Foster care, adoption, smoking and vaping

June 2022

This briefing sets out the joint position of ASH[1], ASH Wales[2] and The Fostering Network[3] in relation to foster care, adoption, smoking and vaping (use of electronic cigarettes). It is intended to set out the current evidence base and aims to support organisations working with foster carers and adoptive parents to develop evidence-based policies on smoking and e-cigarette use.

This briefing includes information on foster care and adoption. The recommendations for fostering providers have been reviewed and endorsed by The Fostering Network. The content for adoption providers has been developed with reference to guidance from CoramBAAF.[4]

The risks of passive smoking to health, particularly children's health, are well known. As an organisation that supports adults to care for children, The Fostering Network's position is that adults in a caring role should not smoke. There may be exceptions where an existing relationship outweighs the health risks to the child, for example within kinship, family and friends care; in these circumstances a cessation plan should be in place to enable the best possible care for all children.

This briefing applies specifically to the legislative context in England and Wales but includes detail on the relevant legislation for all the UK nations. More detailed information about legislation on smoking in the UK nations is available at the links below. A summary of the legislation and guidance for services working with looked after children in each UK nation is available from the NSPCC here.

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1. Introduction

The overriding priority in foster care and adoptive care is the welfare of the child who is being cared for. It always aims to provide a safe, loving and positive environment for a child, helping to improve their chances of being happy and healthy as they grow older.

Smoking rates have been consistently declining among the adult population, reaching a low of 14.1% in the UK in 2019.[5] This decline is mirrored among children (see Appendix 1). However, there is some evidence that the COVID-19 pandemic has disrupted this trend, with smoking rates among 16-17 year olds in England almost doubling between 2019 and 2020, rising from 8.7% to 14.4%.[6]

Smoking and exposure to second-hand smoke present a serious risk to a child's health and having a parent or carer who smokes significantly increases the likelihood that a child will smoke.[7] It is therefore in the interest of all children to be raised in smokefree homes, ideally by non-smoking carers.

E-cigarette use or 'vaping' has been increasingly common since 2012 and there are currently around 3.6 million e-cigarette users (vapers) in Great Britain.[8] The most common reasons for vaping are to quit smoking or cut down on smoking and the vast majority of vapers are current or ex-smokers. Current evidence demonstrates that vaping is significantly less harmful than smoking. In 2015, 2018 and 2020 Public Health England published comprehensive reviews of the evidence on e-cigarettes which, alongside the Royal College of Physicians report: Nicotine without smoke: Tobacco harm reduction from 2016, those interested in further detail may find useful.

All fostering and adoption services should regularly review policies around smoking and vaping in line with new evidence and any changes to regulations. ASH, ASH Wales and The Fostering Network recommend that all fostering service should move towards a situation whereby children and young people are only placed in smokefree homes. Guidance from CoramBAAF states that this should also be the case for adoption services.[4] E-cigarettes may be used to help maintain a smokefree home. Where carers or other family members are using e-cigarettes to abstain from smoking, they should be advised to avoid vaping in front of children (of all ages) to avoid role modelling vaping behaviour.

2. Recommendations

Note: The recommendations for fostering providers have been reviewed and endorsed by The Fostering Network. The content for adoption providers has been developed with reference to guidance from CoramBAAF.[4]

1. Local authorities and fostering and adoption providers should have a clear policy on smoking. This policy should promote non-smoking for all foster carers and adoptive parents and support carers to quit smoking.

2. Local authorities and fostering and adoption providers should have a clear policy on vaping. This should acknowledge the reduced risk of vaping compared to smoking and support adults who choose to use an e-cigarette to quit or abstain from smoking and maintain a smokefree home. Non-smokers and children should be strongly discouraged from vaping.

3. All foster carers and adoptive parents should be supported to maintain a smokefree home, car and other indoor spaces such as caravans or holiday homes. Providers should move towards a situation whereby children and young people are only placed in smokefree homes, even if the carer(s) are smokers i.e. where the carer(s) only smoke outside.

4. In certain situations, such as where a child has a known respiratory illness, it would not be appropriate for that child to be placed in a smoking household.

5. All foster carers and adoptive parents should be supported to protect children in their care from the potential harm of secondhand smoke and the risks associated with parental figures who smoke being seen as role models.

6. Providers should consider how their approach to e-cigarettes can support carers to provide a smokefree home. The National Institute for Health and Care Excellence (NICE) recommends that smokers are offered alternative sources of nicotine such as licenced NRT products or an e-cigarette to help them quit smoking.

7. Foster carers and adoptive parents should be given appropriate support and guidance to address the smoking behaviour of children in their care, including enabling them to access specialist support to quit from healthcare professionals. Vaping is not a recommended substitute to smoking for children under age 18 and children who are vaping should be supported, with advice from healthcare professionals, to use licensed nicotine replacement therapies instead. Staff in children's homes should also be provided with clear guidance on managing smoking and vaping behaviour of children in their care.

8. Smoking and vaping policies should support the provision of accurate, evidence-based information about the relative risks of smoking and vaping, ensuring that foster carers and adoptive parents can provide children in their care with accurate information.

9. Local authority and independent foster care and adoption providers need to work collaboratively to ensure that they provide a clear and consistent approach when working with children, young people and foster carers or adoptive parents regarding their smoking and vaping policies.

10. Where a child has come from a non-smoking household they should be matched with a non-smoking household. A child should never be moved to a placement that poses greater health risks than their current circumstances.
11. Commitment to cessation of smoking should be monitored through foster care and adopter medicals and annual reviews. A minimum 12 months of cessation should be required to be considered a non-smoker.
12. Additional support should be put in place for children who are in a smoking environment to ensure that their health is protected.

What is needed to communicate our policy?

Regardless of the policy your organisation adopts in relation to smoking and vaping, it will be important to consider how this is communicated. There is widespread misunderstanding among the public regarding the harms of nicotine and the relative safety of e-cigarettes compared to tobacco. Any policy should aim to reduce this confusion.

Given the growing number of people who are using e-cigarettes to successfully quit smoking it will also be important to consider how any policy is communicated to them.

When should we review our policy?

Policies should be kept under regular review. The evidence base around e-cigarettes continues to grow and other novel tobacco and nicotine products are being introduced to the market. It will be important for local authorities and independent providers to consider this when deciding how regularly policies will be updated.

For enquiries

Contact ASH here: https://ash.org.uk/contact/

Contact ASH Wales here: https://ash.wales/contact-us/

Contact The Fostering Network here: https://www.thefosteringnetwork.org.uk/about/about-us/contact-us

3. Protecting children from secondhand smoke

Public health campaigns have increased awareness among parents and the public of the dangers of secondhand smoke and research shows attitudes towards smoking in the home have shifted.

ASH's 2021 Smokefree GB survey found that 87% of respondents said that no one smokes in their home most days, while 68% reported that people are not allowed to smoke in the vehicle they use most often, with 9% stating that people are permitted to smoke in the vehicle but not when there are children present.[9]

A socioeconomic divide does, however, still exist. In 2021, 90% of people in the most affluent social grade (AB) reported that no one smokes in their home most days, this compares to 81% of people in the least affluent social grade (DE).[9]

Children who go into foster care are more likely to have lived with parents or carers experiencing disadvantage, who are more likely to be smokers. This makes it essential that services have clear policies to protect children from secondhand smoke in the home. Additionally, services should be aware that children may consider litigation in their later years if they feel their health has been adversely affected by passive smoking.

KEEPING A SMOKEFREE HOME

What is a smokefree home?

A smokefree home is a home where nobody smokes inside, and cigarette smoke isn't regularly drifting in from people smoking outside. This includes leaning out of a window/door with a cigarette.

How can I keep my home smokefree?

Quitting smoking is the best way to protect yourself and other household members from toxic secondhand smoke. This toxic smoke contains over 4,000 chemicals, many of which can seriously impact on health when breathed in.

Use NRT or an e-cigarette to protect yourself and other household members from harmful cigarette smoke.

Take 7 steps outside if you need to smoke and close all doors and windows to stop smoke drifting inside. Smoking indoors with an open door/window won't stop toxic secondhand smoke from drifting into your home. 80% of cigarette smoke is invisible and impossible to control.

Remove lighters and ashtrays and encourage visitors to smoke outside.

Further information:

- ASH. Factsheet: Secondhand smoke. March 2020
- Case study: Smokefree Sheffield
    - Smokefree Sheffield webpage with practical tips for keeping the home smokefree
    - Smokefree Sheffield smokefree home commitment card

THE ROLE OF LOCAL GOVERNMENT AND PROVIDERS

The Governments across the UK have set clear directions for local authorities defining their duties in relation to promoting the health and wellbeing of both children and looked after children. A summary of the legislation and guidance in each UK nation is available here. Protection from smoking clearly falls within this remit. Local authorities currently have a range of policies in place. Some areas insist that potential foster carers or adoptive parents have stopped smoking for at least a year prior to caring for young or high-risk children, others only encourage smokefree homes. We would welcome increased consistency in practice across both local authority and independent fostering provision.

CoramBAAF has made a series of recommendations, including:[4]

- Children under five should not be placed with carers who smoke.
- Children with a disability which means they are often unable to play outside or move away from smoking adults, those with respiratory problems, and those with heart disease or glue ear should not be placed with smoking families.
- In long-term fostering, kinship and adoptive placements, the additional health risks to the child of being placed in a smoking household need to be carefully balanced against the benefits of the placement for the child.
- Carers who have stopped smoking should not be allowed to adopt or foster children in high-risk groups until they have given up smoking successfully for at least a year. This is due to the high risk of relapse to smoking in the first year after quitting.

The recommendations provide comprehensive guidance which has been adopted, or part adopted, by many fostering and adoption services.

The Fostering Network, ASH and ASH Wales believe that all local authorities and independent fostering providers should have a stated policy to minimise the harm to children from exposure to smoking which includes:

- Assessing the smoking status of potential foster carers prior to placement and informing them about the local policy.
- Supporting foster carers and adoptive parents who smoke to quit by signposting them to stop smoking services and advising them on how to minimise any potential harm by establishing a smokefree home and car.
- Providing information to all foster carers and adoptive parents on the dangers of secondhand smoke, the impact of role modelling, and the health benefits to children of smokefree homes and cars.

Children under the age of five are particularly at risk from the harms of secondhand smoke. It is therefore essential that all foster carers and adoptive parents provide a smokefree home and they should be offered support to achieve this. In specific situations, such as where a child has a known respiratory illness, it would not be appropriate for them to be placed in a smoking household.

Local authorities and independent providers must ensure all foster carers or adoptive parents promote a healthy lifestyle. This includes advising and supporting foster carers or adoptive parents who smoke to quit and ensuring they are equipped to manage smoking or vaping behaviour of young people in their care. All

children must be protected from the harms of tobacco and services should work with foster carers and adoptive parents to achieve this. We would expect local authorities and independent providers to take steps to ensure carers maintain a smokefree home. This could include, for example, providing advice on the use of nicotine replacement therapy or an e-cigarette to maintain a smokefree home and aid a quit attempt.

Local government, and independent fostering and adoption providers should ensure that all approved foster carers and adopters have access to good quality information regarding the dangers of smoking and should be signposted to local stop smoking services. Use the links below to find your local stop smoking service:

- England: https://www.nhs.uk/smokefree/help-and-advice/local-support-services-helplines
- Wales: https://www.helpmequit.wales/
- Scotland: https://www.nhsinform.scot/healthy-living/stopping-smoking/help-to-stop/local-help
- Northern Ireland: https://www.stopsmokingni.info/ways-quit/local-help-and-support

In addition, local authorities should ensure that birth parents who smoke are given information about the risks smoke exposure poses to their child and encouraged not to smoke during visits.

Local authorities and independent fostering and adoption services should create and share policies which balance the risk of exposure to smoke against the advantages of a strong and supportive home for a child and ensure decisions are taken accordingly. Local authorities should also ensure that where children are placed with a smoker, action is taken to support the carer to maintain a smokefree home.

THE ROLE OF FOSTER CARERS

Foster carers are primarily concerned about the welfare of the children in their care and they have a responsibility to promote a healthy lifestyle, whether this be in relation to exercise, diet, alcohol or smoking.

Foster carers who smoke, like all smokers, need motivation and support to enable them to quit. Smokers who access free, expert support to quit from local stop smoking services are three times as likely to quit successfully.[10]

All foster carers should be informed about the harm caused by secondhand smoke and the influence that smoking has on the behaviour of young people and children. To encourage healthy environments and ensure that a child's exposure to secondhand smoke is minimised, they should be encouraged to maintain a smokefree home and car – this includes caravans, boats and holiday homes. In line with NICE guidance,[21] they should use licenced nicotine containing products (patches, gum, inhalers) or an e-cigarette to abstain from smoking.

Foster carers should ensure that children in their care are well informed about the risks associated with smoking.

THE ROLE OF ADOPTIVE PARENTS

As with foster carers, adoptive parents are primarily concerned about the welfare of children in their care. Adoptive parents should be encouraged to ensure a child's exposure to secondhand smoke is minimised through maintaining a smokefree home and car.

Potential adopters should be informed of the local authority's policy surrounding adoption and smoking. If

applicants smoke, they should be offered support and information about local services to help them to quit. If they are unable to quit, they should be supported to use licenced nicotine containing products (patches, gum, inhalers) or an e-cigarette to abstain from smoking and protect child health, in line with NICE guidance.[21] They should also be made aware of the risk of children modelling their behaviour on adult and peer role models.

As with foster carers, adoptive parents should ensure that children in their care are well informed about the risks associated with smoking.

For more information on the role of adoptive parents, see CoramBAAF's guidance on the risks of environmental tobacco smoke for looked after children and their carers.

4. Addressing smoking and vaping behaviours of children in care

Evidence suggests there are higher rates of smoking among children in residential care (see page 16). This can have a serious impact on their life chances and reduce the likelihood of them living a long and healthy life. It also has financial implications, with the average smoker spending £2,000 a year on tobacco and nearly a third of smoking households living below the poverty line.[11]

Experimentation with e-cigarettes has increased among young people and is highest among children who have already tried smoking or are current smokers. Therefore, use of e-cigarettes may also be higher among children in contact with the care system.

THE ROLE OF LOCAL GOVERNMENT

Local authorities should have a clear and enforced policy for addressing the smoking behaviour of children in care. This policy needs to be shared with all commissioned services to ensure consistency in knowledge and approach to discouraging looked after children from taking up smoking and supporting them to stop. This should also include clear and enforced guidance on speaking with and educating young people about the impact of their smoking behaviour and prohibiting staff and carers from facilitating or endorsing smoking behaviour.

Policies on supporting children in care to quit smoking should include enabling access to licensed nicotine replacement therapy, but e-cigarettes should not be provided or encouraged for children under the age of 18.

Local authorities should provide residential care staff and foster carers with information and training to raise awareness of issues around smoking and vaping which signposts smokers to local stop smoking services.

THE ROLE OF CARERS

All carers have a central role in looking after the health of children in their care. Carers should support the children they care for to quit smoking and, whilst it may be difficult, should work with the child to establish and enforce no-smoking rules. In line with age of sale and proxy purchasing laws set out above, carers should not provide access to tobacco or e-cigarettes for under-18s. **Access to cigarettes or e-cigarettes should never be used as a means of reward or punishment.** Once a young person who smokes turns 18, carers should consider how to balance the young person's choice to smoke while remaining part of the fostering family with the health and wellbeing of other family members, particularly children.

It is important that carers provide young people with the advice, guidance and support they need to enable them to quit smoking. Carers should facilitate access to stop smoking support for young people in their care and, where appropriate, engage with healthcare professionals who can recommend nicotine replacement therapy (NRT) which is licensed for use by people aged 12 and over.

HOW TO ACCESS STOP SMOKING SUPPORT

Stop smoking support is available in each UK nation. This includes information and support to help people give up smoking, and signposting to free local stop smoking services. Evidence shows people are three times as likely to successfully quit smoking when using local stop smoking services compared with attempting to

quit without help.

- England: https://www.nhs.uk/better-health/quit-smoking/
- Scotland: https://www.nhsinform.scot/healthy-living/stopping-smoking
- Wales: https://www.helpmequit.wales/
- Northern Ireland: https://www.stopsmokingni.info/

Children who smoke should also be supported to engage with healthcare professionals who can recommend NRT which is licensed for use by people aged 12 and over.

Stop smoking services are not designed specifically for young people, although some local authorities do have stop smoking advisors specifically trained to support teenagers and young people. National charities such as QUIT also provide free and confidential stop smoking services and advice for young people. They offer specialist support and provide stop smoking medication to those aged 12 and over.

The below discussion of the evidence should help to inform policy making.

5. What are e-cigarettes?

The following facts about e-cigarettes should inform all policies:

- E-cigarettes, also known as vapes, are not the same as tobacco cigarettes. Unlike cigarettes, e-cigarettes don't contain or burn tobacco and don't produce tar or carbon monoxide. As such, e-cigarettes are not encompassed by legislation applying to smoking or tobacco.
- Most e-cigarettes contain nicotine in an e-liquid which is heated and delivered orally to users in the form of vapour, rather than smoke. This means that e-cigarettes are *vaped* rather than *smoked*.
- E-cigarettes are much closer to licensed nicotine products, such as sprays, patches and gum, than they are to cigarettes.
- Nicotine is an addictive substance. However, the greatest harm caused by cigarettes comes from the other toxic chemicals released in cigarette smoke when tobacco is burnt, including carbon monoxide and tar.[12]
- Other components of e-liquids are vegetable glycerine, propylene glycol and flavourings.
- While not without risk, e-cigarettes are significantly less harmful than smoked tobacco.
    - In 2015 Public Health England (PHE) published an independent review of the evidence noting that while not risk free, e-cigarettes carry a fraction of the risk of cigarettes.[13] PHE's second independent review published in February 2018 further supported the finding that vaping is significantly less harmful than smoking.[14]
    - In 2016 the Royal College of Physicians released a report which said that although the possibility of some harm from long-term e-cigarette use cannot be dismissed, it is likely to be very small, and substantially smaller than that arising from tobacco smoking.[15]
- There are a range of devices classed as e-cigarettes varying in shape, size and appearance. While the first generation of e-cigarettes were generally designed to look like tobacco cigarettes, the e-cigarette market is now dominated by large modifiable tank devices and compact 'pod' systems resembling USB sticks.
- E-cigarettes can be disposable or rechargeable and can be used with pre-filled closed-capsule e-liquid cartridges or refillable cartridges.

USE OF E-CIGARETTES AMONG ADULTS AND YOUNG PEOPLE

In June 2021, the Smokefree GB Survey carried out by YouGov on behalf of ASH found that there are an estimated 3.6 million vapers in Great Britain. This number is almost entirely made up of current and ex-smokers, with just 4.9% of those who have never smoked currently vaping.[8]

Among young people aged 11-17, a large majority have never tried e-cigarettes (77.7%) or are unaware of them (10.5%).[16] Current use of e-cigarettes among 11-17 year olds is highest among current smokers (41.3%) and it is very low in never smokers (0.7%). Children under 16 are less likely to try e-cigarettes than 16-17 year olds. Only 6.5% of 11-15 year olds have tried vaping, compared to 23.2% of 16-17 year olds. Among reasons for using an e-cigarette young people mainly vape just to "give it a try" (49.3%) not because they think it "looks cool" (1.2%).[16]

Although it remains important to monitor the use of e-cigarettes in young people, to date, concerns over gateway progression from e-cigarette use into smoking are unfounded.[16,17]

DO E-CIGARETTES HELP PEOPLE QUIT SMOKING?

E-cigarettes are currently the most popular aid to quitting smoking in England among adults.[18] According to the findings of a large-scale systematic review, nicotine containing e-cigarettes are 70% more effective in helping smokers quit than nicotine replacement therapy (NRT).[19] Similarly, a randomised control trial published in 2019 found that using an e-cigarette combined with behavioural support was approximately twice as effective for cessation as behavioural support combined with NRT.[20]

Guidance [NG209][21] from the National Institute for Health and Care Excellence[22] recommends that adults who smoke:

- have access to nicotine-containing e-cigarettes
- are informed that nicotine-containing e-cigarettes are "more likely to result in them successfully stopping smoking" when combined with behavioural support

Adult smokers who are interested in using e-cigarettes to stop smoking should be:

- given clear, consistent and up-to-date information about nicotine-containing e-cigarettes
- advised how to use nicotine-containing e-cigarettes and how/when to stop
- informed that there is not enough evidence to know whether there are long-term harms from e-cigarette use
- informed that use of e-cigarettes is likely to be substantially less harmful than smoking
- advised about the importance of getting enough nicotine to overcome withdrawal symptoms, and how to get enough nicotine

Some people have concerns that the ongoing use of e-cigarettes or other nicotine containing products does not constitute quitting smoking. However, clinically **this is not the case** and NICE guidance is clear that adults who want to quit smoking using e-cigarettes should be advised about using them "long enough to prevent a return to smoking."

There are currently no e-cigarettes with a medicinal licence available on the UK market, meaning they cannot be prescribed by GPs or other healthcare professionals. However, the Medicines and Healthcare Regulatory Agency (MHRA) – which regulates e-cigarettes in the UK – recently published enhanced guidance paving the way for e-cigarettes to be prescribed on the NHS.

Further information on using e-cigarettes to stop smoking is available from the NHS: www.nhs.uk/live-well/quit-smoking/using-e-cigarettes-to-stop-smoking/

6. Overview of regulation in the UK

There are several laws related to smoking and vaping which are relevant to parents, foster carers, adoptive parents and the children they care for. Much of this legislation is designed to deter children from starting smoking or vaping and to make it more difficult for teenagers to acquire tobacco or e-cigarettes. Further information about relevant tobacco control legislation and guidance is set out below. **A summary of the legislation and guidance for services working with looked after children in each UK nation is available from the NSPCC here.**

Smoking in indoor public places, workplaces and work vehicles *Note: Most foster homes and adoptive homes are not covered by this legislation as they are private residences. While not regulatory, local policy will guide expectations around smoking and e-cigarette use.*		
	Tobacco and cigarettes	**E-cigarettes**
England and Wales	Illegal since 2007 [23]	Not currently prohibited
Scotland	Illegal since 2006 [24]	Not currently prohibited
Northern Ireland	Illegal since 2007 [25]	Not currently prohibited

Smoking/vaping or allowing someone else to smoke/vape in private vehicles carrying under 18s		
	Tobacco and cigarettes	**E-cigarettes**
England and Wales	Illegal since 2015	Not currently prohibited
Scotland	Illegal since 2016	Not currently prohibited
Northern Ireland	Illegal since 2022 [26]	Not currently prohibited

Sale to under 18s		
	Tobacco and cigarettes	**E-cigarettes**
England and Wales	Illegal since 2007	Illegal since 2015 [27]
Scotland	Illegal since 2010*	Illegal since 2017 [28]
Northern Ireland	Illegal since 2008 [29]	Illegal since 2022 [26]

* Note: in Scotland anyone aged under-18 who attempts to purchase tobacco also commits an offence [30]

Proxy purchasing (purchasing tobacco or e-cigarettes on behalf of someone under the legal age)		
	Tobacco and cigarettes	**E-cigarettes**
England and Wales	Illegal since 2014 [31]	Illegal since 2015
Scotland	Illegal since 2010 [30]	Illegal since 2017 [28]
Northern Ireland	Illegal since 2014 [32]	Illegal since 2022 [26]

SMOKEFREE OUTDOOR SPACES

Smokefree outdoor spaces have been implemented to varying degrees across the UK. They are typically enforced, either through national legislation or through organisational policies and local guidance. **It has been illegal to smoke in any pub, restaurant, nightclub, and most workplaces and work vehicles, in the UK since 2007.**

England

In England, there is no legislation requiring outdoor spaces to be smokefree. However, individual organisations can prohibit smoking on their premises if they choose. For example, smoking is banned in most sports grounds, on train station platforms and some hospital grounds. Some local authorities have also required hospitality venues to make outdoor pavement seating introduced during the Covid-19 pandemic smokefree.

Wales

In 2021, the Welsh Government extended smoke-free requirements to more places and settings in Wales. *Note: The legislation only covers smoking tobacco. It does not include e-cigarettes.* New areas which are required to be smokefree include:

- All public playgrounds and outdoor day care and child-minding settings for children
- School grounds
- Hospital grounds

A full summary of the changes is available here: gov.wales/smoke-free-law-guidance-changes-march-2021-html

This legislation is supplemented by a range of local smokefree policies. Most recently, the Football Association of Wales has banned smoking from the side-lines at football matches for ages 5-11-years old from September 2020, followed by 5-12-years from September 2021 and then 5-13-years from 2022.[33]

Scotland

Smoking has been legally prohibited on all NHS grounds in Scotland since 2016.[28] This covers the grounds of hospitals, health centres or GP surgeries, and NHS car parks or gardens. This legislation is supplemented by a range of local smokefree policies applying to sports grounds, train station platforms etc.

Northern Ireland

Like England, Northern Ireland has not introduced legislation requiring outdoor spaces to be smokefree. However, individual organisations can prohibit smoking on their premises if they choose. This includes train station platforms, some sports grounds and Health and Social Care Trust-owned grounds, including car parks.[34]

FURTHER LEGISLATION

Further measures designed to reduce uptake of smoking and vaping among young people in all UK nations (unless specified) include:

- A ban on the sale of cigarettes in vending machines
- A ban on the display of tobacco products in shops
- A ban on cross border (e.g. TV or radio) advertising of e-cigarettes
- Regulation of e-cigarettes including child and tamper proof containers and nicotine content labelling on packaging

It is important for all parents, foster carers and adoptive parents to be informed about this legislation and take appropriate steps to report any breaches in these laws.

7. Impact of exposing children to smoking or vaping

Children who are in, or have been through, the care system can be among the most vulnerable in society. Many will experience emotional or behavioural issues,[35] may suffer from health inequalities and face poorer life chances and outcomes.[36]

Children in care are more likely to have experienced disadvantage, are more likely to be exposed to secondhand smoke[37] [38] and are significantly more likely to smoke themselves.[39] A study from 2003 found that around two thirds of children in residential care in England smoked;[40] at the same time an estimated 9% of children in England aged 11-15 were regular smokers.[41] A 2017 study of foster children in Wales found that those in care were around five times more likely to be smokers than children from private households.[42]

HEALTH IMPACTS

Smoking

Children are particularly vulnerable to the damaging effects of secondhand smoke because of their smaller, maturing and developing organs.[43] Evidence shows that secondhand smoke is a preventable and avoidable cause of health conditions including bronchitis, pneumonia, meningitis.[7] Exposure to secondhand smoke during early childhood is also a significant cause of sudden infant death (SIDS) or cot death.[44]

In 2010, the Royal College of Physicians estimated that household smoking increases the incidence of childhood asthma by as much as 50% and results in 20,000 cases of lower respiratory tract infection each year.[7] Exposure to secondhand smoke in childhood can also lead to long term respiratory problems, including an increased risk of chronic respiratory illness and lung function deficits in later life.[45]

In addition to the well documented physical harm caused by secondhand smoke, research suggests exposure to secondhand smoke may impair mental development and lead to neurobehavioral disorders.[46] [47] Another study found that children who were continuously or intermittently exposed to secondhand smoke were more likely to be physically aggressive and display anti-social behaviour.[48] Further research has found that environmental tobacco smoke exposure, whether alone or in conjunction with prenatal exposure, increases the risk of behavioural problems in school age children.[49]

In 2010, it was estimated that children in the UK breathing in other people's cigarette smoke results in 300,000 GP visits annually.[7] Children exposed to smoke are also likely to have more days off school each year.[50]

A substantial majority of smokers begin smoking as children. Two thirds of those who try smoking go on to become regular smokers, only a third of whom succeed in quitting during their lifetime.[51] Smoking is responsible for the death of half of all life-time smokers,[52] and is responsible for nearly 80,000 preventable, premature deaths a year in England.[53] On average smokers lose 10 years of life compared with non-smokers.[54] Children must be protected from taking up smoking and exposing themselves to smoking related morbidity and mortality.

E-cigarettes

While e-cigarettes are unlikely to be risk-free, they carry a small fraction of the risk of smoking. The RCP estimates that the hazard to health arising from long-term vapour inhalation from e-cigarettes is unlikely to exceed 5% of the harm from smoking tobacco.[15]

Current evidence does not suggest that exposure to secondhand e-cigarette vapour causes harm to bystanders and any risks are likely to be extremely low."[14] Any passive exposure to the nicotine in e-cigarette vapour will vary according to the device and e-liquid being used, as well as the conditions of use (e.g. level to which the liquid is being heated).[55] Although the nicotine in e-cigarette vapour can also be deposited on surfaces,[56] a report from the Royal College of Physicians (RCP) notes that this would occur in such small quantities that: "there is no plausible mechanism by which such deposits could enter the body at doses that would cause physical harm." The report simply concludes that: "Harm to others from vapour exposure is negligible."[15]

Despite the relatively low risk of harm from e-cigarettes compared to tobacco, they are still addictive products and it is important that children and never smokers do not start vaping. The addictiveness of nicotine depends on the delivery system. The chemical addictiveness of e-cigarettes compared to tobacco cigarettes is still unclear.[14] However, survey evidence from ASH found that 11-18 year olds who smoked were more likely to report having moderate, strong, and very strong urges to smoke compared to those who vaped. Around 40% of vapers reported having no urges to vape compared to 20% of smokers who reported having no urges to smoke.[57] More research is needed on the addictiveness of different types and strengths of nicotine vaping products among young people.

IMPACT ON YOUNG PEOPLE'S BEHAVIOUR

Smoking

In addition to the health impacts from exposure to secondhand smoke, parental smoking is strongly linked with smoking in adolescence and in later life. Children with at least one parent who smokes are 72% more likely to smoke in adolescence.[58] In 2011, it was estimated that each year at least 23,000 young people in England and Wales start smoking by the age of 15 as a result of exposure to smoking in the home.[59]

Not only do parents and carers act as role models to children in their care, but children with parents or family members who smoke are likely to find it easier to obtain cigarettes. In 2018, 22% of 11 – 15 year olds who smoked reported being given cigarettes by parents or siblings, despite it being illegal to purchase cigarettes for an under-18.[39] All parents and carers should therefore consider the impact of smoking on the behaviour of young people in their care.

The age at which a child starts to experiment with smoking is significant. The younger children start, the more likely they are to become heavily addicted. They are also likely to find it harder to quit as adults.[60] Fostering and adoption services should minimise the risk to young people, both as children and in later life, by supporting foster carers and adoptive parents to quit smoking and maintain a smokefree home.

E-cigarettes

As the behaviour of using an e-cigarette to some extent mimics the behaviour of smoking, concerns have been raised that e-cigarettes could model smoking behaviour for children and therefore encourage them to smoke. A survey of 10-11 year olds in Wales found that children with a parent who vaped were more likely to be exposed to e-cigarettes or have positive perceptions of vaping, but this did not affect their *exposure to* or *perceptions of* smoking.[61] Children who saw e-cigarettes as quitting aids for adults (64%) were less likely to think they would smoke or vape in the future, although more children thought they would vape (20%) than

smoke (12%).

However, evidence shows that in the UK e-cigarettes are not 'normalising' smoking. An analysis of five large scale youth surveys involving over 60,000 young people aged 11 – 16 years, found a consistent pattern that most e-cigarette experimentation among young people does not lead to regular use, and levels of regular e-cigarette use in young people who have never smoked remain very low.[62] Meanwhile, rates of smoking among young people in the UK continue to decline.[39]

There has been an increase in awareness of e-cigarettes amongst 11 to 18 year olds and an increase in experimentation. However, regular e-cigarette use, defined as once a month or more, is almost entirely confined to those who are current or ex-smokers.[16]

Similar to cigarettes, up to 18% of 11 – 15 year olds who vaped regularly in England reported being given e-cigarettes by parents or siblings in 2018.[39]

PREVENTING ACCIDENTAL HARM

Smoking

Cigarettes were responsible for 7% of accidental house fires from April 2019 – March 2020, equating to over 10,900 fire incidents. While accounting for a small percentage of total house fires, cigarettes were the largest cause of accidental fire deaths accounting for 23% of fire fatalities.[63] Smoking related house fires are estimated to cost the economy in England approximately £324.5 million each year.[64] Quitting smoking and keeping a smokefree home are essential ways to reduce risks from smoking related house fires.

E-cigarettes

E-cigarettes are significantly less harmful than smoked tobacco. As with all new products, long-term or rare adverse effects will remain uncertain until they have been in widespread use for several decades. As such they should be kept under review. Services should refer to information provided by reputable organisations such as the NHS, Public Health Wales or the Office for Health Improvement and Disparities (England).

Poisoning: E-liquids used to refill some e-cigarettes can be toxic if drunk in their concentrated form. **As with other potentially toxic household products such as medicines, e-cigarettes and refill liquids should be kept out of the reach of children and pets.**

Fires: Concerns have also been expressed about product safety following rare instances of e-cigarette batteries exploding/overheating. Guidance for parents from Royal Society for the Prevention of Accidents, the Chief Fire Officers Association and London Fire Brigade states: "Poorly made or counterfeit chargers for e-cigarettes have caused house fires but this is a much smaller number than cigarettes and there are things you can do to manage these risks. **Only buy e-cigarettes from reputable outlets, use the correct charger for the device, follow the manufacturer's instructions and don't leave an e-cigarette charging unattended or overnight. This advice is the same for other electronics such as mobile phones."**[65]

8. Smokeless tobacco

Smokeless tobacco constitutes a wide range of tobacco containing products that are non-combustible (do not burn) but may be chewed, inhaled or placed in the mouth.[66] These include tobacco with or without characterising flavours and sweeteners (eg. Mishri and Qiwam), with alkaline modifiers to increase nicotine absorption and addictiveness (eg. Khaini, Naswar and Gul), and tobacco with areca nut and slaked lime (eg. Gutkha, Zarda, Mawa).[67]

Smokeless tobacco use has been linked to higher risk of oral and pharyngeal cancers, ischaemic heart disease, stroke and adverse perinatal outcomes.[68] [69] [70] Whilst smokeless tobacco is non-combustible and does not expose bystanders to tobacco smoke, it still poses a risk to children through role-modelling, where children imitate adult behaviour. Children living in households where smokeless tobacco is present are also more likely to have access to these products.

Data on the prevalence of smokeless tobacco use in the UK is mixed, but it is predominantly used by South Asians of Bangladeshi, Indian and Pakistani origin. Current use of smokeless tobacco is much more common among smokers than non-smokers. A 2019 ASH survey found that among the South Asian population, smokers were nearly four times as likely to be current users of smokeless tobacco than non-smokers.[71]

Parents or carers who use smokeless tobacco should be advised not to use it in front of children and keep products out of the reach of children. Ideally, they should be supported to stop using tobacco entirely.

Further information:

- ASH. Evidence into practice: Smokeless tobacco products. March 2020

9. Appendices

APPENDIX 1: REGULAR SMOKING RATES (AT LEAST ONE CIGARETTE PER WEEK) AMONG CHILDREN IN THE UK NATIONS

- England: In 2018, 2.1% of 11-15 year olds in England reported being regular smokers, compared to 22% in 1996.[39] Smoking rates are higher among 16-17 year olds, with 8.7% of 16-17 year olds smoking regularly in 2019.[6]
- Wales: In 2019, 4% of 11-16 year olds in Wales reported being regular smokers, indicating no change since 2013/14.[72]
- Scotland: In 2018, 2% of 13 year olds and 7% of 15 year olds in Scotland reported being regular smokers.[73]
- Northern Ireland: In 2019, 4% of 11-16 year olds in Northern Ireland reported being regular smokers, compared to 15% in 2000.

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(B) A separate sample of South Asian adults. Total sample size was 500 adults. Fieldwork was undertaken between 14th February to 9th March. The survey was carried out online. The figures have been weighted and the South Asian sample is representative of Indian, Pakistani and Bangladeshi ethnicities (aged 18+).
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