems, heart disease or glue ear) until they have given up smoking successfully for a minimum period of 12 months. This is because relapse rates in the first three to six months are high; after six months the risk of relapse is less and after 12 months most people will be permanent non-smokers. After 10 years of not smoking an applicant is classed as a non-smoker for insurance purposes.
10. Carers who smoke should receive extra information about the risks of burns and fires from smoking. Fire and burns are the leading cause of death in the home for children. In the UK, 10% of fires ignite with smoking related material and cause between 130 and 180 deaths annually, or one in three of all deaths from fires (Department of Health, 2001).
11. Local authorities and other fostering service providers should move progressively to a situation where no more smoking carers are recruited. This will not only improve the

health of some very vulnerable children but will protect the agencies from potential legal action in the future.

12. Social workers should carefully consider the importance of promoting non-smoking and the positive messages that they convey to young people. They should actively help all looked after children to stop smoking. Promoting a positive health message

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also means that they should not smoke in a car which will be used later to collect children and young people; not smoke outside case conferences or reviews; and not smoke with young people, nor in the view of children.

Conclusion

Many agencies will have already implemented most of the recommendations contained this Practice Note. For others, the guidance may represent a significant challenge. It is recognised that agencies continue to struggle with recruitment of adopters and foster carers and this Practice Note is not intended to add to those difficulties. However, we believe that, in the best interests of children, all agencies and adults who care for children separated from their birth families have a primary responsibility to ensure that what is now well established in the scientific and health community is reflected in practice.

This Practice Note is written with the intention of ensuring that what we do is always in the best interests of the health of vulnerable children.