PRACTICE NOTE 30

Children and Smoking

Introduction

Over the past few years a concerted effort has been made in the UK to discourage smoking because of its proven adverse effects on health. Although official discouragement has stopped short of putting an absolute embargo on cigarette advertising, many work places, restaurants, theatres and cinemas now either forbid smoking altogether or strictly limit areas where it is permitted.

Smoking has many different and adverse effects on health. A burning cigarette produces *mainstream smoke* which is filtered by the cigarette and inhaled by the smoker. This adversely affects the natural protective action of the respiratory tract. *Sidestream smoke* goes into the air to be breathed passively by people nearby. This sidestream smoke is not filtered and it contains harmful chemicals including carbon monoxide and nicotine. Professionals who are responsible for making decisions about the care of children and those who provide the day to day care need information about the effects in order to fulfil those roles. In this Note the effects of active and passive smoking are considered as they relate to different age groups.

Recent research has focused in particular on the effects of smoking on children's health and, as a result, some agencies have drawn up policies regarding how they should deal with applications to adopt or foster from people who smoke.

This Practice Note draws on the efforts of those agencies and on discussions held in the Executive Committee of the BAAF Medical Group and the BAAF Management Committee, our focus throughout being that fostering and adoption agencies' primary duty is to promote the welfare of each child. The Note presents guidelines for consideration in the family placement of children. It outlines (with references) the facts regarding the effects of smoking on health, discusses how these relate to the placement of children of different ages and how to offer guidance to applicants who smoke, and makes recommendations regarding agency policies.

Table 1 Smoking behaviour of 11-15 year olds in England 1982-1990

	1982	1984	1986	1988	1990
Boys	%	%	%	%	%
Regular smoker	11	13	7	7	9
Occasional smoker	7	9	5	5	6
Used to smoke	11	11	10	8	7
Tried smoking	26	24	23	23	22
Never smoked	45	44	55	58	56
Base (100%)	1460	1928	1676	1489	1643
Girls					
Regular smoker	11	13	12	9	11
Occasional smoker	9	9	5	5	6
Used to smoke	10	10	10	9	7
Tried smoking	22	22	19	19	18
Never smoked	49	46	53	59	58
Base (100%)	1514	1689	1508	1529	1478

OPCS Survey, London, HMSO, 1991

Background: Smoking in the UK

Between 300 and 400 people die in the UK each day of smoking related diseases[1] and doctors can now identify these deaths clearly when completing death certificates. Ninety per cent of cases of lung cancer, 30% of all deaths in the age group 40-65, 20% of all coronary heart disease deaths and 8% of heart attacks occurring in men under the age of 45 are associated with smoking. It has been estimated that of 1,000 young adults who smoke cigarettes regularly about 250 will be killed by tobacco.[2] Fifty million working days are lost each year. Thus, the cost of smoking related illness in terms of personal suffering is considerable. In financial terms the annual cost to the NHS is around £437 million. Each year the Health Education Authority spends £5.5 million advising people not to smoke. In England and Wales, during the period between 1972 and 1988, cigarette smoking among men dropped from 52% to 33%. For women the overall decline was from 41% to 33% but the number of younger women who smoke has increased slightly. Thus babies and young children remain at risk since their carers are often in that age group. Smoking remains more frequent in the lower socio-economic groups. Despite a substantial fall in smoking over the past two decades, smoking remains the largest single preventable cause of death in England.[3]

Smoking behaviour in young people is shown in Table 1. In 1990 about one quarter of 15-year-olds were regular smokers (Table 2). Since many adults start to smoke in childhood it is important to discourage children and young people from starting to smoke or to help them stop once they have started.

Table 2 Regular smoking among secondary school children in Britain in 1990, by country, sex and age

	England	Wales	Scotland
Boys	**%**	**%**	**%**
11 year olds	-	-	*
12 year olds	2	2	4
13 year olds	6	5	8
14 year olds	10	10	10
15 year olds	25	20	22
Girls			
11 year olds	1	-	*
12 year olds	2	2	3
13 year olds	9	7	10
14 year olds	16	17	18
15 year olds	25	26	28

OPCS Survey, London, HMSO, 1991
* Scottish children do not enter secondary schools until the age of 12 years.

The effects of passive smoking on the health of children

Pregnancy

Smoking during pregnancy increases the risk of miscarriage, still birth, premature delivery and low birth weight.[4, 5] The risk increases with maternal age and the number of cigarettes smoked.

Infancy

Sudden infant death syndrome or cot death occurs most commonly during the first six months of life. About 2 per 1,000 babies are affected and this results in 1,200 to 1,400 cot deaths each year in England. Smoking by carers during this period increases the risk of cot death. A large prospective study in Sweden in the 1980s concluded that when mothers smoked up to nine cigarettes daily the risk of cot death was doubled.[6] Consumption of ten or more cigarettes daily trebled the risk. The Department of Health has recently issued clear advice in relation to cot deaths that there should be no smoking anywhere near a baby.[7]

During the first year of life digestive and respiratory illnesses occur more frequently when parents or carers smoke.

In 1974 two major studies showed an increased risk of bronchitis and pneumonia in infants whose parents smoked.[8] The risk was doubled in the first year and was highest when both parents smoked, lowest when neither smoked. The association became less consistent after infancy. A later study in New Zealand confirmed these finding and concluded that the adverse effects had disappeared by the third year.[9] Thus passive smoking clearly has undesirable effects on a child's lower respiratory tract during the first two years of life. The effect of smoking away from the immediate vicinity of the child would appear so far to be uncertain, but an important study in Shanghai with mothers who did not smoke during pregnancy, found that significant respiratory illness in their children was related to cigarette smoking in family members.[10] In all the studies the correlation with smoking persists when other factors have been taken into account.

Older Children

In this group also some respiratory symptoms appear to be caused by passive smoking. Studies also suggest that by this time other adverse effects of earlier smoking can be demonstrated, including impaired lung growth and slower developmental progress.

For older children parental smoking has been shown to be associated with cough in non-smoking children. The effect is greater when both parents smoke. Parental smoking is also associated with wheezing and asthma in children. In one study asthmatic children had 47% more symptoms when their mothers smoked.[11] The effect is more severe in boys than girls and greater for older than younger children. In another study there was a 14% increase in wheezy bronchitis when the mother smoked four cigarettes daily compared to an increase of 49% with 14 cigarettes. Not surprisingly passive smoking adversely affects children with cystic fibrosis also. Other effects include an increase in the number of sore throats. Possibly of greater concern is a reported association between middle ear problems and parental smoking[12, 13] and since middle ear problems may affect listening and learning skills the children concerned may be significantly disadvantaged. This association is reflected in another report which relates the degree of snoring in children with the number of cigarettes smoked by their parents.

Finally, two studies have shown a link between passive smoking in childhood and adult lung cancer.[14] This link relates only to high levels of exposure.

Active smoking in children

In Great Britain 450 children start smoking every day.[15] There is clear evidence that the earlier regular smoking is established, the greater the risk of subsequent lung cancer. Early smoking is also associated with more immediate health problems. For example, children who smoke are at risk of respiratory illness, cough, and phlegm production.[16, 17] This effect operates from primary school onwards and results in reduced school attendance. Given the adverse effects of smoking in children and young people it is important to consider the process by which they become smokers. In the early stages positive benefits of smoking are perceived.[18] The child equates smoking with being tough or grown up.[19]

Many children have their first cigarette at home and in one study 22% of children said they had first smoked with their parents. Once smoking has started there is risk of addiction and giving it up becomes very difficult. In one series 65% of young people aged 16 to 19 years who smoked had made at least one attempt to stop. A study in Derbyshire where 6,000 adolescents were surveyed annually showed that girls more often smoked when their fathers smoked and boys when their mothers smoked.[20] Children are twice as likely to smoke if a parent smokes and reassuringly, are seven times less at risk of smoking than their peers if their parents disapprove.[21] In addition, children are positively affected when parents stop smoking and this underlines the need to involve parents and carers in health education programmes. Unfortunately, peer pressure is strong and for some children having a best friend who smokes is a significant risk factor.[22] When school staff smoke there is a higher prevalence of smoking in the pupils.[23] Importantly, where stricter policies are followed in schools, there is a lower prevalence in later life.[24] There is little evidence that knowledge of health risks associated with smoking influences children to be non-smokers.[25] Children, like adults, deny or ignore unwelcome information. Cigarette consumption is proportional to the availability of money and the price of cigarettes. Tobacco advertising probably highlights the perceived benefits of smoking.[26] Children and young people who are underachieving at school are at risk of becoming smokers.[27] In schools, the

National Curriculum now requires children aged between seven and sixteen to be taught about the harmful effects of smoking.[28]

A recent report from the Royal College of Physicians (London), entitled *Smoking and the Young*, comprehensively reviews the subject and makes recommendations for consideration by individuals, agencies and central government.[29]

Applicants who smoke

The responsibility of agencies placing children with families, whether for adoption or foster care, is to put the child's welfare first. In so doing, it is the agency's duty to alert carers regarding what is advisable for each child. Without doubt in the past many smokers have proved to be excellent foster carers or adoptive parents. Also, agencies welcome applications from socio-economic groups where smoking is more prevalent, but where particular strengths and qualities can be offered to children. Especially in the case of older children, such placements comply with the philosophy of the Children Act, often enabling children to be near their homes, to maintain contact with relatives and to attend the same schools. However, the evidence regarding damage caused by passive smoking to babies and toddlers is overwhelming.

Adoption agencies know from their experience in practice that healthy young children needing adoption are heavily outnumbered by applicants seeking to adopt them, and the reality is that, because of this imbalance, many applicants who would be suitable adopters will never succeed in their aim, whether or not they smoke. In these circumstances, applicants hoping to adopt young children and who smoke are putting themselves at a disadvantage. They should be made aware from the outset that whether or not they smoke will be a feature of the overall assessment of their suitability to adopt and that, in observing their duty to consider the best interest of each child, agencies are likely to select from available and equally suitable applicants who do not smoke. This is likely to be particularly evident when children are not only young (and therefore more vulnerable to health hazards) but also have additional risk factors such as respiratory problems, including congenital heart and other relevant conditions.

In arranging any family placement, agencies must weigh disadvantages (and, on the evidence, smoking has to be counted as one) against advantages, which may include personality, experience, age, cultural background, geographical situation of the home and many more. This balancing act must be carried out in the light of the alternatives available for each child, and the number of prospective carers for older children or children with special needs is likely to be limited.

Although applicants should be told early in recruitment that smoking habits will be considered along with other health issues during assessment, it is not helpful for an agency to create an image whereby smokers feel that their applications would automatically be unwelcome. It is sometimes difficult for lifelong non-smokers to comprehend the feelings of those who began to smoke by taking part in an acceptable activity, even carrying with it a certain sophistication, and who now find themselves trapped in a habit which labels them as anti-social. Attitudes reflected in the words 'it's a filthy habit anyway' are not likely to provoke a positive response from smokers, but reasoned discussion focusing on the health needs of the children they hope to help is more likely to do so. For instance, the evidence (19-24) quoted above, indicating that example has a stronger influence than health education on children's smoking habits, might well cause applicants to reflect on the example that they themselves can offer. Discussion with a carer who has given up smoking can also be helpful and social workers who smoke can be asked to abstain when in the presence of applicants. Equally helpful can be a rigorous no-smoking policy for professional carers in agencies' residential establishments, bearing in mind that local authorities are being asked to ensure that all their premises (particularly educational establishments) are covered by appropriate no-smoking policies.[30] Help in locating and attending no-smoking courses should be offered, with, where appropriate, payment of fees, and smokers who have already tried but failed to give up can be encouraged by anecdotal evidence indicating that the success rate increases with each successive attempt. GPs have proved to be particularly successful in helping their patients to stop smoking.[31] Smokers can also be encouraged to phone the Smokers Quitline, which is staffed by trained smoking cessation counsellors and provide a Quitpack acceptable to he HEA (see Useful Addresses).

Some applicants who feel unable to stop may undertake to refrain from smoking in the vicinity of the child. Agencies should consider whether this solution could perhaps place an additional strain on family life, when one or both parents feel obliged to quit family living rooms from time to time in order to smoke. Would smokers feel guilty? Would increasing involvement with the children cause their resolution to slip from time to time? What kind of model would this present as a toddler grew older and realised why a parent, for example, went into another room after every family meal? And as far as

the smokers themselves were concerned, the detrimental effects would continue. When applicants give an undertaking to smoke away from the child, or seem unwilling to try to stop smoking or fail to do so, agencies must perform the balancing act referred to earlier in this Note, setting the positives in caring offered by applicants against the effects of passive smoking and the kind of model offered to young people by adults who smoke.

A similar balancing act must be performed by carers themselves when they are choosing babysitters or visiting friends and relatives who are heavy smokers. How to influence birth parents who smoke and who may visit the child often must also be considered by the carer and social worker. It will always be necessary to balance the health risk against each child's need for contact with a smoker, or simply his or her need for normal social contact. Consideration of these choices should be included in preparation programmes for carers.

Agencies should also be prepared to offer carers support in helping children and young people to stop smoking. Over enthusiastic non-smokers, as the National Foster Care Association has found, can have the opposite effect in some cases. The Health Educational Authority publishes useful material regarding smoking and young people (see Useful Addresses).

Conclusion

This Practice Note has presented many of the adverse effects of active and passive smoking on children and young people for consideration by child care agencies, especially when arranging for children to be looked after away from their birth families. However sympathetic agencies may feel towards applicants hoping to adopt or foster, the focus of work must always remain on what is likely to be in the best interests of each child for whom they are responsible. Consideration has to be given to both short and long term effects for the child and to the harmful effects on the health of the smoker and other carers. Clearly, passive smoking presents a danger to babies and is harmful to young children, especially those with respiratory problems. Older children remain at some risk of respiratory problems and are more likely to become smokers themselves if placed with carers who smoke.

Although this Note was drafted before publication of the Heath Education Authority's report, *The Smoking Epidemic*[32], the chapter on passive smoking supports these points. In addition, the consultative document on the review of adoption law, published by the Department of Health in October 1992 indicates that guidance to new adoption legislation will include general principles regarding the health of the applicants, including smoking.[33]

The Executive Committee of the BAAF Medical Group therefore makes the recommendations set out below to agencies responsible for the placement of children. BAAF recognises that these recommendations represent a challenge to agencies, to management, to field and residential staff and, not least, to foster carers and adopters. Action required to implement them includes advocacy in management committees, influencing staff in agencies dedicated to free choice and equal opportunities, providing accurate information for child care staff and for applicants, and enlisting the support of already approved foster carers and adopters. In some instances it may also include defending policies on the media and arguing with local smoking lobbies. Such tasks cannot be accomplished overnight (drawing up the recommendations took full discussions in BAAF over several months) but the accumulating evidence indicates that issues around smoking and children deserve urgent attention.

Recommendations

- Agency managements, together with their adoption and fostering panels, should establish clear guidelines on their approach to carers who smoke, which should be made available to all staff and to carers and prospective carers.
- Applicants who wish to adopt or foster should be advised at an early stage that smoking habits will be considered during assessment along with other health issues. Since smoking is harmful to the smoker(s) as well as others in the household, advice and assistance should be offered to promote no smoking. Applicants who smoke should be encouraged to consult their GPs, who are a focal point in the national campaign to discourage smoking.
- Information regarding the harmful effects should be included in preparation and training programmes for prospective and already approved foster carers and adopters. Also included should be discussion on the choices carers are likely to face regarding baby-sitters or day carers who smoke, visitors to the home, and so on.
- Babies and young children up to the age of two years and all children with respiratory problems are at particular risk and it is therefore not in their best health interests to be placed in households with smokers when equally suitable non-smokers are available unless there are exceptional reasons

for doing so, for example, when the prospective carer is a member of a child's extended family. Any such reasons should be recorded on the agency's files.

- Agencies should acknowledge the dangers to which children and young people who smoke are exposed. In the light of the information available they should review their policies and procedures for example, for residential establishments with a view to discouraging smoking by both young people and the staff responsible for them.

Useful addresses

Health Education Authority
Hamilton House
Mableton Place
London WC1H 9TX
Tel: 071 383 3833

QUIT
(helping smokers to quit)
102 Gloucester Place
London W1H 3PH
Tel: 071 487 2858

Action on Smoking & Health (ASH)
109 Gloucester Place
London W1H 3PH
Tel: 071 935 3519

Parents against Tobacco
Milestone House
39 Main Road
Long Benington, nr Newark
Notts N923 5DJ
Tel: 0400 81018

QUITLINE 071 487 3000
A national telephone helpline for smokers who need advice or help in stopping. Ex-smokers can also ring for encouragement. Staffed by 'stop smoking' experts as well as trained volunteers. Quitline gives details of local groups. Lines are open 24 hours, with recorded messages outside office hours. Will also send an information 'Quitpack' on request.

Further Help

Several good paperbacks on how to stop smoking are available from bookshops. There are also treatment aids – including tablets and lozenges – available from your pharmacist. These include nicotine chewing gum, which can be helpful if the instructions are followed. For more details about treatment aids, phone Quitline on 071 487 3000.

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