**Foster Carers and Adopters and Smoking**

1. **Purpose**
	1. The procedure sets out the process that social workers must follow when considering the suitability of applicant foster carers and adopters who smoke.
	2. The procedure is aimed at reducing the harmful effects of passive smoking on Children in Care and children placed for adoption.
2. **Scope**
	1. This procedure applies to all applicant foster carers and adopters and it applies to the placement in foster care or for adoption of all children in Barnsley’s care, including where there is consideration of a placement with another agency foster carer or adopter.
3. **References**
	1. British Association for Adoption and Fostering (BAAF) Position Statement on Foster Carers and Adopters Who Smoke
	2. The National Safety Council (NSC) Guidance for Parents Who Smoke.

*(May 2018 - In response to the increasing numbers of cigarette smokers giving up on cigarettes and using e-cigarettes instead the British Association for Adoption and Fostering made a formal statement in 2015 (*[*BAAF Statement on E-Cigarettes*](https://www.actionforchildren.org.uk/media/6006/coram-baaf-statement-re-e-cigarettes.pdf)*).*

*BAAF were clear that at that time there was insufficient evidence to suggest that vaping and e-cigarettes were harmful to children and carers who vaped should not be treated as those who smoked cigarettes.*

*In the light of this statement BMBC decided to follow BAAF’s recommendations and not exclude those who used e-cigarettes or who vaped for caring for children under 5 either as adopters or as foster carers.*

*BMBC recognises that there is currently only limited research into the impact of vaping and e-cigarettes and recognises that this position might need to change at any time in the light of further evidence.)*

1. **Definitions**
	1. In this procedure, where reference is made to foster carer or adopters who smoke, this is deemed to include circumstances where foster carers or adopters regularly permit others to smoke in their own home.
	2. Whilst passive smoking is known to be harmful to all children, there are particular groups of children for whom the risk of harm is increased. In this procedure when referring to “high risk groups” this means children aged under 5 years old, 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.
	3. This procedure will refer to the need for social workers to ‘prioritise the health of Children in Care’ and balance the positive aspects of any placement or foster carer/adopter, against the negative impact of smoking. This means making a judgment that the positive benefit to the child of the placement outweighs the negative factors, including smoking in the home, and that on the basis of that judgment that the placement is the optimum placement available for the child. The degree of risk may vary in any given case and it is the degree of risk from smoking not simply the fact of smoking which needs to be balanced.
2. **Actions**

|  |  |
| --- | --- |
| **Action** | **Person Responsible** |
| 5.1 | The Team Manager, Fostering and Team Manager, Adoption are to ensure that information and advice to prospective foster carers and adopters and existing foster carers, explains Barnsley’s approach to carers and adopters who smoke and the way in which, in relation to this, we will prioritise the health of children in care. | Team managers Adoption and Fostering  |
| 5.2 | When first responding to expressions of interest in fostering or adoption, fostering and adoption social workers must discuss Barnsley’s approach to carers and adopters who smoke and ascertain whether the enquirer smokes or not, the social worker will be able to advise the enquirer further about the extent to which their smoking may limit their potential to be a foster carer or adopter. | Adoption and Fostering Social Workers |
| 5.3 | Social workers as a general rule should not seek to progress applications from those wishing to foster and adopt children in high risk groups (see 4.2 above) where those applicants smoke. | Adoption and Fostering Social Workers |
| 5.4 | Where enquirers/applicants are wishing to foster or adopt children outside of the high risk groups, social workers and others (team manager, fostering and adoption panels) should not seek to prevent an application or refuse approval of an applicant who smokes simply on the basis of meeting a single requirement – not smoking. Assessing social workers should therefore consider the importance of foster carers or adopters smoking as a very significant element but never the sole element, in a decision or not about their suitability to foster or adopt. | Social Workers Team Manager/ Panels |
| 5.5 | When assessing the suitably of an applicant who smokes to foster or adopt, social workers should be mindful of the Service’s need to prioritise the health of Children in Care as detailed in 4.3 above. Therefore, an applicant would need to be able to provide sufficient positive benefits to any child or young person who might be placed in the future which would outweigh the negative impact of smoking. Social workers and applicants should be mindful that children will be placed with non smokers where the choice is between a non smoking household and a smoking household where all other factors are equal. | Social Worker |
| 5.6 | Social workers should provide information and advice about smoking cessation to enquirers or applicants who smoke, as well as existing carers and adopters. | Foster and Adoption Social Worker |
| 5.7 | Where foster carers or adopters who smoke are approved, social workers should ensure that they follow of the guidelines in the Barnsley Guidance for Foster Carers and Adopters who Smoke (see below) which is intended to limit the effects of passive smoking. | Foster and Adoption Social Worker |
| 5.8 | Social workers should not place children in high risk groups with foster carers or adopters who smoke. | Foster and Adoption Social Worker |
| 5.9 | When considering the placement of children outside of the high risk groups with foster carers or adopters who smoke, social workers should account for the need to prioritise the health of children in care, which means going thorough the process detailed in 4.3 above. See Barnsley Guidance for Foster Carers and Adopters who Smoke for further details (below) | Foster and Adoption Social Worker |
| 5.10  | In relation to the approval of and placement of a child with connected people (family and friends) who smoke, social workers should weigh the risk to the health of a child resulting from being placed with a smoking carer against the potential benefits to that child of being placed with a family member or other person with whom they have a pre-existing bond. | Foster and Adoption Social Worker |

**6. Documentation**

6.1 None**BARNSLEY METROPOLITAN BOROUGH COUNCIL**

## SMOKING GUIDANCE FOR FOSTER CARERS AND ADOPTERS

1. **Introduction**
	1. Because of what is now known about the harmful effects of passive smoking on children, the Local Authority believe that when placing children away from home, it is in the child’s best interests to avoid a smoking environment.
	2. The Authority wants to work towards a position where no child in care will be living in a smoking household.

1.3 This guidance aims to reduce children’s exposure to passive smoking within their foster or adoptive homes, to discourage people from taking up smoking, and to protect the Local Authority from potential legal action in the future if a child formerly in care in a smoking household develops a smoking related condition.

1.4The British Association for Adoption and Fostering (BAAF) has produced a position statement on foster carers and adopters who smoke. The guidance set out below is based largely on BAAF’s guidance.

1.5 The Local Authority acknowledges the proven skills and abilities of the small number of its foster carers and adopters who smoke or who regularly permit smoking by others in their own home. However, the health of Children in Care, and those children placed for adoption, and the child’s best interest in general, must be the Local Authority’s primary consideration.

1. **The Harmful Effects of Passive Smoking**
	1. 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.
	2. 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 children of non smoking mothers; those infants of smoking mothers have almost 5 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.

2.3 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.

* 1. 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, 2004, published by BAAF) and in *Smoking and the Young* (Royal College of Physicians, 1992).
	2. The World Health Organisation (W.H.O) (1999) reported that children living with parents who smoke are nearly 3 times more likely to be smokers than those whose parents do not smoke. Growing up in a household where adults smoke often means children will perceive smoking as the norm.
1. **Prioritising the Health of Children in Care**

3.1 The Local Authority has a number of excellent foster carers and adoptive parents who smoke. However, in light of the above, the authority will need to prioritise the health of Children in Care, and balance the positive aspects of any placement, or foster carer/adopter, against the negative impact of smoking. This means making a judgement that the positive benefits to the child of the placement outweigh the negative factors, including smoking in the home, and that, on the basis of that judgement, making a further judgement that the placement is the optimum placement available for the child. However, the evidence of risk as set out above shows that the degree of risk may vary in any given case and in making a judgement it is the degree of risk from smoking that needs to be balanced and not simply the fact of smoking. It also means protecting children from smoking in the home by undertaking a range of positive health promotional actions to encourage foster carers and adoptive parents to cease smoking.

* 1. Taking action to protect children in care from the effect of passive smoking, as detailed in this guidance, will help to protect the Authority from 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 a family member smokes.
	2. The guidance and the procedure sets out the way in which the Authority aims to protect Children in Care or children adopted from the effect of passive smoking, in a way that is supportive of carers attempts to quit smoking,
	3. Children under 5 years old should not be placed with foster carers or adopters who smoke because of the potential risk to health. 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.

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 foster carers or adopters who smoke

There is however no intention that children already placed should be moved from foster carers who smoke as a result of this guidance. However, if a review of the placement is required for other reasons and a judgment has to be made as to whether the positive benefits of the placement for the child outweigh the negative factors then the fact that the foster carers smoke will be considered as a negative factor to be weighed in the balance in coming to a professional judgment. It is unlikely, but not impossible, that the fact of smoking may tip the balance of judgment in favour of seeking a change of placement for the child. It is highly unlikely that the negative factor of smoking alone would outweigh positive factors but that might be the case in exceptional circumstances, for example where the carers were found to have positively encouraged the child to smoke.

* 1. In all 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 available benefits of the placement for the child and a professional judgment of the sort outlined above made. This is because the significant risks of exposure to passive smoking increase with time.
	2. In relation to the placement of children with extended family member foster carers (family and friends/connected carers); there are additional complexities that need to be considered with regards to the above guidance. Children generally have better outcomes in such placements, and the Local Authority has a legal responsibility to place children with extended family members whenever possible because of the acknowledged benefits of such placements.
	3. Therefore, for Family and Friends placements, any risk to the health of a child resulting from being placed with a carer who smokes, will need to be weighed against the potential benefits to that child of being placed with a family member with whom they are likely to have a pre-existing bond. This means that when a judgment of the sort outlined above has to be made, the acknowledged benefits of a kinship placement as positive factors in the balance of judgment have to be given considerable weight and may well prove to be determinative. It must also be recognised that in such cases, the views of the child’s parents and of other persons interested in the child’s welfare have to be given proper weight, especially where the Local Authority does not have the legal authority to decide the child’s placement. In other cases, where children have been brought before the Court, the Local Authority must recognise that it is the responsibility of the Court to make the final decision in the best interests of the child’s welfare. In such a case, it is the duty of the Local Authority to ensure that the appropriate evidence of the benefits and detriments of a particular placement is placed before the court so that the best decision can be made.
	4. In some cases, children are placed with foster carers (including family and friends carers) on successive occasions. This may occur where a child who is fostered is rehabilitated home but subsequently requires to be fostered again. If the previous foster placement is available it may be to the benefit of the child to be placed in that placement again. Where those foster carers smoke, that fact of their having provided care to the child previously will be a positive factor in the balance of judgment outlined above.
	5. In other cases, children may be fostered – or placed with prospective adoptive parents – so that they can be placed together with a sibling or siblings who are already placed there. Where those foster carers or adoptive parents smoke, the fact of their already caring for or having adopted a sibling or siblings will be a positive factor in the balance of judgment outlined at paragraph 3.1 above and will have considerable weight which may well be determinative

3.10 Children from non-smoking birth families should not be placed with substitute carers who smoke.

3.11 All older children who are able to express a view must be given a choice to be placed with a non-smoking family.

3.12 New applicant foster carers or adopters who have successfully given up smoking should not be allowed to adopt or foster high-risk groups (children under 5, 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 3 to 6 months are high; after 6 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 nonsmoker for insurance purposes.

3.13 In the matter of the recruitment and approval of foster carers (excluding family and friend carers who will be approved for the placement of a specific child) and adopters themselves, the Service will strive to move progressively to a position where no more smoking foster carers are recruited. This will not only improve the health of some very vulnerable children but will protect the authority from potential legal action in the future.

3.14 However, where the Council has a discretionary power (in this case a discretion whether or not to approve persons as foster carers or adopters) the law makes a general requirement that that discretion must not be “fettered” by the Council imposing rigid rules that limit the exercise of the discretion. This is part of a general requirement that persons who come to the Council to request a service are entitled to have their request considered fairly. The following paragraphs aim to respect this requirement by clearly identifying how this policy will be applied to the recruitment of foster carers and adopters whilst allowing appropriate leeway for special cases where a judgment is made that the general policy can be relaxed.

3.15 From the point of approval of this guidance, as a general rule no new foster carers or adopters will be recruited specifically for the placement of children in the high risk groups if they smoke, or have not ceased smoking for at least 12 months. As is set out above, this group of children is particularly vulnerable to the effects of smoking. However, in cases involving family and friend carers, this guidance will be relaxed where the professional judgment is that the benefit of placement to a particular child or children outweighs any negative factors, including the foster carers or adopters smoking. The Council will, nevertheless address the issue of smoking with those foster carers or adopters in an open and proactive health promotion stance as indicated above.

3.16 In addition to the general legal requirement about the exercise of a discretion referred to above, the approval or non-approval of foster carers under the Fostering Services Regulations 2002 and of adopters under the Adoption Agencies Regulations 2005 require an application to be approved as a foster carer or an adopter to be a broad based decision based on a consideration of all the evidence. Further both sets of Regulations provide for a refusal to be subject to a review by an Independent Panel. It is therefore not possible to refuse approval simply on the basis of meeting a single requirement – not smoking. Therefore, the Council will, as part of the approval process, consider the importance of the foster carers or adopters not smoking as a very significant element – but never the sole element – in a decision whether or not to approve their application

3.17 All carers should discourage children and young people from taking up smoking and in no circumstances buy cigarettes for them. Carers should seek advice from the social worker where young people they care for smoke.

1. **Guidelines for Carers who Smoke**
	1. 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 and adopters should follow these guidelines, which will also be incorporated into preparation courses for applicant foster carers and adopters. All foster carers will be required to sign an agreement committing to advising the Fostering Service of their smoking habits, and for those who do smoke, to follow the following guidelines.
* Don’t smoke around children or permit others to do so. Their lungs are particularly susceptible to smoke.
* Keep 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.
	1. Stopping smoking will protect not only the health of children but also the health of their carers. The Service has a primary responsibility to ensure that where a relationship is established between a child and a carer, 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. The Service will therefore encourage all 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 the fostering and adoption 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
	1. 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 per cent of fires ignite with smoking related material and cause between 130 and 180 deaths annually, or 1 in 3 of all deaths from fires (Department of Health, 2001).