

Exposure to second-hand smoke:

ARE WE PROTECTING OUR KIDS?

A Position Paper by the Ontario Medical Association



Table of Contents

Executive Summary	p. 1
OMA Recommendations to Protect Children from Exposure to Second-Hand Smoke	p. 2
1. Introduction	p. 3
2. Second-Hand Smoke and its Impact on Child Health	p. 3
2.1 Prenatal Exposure	p. 3
2.2 Sudden Infant Death Syndrome (SIDS)	p. 3
2.3 Respiratory Illness and Asthma	p. 3
2.4 Child Cognition	p. 4
2.5 Cancer in Adulthood	p. 4
2.6 Heart Disease	p. 4
3. Smoking in the Home and in Vehicles	p. 4
3.1 Smoking in the Home	p. 5
3.2 Smoking in Vehicles	p. 6
4. Children in Regulated Care	p. 6
4.1 Children in Government Care	p. 6
4.2 Private Home Day Cares	p. 7
5. Second-hand Smoke and Child Custody Decisions	p. 8
6. Public Health Campaigns	p. 9
7. Interventions by Health-Care Professionals	p. 10
8. Conclusion	p. 12
Acknowledgments	p. 12
References	p. 12

Appendix I

- Sample of Smoking Policies from Children’s Aid Societies Agencies in Ontario (p. 17)

Appendix II

- Smoking Policy for Halton Region Children’s Aid Society – 2004 (p. 17)

Exposure to second-hand smoke: are we protecting our kids?

A Position Paper by the Ontario Medical Association

Executive Summary

The Ontario Medical Association (OMA) is the professional association of the province's 25,000 physicians, and represents its members in a variety of clinical, policy and economic areas. The mission of the Association is to "serve the medical profession and the people of Ontario in the pursuit of good health and excellence in health care."

The OMA has issued statements indicating the need to prevent exposure of children to second-hand smoke (SHS).

In its 1996 position paper entitled "Second-Hand Smoke and Indoor Air Quality," the OMA recommended that all Ontario workplaces and public places become smoke-free (this paper is posted online at: <http://www.oma.org/phealth/tobacomain.htm>).

Furthermore, it was suggested that an expert advisory group, including individuals with expertise in law, medicine, civil and individual rights, and ethics, be formed in order to consider the comprehensive control of SHS, including elimination of SHS in the home.¹

There is growing awareness that

adult tobacco use is also a child health problem.^{2,3} Prenatal and postnatal exposure to SHS has multiple significant negative effects on a child's health during both childhood and subsequent adulthood.

SHS is known to increase the risk of low birth weight, serve as a trigger for asthma symptoms and lower respiratory infections, and has been associated with sudden infant death syndrome (SIDS), ear infections, and an increased risk for development of cancer and heart disease in adults.

Furthermore, there is now emerging evidence that exposure to SHS can negatively impact behaviour, attention, and cognition.^{4,5}

A substantial number of children continue to be at risk as a result of

exposure to SHS in homes and vehicles, and many public settings that children frequent are still not smoke-free.

Tobacco control efforts across Ontario are increasing with the passage of smoking bylaws in a majority of municipalities making public places and workplaces smoke-free.

The provincial government has also made a strong commitment to implement a comprehensive provincewide smoking ban by 2007.

Nonetheless, protection for children where they are most commonly exposed remains a concern, and could become a more acute problem if a growing number of parents and caregivers begin to view their homes and vehicles as among the few places where they are able to smoke.

SHS exposure is a compelling problem for Ontario's children. It has now been established that levels of SHS in homes can reach those found in bars.⁶ Exposure in vehicles is known to be especially potent because of the restricted space.⁷

There is strong evidence that even though some caregivers practice indoor smoking bans, significant exposure to SHS can still occur.^{8,9}

Parents who continue to use tobacco in the presence of their children — either because they are unaware of the detrimental health

effects, or are unable to quit because of a heavy dependence — need guidance and ongoing support to be able to decrease the exposure of their children to SHS.

The OMA has a longstanding commitment to the reduction of SHS exposure, and it is now time to address its impact on children in home settings.

Furthermore, evidence makes it clear that SHS exposure in vehicles

should be dealt with through legislation.

The purpose of this document is to outline the position of the OMA with respect to the importance of protecting children from exposure to SHS.

This is not only relevant in homes and vehicles, where children are most commonly exposed, but also in situations where organizations such as Children's Aid Societies (CAS)s, family court, and day cares

can regulate such exposure.

The OMA believes that, if implemented, the recommendations in this report will lead to a significant reduction in children's exposure to SHS.

Efforts underpinning the implementation of these recommendations will increase public and professional awareness of this important children's health issue, and promote interventions to eliminate children's exposure to SHS.

OMA Recommendations to Protect Children from Exposure to Second-Hand Smoke

1. Individuals responsible for the care of children who have tried quit methods that were unsuccessful, should be encouraged to use nicotine replacement therapies (NRTs) as a way to decrease second-hand smoke (SHS) levels in their homes and cars. Because there is not much public information on the use of NRTs for this purpose, a public information campaign should be conducted to recommend and educate parents and caregivers about the use of NRTs to avoid smoking in homes and vehicles.

2. The government should publicly fund NRTs, and the Ontario Drug Benefit Plan should include funding NRTs, as is currently done in Quebec.

3. Caregivers should not be permitted to smoke in vehicles while transporting children, and the provincial government should take steps to ensure the protection of children from SHS while traveling in vehicles through the introduction of legislation banning the use of tobacco inside vehicles used to transport children.

4. The Ministry of Children and Youth Services should work closely with the Ontario Association of Children's Aid Societies (OACAS) and the Children's Aid Societies (CAS)s to develop a uniform smoking policy, and to provide ongoing education and support programs to enable foster parents to decrease the amount of SHS that children are exposed to in homes, and prohibit exposure in vehicles.

5. Information about the health effects of SHS should be included in professional education, project co-ordination,

and public education and awareness programs that are currently offered through umbrella agencies such as the Home Child Care Association of Ontario (HCCAO).

6. The provincial government should amend the Day Nurseries Act to ban smoking, and provide enforcement to ensure compliance in any homes and/or facilities that provide childcare.

7. A system which facilitates the dissemination of medical and legal information regarding SHS and children should be researched by an Expert Panel and then made available to lawyers and judges in order to improve their access to necessary information for making decisions regarding child welfare in the courts.

8. The provincial government should provide public health departments with adequate funding to meet their obligations under the Mandatory Programs and Services Guidelines, including providing funding for the Breathing Space campaign to become provincewide.

9. Programs should be created to enhance health professionals' ability to prevent parents from exposing their children to SHS. Effective training programs that allow for health professionals to provide brief interventions should also be offered across all disciplines wherein the opportunity exists to interact with parents and their children. This training should become integral at the undergraduate training level, as well as within postgraduate and continuing education programs for practicing professionals.

Introduction

Exposure of children to second-hand smoke (SHS) in the home is a widespread problem in Ontario.

In 1999, approximately one in four Ontario households reported that at least one person used tobacco inside the home on a daily basis. Half of all households with young children and tobacco users reported that smoking occurred within the home.¹⁰

In 2001, it was reported that daily smoking occurred in 21 per cent of homes in Canada with children under the age of 12 — this means that just over 800,000 children were regularly exposed to the hazards of SHS in their homes.¹¹

The Canadian Tobacco Use Monitoring Survey for the first half of 2003 reports that 10.6 per cent of Ontario households with children under the age of 14 had someone smoking in the home every day, or almost every day — a decrease from the reported 14 per cent in 2002.¹²

Within Ontario households surveyed in 2001-2002, those in which all adults smoked, and children were present, 64 per cent of residents were exposed to SHS, compared to 79 per cent in homes with no children. In households where only some adults smoked, and children were present, 35 per cent of residents were exposed to SHS, as opposed to 54 per cent in homes with no children.¹³

Exposure to SHS can also occur in homes and home-like settings other than a child's own home. At this time, there is no provincial umbrella of protection from SHS for children who are not in their parents' care. Because these children are cared for in home-like settings, such as foster care or home-based day cares, regulation of SHS exposure is also a challenge for these settings.

Ontario's new Ministry of Children and Youth Services, established in October 2003, legislates child protection in the province. Local CASs provide child protection services and have exclusive responsibility for the provision of services under the Child and Family Services Act.

Ultimately, the actual care of the

children is carried out by foster parents in homes that have been approved by the government or welfare agency.¹⁴

Where the government assumes responsibility for any child, this should include the responsibility of protecting the child from SHS. However, at the institutional level, a smoke-free policy continues to be difficult to implement.

The Tobacco Control Act protects children in licensed day cares from SHS exposure. However, many Ontario children are cared for in private home day care environments, which may or may not be regulated by an agency.

Despite the fact that there are associations that regulate agencies under their membership — thereby providing some form of regulation for private home childcare — there remains variability in smoking policies among the individual agencies.

There are also caregivers in private homes that do not have membership under a larger agency, therefore leaving these environments unregulated for SHS exposure.

The family court is an arena in which the presence or absence of smoking in the home is receiving increasing, but still sporadic, attention in child custody cases. Although there has been some movement to give custody to the non-smoking parent, there is no standard across the province, and it may be of benefit to provide education to legal practitioners about the impact of SHS on child health, and the need to take parental smoking into account in determining what is in the best interests of the child.¹⁵

Second-hand smoke and its impact on child health

Several comprehensive scientific reviews on the health effects of SHS in children have appeared in the last decade.

It is clear that the impact of SHS on child health is substantial. In addition to its impact on respiratory health (including otitis media), low birth weight, and sudden infant

death syndrome, research has also identified SHS exposure in childhood as a risk factor for the development of cancer and heart disease in adult life.¹⁶

Furthermore, there is now emerging evidence that exposure to SHS during prenatal and/or postnatal periods can impact behaviour, attention, and children's ability to reason and understand.^{4, 5, 17-20}

Prenatal exposure

Despite the well-known risks of smoking during pregnancy, there continues to be a population of women who either use tobacco products throughout their pregnancies²¹ and/or are exposed to SHS.

Nicotine can cross the placental barrier, thereby decreasing blood flow to the fetus, and affecting the fetal cardiovascular system, gastrointestinal system, and central nervous system.²²

Other components of cigarette smoke, such as carbon monoxide, have also been demonstrated to adversely affect fetal growth, leading to low birth weights.²³⁻²⁵

Sudden Infant Death Syndrome

The relationship of tobacco smoke exposure and sudden infant death syndrome has been extensively studied, and SHS is now a recognized risk factor for SIDS.

In addition to maternal tobacco use, the impact of tobacco use by other caregivers in the home must also be recognized.

Several studies have established an association between paternal tobacco use and SIDS, while accounting for maternal tobacco use.²⁶⁻²⁹ It has also been found that the amount of household SHS exposure can be correlated to the incidence of SIDS in a dose-response relationship.^{26, 27, 29}

Respiratory illness and asthma

Studies on SHS and lower respiratory illnesses provided some of the first evidence of the adverse effects of SHS. Some of the earliest studies in this area showed an association between the tobacco use of women during

pregnancy, and subsequent admissions of their infants to hospital for bronchitis and pneumonia^{30,31}

In addition, the number of admissions increased with the number of cigarettes smoked. Since then, the causative association between SHS exposure from both mothers and fathers, and respiratory illnesses in infants and children, has been firmly established.^{31,32}

At present, there is an extensive international body of knowledge highlighting the increased risk of lower respiratory tract infections in infants with parents who use tobacco (this includes a report from the Canadian Institute for Child Health in 2000.³³) A 1992 report by the U.S. Environmental Protection Agency (EPA) estimated 150,000 to 300,000 cases annually in infants and younger children up to 18 months.³⁴ More recently, an analysis that combined data from 39 studies showed a 50 per cent increase in respiratory illness risk if either parent smoked.³⁵

Exposure to SHS is a well-established risk factor for asthma. Statistics from the U.S. EPA (1992) estimate that 200,000 to 1,000,000 asthmatic children have their condition worsened by exposure to SHS,³⁴ and recent research continues to support and expand these findings³⁶ (this includes a study of Canadian school children³⁷).

This disease is one that has led to more and more recommendations to reduce SHS exposure in the home environment. In fact, all recommendations for the management of asthma urge reduction of SHS exposure in the home.

SHS is known to affect the prevalence and severity of asthma symptoms. First, SHS is an established contributor to the incidence of respiratory illnesses, and evidence has shown that asthma can arise as a long-term consequence of increased occurrence of lower respiratory tract infection in early childhood, or through other pathophysiological mechanisms, including inflammation of the respiratory epithelium.^{38,39}

In fact, assessment of airways

responsiveness shortly after birth has shown that infants whose mothers used tobacco during pregnancy have increased airways responsiveness, and reduced ventilatory function, compared with those whose mothers do not use tobacco.^{40,41}

Second, studies have shown that children with asthma, whose parents use tobacco products, may have more frequent episodes and more severe symptoms.

Exposure to SHS in the home has been shown to increase the number of emergency room visits made by asthmatic children.^{42,43} In addition, asthmatic children with mothers who use tobacco products are more likely to use asthma medications.⁴⁴ In one intervention study, a reduction in smoking by parents resulted in a decrease in the severity of asthma symptoms in their asthmatic children.⁴⁵

The relationship between exposure to SHS and diseases of the ear has also been established in several studies. A significant correlation between otitis media and SHS exposure has been established in pediatric patients.⁴⁶⁻⁴⁹

Child cognition

A less-known effect of SHS exposure is its impact on cognition. Emerging literature on SHS exposure is now showing an impact on a child's attention, behaviour, and ability to reason and understand (cognition).

Children whose mothers did not use tobacco, but were exposed to SHS during pregnancy, scored lower in cognitive tests than those children whose mothers were not exposed during pregnancy.¹⁷

Several studies over the last while have validated a significant relationship between exposure to SHS and attention, behaviour and cognition in children.^{4,18-20}

Furthermore, it has now been reported that a significant association exists between maternal smoking during pregnancy, and symptoms of attention deficit hyperactivity disorder (ADHD), which is independent of other factors previously identified.⁵

Cancer in adulthood

The U.S. EPA^{16,34} and the International Agency for Research on Cancer,⁵⁰ have both concluded that SHS is a group A carcinogen (i.e. it causes cancer in humans).

A small number of studies have examined the relationship between exposure to SHS during childhood, and cancer risk. Overall, cancer risk is greater for individuals with exposure to SHS during both childhood and adulthood than for individuals with exposure during only one period.⁵¹

When specific cancer types are considered, it has been found that leukemia and lymphoma among adults are significantly related to exposure to maternal tobacco use before 10 years of age.⁵²

A study in the *New England Journal of Medicine* concluded that approximately one out of every five instances of lung cancer in non-smokers could be contributed to childhood SHS exposure.⁵³

Heart disease

A link between heart disease and SHS exposure has been substantiated by several studies, especially over the last five years.⁵⁴⁻⁵⁷

There is strong evidence that shows involuntary exposure to SHS is a cause of coronary heart disease morbidity and mortality.

When researchers looked to childhood exposure to SHS, correlations were discovered that now identify early exposure as a possible cause of premature coronary heart disease.^{58,59}

Smoking in the home and in vehicles

The health effects of SHS have become more understood and recognized over the last 10 years.

Despite a growing protection from SHS in Ontario due to the implementation of bylaws, and the prospect of future implementation of a provincewide smoking ban in public places and workplaces, there continues to be significant sources of SHS for children in homes and vehicles.

Homes which allow smoking are a

significant source of exposure to SHS because of the amount of time children spend indoors (especially when younger), close physical contact with their caregivers, and prolonged exposure over time. In fact, in homes that include smoking, air pollution can reach the levels found in bars.⁶

Vehicles provide a potent source of SHS because of the restricted area within which the smoke is circulated.⁷

Smoking in the home

Attention must be directed toward using prevention/protection measures in households with infants and younger children because of their physical dependence on caregivers, as well as their susceptibility to the effects of SHS.

Because of higher respiratory rates, children experience a higher internal exposure to SHS.^{60,61} A recent study measuring levels of urinary cotinine — a well-known breakdown product of nicotine — found lower levels in households where smoking was completely banned inside the home. Effective protection cannot be achieved by actions such as opening a window, smoking in another room, or using an air purifier.^{62,67}

New research has found that children exposed to SHS in homes — regardless of whether or not smoking was allowed indoors or restricted to outside — will show levels of exposure higher than children in non-smoking homes.⁶⁸⁻⁷⁰ In fact, a child's exposure can still be five to seven times higher when adults smoke outside compared to smoke-free homes.⁸

In a study published earlier this year, Matt et al. cite possible reasons for the observed exposure levels in children that live in homes where adults use tobacco outside. Their findings indicate there are some sources of SHS that parents cannot easily control through indoor smoking bans. In fact, SHS can remain in the home even if smoking took place days, weeks and months earlier⁹ through contaminated dust and surfaces, and a smoker's finger.

Additionally, SHS can find its way

into the home through windows and doors if cigarettes are smoked outside, and through contaminated clothes, skin and dust carried into the home if cigarettes are smoked elsewhere.⁸

Most parents are aware of the health hazards of SHS exposure, and make efforts to stop smoking or change their smoking behaviour to protect their children.⁶⁶

In a major Canadian study commissioned by Health Canada in 1995, it was shown that about 30 per cent of the parent population was somewhat or very likely to respond to messages about SHS.⁷¹

Using data from population-based surveys of adults in Ontario conducted in 1992, 1993, 1995, and 1996, trends in attitudes and current practices concerning smoking in the home were determined. Between 1992 and 1996, the percentage of respondents who agreed that parents spending time at home with small children should not smoke increased from 51 per cent to 70 per cent. However, data from the survey in 1996 showed only 20 per cent of homes with children and any daily tobacco users were smoke-free.⁷²

Despite these changing attitudes and behaviours with regard to SHS in the home, challenges and considerations remain. A 1994 Winnipeg study found that although 90 per cent of respondents indicated knowledge regarding the harmful effects of SHS in the home, only 24 per cent implemented any SHS controls.⁷³

However, more recent data are encouraging. Another population study conducted between May and December 2000 showed 27 per cent of Ontario residents were exposed to SHS in their homes — 21 per cent on a daily basis, and six per cent on an occasional basis.

Homes with adult smokers, and children present, were more likely to have smoking restrictions in place for family members than homes without children (61 per cent compared to 46 per cent). Having at least one adult non-smoker in a home where children and other adult smokers are present increased

the likelihood of having smoking restrictions to 73 per cent, compared to 60 per cent in homes where all adults smoked.⁷⁴

Nonetheless, survey results from Ontario show strong support for voluntary restrictions on SHS exposure.⁷⁵⁻⁷⁷ In fact, a 1996 report showed 35.4 per cent of the population favoured a legal restriction on smoking in the home,⁷⁷ suggesting that interventions directed at decreasing SHS in homes and vehicles in Ontario could be well received.

This is confirmed by a 2003 Ontario survey that showed 87 per cent of respondents agreed that parents should not be allowed to smoke in homes with small children. When asked whether there should be a law to prohibit parents from smoking inside a home if children are living there, 63 per cent of respondents agreed.¹²

Many of the interventions that have been evaluated and have shown success are targeted at the mother, and are more effective if the mother is the only individual using tobacco in the home. When the mother is not the only smoker, or when she is not a smoker herself, the counseling and changes expected of her become much more difficult to implement. The mother would be expected to influence members of her family to make changes in their smoking behaviours — this can be difficult, and often times impossible.⁷⁸

The size and type of living space, single parenting, other household members who smoke, and lower education levels are all related to higher levels of SHS exposure.^{75,79,80}

In addition, persons of lower socioeconomic status may face a particularly greater challenge in modifying SHS in their homes if they have fewer opportunities to smoke away from their children, if their homes are smaller with fewer rooms, and if they do not have garages, balconies, or other places to smoke outdoors.⁸¹

A 1994 Harvard-based Stop Tobacco Outreach Program offered smoking parents of children seen in an outpatient pediatric clinic, three brief coun-

seling sessions, written materials, free nicotine replacement therapy (NRT), proactive referral to a free state telephone quit line, and fax referral to the parents' primary clinician.

Of the parents who enrolled in the study, 81 per cent completed all three counseling sessions, and 78 per cent accepted free NRT at the time of enrolment. At a two-month follow-up, more than half of the participants had made a serious quit attempt. More notably, the mean number of cigarettes smoked inside the home and car declined over two months. This approach may be effective in reaching smokers who are otherwise unlikely to access smoking cessation interventions.⁸²

It is well understood that tobacco dependence can make the idea of not smoking overwhelming for heavily addicted individuals.

In the 1999 OMA paper entitled "Rethinking Stop-Smoking Medications — Myths and Facts," NRT use was suggested for smokers who are not able, or willing, to quit smoking in order to help them substantially reduce their cigarette consumption. As a potential side benefit, this type of avoidance technique could lead to eventual quit attempts for these individuals.⁸³ (This paper is posted online at: <http://www.oma.org/phealth/tobaccomain.htm>.)

With the compounding issue of parents being unable to leave children unattended while going outside to smoke, or being unable to avoid smoking during longer car trips, NRT use in the home and in vehicles would be an effective alternative.

The OMA recommends that individuals responsible for the care of children who have tried quit methods that were unsuccessful, should be encouraged to use NRTs as a way to decrease SHS levels in their homes and cars. Because there is not much public information on the use of NRTs for this purpose, a public information campaign should be conducted to recommend to, and educate, parents and caregivers about the use of NRTs to avoid smoking in homes and vehicles.

Cost remains a significant barrier to

the access of NRTs. It is not currently possible to purchase a one-day dose of NRTs. Individuals must purchase NRTs in a one-week supply (approximately \$30 per package), making the cost much higher than the purchase cost of a single package of cigarettes (approximately \$7.50 in Ontario).

Furthermore, the greater expenditure is problematic for low-income individuals who tend to have higher smoking rates and lower quitting rates.⁸⁴

In its 1999 paper, the OMA recommended that the provincial government and the pharmaceutical industry work together to closely match the package quantity and cost of NRTs to the package quantity and cost of tobacco products.

The OMA again recommends that the government publicly fund NRTs, and that the Ontario Drug Benefit Plan should include funding for NRTs, as is currently done in Quebec.

Smoking in vehicles

Research has shown that SHS can reach very high levels in vehicles. A comprehensive study that measured cigarette smoke in vehicles showed that while driving with the windows closed, a single smoker can raise the interior carbon monoxide levels significantly by the third cigarette.

Furthermore, blood carboxyhemoglobin levels of both the individual using tobacco, and the individual exposed to SHS (as measured in breath), increase significantly after smoking has occurred.⁷ This, taken in relation to the fact that children have much higher respiratory rates and metabolism than adults, makes SHS exposure in vehicles a serious problem for children.

Based on the evidence that exposure to SHS in a vehicle is 23-times more toxic than in a house due to the smaller enclosed space, the state of Colorado drafted a bill that would impose fines on adults caught smoking in cars when a child is present.⁸⁵

Earlier this year, the state of Georgia moved to an advanced stage of process that would allow police to pull over and fine drivers who are smok-

ing in cars that have a child in a safety seat, once the law is enforced.⁸⁶

A similar bill was introduced in New Hampshire this year.⁸⁷

In June, California moved closer to becoming the first state to have a ban in force on smoking in vehicles carrying children by approving a bill via the state's Senate committee. The bill would make it an infraction to smoke in motor vehicles carrying children who were under the age of six, or weighed less than 60 pounds and were required by law to ride in child safety seats. The bill would take effect January 1, 2006, and require that any fines generated by the legislation be used for public education programs about the dangers of SHS.⁸⁸

In a 1996 Ontario survey, 54.6 per cent of respondents said they would support a law prohibiting children's exposure to SHS in vehicles.⁷⁷ Data from a 2003 survey showed a significant increase in support, with 73.2 per cent of respondents saying there should be a law that prohibits parents from smoking inside a car if children are present.¹²

The OMA recommends that caregivers should not be permitted to smoke in vehicles while transporting children, and that the provincial government take steps to ensure the protection of children from SHS while traveling in vehicles through the introduction of legislation banning the use of tobacco inside vehicles used to transport children.

Children in regulated care

Children in government care

In Ontario, the Child and Family Services Act provides the Minister of Children and Youth Services with guardianship of children who have been removed from their parents' custody because they are unwilling or unable to provide a safe environment for their children.

By acting as temporary guardians, the government assumes all of the responsibilities of natural parents for the duration a child is in care. Government-approved agencies, and their foster parents, carry out the

actual responsibility of caring for the children.

There are currently 52 government-approved Children's Aid Societies (CASs) in Ontario, 51 of which are members of the Ontario Association of Children's Aid Societies (OACAS).

Using provincial requirements and local guidelines, each CAS is required to conduct an assessment of potential foster families before the placement of a child can occur.

Within the regulations, it is clearly stated that an assessment of the child must be done prior to placement, and includes assessing the medical needs of the child.

In response to a motion that was passed in 1996 by the Foster Parent Society of Ontario, which supported a ban on smoking in foster homes, and the release of a 1996 OMA paper addressing the harmful effects of SHS, a focus group was held at the OACAS in 1997 to discuss smoking in foster homes, and the effects that SHS exposure has on children in these homes.

Participants included experts in the field, foster parents, and CAS staff. As a result of these meetings, and a subsequent survey, it was concluded that SHS in foster homes is a challenging issue. In order to address the problem, the OACAS prepared a background paper and information package about SHS and its detrimental effect on the health of children, to be distributed to all agencies in the province.⁸⁹

The OACAS directs individual agencies to implement their own policies, but does not have a comprehensive smoking policy for foster homes because of the great concern about availability of placements for the many children in need of care.

The official position of the OACAS emphasizes the hazards of exposing children to SHS, and encourages the individual agencies to implement practices, positions or policies that protect children from SHS in foster homes.

"Our position is that SHS is dangerous, and children shouldn't be

exposed to it, therefore agencies should take that into consideration.

"There are agencies that advise parents not to smoke in their homes, and there are others that have policies regarding very young children, or children with medical conditions."⁹⁰

The OACAS does not, however, have the authority to enforce a provincewide policy, and its position does not ensure that local agencies will implement a policy.

Furthermore, individual local agencies have expressed concerns that by refusing potential foster parents because of their smoking status, there could be a further decline of much-needed care for children in crisis.⁹¹

At the present time, there are several CASs in Ontario that have smoking policies or positions on smoking in foster homes (see Appendix A, p. 17).

For example, the CAS office in Kingston asks all foster parents not to smoke in the presence of children in their care, while the Toronto CAS will not place any children under five in homes where smoking is allowed, but will only prohibit such a placement of children over the age of five if a child has a medical condition that is exacerbated by exposure to SHS.

Halton CAS includes smoke-free environments as a consideration for approval of a foster home, and opening windows or smoking in another room do not meet the criteria for a smoke-free environment (See Appendix B, p. 17).

Enforcement of Halton CAS smoking policy has not required any extra funding and/or staff, and feedback has shown little resistance from long-time and/or new foster parents.

For the period between April 1, 2003, and March 31, 2004, it was projected that CASs in Ontario would provide substitute care for 24,578 children. It is encouraging to note that between March 31, 1998, and March 31, 2003, there was a 42 per cent increase in the availability of foster homes, and a 43 per cent increase in the availability of adoptive homes.

As of March 31, 2004, there was

an increase of 51 per cent and 59 per cent respectively in foster home and adoptive home availability since March 31, 1998.⁹² These increases could help to allay concerns that implementation of a comprehensive smoking policy would reduce availability of foster homes.

In a ground-breaking decision, the state of Maine implemented a law in October 2003 that prohibits foster parents from smoking in their homes when children in their care could be exposed to SHS. The original bill, which would have also prohibited foster parents from smoking in their cars, was amended because officials thought it was too restrictive.⁹³

In 2003, New York City Mayor Michael Bloomberg made foster parents part of his anti-smoking platform by announcing that foster parents who smoke will undergo extra scrutiny before the city places children in their homes.⁹⁴

British adoption and fostering agencies implemented guidelines in 1993 that ban smokers from adopting or caring for young children. The British Agencies for Adoption and Fostering referred to overwhelming evidence that children younger than two years of age, and those with respiratory illnesses, are at particular risk from SHS exposure.⁹⁵

The OMA recommends that the Ministry of Children and Youth Services work closely with the OACAS and CASs to develop a uniform smoking policy, and to provide ongoing education and support programs to enable foster parents to decrease the amount of SHS that children are exposed to in homes and vehicles.

Private home day cares

In Ontario, home childcare is provided to children in approved private homes other than that of the parent/caregiver, for up to a maximum of five children under the age of 10.

Standards of care are set by the Ministry of Children's Services under the Day Nurseries Act.

While Ontario's Tobacco Control Act mandates that all educational institutions, including licensed day

nurseries, be smoke-free, this coverage does not extend to homes in which private home-based childcare is offered. Government does not provide policies to protect children in home childcare from exposure to SHS.

The Home Child Care Association of Ontario (HCCAO) estimates that over 80,000 children in the province are being cared for in childcare facilities that are regulated by approximately 70 Home Child Care agencies.⁹⁶ These agencies provide assurance that legislated standards are met and maintained in each caregiver's home.

Agencies that are licensed to manage individual home childcare facilities are also subject to inspections by the Ministry.

While individual agencies may have smoking policies in place, they do vary. Most will advise parents of any smoking that occurs in the home childcare environment, and will distribute information about the benefits of smoke-free homes.⁹⁷ However, without a comprehensive smoking policy in place, there is no way to ensure a smoke-free environment for children in these settings.⁹⁸ Furthermore, there are also several home-based childcare environments that are not part of a larger agency, and therefore not regulated.

Individual municipalities are responsible for managing licensed childcare agencies, thus providing a valuable opportunity to intervene with respect to protecting children from second-hand smoke exposure.

Childcare centres are eligible to receive subsidization, and must therefore sign a contract with the municipalities.

For example, in May 2003, the Region of Waterloo Social Services revised its contracts for home-based day care providers who apply for subsidization from the Region. Previously, home-based day care providers in Waterloo were encouraged to provide smoke-free spaces during childcare hours. The contract now includes the following statement: "The indoor areas of a caregiver's residence and all indoor places where the child attends with the care-

giver shall be smoke-free during childcare times."

The OMA recommends that information about the health effects of SHS be included in professional education, project co-ordination, and public education and awareness programs that are currently offered through umbrella agencies such as the HCCAO.

The OMA recommends that the provincial government amend the Day Nurseries Act to ban smoking and provide enforcement to ensure compliance in any homes and/or facilities that provide childcare.

Second-hand smoke and child custody decisions

Custody decisions focus on the best interests of the child, and in doing so, place the needs of children ahead of parents' interests.⁹⁹

Legislation clearly states that the physical health of the child is an important factor in determining a child's best interests, and both provincial and federal law dictate that judges are required to make the best interests of the child a major factor in their decisions.¹⁵ Therefore, parental smoking is an issue that can be considered by the court, and thereby provides an opportunity for intervention with respect to restricting a child's exposure to SHS in the home.

Children with asthma have been a focus for Canadian cases involving access to children, and custody by smoking parents.^{100, 101} Parents who refuse to provide smoke-free environments for asthmatic children have been denied access or custody.

A review of custody cases in the United States from 1997 shows that most decisions favoured protection of the child from SHS, and although some cases allowed for smoking in other parts of the home, most involved a complete ban, including a ban in vehicles, that was applicable to both parents.¹⁰¹

The first Canadian case to consider parental smoking took place in 1988. An Ontario court terminated a father's access to his daughter after the child's asthma and allergies were proven to

be affected by her father's smoking during visitations.¹⁰²

There have since been several cases in all levels of the Canadian court system that have made SHS a consideration in custody determinations.

In a well-publicized case from 2002, a father in British Columbia refused to give signed permission for his former wife to travel outside of Canada with their son because she would not agree to refrain from smoking in the car. When she finally agreed in court to smoke outside the vehicle, the judge decided the case did not need to be pursued any further.¹⁰³

An Ontario Superior Court decision (2002) ordered the removal of a child with serious health problems from his mother's home, and ruled that the father would become the primary residential parent because the mother refused to stop smoking. The court reached its decision on the basis that the child's health was being placed at risk when in the care of his mother.¹⁰⁴

Custody hearings provide an opportunity to place the needs and well-being of the child at the forefront of any decision-making.

When parental smoking is addressed, experience has shown that objections may be raised on the basis of the addictive nature of smoking. However, a significant number of court decisions have determined that other addictions place children at risk, and have subsequently established that such addictions could be indicative of lack of parental fitness.¹⁰⁰

The consideration of parental smoking during custody determinations can also serve an important educational purpose.

First, any publicity that comes from such cases is beneficial in educating the public about the impact of SHS on children's health.

Second, the solutions developed by some courts show that there are effective ways to decrease a child's exposure to SHS in the home.

For example, some courts have ordered a restriction of parental smoking around children that requires parents to be aware of where and when they smoke. In most cases, it

implies parents simply have to go outside to smoke.⁹⁹

Because of an increasing number of court cases that involve parental smoking, lawyers and judges have access to rulings regarding SHS which have set legal precedent. However, it is still essential that awareness of the health issues be available to these decision-makers.

The OMA recommends that a system which facilitates the dissemination of medical and legal information regarding SHS and children be researched by an expert panel, and then made available to lawyers and judges in order to improve their access to necessary information regarding child welfare in the courts.

Public health campaigns

Research in health promotion has shown that mass media messages, in combination with community-based interventions, can have a great impact on increasing awareness and encouraging behavioural change. However, evaluations of community-based programs have shown both success and failure in being able to decrease SHS in homes and vehicles.¹⁰⁵⁻¹⁰⁸

Breathing Space: Community Partners for Smoke-Free Homes is a social marketing campaign meant to be delivered by public health units across Ontario, along with community-based education, in an effort to inform people of the dangers of SHS in homes and vehicles.

The campaign focuses on motivating people to make their homes 100 per cent smoke-free, with a long-term goal of increasing the proportion of smoke-free homes by 2010.

Using radio, newspaper and transit advertising, the messages are delivered to a target audience of individuals who smoke in the home, or allow smoking in the home, particularly those with children under the age of 18. The campaign was conducted in 2000, 2001, and 2003, with funding support from the Tobacco Control Programme, Health Canada, and the Ontario Tobacco Strategy of the Ministry of Health and Long-Term Care.

The campaign initially involved

seven public health units, with subsequent evaluation results showing there was a significant impact on attitudes and behavioural intentions of the target audience. Furthermore, the campaign was shown to increase awareness of the health-hazards of SHS, as well as the likelihood that individuals would ask someone who smoked to refrain from smoking in the home.¹⁰⁹

In response to the evaluation, the winter 2003 campaign was expanded to include 23 of Ontario's 37 health units, thereby allowing for regions in Ontario with limited funds and resources to benefit from a province-wide campaign. The campaign materials were translated into French, and a smaller selection was translated into Ojibway, Ojicree, and Cree by request from Northern communities.

Numerous municipalities across Ontario have participated in Breathing Space: Community Partners for Smoke-Free Homes,¹⁰⁹ however, not all boards of health participated in the campaign and/or have adequate resources to administer them.

A review compiled for Health Canada in April 2003 summarized the effectiveness of the media component of the campaign. The results were encouraging, and showed an increase in the number of individuals — from 63 per cent in 2000 to 74 per cent in 2003 — who would be willing to ask someone to smoke outside if children were present.

There was also an increase in agreement among participants that SHS is a serious health hazard, rising from 74 per cent in 2000 to 88 per cent in 2003.

The major limitation of this evaluation is that it was restricted to attitudes and behavioural intentions, and did not measure actual impact on the prevalence of smoking in homes with children.

Budget constraints are a major impediment to being able to measure the overall effectiveness of the campaign on behaviour change. Instead, the boards of health from participating health units have relied on word-of-mouth feedback

from parents and community members to provide some measure of the effectiveness of the messages.

In order to keep the smoke-free homes message alive in the community, health units are encouraged to participate by contributing their own funding and resources to supplement broad media campaigns in their area.

In Ontario, the 1997 *Public Health Mandatory Health Programs and Services Guidelines* (MHPSG) mandate programming for boards of health. As such, many health units are able to participate in the campaign because it meets the initiatives outlined for SHS control in the MHPSG. However, several health units have not participated due to financial and/or other resource shortages during times of campaign implementation.

In early 2004, the partnering 23 health units, and Cancer Care Ontario – Prevention Unit, provided in-kind and financial resources to develop and focus test campaign creative addressing hard-to-reach audiences. The partnership has grown to 33 health units, currently seeking financial support to fund the implementation of a provincewide media campaign using this new creative.¹¹⁰

The Breathing Space campaign has been presented at more than a dozen conferences and workshops across Ontario, Canada, and internationally. As a result, several Canadian provinces and other countries continue to seek information and consultation from Breathing Space in designing, implementing, and evaluating their own smoke-free homes initiatives.

Materials from the campaign are also valuable in other public education endeavours, and are used in public health programs, including: Best Start; Healthy Babies, Healthy Children; Heart Healthy programs; Heart Smart; Workplace Wellness Days and cessation displays; and health fairs.¹⁰⁹

The OMA recommends that the provincial government provide public health departments with adequate funding to meet their obligations under the Mandatory Programs and Services Guidelines, including providing funds

for the *Breathing Space* campaign to become provincewide.

The campaign should have adequate funding to focus on hard-to-reach audiences, and allow for the recommended duration/frequency required to have the desired impact on the public.

Funding should also be available to allow for the use of such methods as repeat surveys to allow for a thorough assessment of the campaign's effectiveness in reducing the number of homes and vehicles that allow smoking.

Interventions by health-care professionals

Although there is evidence to support the incorporation of smoking interventions by primary care clinicians in a public health approach, evaluations of the effectiveness of these programs have also shown varied success in reducing children's exposure.^{111, 112} These varied findings provide solid evidence of the need for ongoing research to improve intervention attempts and compliance.

One of the greatest challenges to success lies in developing strategies to address the factors that reinforce smoking and SHS exposure, such as addiction, and the influence of family and friends. This can fall beyond a practitioner's ability to deliver brief, or one-time, counseling sessions.¹¹²

Wall and colleagues, however, reported that new mothers who received literature about SHS, and a letter advising them to quit smoking, as well as written and oral advice during four subsequent well-baby visits, demonstrated significantly higher cessation rates, and significantly lower relapse rates, than mothers receiving initial literature alone. This study showed that brief interventions over repeated contacts can reduce smoking rates.¹¹³

Furthermore, it supports the suggestion that opportunities exist for counseling parents on the effects of SHS exposure.

The effectiveness of informing parents about the dangers of SHS, and offering advice/assistance with smok-

ing interventions during parent-child visits to health professionals — primarily family physicians — must be investigated and evaluated.

There are chronic and acute childhood health problems that are linked to SHS exposure, and it is clear that these interactions provide valuable teachable moments for effecting change, particularly among specialists who commonly treat these illnesses (e.g., pediatricians, allergists, respirologists, ear nose and throat specialists, and emergency room physicians — particularly pediatric).

Successful training and implementation of tobacco interventions by clinicians should be applied to all disciplines, especially those that work closely with children most adversely affected by SHS exposure, including nurses, obstetricians, midwives, respiratory therapists, pharmacists, dentists and psychiatrists.

When Wall and associates focused on interventions with newborn infants, they saw benefit from the motivation of new mothers to protect their newborn children.¹¹³

Another study by Butz and colleagues — a comparison of SHS among children with chronic respiratory diseases, including cystic fibrosis, to healthy children and children with non-respiratory chronic illnesses — showed that more than 80 per cent of the asthma and cystic fibrosis respondents showed a change in parents' smoking behaviour (i.e. smoking outside the home or smoking fewer cigarettes) after the diagnosis of their child's illness, versus only 40 per cent in the non-respiratory groups.¹¹⁴

Several studies examining the prevalence of smoking advice and/or cessation assistance among clinicians and practitioners have reported that barriers to providing advice include: lack of time, feelings that parents did not expect to receive advice, and feeling ill at ease offering advice.¹¹⁵

In 2005, the Ontario Tobacco Research Unit¹¹⁶ is expected to publish data concerning findings of a national evaluation of interventions among pediatricians and family practitioners

regarding their practices in advising parents about smoking.

Using data from the U.S. National Ambulatory Medical Care Survey between 1997 and 1999, a comprehensive assessment of the frequency of clinician-reported delivery of counseling for avoidance of child SHS exposure was conducted during periodic well-child visits and illness visits for both asthma and otitis media. Results collected from 1997 to 1999 showed a very low rate of tobacco counseling for well-child visits, and for diagnoses affected by SHS, with 4.1 per cent at well-child visits, 4.4 per cent at illness visits for asthma, and 0.3 per cent of illness visits for otitis media.¹¹⁷

In a 2003 study from Boston's Children's Hospital, a telephone survey of households (conducted from July 2001 to September 2001) collected data to examine and compare rates of pediatrician and family practitioner screening and counseling for parental tobacco use.

The study found that although there was a higher rate of discussion about parental smoking with pediatricians versus family practitioners, fewer than half reported being counseled by either specialty about the dangers of SHS, or the risks of modeling smoking behaviour. Similarly, fewer than half received advice to quit smoking.¹¹⁸

There is an encouraging increase in the number of studies designed to measure and analyze smoking intervention methods among clinicians.

For example, in 1993, the American Academy of Pediatrics created a workshop, entitled "Clean Air for Children: Three Hour Training Workshop," to train pediatricians in smoking-cessation counseling.

Pediatricians from the same academic medical centre were divided into two groups — those who did, and those who did not, attend the training session. Evaluators then assessed changes in practice related to smoking intervention. Those pediatricians who had attended the training session were more likely to inquire about parental smoking status, iden-

tify smokers, and offer advice about the effects of SHS exposure.¹¹⁹

A recent survey of pediatricians conducted by the University of Michigan found that the percentage of physicians with reported high levels of self-efficacy when screening parents of asthmatic children to identify smokers, and/or counsel them, was directly related to the amount of formal training in smoking cessation throughout their careers.¹²⁰

Since 1996, the OMA's Clinical Tobacco Intervention (CTI) Program has helped to educate and support Ontario physicians to assist patients with their smoking-cessation efforts.

In 2000, the Ontario Dental Association and the Ontario Pharmacists' Association joined with the OMA for delivery of CTI, with funding provided by the provincial government.

CTI is an evidence-based program designed to recruit and educate physicians, dentists and pharmacists to perform tobacco-cessation interventions with patients. This is done through the provision of educational programs, patient materials, ongoing support, and special projects.

CTI focuses on the minimal contact intervention approach (brief patient interventions lasting three to five minutes), and the "five A's" model, which entails: asking patients about their smoking status, advising patients about the health risks, assessing patients' readiness to quit, assisting patients who are ready to quit, and arranging follow-up.

Ongoing collaboration among the three associations works to provide clear and consistent messages to patients about the importance of ceasing tobacco use.¹²¹ However, despite its effectiveness, this type of programming has yet to be extended in order to enable health professionals to provide interventions to parents and caregivers regarding their tobacco use and its impact on children.

Gidding suggests that pediatricians take advantage of the recommended series of well-child visits in order to counsel parents on the effects of SHS on children.⁸²

In Ontario, these visits are conducted by both pediatricians and, most often, family physicians, or throughout the first six years of life, as well as during additional office visits for treatment of illnesses.

These visits create a valuable opportunity to provide ongoing information to parents on SHS and its dangers.⁸²

Surveys of parents suggest that intervention by health-care professionals regarding SHS exposure and children is warranted, and thought to be appropriate, with a majority of parents indicating that they would be receptive to receiving information and/or advice regarding their tobacco use.^{115, 122, 123}

The importance of including smoking cessation instruction within medical school curricula has resulted in increasing attention toward educational methods for training medical students in tobacco intervention. However, there are still gaps in the curriculum, including a lack of integration during the four years of medical school curricula, specific training in the use of nicotine replacement therapies, tobacco intervention training that addresses cultural issues, and long-term studies showing that such training is retained in practice.^{124, 125}

A comprehensive 1997 survey of Canadian schools that train health professionals showed more hours were devoted to education about the diseases caused by smoking than to counseling patients to quit. Many schools had no smoking counseling curriculum, and the average number of hours devoted to counseling among those who replied to the survey was only two.¹²⁶

The family and community medicine department at the University of Toronto designed and implemented a module called Project CREATE that addresses smoking cessation, for use by medical students, residents and faculty.

Presentations have already been made to second-year medical students at the University of Toronto, and there are plans for the module to be updated for future comprehen-

sive use. However, this program has yet to be extensively implemented in Ontario medical schools.¹²⁷

Primary health-care providers regularly address parents about nutrition, lead poisoning, and other child health safety issues, including those in the home, and their involvement has contributed to changes in social norms, including infant car seats and bicycle helmets. It is clear that assistance in the management of SHS exposure may also result in significant reductions in tobacco-related illnesses.

As the people most knowledgeable about child health in their communities, health-care providers who treat children and their families can also play a role in reducing children's exposure to SHS in two ways — by counseling parents, and by working within the community to enact more comprehensive policies regarding SHS in homes and vehicles.¹²⁸

There is also a place for intervention among other health professions, including nurses (both in hospitals and in public health), nurse practitioners, physicians' assistants, obstetricians, midwives, lactation consultants, pre-natal and post-partum social workers, respiratory therapists, pharmacists and dentists.

It is important to recognize and support programs that have the potential to impact families with children.

For example, the Healthy Babies, Healthy Children program provided by Ontario's 37 health units supplies information and extra support to families with children from birth to age six. This program includes home visits, thereby providing a valuable opportunity for public health nurses to assess and intervene regarding SHS exposure in home environments.¹²⁹

Programs such as Pregnets — formed in March 2002 to encourage Ontario health professionals across all disciplines, including researchers and policy-makers, to develop a network that will focus on the issue of smoking in pregnancy and postpartum — are also extremely valuable in

establishing a network across various health professions.¹³⁰

The trained quit specialists at the Canadian Cancer Society's Smokers' Helpline can also provide a valuable support to parents who are trying to make changes regarding tobacco use in their homes and vehicles.

Because of their unique opportunity to interact with parents and children, health-care and other professionals who work closely with families should be trained to intervene in families where smoking is prevalent. In order for this to occur, however, evidence has shown that additional training and guidance is required for these individuals to be able to implement effective assessment and intervention practices.

The OMA recommends that programs be created to enhance health professionals' ability to prevent parents from exposing their children to SHS. Effective training programs that allow for health professionals to provide brief interventions should also be offered across all disciplines wherein the opportunity exists to interact with parents and their children. This training should be integral at both the undergraduate medical school level, as well as within postgraduate and continuing education programs for practicing professionals.

Conclusion

The purpose of this document is to outline the position of the OMA concerning the impact of SHS exposure on the health of children, and what should be done to lessen this exposure.

SHS poses a major risk to the health and well-being of children, and steps can be taken to significantly reduce the exposure that children in Ontario currently experience.

Information about the effects of SHS on child health must be disseminated to the public, especially parents and individuals responsible for the care of children, including foster parents, the family courts, and day care workers.

Support must also be provided to enable those attempting to reduce or

eliminate SHS in their homes and vehicles to achieve success.

If progress is made toward implementing the recommendations outlined in this document, a significant improvement in the health of Ontario's children would be inevitable.

The OMA urges the individuals who have the ability to make a difference in this matter, including parents, educators, public health, health-care providers and legislators, to take immediate steps toward accomplishing this goal.

Acknowledgments

This paper was prepared by Louise Gleeson, Policy Research Officer for the Ontario Campaign for Action on Tobacco (OCAT), with direction and support from Dr. Ted Boadway, Executive Director, OMA Health Policy Department, and Flora Aronshtam, Senior Adviser, OMA Health Policy Department.

The OMA wishes to express its gratitude to the many individuals and representatives of groups for their valued comments during the development of this position paper, notably: Michael Perley, Director, Ontario Coalition Against Tobacco (OCAT); OMA Committees and Clinical Sections; external reviewers, including clinical, research, and public health experts in the province.

The development of this position paper was initiated and supported by the OMA Committee on Child Health: Dr. Robin Williams, Chair, Dr. Alan Hudak, Dr. William Watson, Dr. Eugene Ng, Dr. Ahmed Boachie, and Dr. Umberto Cellupica.

References

1. Ontario Medical Association, Committee on Population Health. Second-hand smoke & indoor air quality. Toronto, ON: Ontario Medical Association; 1996 Nov.
2. American Academy of Pediatrics, Committee on Environmental Health. Environmental tobacco smoke: a hazard to children. *Pediatrics* 1997 Apr;99(4):639-642.

3. Kessler DA, Natanblut SI, Wilkenfield JP, et al. Nicotine addiction: a pediatric disease. *J Pediatr* 1997 Apr;130(4):518-524.

4. Weitzman M, Byrd R, Aligne A, et al. The effects of tobacco exposure on children's behavioural and cognitive functioning: implications for clinical and public health policy and future research. *Neurotoxicol Teratol* 2002 May-Jun;24(3):397-406.

5. Thapar A, Fowler T, Rice F, et al. Maternal smoking during pregnancy and attention deficit hyperactivity disorder symptoms in offspring. *Am J Psychiatry* 2003 Nov;160(11):1985-9.

6. Repace JL. Risk management of passive smoking at work and at home. *Saint Louis Univ Public Law Rev* 1994;13(2):763-785.

7. Ott W, Langan L, Switzer P. A time series model for cigarette smoking activity patterns: model validation for carbon monoxide and respirable particles in a chamber and an automobile. *J Expo Anal Environ Epidemiol* 1992;2(Suppl 2):175-200.

8. Matt GE, Quintana M, Hovell MF, et al. Households contaminated by environmental tobacco smoke: sources of infant exposures. *Tob Control* 2004 Feb;13(1):29-37.

9. Daisey JM, Mahanama KR, Hodgson AT. Toxic volatile organic compounds in simulated environmental tobacco smoke: emission factors for exposure assessment. *J Expo Anal Environ Epidemiol* 1998 Jul-Sep;8(3):313-34.

10. Ontario Tobacco Research Unit. Protection from second-hand tobacco smoke in Ontario: a review of the evidence regarding best practices. Toronto, ON: University of Toronto; 2001 May. Available from: http://www.otru.org/pdf/special/special_ets_eng.pdf. Accessed: 2004 Jul 7.

11. Health Canada. Canadian tobacco use monitoring survey (CTUMS) 2001: environmental tobacco smoke: at home, at work, and in public places. Ottawa, ON: Health Canada; 2001. Available from: <http://www.hc-sc.gc.ca/hecs-sesc/tobacco/research/ctums/2001/2001ets.html>. Accessed: 2004 Jul 7.

12. Health Canada. Canadian tobacco

- co use monitoring survey (CTUMS): wave 1: February to June 2003. Ottawa, ON: Health Canada; 2004. Available from: <http://www.hc-sc.gc.ca/hecs-sesc/tobacco/research/ctums/index.html>. Accessed: 2004 Jul 7.
13. Ferrence R, Dioso R, Ashley MJ, et al. A national study of ETS in Canadian homes: regional patterns of exposure to second-hand smoke. Invited plenary presentation on cessation and protection, presented at: 3rd National Conference on Tobacco or Health; 2002 Dec 1-4; Ottawa, ON.
14. Physicians for a Smoke-Free Canada. Children in care: protecting children from second-hand smoke when governments are the "parent." Ottawa, ON: Physicians for a Smoke-Free Canada; 2002 Aug. Available from: http://www.smoke-free.ca/pdf_1/government%20as%20parent.pdf. Accessed: 2004 Jul 7.
15. Physicians for a Smoke-free Canada. Custody & access: protecting children from second-hand smoke during custody disputes. Ottawa, ON: Physicians for a Smoke-Free Canada; 2002 Aug. Available from: http://www.smoke-free.ca/pdf_1/custody%20and%20access.pdf. Accessed: 2004 Jul 7.
16. California Air Resources Board; California Environmental Protection Agency, Office of Environmental Health Assessment. Proposed identification of environmental tobacco smoke as a toxic air contaminant: draft report part A and B. Sacramento, CA: California Air Resources Board; 2003 Nov [updated 2004 Mar 30]. Available from: URL: <http://www.arb.ca.gov/toxics/ets/dreport/dreport.htm>. Accessed: 2004 Jul 7.
17. Makin J, Fried PA, Watkinson B. A comparison of active and passive smoking during pregnancy: long-term effects. *Neurotoxicol Teratol* 1991 Jan-Feb;13(1):5-12.
18. Fried PA, Watkinson B. Differential effects on facets of attention in adolescents prenatally exposed to cigarettes and marihuana. *Neurotoxicol Teratol* 2001 Sep-Oct;23(5):421-430.
19. Wasserman GA, Liu X, Pine DS, et al. Contribution of maternal smoking during pregnancy and lead exposure to early child behaviour problems. *Neurotoxicol Teratol* 2001 Jan-Feb; 23(1):13-21.
20. Fried P, Watkinson B, Gray R. Differential effects on cognitive functioning in 13- to 16-year-olds prenatally exposed to cigarettes and marihuana. *Neurotoxicol Teratol* 2003 Jul-Aug; 25(4):427-436.
21. Johnson IL, Ashley MJ, Reynolds D, et al. Prevalence of smoking associated with pregnancy in three Southern Ontario Health Units. *Can J Pub Health* 2004 May-Jun;95(3): 209-13.
22. Stillman RJ, Rosenberg MJ, Sachs BP. Smoking and reproduction. *Fertil Steril* 1986 Oct; 46(4):545-66.
23. Visscher WA, Feder M, Burns AM, et al. The impact of smoking and other substance use by urban women on the birth weight of their infants. *Subst Use Misuse* 2003 Jun; 38(8): 1063-93.
24. Martin TR, Bracken MB. Association of low birth weight with passive smoke exposure in pregnancy. *Am J Epidemiol* 1986 Oct;124(4):633-42.
25. Rubin DH, Krasilnikoff PA, Leventhal JM, et al. Effect of passive smoking on birth-weight. *Lancet* 1986 Aug 23;2(8504):415-417.
26. Mitchell EA, Ford RP, Stewart AW, et al. Smoking and the sudden infant death syndrome (SIDS). *Pediatrics* 1993 May;91(5):893-96.
27. Klonoff-Cohen HS, Edelstein SL, Lefkowitz ES, et al. The effect of passive smoking and tobacco exposure through breast milk on sudden infant death syndrome. *JAMA* 1995 Mar 8; 273(10):795-8.
28. Nicholl J, O'Cathain A. Antenatal smoking, postnatal passive smoking, and the sudden infant death syndrome. In: Poswillo, D, Alberman, E, eds. *Effects of Smoking on the Fetus, Neonate, and Child*. New York, NY: Oxford University Press; 1992, p. 138-149.
29. Blair PS, Fleming PJ, Bensley D, et al. Smoking and the sudden infant death syndrome: results from 1993-1995 case-control study for confidential inquiry into stillbirths and deaths in infancy. *BMJ* 1996 July 27;313 (7051):195-8.
30. Harlap S, Davies AM. Infant admissions to hospital and maternal smoking. *Lancet* 1974 Mar 30;1(7857): 529-32.
31. Colley JR, Holland WW, Corkhill RT. Influence of passive smoking and parental phlegm on pneumonia and bronchitis in early childhood. *Lancet* 1974 Nov 2;2(7888):1031-4.
32. Strachan DP, Cook DG. Health effects of passive smoking. 1. Parental smoking and lower respiratory illness in infancy and early childhood. *Thorax* 1997 Oct;52(10):905-914.
33. Kidder K, Stein J, Fraser J. The health of Canada's children: a CICH profile. 3rd ed. Ottawa, ON: Canadian Institute of Child Health; 2000.
34. U.S. Environmental Protection Agency, Office of Research and Development, Office of Health and Environmental Assessment. Respiratory health effects of passive smoking: lung cancer and other disorders. Washington, DC: U.S. Environmental Protection Agency; 1992 Dec. Report No.: EPA/600/6-90/006F. Available from: http://oaspub.epa.gov/eims/eimscomm.getfile?p_download_id=36793. Accessed: 2004 Jul 7.
35. Ugnat AM, Mao Y, Miller AB, et al. Effects of residential exposure to environmental tobacco smoke on Canadian children. *Can J Public Health* 1990 Sep-Oct;81(5):345-9.
36. Wilson NW. Second-hand cigarette smoke is a major contributor to asthma in children. *W V Med J* 2001 Jan-Feb;97(1):27-8.
37. Dales RE, Choi B, Chen Y, et al. Influence of family income on hospital visits for asthma among Canadian school children. *Thorax* 2002 Jun;57 (6):513-7.
38. Samet JM, Tager IB, Speizer FE. The relationship between respiratory illness in childhood and chronic airflow obstruction in adulthood. *Am Rev Respir Dis* 1983 Apr; 127(4):508-523.
39. Tager IB. Passive smoking—bronchial responsiveness and atopy. *Am Rev Respir Dis* 1988 Sep;138(3): 507-509.
40. Young S, Le Souef PN, Geelhoed GC, et al. The influence of a family history of asthma and parental smoking

- ing on airway responsiveness in early infancy. *N Engl J Med* 1991 Apr 25; 324(17):168-73.
41. Hanrahan JP, Tager IB, Segal MR, et al. The effect of maternal smoking during pregnancy on early infant lung function. *Am Rev Respir Dis* 1992 May;145(5):1129-35.
42. Evans D, Levison MJ, Feldman CH, et al. The impact of passive smoking on emergency room visits of urban children with asthma. *Am Rev Respir Dis* 1987 Mar;135(3):567-72.
43. Cunningham J, O'Connor GT, Dockery DW, et al. Environmental tobacco smoke, wheezing and asthma in children in 24 communities. *Am J Respir Crit Care Med* 1996 Jan;153(1):218-24.
44. Weitzman M, Gortmaker S, Walker DK, et al. Maternal smoking and childhood asthma. *Pediatrics* 1990 Apr;85(4):505-511.
45. Murray AB, Morrison BJ. Passive smoking by asthmatics: its greater effect on boys than on girls and on older than on younger children. *Pediatrics* 1989 Sep;84(3):451-9.
46. Ey JL, Holberg CJ, Aldous MB, et al. Passive smoke exposure and otitis media in the first year of life. Group Health Medical Associates. *Pediatrics* 1995 May;95(5):670-7.
47. Kitchens GG. Relationship of environmental tobacco smoke to otitis media in young children. *Laryngoscope* 1995 May;105(5 Pt 2 Suppl 69):1-13.
48. Adair-Bischoff CE, Sauve RS. Environmental tobacco smoke and middle ear disease in preschool-age children. *Arch Pediatr Adolesc Med* 1998 Feb;152(2):127-33.
49. Strachan DP, Cook DG. Health effects of passive smoking. 4. Parental smoking, middle ear disease and adenotonsillectomy in children. *Thorax* 1998 Jan;53(1):50-6.
50. International Agency for Research on Cancer. Tobacco smoke and involuntary smoking. Lyon, France: IARC Press; 2004. (IARC Monographs; 83).
51. Sandler DP, Wilcox AJ, Everson RB. Cumulative effects of lifetime passive smoking on cancer risk. *Lancet* 1985 Feb 9;1(8424):312-5.
52. Sandler DP, Everson RB, Wilcox AJ, et al. Cancer risk in adulthood from early life exposure to parents' smoking. *Am J Public Health* 1985 May;75(5):487-92.
53. Janerich DT, Thompson WD, Varela LR, et al. Lung cancer and exposure to tobacco smoke in the household. *New Eng J Med* 1990 Sep 6;323(10):632-6.
54. de Groh M, Morrison H. Environmental tobacco smoke and deaths from coronary disease in Canada. *Chronic Dis Can* 2002;23(1):13-16.
55. Otsuka R, Watanabe H, Hirata K, et al. Acute effects of passive smoking on the coronary circulation in healthy young adults. *JAMA* Jul 2001;286(4):436-41.
56. Fichtenberg CM, Glantz SA. Association of the California Tobacco Control Program with declines in cigarette consumption and mortality from heart disease. *New Eng J Med* 2000 Dec 14;343(24):1772-7.
57. Dietrich M, Block G, Norkus EP, et al. Smoking and exposure to environmental tobacco smoke decrease some plasma antioxidants and increase gamma-tocopherol in vivo after adjustment for dietary antioxidant intakes. *Am J Clin Nutr* 2003 Jan;77(1):160-166.
58. Maturri L, Lavezzi AM, Ottaviani G, et al. Intimal preatherosclerotic thickening of the coronary arteries in human fetuses with smoking mothers. *J Thromb Haemost* 2003 Oct 1; 1(10):2234-8.
59. Moskowitz WB, Mostellar M, Schieken RM, et al. Lipoprotein and oxygen transport alterations in passive smoking preadolescent children. The MCV Twin Study. *Circulation* 1990 Feb;81(2):586-92.
60. Emmons KH, Hammond SK, Abrams DB. Smoking at home: the impact of smoking cessation on non-smoker's exposure to environmental tobacco smoke. *Health Psychol* 1994 Nov;13(6):516-520.
61. Haufroid V, Lison D. Urinary cotinine as a tobacco-smoke exposure index: a minireview. *Int Arch Occup Environ Health* 1998 May;71(3):162-68.
62. Canada Mortgage and Housing Corporation. The clean air guide: how to identify and correct indoor air problems in your home. Ottawa, ON: Canada Mortgage and Housing Corporation; 1993. Available from: <http://www.cmhc-schl.gc.ca/publications/en/rh-pr/tech/93-203.pdf>. Accessed: 2004 Jul 7.
63. Lofroth G. Environmental tobacco smoke: multicomponent analysis and room-to-room distribution in homes. *Tob Control* 1993 Sep;2(3):222-225.
64. Pirkle JL, Flegal KM, Bernert JT, et al. Exposure of the US population to environmental tobacco smoke: the Third National Health and Nutritional Survey, 1988 to 1991. *JAMA* 1996 Apr 24;275(16):1233-40.
65. Blackburn C, Spencer N, Bonas S, et al. Effect of strategies to reduce exposure of infants to environmental tobacco smoke in the home: cross sectional survey. *BMJ* 2003 Aug 2; 327(7409):257-60.
66. Lund KE, Skrondal A, Vertio H, et al. To what extent do parents strive to protect their children environmental tobacco smoke in Nordic countries? A population-based study. *Tob Control* 1998 Spring;7(1):56-60.
67. Johansson A, Hermansson G, Ludvigsson J. How should parents protect their children from environmental tobacco smoke exposure in the home? *Pediatrics* 2004 Apr;113(4):e291-e295.
68. Mascola MA, Van Vunakis H, Tager IB, et al. Exposure of young infants to environmental tobacco smoke: breast-feeding among smoking mothers. *Am J Public Health* 1998 Jun; 88(6):893-96.
69. Johansson A, Halling A, Hermansson G. Indoor and outdoor smoking: impact on children's health. *Eur J Public Health* 2003 Mar;13(1):61-66.
70. Bahceciler NN, Barlan IB, Nuhoglu Y, et al. Parental smoking behavior and the urinary cotinine levels of asthmatic children. *J Asthma* 1999;36(2):171-5.
71. Ashley MJ, Ferrence R. Reducing children's exposure to environmental tobacco smoke in homes: issues and strategies. *Tob Control* 1998 Spring;7(1):61-65.

72. Ashley MJ, Cohen J, Ferrence R, et al. Smoking in the home: changing attitudes and current practices. *Am J Pub Health* 1998 May;88(5):797-800.
73. Goldstein JE. Informal smoking controls in Winnipeg households. *Can J Public Health* 1994 Mar-Apr; 85(2):106-9.
74. Ontario Tobacco Research Unit. Environmental tobacco smoke (ETS) in Ontario homes: behaviours and beliefs about health risks. Research Update 2002 Sep. Available from: http://www.otru.org/pdf/updates/update_sept2002.pdf. Accessed: 2004 Jul 7.
75. Ferris J, Templeton L, Wong S. Alcohol, tobacco and marijuana: use, norms, problems, and policy attitudes among Ontario adults. A report of the Ontario Alcohol and Other Drug Opinion Survey, 1992. Toronto, ON: Addiction Research Foundation; 1994 Sep. (Internal document; 118).
76. Bondy SJ, Ferrence RG. Smoking behaviour and attitudes in Ontario, 1993. A report of the 1993 Ontario Alcohol and Other Drugs Opinion Survey. Toronto, ON: Ontario Tobacco Research Unit; 1995. (Working papers series; 2).
77. Anglin L, ed. The Ontario experience of alcohol and tobacco: new focus on accessibility, violence, and mandatory treatment. A report of the Ontario Alcohol and Other Drug Opinion Survey (OADOS), 1995. Toronto, ON: Addiction Research Foundation of Ontario; Nov 1995. (Internal document; 122).
78. Hovell MF, Zakarian JM, Wahlgren DR, et al. Reducing children's exposure to environmental tobacco smoke: the empirical evidence and direction for future research. *Tob Control* 2000 Jun;9 (Suppl 2):ii40-ii47.
79. Greenberg RA, Bauman KE, Glover LH, et al. Ecology of passive smoking by young infants. *J Pediatr* 1989 May;114(5):774-80.
80. Cook DG, Whincup PH, Jarvis MJ, et al. Passive exposure to tobacco smoke in children aged 5-7 years: individual, family and community factors. *BMJ* 1994 Feb 5;308(6925): 384-89.
81. Gehrman CA, Hovell MF. Protecting children from environmental tobacco smoke (ETS) exposure: a critical review. *Nicotine Tob Res* 2003 Jun;5(3):289-301.
82. Gidding SS, Schydlower M. Active and passive tobacco exposure: a serious pediatric health problem. *Pediatrics* 1994 Nov;94(5):750-751.
83. Ontario Medical Association, Committee on Drugs & Pharmacotherapy. Rethinking stop-smoking medications — myths and facts. Toronto, ON: Ontario Medical Association; 1999 Jun.
84. Shiffman S, Gitchell J, Pinney JM, et al. Public health benefit of over-the-counter nicotine medications. *Tob Control* 1997 Winter;6(4):306-310.
85. Sanko J. Bill targets smokers in cars: Boulder Senator says state should step in on behalf of children. *Rocky Mountain News* (Denver, Colorado) 1998 Jan 10:6A.
86. Car smoking bill. Broadcast News 2004 Feb 4.
87. State of New Hampshire, General Court. House Bill 1129: an act prohibiting smoking in vehicles when child passenger restraints are required. Concord, NH: New Hampshire General Court; 2004. Available from: <http://www.gencourt.state.nh.us/legislation/2004/HB1129.html>. Accessed: 2004 Jul 7.
88. Lawrence S. Senate committee OKs ban on smoking in cars carrying young kids. New York, NY: Associated Press; 2004 Jun 16. Available from: <http://www.montereyherald.com/mld/montereyherald/news/politics/8940431.htm>. Accessed: 2004 Jul 7.
89. Ontario Association of Children's Aid Societies. Second-hand smoke in foster homes. Toronto, ON: Ontario Association of Children's Aid Societies; 1999 Jan.
90. Gleeson L (Ontario Campaign for Action on Tobacco, Ontario Medical Association, Toronto, ON). Telephone conversation with: Gail Vandermeulen (Director of Communications, Ontario Association of Children's Aid Societies, Toronto, ON). 2003 Oct 15.
91. Gleeson L (Ontario Campaign for Action on Tobacco, Ontario Medical Association, Toronto, ON). Telephone conversation with: Jeanette Lewis (Executive Director, Ontario Association of Children's Aid Societies, Toronto, ON). 2003 Oct 14.
92. Ontario Association of Children's Aid Societies. Ontario child welfare statistics. Toronto, ON: Ontario Association of Children's Aid Societies. Available from: <http://www.oacas.org/resources/casstats.htm>. Accessed: 2004 Jul 7.
93. Foster parent rights must be considered in enforcement of law. *Kennbec Journal — Morning Sentinel* 2003 Oct 4.
94. Edozien F. City has wary eye on 'puff' parents. *New York Post* 2003 Apr 25:3.
95. Smokers rejected as adoptive parents. *The Journal*, Addiction Research Foundation 1993 May 22(3):7.
96. Gleeson L (Ontario Campaign Action on Tobacco, Ontario Medical Association, Toronto, ON). Telephone conversation with: Mary-Lou James (President, Home Child Care Association of Ontario, Toronto, ON). 2003 Dec 16.
97. Gleeson L (Ontario Campaign for Action on Tobacco, Ontario Medical Association, Toronto, ON). Telephone conversation with: Mary-Lou James (President, Home Child Care Association of Ontario, Toronto, ON). 2003 Dec 17.
98. Gleeson L (Ontario Campaign for Action on Tobacco, Ontario Medical Association, Toronto, ON). Telephone conversation with: Judy MacLeod (Ministry of Community and Social Services and Ministry of Children's Services, Toronto, ON). 2003 Dec 9.
99. Ezra DB. Sticks and stones can break my bones, but tobacco smoke can kill me: can we protect children from parents that smoke? *Saint Louis Univ Public Law Rev* 1994;13(2): 547-590.
100. Liberman E. Custody and access: no smoking allowed! Toronto, ON: Ontario Tobacco Research Unit; 1995 Apr.
101. Sweda EL. Summary of legal cases regarding smoking in the workplace and other places. Boston, MA: Tobac-

- co Control Resource Center; 1997 Jul. 102. Bourdon v. Casselman [1988] O.J. No. 2385.
103. Meissner D. Boy allowed on trip after mom tells court she won't smoke in car. Toronto, ON: Canadian Press; 2002 Dec 15. Available from: http://lifewise.canoe.ca/Health/0012/15_smoking-cp.html. Accessed: 2004 Jul 7.
104. Brean J. Judge orders boy removed from smoking mother's home. *National Post* 2002 Oct 18:A1.
105. Greenberg RA, Strecher VJ, Bauman KE, et al. Evaluation of a home-based intervention program to reduce infant passive smoking and lower respiratory illness. *J Behav Med* 1994 Jun;17(3):273-290.
106. Bondy SJ, Connop H, Pope M, et al. Promoting smoke free families. Report of a pilot intervention trial to reduce environmental tobacco smoke in family homes. Toronto, ON: Ontario Tobacco Research Unit; 1995 Aug. (Working papers series; 3).
107. Vineis P, Ronco G, Ciccone G, et al. Prevention of exposure of young children to parental tobacco smoke: effectiveness of an educational program. *Tumori* 1993 Jun 30;79(3):183-186.
108. Green E, Courage C, Rushton L. Reducing domestic exposure to environmental tobacco smoke: a review of attitudes and behaviors. *J R Soc Health* 2003 Mar;123(1):46-51.
109. Breathing space: community partners for smoke-free homes: final report: mass media activities. Ottawa, ON: Health Canada, Federal Tobacco Control Strategy; 2003 Apr 30.
110. Thibault S (Co-ordinator, Breathing Space Campaign, Toronto, ON). Breathing space campaign. [Internet]. Message to: Louise Gleeson (Ontario Campaign for Action on Tobacco, Ontario Medical Association, Toronto, ON). 2003 Oct 23, 9:47 am. [about 2 screens].
111. McIntosh NA, Clark NM, Howatt WF. Reducing tobacco smoke in the environment of the child with asthma: a cotinine-assisted, minimal contact intervention. *J Asthma* 1994; 31(6):453-62.
112. Chilmonczyk BA, Palomaki GE, Knight GJ, et al. An unsuccessful cotinine-assisted intervention strategy to reduce environmental tobacco smoke exposure during infancy. *Am J Dis Child* 1992 Mar;146(3): 357-360.
113. Wall MA, Severson HH, Andrews JA, et al. Pediatric office-based smoking intervention: impact on maternal smoking and relapse. *Pediatrics* 1995 Oct;96(4 Pt 1):622-8.
114. Butz AM, Rosenstein BJ. Passive smoking among children with chronic respiratory disease. *J Asthma* 1992;29(4):265-72.
115. Frankowski BL, Weaver SO, Secker-Walker RH. Advising parents to stop smoking: pediatricians' and parents' attitudes. *Pediatrics* 1993 Feb;91(2):296-300.
116. Brewster J (Research Scientist, Ontario Tobacco Research Unit, Toronto, ON). Smoking cessation - pediatricians. [Internet]. Message to: Louise Gleeson (Ontario Campaign for Action on Tobacco, Ontario Medical Association, Toronto, ON). 2003 Nov 6, 4:54 pm. [about 1 screen].
117. Tanski SE, Klein JD, Winickoff JP, et al. Tobacco counseling at well-child and tobacco-influenced illness visits: opportunities for improvement. *Pediatrics* 2003 Feb;111(2): E162-7.
118. Winickoff JP, McMillen RC, Carroll BC, et al. Addressing parental smoking in pediatrics and family practice: a national survey of parents. *Pediatrics* 2003 Nov;112(5):1146-51.
119. Klein JD, Portilla M, Goldstein A, et al. Training pediatric residents to prevent tobacco use. *Pediatrics* 1995 Aug;96(2 Pt 1):326-30.
120. Cabana MD, Rand C, Slish K, et al. Pediatrician self-efficacy for counseling parents of asthmatic children to quit smoking. *Pediatrics* 2004 Jan;113(1):78-81.
121. Hart J (Director, CTI Program, Ontario Medical Association, Toronto, ON). CTI blurb. [Internet]. Message to: Louise Gleeson (Ontario Campaign for Action on Tobacco, Ontario Medical Association, Toronto, ON). 2004 Jun 9, 3:33 pm. [about 2 screens].
122. Hopper JA, Craig KA. Environmental tobacco smoke exposure among urban children. *Pediatrics* 2000 Oct;106(4):E47.
123. Cluss PA, Moss D. Parent attitudes about pediatricians addressing parental smoking. *Ambul Pediatr* 2002 Nov-Dec;2(6):485-88.
124. Ferry LH, Grissino LM, Runfola PS. Tobacco dependence curricula in US undergraduate medical education. *JAMA* 1999 Sept 1;282(9): 825-9.
125. Spangler JG, George G, Foley KL, et al. Tobacco intervention training: current efforts and gaps in US medical schools. *JAMA* 2002 Sept 4;288(9):1102-09.
126. Thomas R. A survey of the training of Canadian health professionals to counsel against smoking. *Chronic Dis Can* 1997;18(3):120-9.
127. Kahan M (Department of Family and Community Medicine, University of Toronto, Toronto, ON). Smoking cessation curriculum. [Internet]. Message to: Louise Gleeson (Ontario Campaign Action on Tobacco, Ontario Medical Association, Toronto, ON). 2003 Nov 11, 4:01 pm. [about 1 screen].
128. McMillen RC, Winickoff JP, Klein JD, et al. US adult attitudes and practices regarding smoking restrictions and child exposure to environmental tobacco smoke: changes in social climate from 2000-2001. *Pediatrics* 2003 July;112(1 Pt 1):e55-e60.
129. Cooper J (Co-ordinating Manager, Healthy Babies, Healthy Children, Toronto Public Health, Toronto, ON). Healthy babies, healthy children. [Internet]. Message to: Louise Gleeson (Ontario Campaign for Action on Tobacco, Ontario Medical Association, Toronto, ON). 2003 Nov 3, 8:05 pm. [about 1 screen].
130. Dragonetti R (PREGNETS, Toronto, ON). Question. [Internet]. Message to: Louise Gleeson (Ontario Campaign for Action on Tobacco, Ontario Medical Association, Toronto, ON). 2004 Jan 9, 12:25 am. [about 1 screen].

Appendix A Sample of Smoking Policies from Children’s Aid Societies Agencies in Ontario

Agency	Policy
Kingston	<ul style="list-style-type: none"> • Prohibits foster parents from smoking in the presence of foster children (parents are allowed to smoke outside). • Society also attempts to identify any children with medical conditions exacerbated by SHS, and place those children in non-smoking homes. • No smoking while transporting children.
Toronto	<ul style="list-style-type: none"> • No children under the age of five are placed in homes where smoking is allowed. • Special considerations are made for children with medical conditions that are affected by exposure to SHS.
Perth	<ul style="list-style-type: none"> • Prohibits placement of infants and preschoolers in homes of a foster parent who smokes.
Ottawa-Carleton	<ul style="list-style-type: none"> • Restricts smoking in the workplace and residential facilities, but does not include foster homes. • Restricts smoking in vehicles in the presence of children.
Halton	<ul style="list-style-type: none"> • Foster parents are not permitted to smoke in homes (must go outside) where there are children of any age. • Children under the age of five are placed in non-smoking homes exclusively. • Restricts smoking in vehicles in the presence of children. • All residential programs, and the properties owned and used by them, are declared smoke-free.
St. Thomas & Elgin	<ul style="list-style-type: none"> • No children under the age of five are placed in homes where smoking is allowed. • Children with medical conditions that are affected by exposure to SHS, and children that are medically fragile, are not placed in homes where smoking is allowed. • Staff, volunteers and foster parents are asked not to smoke in the presence of children. • Restricts smoking in vehicles in the presence of children.
Oxford County	<ul style="list-style-type: none"> • Children under the age of five are placed in non-smoking homes only (this policy is currently being amended to include children up to the age of 10). • For children over the age of five, caregivers must guarantee that there is no smoking allowed inside the home.

Appendix B Smoking Policy for Halton Region Children’s Aid Society – 2004

The Children’s Aid Society is concerned for the health, safety and welfare of all children in care who may be harmed due to exposure to second-hand smoke, therefore:

- Any child suffering from a medical condition exacerbated by smoke will be placed with non-smoking foster parents.
- Children under the age of five years will be placed with non-smoking foster parents.
- Non-smoking foster parents and smoke-free environments will be considered as one of the criteria considered for approval of a foster home. Moving to another room or opening a window will not meet the criteria of a smoke-free environment.
- No staff or agents of the Society, including foster care providers, may smoke in their vehicles while transporting children in the care of the Society.
- Foster care providers will not provide tobacco products to children under 19 years of age, and will not permit children to smoke in foster homes.
- There may be situations regarding availability of foster care beds that may create exceptions to this policy. Children placed in these situations due to resource availability must be reviewed and approved by the Resource Supervisor.
- All foster care providers, regardless of the age of the children placed in their care, will limit smoking to areas outside the immediate living environment of the children/youth in their care.

OMR