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Executive Summary

Secondhand smoke is a known human carcinogen. Exposure to this toxic poison is hazardous to all, but particularly to children, and even more so to children whose health is already compromised. Foster children, who suffer a disproportionate number of chronic health conditions, including a high prevalence of respiratory illness, are especially susceptible to the health hazards of secondhand smoke. As wards of the state, foster children are dependent upon local and state agencies to ensure that they reside in a safe, healthy foster home environment and that the state is fulfilling its legal responsibility and moral obligation to look after their best interests.

This issue brief examines policy options for providing a safe smoke-free environment for foster children — both in foster homes and in vehicles transporting foster children. It describes the risks of secondhand smoke to children in foster care, presents an overview of the foster care legal and regulatory system, and explores policy considerations and challenges in regulating smoke-free foster homes. It then examines smoke-free foster care legislation around the U.S. and key components in regulating smoke-free foster care facilities. Finally, it presents several policy options for jurisdictions considering smoke-free requirements for foster care homes.
Introduction

Since 1964, thirty Surgeon General’s reports have documented with numbing regularity the devastating health effects of smoking, as well as the growing medical evidence that there is no safe level of exposure to tobacco smoke. The 2010 Surgeon General’s report presents a formidable compilation of scientific studies providing irrefutable proof of the health hazards of tobacco use and secondhand smoke exposure.¹ As a result of this research, a growing number of U.S. workplaces and other public places, as well as many multi-unit dwellings and even outdoor venues, are now smoke-free. Today, the one indoor space where adults, and above all children, are most exposed to secondhand smoke is the home.² Almost 60 percent of U.S. children aged 3 to 11 years — close to 22 million children — are exposed to secondhand smoke in their homes.³ Included in this statistic are many of the most vulnerable and victimized members of our society: children who reside in foster care.

More than 400,000 children live with foster families in the United States.⁴ These children face a disproportionate number of health-related challenges due to backgrounds that can include physical and emotional abuse, neglect, malnutrition, and in-utero alcohol or drug exposure. Approximately 80 percent of all foster children have at least one chronic medical condition, with serious respiratory illness highly common.⁵

At least twenty-one states protect children in foster care from the health hazards of secondhand smoke by prohibiting smoking in foster homes and motor vehicles transporting foster children. Many other states are considering similar laws or regulations that regulate smoking in foster care facilities and vehicles when children are in placement. In the meantime, however, thousands of foster children each year continue to be exposed to hazardous tobacco smoke — toxic chemicals proven to cause lung cancer and cardiac disease in nonsmokers, as well as severe asthma attacks, respiratory infections, and ear infections, particularly in the elderly, disabled and children. Tobacco smoke can cause serious health problems and exacerbate existing health conditions prevalent among foster children, which can in turn jeopardize their chances of reuniting with their birth families or extended family members or being placed with adoptive families.⁶

Public Health Rationale

Over the last several decades, the medical profession has exhaustively studied the direct health effects of exposure to secondhand smoke. The Surgeon General’s recent report not only validates earlier findings that there is no safe level of exposure to tobacco smoke, but presents a formidable scientific base — drawn from hundreds of medical studies — documenting the way in which mainstream and secondhand smoke exposure damages the human body and directly leads to chronic disease.⁷

Health Risks of Secondhand Smoke

Individuals who inhale cigarette smoke, whether directly or secondhand, breathe in more than 7,000 chemicals, hundreds of which are hazardous and at least sixty-nine of which are known to cause cancer.⁸ The complex chemical mixture of combustion compounds in tobacco smoke cause cardiovascular and pulmonary diseases. Even low levels of exposure to secondhand smoke lead to a rapid and sharp increase in the dysfunction and
inflammation of the lining of the blood vessels, thus impairing endothelial function, which can cause heart attacks and stroke.\textsuperscript{9}

Damage from tobacco smoke is immediate, which means the chemicals in secondhand smoke can reach the lungs quickly each time one inhales. Toxicants are carried in the bloodstream to every organ in the body, damaging blood vessels, and making blood more likely to clot, which can lead to heart attacks, strokes and even sudden death. The chemicals and toxicants in tobacco smoke also damage DNA, which can lead to cancer.\textsuperscript{10}

Chemicals in tobacco smoke cause inflammation and cell damage and can weaken the immune system and complicate the regulation of blood sugar levels, exacerbating health issues resulting from diabetes. These chemicals can also inflame the delicate lining of the lungs and cause permanent damage that reduces the ability of the lungs to exchange air efficiently and leads to chronic obstructive pulmonary disease, which includes emphysema and chronic bronchitis.\textsuperscript{11}

**Acute Health Risks to Children**

While the science is clear that exposure to secondhand smoke is harmful to adults and can trigger catastrophic health events, such as a heart attack or stroke, the physical effects of exposure to smoke can be particularly dangerous to infants and children, whose bodies are still developing. Children 3 to 11 years old who live in households with smokers have cotinine levels (a biological marker for secondhand smoke exposure) more than twice as high as nonsmoking adults.\textsuperscript{12} Moreover, exposure to secondhand smoke is even more hazardous for children with special health conditions.\textsuperscript{13}
The Surgeon General has cited hundreds of medical studies and reports proving the toxic effects of tobacco smoke on infants and children and including the following findings:

- Both babies whose mothers smoke while pregnant and babies who are exposed to secondhand smoke after birth are more likely to die from sudden infant death syndrome (SIDS) than babies who are not exposed to cigarette smoke.\(^{14}\)

- Secondhand smoke exposure causes acute potentially fatal respiratory tract infections, such as bronchitis and pneumonia, in infants and young children, and respiratory symptoms, including cough, phlegm, wheezing, and breathlessness, among school-aged children.\(^{15}\)

- Exposure to secondhand smoke causes children who have asthma to experience more frequent and severe attacks than children in non-smoker households.\(^{16}\)

- Children exposed to secondhand smoke are at increased risk for eye and ear infections and are more likely to need operations to insert ear tubes for drainage.\(^{17}\)

- Children living in smoking households are more likely than children in nonsmoking households to develop metabolic syndrome, a disorder associated with excess fat around the abdomen, which can lead to increased risk for type 2 diabetes, heart disease and stroke.\(^{18}\)

- Children who live in households with smokers have a greater risk of getting lung cancer during their lifetimes than children raised in a smoke-free environment.\(^{19}\) Even if children living with smokers do not immediately show physical effects of exposure to secondhand smoke, they may eventually develop cancer or other smoking-related chronic diseases, because the latency period between exposure to tobacco and onset of these diseases can be as long as thirty years.\(^{20}\)

- Children exposed to secondhand smoke are more likely than those in nonsmoking households to experience learning and behavioral problems\(^{21}\) and to become smokers in adolescence or adulthood.\(^{22}\)

The science is clear: secondhand smoke is a serious health hazard that causes premature death and disease in children and nonsmoking adults.\(^{23}\) Quite simply, there is no safe level of secondhand smoke exposure. And children are particularly vulnerable. “Every inhalation of tobacco smoke,” writes the Surgeon General, “exposes our children, our families, and our loved ones to dangerous chemicals that can damage their bodies and result in life-threatening diseases.”\(^{24}\)

**Toxic Litter and Fire Hazards**

Cigarette butts are not only poisonous, but can be fatal when ingested by children. The average cigarette contains from 9 to 30 milligrams of nicotine, while the average cigarette butt contains 0.1 to 1.5 milligrams.\(^{25}\) Ten milligrams of nicotine are lethal, and one to two milligrams are toxic to children.\(^{26}\) Thus, ingesting just one cigarette butt could be toxic to a child, and ingesting an entire cigarette could be lethal.\(^{27}\) Each year, poison control centers in the United States receive thousands of reports of potentially toxic exposures to tobacco products among children.\(^{28}\) These reports are often triggered by young children ingesting cigarettes, cigarette butts, and other tobacco products that they find around the house, in ashtrays, or in the garbage.\(^{29}\) One study has shown that the mean age of children involved in ingesting cigarette butts was just 12 months; 77 percent of the children were between the ages of 6 and 12 months.\(^{30}\)
In addition, fires started by lighted tobacco products — principally cigarettes, and often involving children — constitute the leading cause of fatal home fires in the United States.\(^{31}\) Home fires caused by cigarettes are responsible for more than $535 million in direct property damage, approximately 1,300 injuries, and over 500 deaths annually.\(^ {32}\) Each year, 300 children suffer from injuries resulting from smoking-caused fires.\(^ {33}\) Although the widespread use of fire-safe cigarette legislation has led to a decrease in the number of U.S. smoking-material fire deaths in recent years, reports still show that half of all U.S. home fires resulting from children playing with fire were started with tobacco products, including lighters and matches.\(^ {34}\)

## Thirdband Smoke

Not only are children exposed to acute health risks in their homes and in vehicles as a result of secondhand smoke, and to toxic litter and fire hazards from the presence of tobacco products in homes, but new research indicates that yet another danger lurks in smoker residences: the residual contamination that can linger on surfaces long after cigarettes have been extinguished.

Exposure to this invisible toxic brew of gases and particles (what has been coined “thirdband smoke”)\(^ {35}\) can also pose hazards to the health of children. Studies have shown that days, weeks and even months after a cigarette was smoked, harmful particulates remain on countertops, floors, upholstery, carpets, clothing and other surfaces and fabrics.\(^ {36}\) Even when smokers do not smoke indoors, their clothing, skin and hair can retain tobacco toxins which can be exhaled into the air for several minutes after a cigarette is extinguished.\(^ {37}\)

Infants and children are particularly susceptible to thirdband smoke exposure because of their immature respiratory and immune systems, lower metabolic capacity, and their tendencies to crawl and play on, breathe near, touch and mouth contaminated surfaces, such as floors and fabrics.\(^ {38}\) Moreover, their developing brains are particularly vulnerable to even low levels of toxins. As with low levels of lead exposure, low levels of tobacco-related carcinogens have been associated with cognitive deficits among children.\(^ {39}\)

Because the science of thirdband smoke is still emerging, more research is needed to establish links between thirdband smoke exposure and disease, and to quantify its risks to infants and children.\(^ {40}\) What is known, however, is that an environment where children are exposed to tobacco smoke is unsafe by any measure. Current heating, ventilating and air conditioning systems cannot control exposure to secondhand smoke or the potent carcinogens in thirdband smoke. As the American Society of Heating, Refrigeration and Air-Conditioning Engineers reported back in 2005, and reiterated in 2008: “[T]he only means of eliminating health risks associated with indoor exposure [to tobacco smoke] is to ban all smoking activity.”\(^ {41}\)
Foster Children and the State

Foster care is substitute care for children who can no longer live safely with their parents or guardians. Although the foster home is intended to be a temporary haven with the ultimate goal a permanent living arrangement (either back with the child’s biological family, or with an adoptive family or other planned placement), many foster children remain in foster care for years. During this time, for most of the more than 400,000 foster children in the U.S., the foster home is the safest and most stable environment in which they have ever lived.

The state (typically, child welfare agencies) is responsible for removing children from unsafe homes and is also responsible for ensuring that they are placed in safe, stable, nurturing, and healthy environments. These foster care environments include a variety of settings: family foster homes, foster homes of relatives (often called “relative placements” or “kinship care”), group homes, emergency shelters, residential facilities, child care institutions, and preadoptive homes. As discussed below, foster caretakers in each setting are required to comply with certain policies to ensure that the children’s foster home environment is safe and healthy. The overriding concern of the state and its agents is to protect the well-being of these children.

A Uniquely Vulnerable Population

In their short lives, many foster children and adolescents have already suffered years of adversity. Children are placed in foster care because of abuse, neglect or abandonment or parental problems such as illness (physical or psychological), incarceration, or alcohol/substance abuse. These children have often moved from one risky environment to another and are a uniquely vulnerable population. The American Academy of Pediatrics classifies them as children with special health care needs because of the high prevalence of chronic medical, developmental and mental health problems that typically precede placement. Nearly 40 percent of children placed in foster care are born prematurely and/or with low birth weight, two factors that increase the likelihood of medical problems and developmental delay. These infants and toddlers are involved in over one-third of all substantiated neglect reports and more than half of all substantiated medical neglect reports.

Approximately 80 percent of all foster children have at least one chronic medical condition, with nearly one-quarter having three or more chronic problems, such as diabetes, HIV, and tuberculosis. Numerous studies document the prevalence of serious respiratory illness among foster children. An oft-cited study of foster children from Oakland, California, revealed that 16 percent had asthma — about three times the national average for asthma. Given such grim statistics, foster placement can represent a lifeline for these vulnerable children, an opportunity to heal and grow in a safe and healthy environment — a chance for them to regain their childhood and thrive. If their foster care environment is neither safe nor healthy, foster children — victims once — will be victimized anew.

Wards of the State

Foster children are considered “wards of the state” (or, in some jurisdictions, “wards of the court”). The state, which thus assumes the role of legal guardian, has a legal obligation to protect foster children and to ensure that they reside in safe and healthy foster care environments. To meet this mandate, each state has foster care policies (often found
in state regulations or administrative laws or codes), as well as licensing requirements for many foster parents. A state agency, such as the department of social services, child and family services, or human services, typically oversees foster care programs and is responsible for enforcement activities. In some states, counties or private agencies are responsible for enforcement, and may set their own foster care placement policies. The federal Department of Health and Human Services monitors each state’s compliance with federal foster care requirements through, for example, Child and Family Services Reviews, Title IV-E Foster Care Eligibility Reviews, Adoption and Foster Care Analysis and Reporting System and Statewide Automated Child Welfare Information System Assessment Reviews. Moreover, Title IV-E of the Social Security Act, which governs the provision of foster care and adoption services for states receiving federal money to fund these programs, requires states to ensure that the child’s health and safety is “the paramount concern” throughout the placement.

The state and federal government typically cover medical costs for foster children. When foster children, either with or without chronic health conditions, are exposed to secondhand smoke, they are more likely to experience medical needs that result in additional costs to the government. According to a study published by the Society of Actuaries, the total annual economic cost of secondhand smoke exposure in the U.S. is over $5 billion in direct medical costs and over $5 billion in indirect costs. When foster children reside in environments where their health is compromised by exposure to secondhand smoke, the state’s health care costs for tobacco-related medical conditions will almost certainly rise. These medical costs are only likely to continue as these children age out of the foster care system and become adults.

The American Academy of Pediatrics classifies foster children as having special health care needs because of the high prevalence of chronic medical, developmental and mental health problems that typically precede placement.
In light of the government’s duty to ensure a safe foster care environment and the vast body of scientific evidence on the health hazards of exposure to secondhand smoke, many states and local communities have either passed, or are considering passing, laws or regulations to protect foster children by prohibiting smoking in foster care homes or vehicles when foster children are being transported. In addition, a number of states have passed, or are considering, legislation prohibiting smoking in private cars when any child is present.  

Legal Authority

The state has the legal authority, responsibility and moral obligation to protect the health, safety and welfare of its youngest residents, and a special duty to protect those children in its charge.

Duty to Protect the Child

Under the legal doctrine of parens patriae, the state acts as the “ultimate parent” of children under its jurisdiction, and can exert its legal authority to ensure that their best interests are met. Family, juvenile and trial courts, applying the “best interest of the child” standard in custody cases, have been increasingly willing to take judicial notice of the negative impact of secondhand smoke exposure on children, especially when the child suffers illnesses exacerbated by secondhand smoke. As a result, more non-smoking parents are asking the courts to grant them custody, and are being granted custody, based on a child’s likelihood of harm in being exposed to secondhand smoke when in the smoking parent’s care.

Duty to Protect the Foster Child

The state (or county or related agency acting on behalf of the state) is legally responsible for protecting the interests and welfare of the foster child and ensuring that the child’s best interests guide placement decisions. As the child’s legal guardian, the state (and local) government has the authority to require foster parents to meet certain standards to retain a foster care license and/or custody of a foster child.

Foster parents also are legally obligated to protect their foster children from harm. To obtain a license, for example, foster parents enter freely into an agreement to care for the health and safety of a child and to abide by state regulations, some of which dictate behavior within the home. In exchange, foster parents receive financial compensation from the state. Whether a smoke-free policy is a licensing rule or a child placement regulation or preference, it is similar to dozens of other health and safety requirements that foster parents must meet to be certified and entrusted with the welfare of a child. These requirements include, for example, compliance with fire, health, building and zoning codes, emergency evacuation routes, pet restrictions, capacity limitations, food and safety rules, drug and alcohol strictures, and physical environment regulations, including those prohibiting exposure to hazardous chemicals or substances, such as paint lead, radon, and asbestos. Secondhand smoke, which has been classified as a “known human carcinogen” by the U.S. Environmental Protection Agency, the U.S. National Toxicology Program, and the International Agency for Research, is clearly a hazardous substance as well.
Legal and Political Considerations

Opponents to legislation restricting smoking in foster care homes occasionally express concerns that the requirement will violate privacy rights, pose enforcement problems or reduce the number of foster parents in the state. Below are a few of the most common legal and political issues raised.

Privacy and Autonomy

No Constitutional Right to Smoke

Some opponents to smoke-free legislation may contend that a proposed law violates their constitutional right to privacy under the Due Process Clause of the Fourteenth Amendment. The overall argument that smoke-free policies infringe on one’s privacy can be easily debunked. Smoking is not a specially protected liberty interest under the Due Process Clause. Moreover, smokers are not a specially protected category of people under the Equal Protection Clause. The constitutional right to privacy simply does not extend to smoking. State and local governments have the authority to pass smoke-free laws and policies if they are “rationally related to a legitimate government goal.”

Best Interest of Child Trumps Right to Privacy

The privacy argument may resonate with some foster parents — particularly kinship foster parents — who may argue that a smoke-free foster home policy is invasive and represents government interference with activities that occur within a private residence. While it is true that both parents and foster parents have a right of privacy, especially in the home, and significant autonomy in raising children free of government interference, these rights do not outweigh the best interests of the child. Moreover, foster parents are obliged to comply with site visits, inspections, and other policy restrictions on their autonomy and privacy, since the state is ultimate legal guardian of the child and has both the authority and obligation to take necessary measures to ensure the health and well-being of foster children. Finally, as mentioned earlier, a growing number of legislatures have exercised their authority to protect public health and safety by passing laws prohibiting smoking in vehicles when any child is a passenger. When an important public interest is at stake, the government has the power to regulate private conduct. The right to privacy is not absolute.

No Cessation Requirement

Some opponents to smoke-free foster care policies raise objections based on the fear that these policies prohibit foster parents from using tobacco products at all and essentially ban adults who smoke from serving as foster parents. This is a misunderstanding of these policies, which are about protecting children, not mandating smoking cessation. Foster parents are not prohibited from smoking altogether — simply from exposing the children under their charge to secondhand smoke.

Enforceability

Routine Compliance Checks

In the approximately eighteen states with smoke-free foster care policies, the methods of enforcement vary slightly; still, the basic process is the same as it is for all foster parent
requirements. Most licensed foster homes are already heavily regulated and monitored. As part of the licensing process, prospective foster parents are provided information about policies, including the smoke-free requirement, and sign contracts agreeing to comply with these policies. Social services administration personnel (caseworkers and licensing staff) conduct home visits with both foster children and foster parents on a regular basis to monitor and oversee compliance with licensing requirements. In addition, child protection workers visit many foster homes, and are expected to report apparent violations to licensing staff.

When smoking is suspected or observed during a visit, or social service personnel receive complaints about smoking on the premises, the social service workers typically discuss the situation, review the policy and revisit the compliance plan with the foster caretakers. Social service personnel are not required to conduct any additional or cumbersome tests to ensure adherence to the smoke-free policy. Monitoring compliance might be achieved by simply smelling tobacco smoke or observing tobacco products in a foster home when checking on other requirements. Repeated violations can result in investigations, reprimands, citations or other notices of violation, with the ultimate penalty for ongoing certification violations, the possible removal of children from the home and loss of foster care status.
Some opponents to smoke-free foster care proposals contend that monitoring compliance will be difficult, if not impossible, to enforce—particularly since home visits are typically scheduled in advance and foster parents can thus eliminate much evidence of smoking prior to visits. The underlying assumption here is that many foster parents would be willing to violate an agreement with a state agency and jeopardize the health of their foster children and their foster family status rather than comply with a smoke-free policy.

Based on recent informal interviews with foster care managers in fifteen states with legislation or regulations prohibiting smoking in both licensed and kinship foster homes, this assumption has not borne out. In most states, few complaints were heard after the policies took place. In the states that initially reported complaints from foster care parents, education and relationship-building helped address their concerns. States reported that smoking foster parents have complied with smoke-free policies without any major problems. Although the survey did not specifically ask if any foster provider’s license was terminated or children removed from a home due to smoking violations, none of the states reported that this occurred. Moreover, many states offer alternatives to such drastic measures. In some states, for example, the few reports of smoke-free foster home violations led to “working agreements,” where caseworkers and foster parents devised plans for where and when the foster parents would smoke so as to prevent the foster child’s exposure to secondhand smoke in the future.

Interestingly, states with strong smoke-free laws in effect that predated the foster care policies found that the decreased rate of smokers in the general population, and the general social norm of smoking outside, appeared to increase overall acceptance of the foster care policy and compliance. Their experiences might be of interest to states considering regulatory options for their own smoke-free foster care policies.

Limited Value of Voluntary Measures

Public health advocates often employ educational campaigns and voluntary measures when insufficient evidence exists to compel legislative action. Given the overwhelming medical evidence of the hazards of secondhand smoke and the health benefits of smoke-free environments, the trend—not just nationally, but internationally—has been to pass laws and regulations with enforcement provisions. For example, the official guidelines for the implementation of the Framework Convention on Tobacco Control, ratified unanimously by over 180 nations, clearly state that “Protection from exposure to tobacco smoke requires the full backing of the law.” Since foster children are wards of the state, legislators have a heightened duty to protect them from being involuntarily exposed to hazardous tobacco smoke, and to do this in the most effective way possible. A smoke-free foster care requirement, with sanctions and other consequences if violated, will result in higher rates of compliance and greater protection for children than self-regulatory or voluntary measures.

Effect on Foster Parent Recruitment and Retention

No Decline in Foster Parents

Another concern raised about smoke-free foster home policies is that they could have a deterrent effect on the recruitment or retention of foster parents. Due to the chronic need for qualified foster parents in the U.S., any decrease in the number of foster parents available to care for children could result in more children remaining in institutional settings. Opponents often argue that the smoke-free policy poses a dilemma: Provide a needy child a life-changing opportunity with an otherwise qualified foster parent who smokes vs. consign a needy child
to an institutional environment indefinitely. This choice misrepresents both the issue and the policy at hand. As noted earlier, smoke-free foster care policies do not prohibit foster parents from smoking — only from exposing foster children to the hazards of tobacco smoke. Moreover, despite the concern that implementing these policies would impair recruitment or reduce the number of foster homes available, foster care managers and social service administrators in states with these policies reported no drop in the number of foster parents attributable to the smoke-free policies since they took effect. Three out of the fifteen state managers surveyed claim their state recruitment numbers vary, but none reported a causal link to the smoke-free foster care policy.

Michigan’s Study on Foster Parents and Secondhand Smoke

That a smoke-free foster care policy might affect the recruitment of foster caregivers is a genuine concern, however — even though this concern is largely speculative, analogous to unreliable predictions about the economic impact of smoke-free laws on bars and restaurants. One state that has attempted to assess the possible impact of a smoke-free foster care policy on foster homes is Michigan. Back in 2006, under state legislative mandate, the Michigan Department of Human Services conducted a study to determine the number of foster parents in the state who smoke and to assess how a smoke-free regulation might affect the foster care community.

Based on this survey, the Department concluded that, in 2006, over 4,000 Michigan foster children resided in households where adults smoked. The resulting health problems of these children were significant, with annual health care costs for tobacco-related conditions estimated to be between $1.7 and $3.7 million. The survey asked participants whether they would still be foster parents if they were required (1) not to smoke around children, or (2) not to smoke anywhere, even when children were not present. In response to the first question, 95.6 percent of the respondents said they would still be foster parents. If foster parents actually carried through with this, it might result in a loss of 4 percent of foster parents. In response to the second question, 92 percent of survey respondents said they would still be foster parents even if they were required not to smoke at all. This might result in a loss of 8 percent.

Although suggestive, these findings remain speculative and are unlikely to be a reliable predictor of how foster parents in a given jurisdiction will respond to a nonsmoking foster home policy when presented with information about the health hazards of secondhand smoke, the impact on children, and related tobacco control and cessation resources.

Public and Professional Support

Over the last ten years, support for smoke-free environments has grown exponentially. By November 2012, 24 states, 547 municipalities, 2 territories and the District of Columbia had strong 100 percent smoke-free workplace, restaurant and bar laws in effect, protecting almost half the U.S. population. The movement toward more comprehensive smoke-free measures reflects a national decline of 15 percent in adult smoking prevalence since 1999. In some states, this decline has been much greater. In Minnesota, for example, adult smoking prevalence decreased 27.1 percent — from 22.1 percent in 1999 to 16.1 percent in 2010. In addition, over the same period in Minnesota, a far higher percentage of adults reported that smoking was restricted in their homes (87.2 percent in 2010 versus 64.5 percent in 1999), and adults were less likely to report exposure to secondhand smoke (45.6 percent in
2010 versus 67.2 percent in 1999). Public awareness of the health risks of smoking and exposure to secondhand smoke is definitely having an impact on the number of people who smoke in their homes.

Several years ago, most statewide smoke-free laws exempted private residences. Over the last five years, as it has become more legally, politically and socially unacceptable to smoke indoors and as the hazards of secondhand smoke have become widely known, communities have begun to extend their smoke-free measures to cover previously exempt areas, such as campuses, casinos, some outdoor venues (like parks, playgrounds and beaches), commercial day care centers, vehicles in which children are transported, and a growing number of residential settings. These settings include college dormitories, nursing homes, common interest communities (including public housing, condominiums and townships), residential healthcare facilities, correctional facilities, licensed residential facilities for children, and foster homes.

Although no formal polling has been conducted of foster parents, states where smoke-free foster care policies are in place report widespread compliance with the policies in the foster care community. Moreover, the National Foster Parent Association, a non-profit volunteer organization organized in 1972 that represents thousands of foster families nationwide through foster parent affiliates, strongly endorses smoke-free foster care policies. Its website prominently posts its position statement on smoke-free policies:

"Therefore, be it resolved that the National Foster Parent Association supports legislation and other rules that prohibit the use of tobacco in foster or kinship homes and in vehicles while transporting a child in foster or kinship care."

The movement toward more comprehensive smoke-free measures reflects a national decline of 15 percent in adult smoking prevalence since 1999.
Smoke-free Foster Care Policies in Effect

By late 2012, at least twenty-one states had passed laws or regulations regulating smoking in foster care homes: Alaska, Arizona, Colorado, Illinois, Iowa, Kansas, Maine, Maryland, Montana, New Jersey, North Dakota, Oklahoma, Oregon, Pennsylvania, Texas, Vermont, Washington, and Wyoming. The table in Appendix A summarizes state smoke-free foster care regulations in effect as of December 2012. Three of these policies are in statutes (i.e., “clean indoor air acts”) and the rest are in administrative codes and regulations.

State and Local Authority to Protect Public Health

States have legal authority to pass smoke-free laws by virtue of the Tenth Amendment to the U.S. Constitution, which confers on state governments “police powers” to make laws and regulations intended to improve “morbidity and mortality” (that is, promote the public health and welfare) of the population. All states, to one extent or another, delegate these powers to local governments: counties, parishes, cities, towns or villages. Thus, if a state’s law does not preempt local governments from passing smoke-free laws or regulations that are more stringent than the state law, these governments typically have the authority to pass stronger policies in their jurisdictions. Similarly, if a state’s law is not preemptive and the state has yet to pass a smoke-free law, local governments may exercise their authority to enact smoke-free policies of their own.

Several communities in states without a broad smoke-free foster care law have enacted local smoke-free foster home policies. In California, for example, three of the state’s largest counties (Monterey, San Luis Obispo and Santa Cruz) have passed policies requiring smoke-free foster homes. In Minnesota, a growing number of counties have implemented smoke-free foster home policies.

Key Policy Components

Below is a summary of policy elements found in current U.S. smoke-free foster home policies.

Definitions. At least three states have clean indoor air acts with statutory definitions that include “foster homes” under “public place” or “place of employment.” In Oklahoma, for example, the state’s Smoking in Public Places and Indoor Workplaces Act exempts “child care facilities” from the definition of “private residence” and includes them under the definition of “public places” and “work places.” Under Oklahoma’s Child Care Facilities Act, a “child care facility” includes “foster family home.”

Coverage. Some policies are less explicit than others when describing when or where foster parents may smoke or what “exposing foster children to tobacco smoke” means. North Dakota, for example, prohibits smoking in the foster home “in circumstances which present a hazard to the health of a foster child.” All but two states prohibit smoking both in the foster home and in vehicles where foster children are transported. In addition, four states explicitly prohibit smoking outside, but near the foster home. Outdoor smoking is allowed “when no child in placement is present” or “away from children” but not in a child’s presence or “within 10 feet of a child in foster care” or “within 15 feet of entrances, exits, windows that open and ventilation intakes that serve an enclosed area where smoking is prohibited.” Maryland requires foster parents to “provide an environment for foster children free from exposure to secondhand smoke,” which arguably covers an outside range.

Grandfathering. Wyoming is the only state with a policy that applies to foster parents licensed after the policy took effect. Foster care parents/providers at the time the policy was
enacted are “grandfathered” in and do not need to comply with the smoke-free requirement.\textsuperscript{115}

**Tribal exemptions for Native Americans.**
Some states, such as Illinois, Montana and Washington, contain exemptions for traditional or Native American ceremonies involving the use of tobacco.\textsuperscript{116}

**No smoking during limited child absences.**
Both Maine and Kansas prohibit smoking within the family foster home whether the child is on the premises or not.\textsuperscript{117} Maine also requires no smoking in the home or vehicle when a child is absent from the foster home and expected to return within 12 hours.

**Ventilation loophole.** Alaska permits smoking in well-ventilated areas away from the immediate living area, after the licensor approves a foster parent plan that addresses how children in care will be protected from secondhand smoke.\textsuperscript{118} Indiana allows smoking in rooms “where windows can be opened and/or air purifiers can be used,” restricting smoking to areas outside the “immediate living area” or child’s sleeping area, as long as it is not in the presence of foster children.\textsuperscript{119}

**No smoking by foster children.** Most policies explicitly or implicitly forbid foster children from using tobacco products in placement — provisions that echo state youth access laws.

**Experiences of Several States**

Each of the state smoke-free foster care policies cited in this brief has been in effect for at least a year. Eleven have been in effect for three or more years, and at least four have been in effect for one or two years. No formal studies have been released to date assessing the effectiveness of these policies, their impact on the foster care community, or effect on foster parent recruitment. Recently, however, a few agencies and organizations have conducted informal surveys to assess the experiences of jurisdictions with smoke-free foster care policies in place. One of these jurisdictions, as mentioned earlier, was Hennepin County, Minnesota.

Between December 2009 and October 2010, the Hennepin County Human Services and Public Health Department / Public Health Promotion in Minnesota conducted an informal survey of foster care managers in fifteen states with smoke-free foster care policies. The survey’s objective was to learn each state’s experiences once its foster care policy was enacted; the community’s overall reaction to the policy; whether states experienced a drop in the number of foster care parents once the smoke-free policy took effect; whether states experienced problems in recruiting foster parents as a result of the smoke-free policy; enforcement issues or problems; and general comments. The survey consisted of phone interviews of eight to ten open-ended questions.\textsuperscript{120}

The Hennepin County survey, though qualitative and limited in scope and methodology, does provide at least a snapshot of how states have fared, and how the foster care community has reacted, a year or more after smoke-free foster care policies took effect. Several states reported initial concern about anticipated opposition from foster parents, enforcement difficulties, and impact on the recruitment and retention of provider parents. Nevertheless, the consensus of survey respondents was that (1) implementing, enforcing and overseeing smoke-free foster home policies in each state ended up being straightforward and noncontroversial over time, and (2) the policies had no discernable impact on the recruitment or retention of foster parents.

On an even more informal basis, on June 3, 2010, the Tobacco Control Network posted a query on its website soliciting input from states on actions they have taken to restrict smoking in foster homes, and related information on their experiences following the implementation of any smoke-free laws and policies. Policy information from the limited responses to the TCN survey echoed much of the feedback from the Hennepin survey and is included in Appendix A.\textsuperscript{121}
Policy Considerations for Smoke-free Foster Care

State and local authorities have several options to consider when drafting a smoke-free foster home policy. Policy choices may be influenced by jurisdiction-specific laws and regulations, and the political context and climate. Some local communities, for example, may choose to pass their own smoke-free foster home policies, without waiting for state action (as long as these policies are not inconsistent with, or preempted by, state law). The following list of policy elements is intended for public health professionals, advocates and policymakers who are considering a smoke-free foster care law or regulation for their state or community.

Policy Planning

Background Research. A wealth of sound scientific research exists on both the dangers of secondhand smoke and the health and economic benefits of a smoke-free environment. Useful data on the number of foster families and foster children in a particular jurisdiction and related information on the health, and annual projected health care costs, of foster children is available through the U.S. Health and Human Services Administration’s Children’s Bureau, a good source of U.S. and state foster care statistics and related research. Other foster care resources include the National Resource Center for Permanency and Family Connections at the Hunter College School of Social Work, the Child Welfare Information Gateway, and the National Foster Parent Association.

Tobacco control and public health professionals, advocates, attorneys, and advocacy organizations like Americans for Nonsmokers’ Rights can provide insight on relevant smoke-free policy initiatives, as well as pending smoke-free foster care legislation. Foster care community information is best obtained from foster care and social services personnel — both local and state agencies — and from states with smoke-free foster care policies in effect.

Clarifying the Policy Goal. “Findings” is a legal term for brief statements of fact or statistics that outline an issue, support the need for a policy, and help clarify the policy goal. Regardless of whether findings are included in a smoke-free foster care regulation or law, the policy goal should be clear: to prevent children’s exposure to tobacco smoke. The policy focus should also be just as clear: the health benefits of smoke-free environments, the legal duty of the state to protect the children in its care, and the state’s legal obligation to ensure that the best interest of the child is paramount in any licensing or foster care setting.

For some foster parents, the objective of a smoke-free policy may be unclear. They may see such a requirement as an unnecessary imposition by the state, another in a long list of mandates for caregivers. Anticipate concerns, including the legal and political issues described earlier, prepare an educational campaign, and be willing to discuss the policy’s public health rationale with key stakeholders and the foster care community.

Policy Drafting

Concise Definitions and Language. Defining important terms clearly and consistently helps ensure that a policy is interpreted easily, and implemented and enforced effectively. Avoid language that allows caregivers to determine whether tobacco smoke on the premises presents a hazard to the child or that allows smoking within certain areas of the foster home. Note that requiring an environment “free from
exposure to secondhand smoke,” makes the foster parents responsible for ensuring that no smoking occurs in the foster home, a vehicle transporting a foster child, or the immediate vicinity of the child.

**Well-planned Enforcement and Implementation Process.** State agencies and other licensing authorities often make efforts to ensure that infants and children with health problems, including asthma and other respiratory difficulties, are not placed in foster homes where smokers reside. While a smoke-free foster home policy would appear the next logical step, some policymakers may propose a more gradual transition, with existing foster parents “grandfathered” in at the time the policy was enacted, and thus not subject to the smoke-free requirement. The problem with such a provision is that it sets up two classes of foster children — those who receive immediate protection from secondhand smoke, and those who do not. A strong argument can be made that all foster children, regardless of when their foster parents were licensed or otherwise certified, deserve a safe and smoke-free home environment.

**Education and Training.** Many states with smoke-free foster care regulations hold trainings for prospective and current foster parents, social service and child protection workers, and related personnel, that cover the health risks of tobacco and exposure to secondhand and thirdhand smoke and the benefits of a smoke-free foster care policy. Tobacco control professionals at the local and state health departments and local advocates can be sources of useful information.

While all parents could benefit from this type of training, authorities might want to consider making a special educational outreach to kinship caregivers. Compared with nonkinship foster parents, research has found that kinship caregivers are less likely to request or receive foster parent training, educational or mental health assessments, individual or group counseling, or tutoring for the children in their care. These providers also receive less information and supervision from the child welfare agency. Moreover, based on reports from states with smoke-free foster policies, kinship caregivers tend to be the providers in the foster community with the most questions and initial concerns about a smoke-free policy and what they perceive as an intrusion on their private lives.

Also, foster children are often exposed to secondhand smoke on visits with birth parents and other relatives. Because of this, states could consider including birth parents and relatives of foster children in any educational initiatives on the hazards of secondhand smoke.

Authorities might want to adopt a positive, nonjudgmental approach in trainings and educational literature and ensure that the information they provide focuses on what the policy will and will not do. They might emphasize, for example, that the policy will not prevent foster parents from smoking or require that they stop smoking altogether. It will not interfere with the state’s policy goal or legal mandate to reunite families. It will not violate the constitutional privacy rights of foster parents. It will not pose an additional burden on licensing personnel to monitor compliance. Also, based on the experience of communities where these policies are in effect, it will not reduce the number of foster parents in the jurisdiction.

**Tobacco Cessation Services and Resources.** In training sessions and regular interactions with foster parents, some agencies have considered promoting tobacco quitlines directly to foster parents or offering low- or no-cost nicotine replacement therapy services to help smokers who reside in foster homes quit smoking. At the very least, agencies should provide current and prospective foster parents with information about tobacco cessation services and resources.
Conclusion

The scientific debate about the risks of secondhand smoke ended years ago. Medical studies have exhaustively detailed the ways exposure to secondhand smoke damages the human body and directly leads to chronic disease, such as cancer, heart disease and stroke. Research has proven that children are especially susceptible to the toxic chemicals in tobacco smoke, and that children whose health may already be compromised, such as the vast majority of foster children, are disproportionately affected by exposure to secondhand smoke.

At a time when close to half of the U.S. population is covered by local and state laws prohibiting smoking in workplaces, bars and restaurants, more than thirty states still allow foster parents to expose foster children — a uniquely vulnerable population — to the hazards of tobacco smoke. The state, as the legal guardian of foster children, has a legal and moral obligation to act in their best interests. These children were removed from their homes for their health and safety. A smoke-free foster care policy will help ensure that their best interests are being met, and their welfare not jeopardized anew, in the “safe haven” of a foster home.
## Appendix A. Overview of U.S. Smoke-Free Foster Care Regulations

<table>
<thead>
<tr>
<th>State</th>
<th>Law or policy</th>
<th>No smoking</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Alaska</td>
<td>ALASKA ADMIN. CODE tit. 7 § 10.1085 (2007)</td>
<td>✔</td>
<td>Allows smoking in well-ventilated areas away from immediate living area, after department approves foster parent plan that addresses how children in care will be protected from smoke.</td>
</tr>
<tr>
<td>Arizona</td>
<td>ARIZ. ADMIN. CODE § 6-5-7465(K) (2006)</td>
<td>✔</td>
<td>Prohibits licensed foster parents from exposing foster children to tobacco products or smoke (which implies enclosed areas such as cars), allowing “any person” to use tobacco products within buildings with foster child, and allowing foster child to use or possess tobacco products.</td>
</tr>
<tr>
<td>Arkansas</td>
<td>ARK. ADMIN. CODE 016.15.3-5 (Amended Aug. 12, 2012)</td>
<td>Rebuttable presumption</td>
<td>Division of Children &amp; Family Services (DCFS) policy is that second-hand smoke is detrimental to a child’s health and the presumption is that it is not in a child’s best interest to be placed in a foster home that permits smoking in the presence of a child in foster care. To rebut this presumption, the worker must clearly identify why it is in the child’s best interest to be exposed to second-hand smoke. DCFS shall not place or permit a child in foster care to remain in any foster home if the foster parent smokes or allows anyone else to smoke in the presence of any child in foster care unless it is in the child’s best interest to be placed in or remain in the foster home.</td>
</tr>
<tr>
<td>Colorado</td>
<td>12 COLO. CODE REGS. §§ 2509-8:7.708.2, 7.708.21 (2007)</td>
<td>✔</td>
<td>Prohibits smoking inside foster home and in foster parents’ or substitute caregiver’s motor vehicle “at all times” when child is in placement.</td>
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<tr>
<td>Illinois</td>
<td>410 ILL. COMP. STAT. 82/10 (2010)</td>
<td><img src="https://example.com/checkmark" alt="" /> <img src="https://example.com/checkmark" alt="" /></td>
<td>Under Smoke Free Illinois Act, which prohibits smoking in public places and places of employment, “a home that provides foster care” is defined as both a public place and a place of employment. No smoking within 15 feet of entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited. Exemption for smoking associated with a native recognized religious ceremony, ritual, or activity by American Indians.</td>
</tr>
<tr>
<td>Kansas</td>
<td>KAN. ADMIN. REGS. § 28-4-816; 819 (2009); 27 KAN. REG. 326, 329 (March 13, 2008)</td>
<td><img src="https://example.com/checkmark" alt="" /> <img src="https://example.com/checkmark" alt="" /> <img src="https://example.com/checkmark" alt="" /></td>
<td>Prohibits smoking inside family foster home when foster child is in placement “whether the child is physically present on the premises or not.” Prohibits smoking by any member of the foster family outside the family foster home within 10 feet of a child in foster care. Foster parents must prohibit smoking or other tobacco use by foster children under age 18.</td>
</tr>
<tr>
<td>Maine</td>
<td>10-148 ME. CODE R. § 16 (2004)</td>
<td><img src="https://example.com/checkmark" alt="" /> <img src="https://example.com/checkmark" alt="" /> <img src="https://example.com/checkmark" alt="" /></td>
<td>Prohibits smoking when a foster child is absent from the foster home within 12 hours prior to the child’s expected return; also prohibits smoking in a foster parent’s motor vehicle within 12 hours prior to a foster child’s presence in the vehicle.</td>
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<td>State</td>
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<td>Mississippi</td>
<td>MISS. ADMIN. CODE 18-6-1:F-II (2012)</td>
<td>✔️</td>
<td>Smoking in the resource home or vehicle when the foster child is present is prohibited. Resource families will designate an area of the home for smoking where the foster child will not be present.</td>
</tr>
<tr>
<td>Montana</td>
<td>MONT. ADMIN. R. 37.51.825 (2006)</td>
<td>✔️</td>
<td>Foster parents must not provide tobacco products in any form to their foster children under the age of 18 and must not allow foster children to be exposed to secondhand smoke in “the foster parents’ home or vehicle.” Exemption for traditional or Native American ceremonies involving the use of tobacco.</td>
</tr>
<tr>
<td>New Jersey</td>
<td>N.J. ADMIN. CODE § 10:122C-7.2 (2004)</td>
<td>✔️ ✔️ ✔️</td>
<td>Foster parents shall prohibit smoking and the use of smokeless tobacco by children in placement. The foster parent shall prohibit any person from selling, giving, or furnishing tobacco products to a minor. The foster parent may permit smoking outdoors when no child in placement is present.</td>
</tr>
<tr>
<td>New Mexico</td>
<td>N.M. ADMIN. CODE 8.26.4 (2011)</td>
<td>✔️</td>
<td>Smoking is prohibited in the house and in any vehicle used for transporting foster children. A foster home license may be revoked or not renewed by the licensing agent at any time due to exposure of the child to cigarette smoke and tobacco products.</td>
</tr>
<tr>
<td>North Dakota</td>
<td>N.D. ADMIN. CODE 75-03-14-04 (2007)</td>
<td>✔️</td>
<td>No person may smoke in the foster home “in circumstances which present a hazard to the health of a foster child. All foster parents should be aware of the potential hazards of smoking in the presence of children, particularly infants and children with respiratory or allergic sensitivity.”</td>
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<tr>
<td>Oklahoma</td>
<td>OKLA. STAT. ANN. tit. 63, §§ 1-1521 et seq. (2007); OKLA. ADMIN. CODE § 340:110-5-60 (2007)</td>
<td>✔️</td>
<td>Under Oklahoma Child Care Facilities Act, definition of “child care facility” includes “foster family home.” The state’s Smoking in Public Places and Indoor Workplaces Act exempts child care facilities from definition of “private residence” and specifically defines them as “public places” and “work places.”</td>
</tr>
<tr>
<td>Oregon</td>
<td>OR. ADMIN R. 413-200-0335(2)(h) (2012)</td>
<td>✔️</td>
<td>A child or young adult cannot be exposed to any type of secondhand smoke in the certified family’s home or vehicle. No member of a foster household may provide any form of tobacco products to a child or young adult.</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>35 PA. STAT. §§ 637.1 to 637.11 (2008)</td>
<td>✔️</td>
<td>Pennsylvania’s Clean Indoor Air Act prohibits smoking in nearly all public places and work places in the state, including homes and vehicles of resource parents (foster care or pre-adoptive parents) when a child, 18 years of age or younger, is present. Child welfare agencies are charged with screening resource parents with the law in mind. Penalties for non-compliance include discontinuation of service as a resource parent, fines ($250) and incarceration.</td>
</tr>
<tr>
<td>Texas</td>
<td>40 TEX. ADMIN CODE § 749.2931 (2007)</td>
<td>✔️</td>
<td>Prohibits foster parents from exposing children to secondhand smoke in their homes and cars that transport a foster child. A foster child may not use or possess tobacco products.</td>
</tr>
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</table>
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Overview of U.S. Smoke-Free Foster Care Regulations

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<td>Vermont</td>
<td>VT. DEP’T. FOR CHILDREN AND FAMILIES, FAMILY SERVICES DIV., LICENSING REGULATIONS FOR FOSTER CARE 14 (No. 403) (2005)</td>
<td>✔️</td>
<td>“Foster parents shall ensure that children in the custody of the Department shall not be exposed to secondhand smoke in the foster parent’s home or vehicle.”</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Wy. Dep’t Family Services, Family Foster Care Foster Parent Responsibilities 7 (2007)</td>
<td>✔️</td>
<td>Foster parents should maintain a “smoke-free environment.” Prohibits smoking in any space connected to the home environment, including the garage, bathroom or house, and all motor vehicles transporting foster children. Exceptions may be granted for homes certified before 7/1/2006 by written approval of district manager.</td>
</tr>
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## Appendix A.
### Overview of U.S. Smoke-Free Foster Care Regulations
#### Policies Not Yet Codified

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<tbody>
<tr>
<td>Indiana</td>
<td>Letter from James W. Payne, Dir., Ind. Dep’t of Child Services to Reg’l Managers, Directors, Local Offices, Dep’t of Child Services (Oct. 1, 2009)</td>
<td>Inside home</td>
<td>Smoking limited to rooms where “windows can be opened and/or air purifiers can be used.” Smoking should not occur in immediate living area and cannot be done in presence of children under Dept. of Child Services care and supervision. Smoking prohibited in child’s sleeping area. No smoking in vehicles “while transporting children in DCS care and supervision.”</td>
</tr>
</tbody>
</table>
| New York | Letter from Nancy W. Martinez, Dir. Strategic Planning and Policy Dev., Office of Children & Family Services to Local District Commissioners, Executive Directors of Voluntary Agencies (June 18, 2004) | Inside home | NY State Office of Children & Family Services issued an Informational Letter in 2004 recommending that local agencies “review their current policy and practices concerning foster parents and foster children and the smoking of tobacco, if such a review has not been undertaken in the last few years. This review is recommended to support the good health of foster children residing in foster homes and to take necessary steps to avoid the dangers caused by a child smoking tobacco or being exposed to second-hand smoke. . . . It is not recommended that you establish any steps that are likely to reduce your cadre of foster parents to an insufficient level to meet your projected need for foster homes.”

Recommends against placing very young allergic and asthmatic foster children in homes where one or more of the residents smoke. If placement is in child’s best interest due to lack of alternative foster homes, the agencies should educate the foster parents about the potential dangers to the child.
Appendix B. Glossary

**Federal Foster Care Program:** Annually appropriated program authorized by Title IV-E of the Social Security Act, as amended, and implemented under the Code of Federal Regulations (CFR) at 45 CFR parts 1355, 1356, and 135, with specific eligibility requirements and fixed allowable uses of funds for foster parents.

**Foster care:** Twenty-four hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and preadoptive homes. A child is in foster care in accordance with this definition regardless of whether the foster care facility is licensed and payments are made by the State or local agency for the care of the child, whether adoption subsidy payments are being made prior to the finalization of an adoption, or whether there is Federal matching of any payments that are made. 45 C.F.R. § 1355.20 (2000)

**Foster family home:** To be eligible under Title IV-E of the Social Security Act (the Federal Foster Care Program), the home of an individual or family licensed or approved as meeting the standards established by the State licensing or approval authority (ies) (or with respect to foster family homes on or near Indian reservations, by the tribal licensing or approval authority (ies)), that provides 24-hour out-of-home care for children. The term may include group homes, agency operated boarding homes or other facilities licensed or approved for the purpose of providing foster care by the State agency responsible for approval or licensing of such facilities. Foster family homes that are approved must be held to the same standards as foster family homes that are licensed. 45 C.F.R. § 1355.20 (2000)

**Foster home:** Often referred to as “resource family home” (see below).

**Foster parent:** Also referred to as “provider parent” or “host parent.” Although this term is used in various contexts, it generally refers to adults who are licensed by the state or county to provide a temporary home for children whose birth parents are unable to care for them. These services may be provided with or without compensation, and can often continue for several months or even years, depending on the circumstances of the child and the foster parents.

**Resource family home:** Used by some states to refer to private residences, other than a children’s group home, treatment home, teaching family home, alternative care home or shelter home, in which board, lodging, care and temporary out-of-home placement services are provided by a resource family parent on a 24-hour basis to a child under the auspices of the state; it includes foster homes.

**Kinship care (or “relative care”):** The full-time care and nurturing of a child by someone who is related to a child by family ties or by a significant prior relationship connection. Each state defines “relative” differently, including relatives through blood, marriage, or adoption ranging from the first to the fifth degree. Generally, preference is given to the child’s grandparents, followed by aunts, uncles, adult siblings, and
cousins. For Indian children, six states allow members of the child’s tribe to be considered “extended family members” for placement purposes.

**Legal guardianship:** A judicially created relationship between child and caretaker, which is intended to be permanent and self-sustaining as evidenced by the transfer to the caretaker of the following parental rights with respect to the child: protection, education, care and control of the person, custody of the person, and decision-making. The term “legal guardian” means the caretaker in such a relationship. 45 C.F.R. § 1355.20 (2000)

**Parens patriae doctrine:** Latin for “parent of the nation.” Doctrine that grants the inherent power and authority of the state to protect persons (such as children) who are legally unable to act on their own behalf.
Appendix C. Select Resources

Foster Care Resources


National Resource Center for Permanency and Family Connections: A training, technical assistance, and information services organization that helps strengthen the capacity of state, local, tribal and other publicly administered or supported child welfare agencies to meet the needs of children, youth and families. http://www.hunter.cuny.edu/socwork/nrcfcpp/

Smoke-free Policy Resources

Americans for Nonsmokers’ Rights: Compilations of ongoing smoke-free legislative initiatives, smoke-free policy resources, and research studies on health hazards of secondhand smoke exposure. http://www.no-smoke.org/

Campaign for Tobacco-free Kids: Information on tobacco toll in terms of economic costs and health harm, specifically to children. http://tobaccofreekids.org/


State and Federal Laws


Endnotes


3 Id. at 140 (“based upon serum cotinine measures (tobacco smoke measures), approximately 22 million children aged 3 through 11 years, 18 million nonsmoking youth aged 12 through 19 years, and 86 million nonsmoking adults aged 20 or more years in the United States were exposed to secondhand smoke in 2000”). Id.


7 See 2010 SURGEON GENERAL REPORT, supra note 1.


10 See id. Nearly one-third of all cancer deaths each year are directly linked to smoking, with 85 percent of all lung cancers in the U.S. caused by smoking. Id.

11 Id.


14 Id.

15 Id. Each year, between 150,000 and 300,000 children younger than 18 months experience respiratory infections caused by secondhand smoke. CAL. ENVTL. PROT. AGENCY, HEALTH EFFECTS OF EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE (2005),http://oehha.ca.gov/air/environmental_tobacco/pdf/app32005.pdf (last visited Nov. 13, 2012).

CDC, Health Effects of Secondhand Smoke, supra note 13.

Kimberly Yolton et al., Exposure to Environmental Tobacco Smoke and Cognitive Abilities of U.S. Children and Adolescents, 113 Env. Health Persp. 92 (2005).


Michael Weitzman et al., Tobacco Smoke Exposure is Associated with the Metabolic Syndrome in Adolescents, 10 Circulation 1161 (2005).

Susan Olivo-Marston et al., Childhood Exposure to Secondhand Smoke and Functional Mannose Binding Lectin Polymorphisms are Associated with Increased Lung Cancer Risk, 18 Cancer Epidemiology, Biomarkers & Prevention 3375 (2009).


U.S. DEPT OF HEALTH & HUMAN SERVS., supra note 8, at iii.


See id.

Alvin Bronstein et al, 2008 Annual Report of the American Association of Poison Control Centers’ National Poison Data System, 47 Clinical Toxicology 911, 1039 (2009). In 2008, for example, the American Association of Poison Control Centers received 7,310 reports of potentially toxic exposures to tobacco products among children younger than six years of age in the U.S. Id.


Id.


Id. at i.


Jonathan P. Winickoff et al., Beliefs About the Health Effects of “Thirdhand” Smoke and Home Smoking Bans, 123 Pediatrics e74, e75 (2009).

Winickoff et al., supra note 35, at e74.


Winickoff et al., supra note 35, at e78.


45 C.F.R. § 1355.20 (2000) (Administration for Children and Families definition of “foster care”). Note that the term “foster care” may also be used to apply to adult foster care family homes, small group homes or large group homes. This brief is focused on foster care for children, although many of the issues raised apply to other residential settings as well.

See U.S. DEPT OF HEALTH & HUMAN SERVS, CHILD WELFARE INFORMATION GATEWAY, FOSTER CARE STATISTICS 3 (2010), available at http://www.childwelfare.gov/pubs/factsheets/foster.pdf. Approximately 29 percent of foster children spend from 24 months to over 5 years in placement, despite the Adoption and Safe Families Act of 1997, which recommends termination of parental rights and encourages adoption if a child has been in foster care for 15 out of the previous 22 months. Id. at 6.


Some states use the term “resource family” instead of “foster family.” See Appendix B.


Id.

See DHHS NATIONAL SURVEY OF CHILD AND ADOLESCENT WELL-BEING, supra note 5.

Dicker et al., supra note 49; see also Sandra Jee et al., Factors Associated with Chronic Conditions among Children in Foster Care, 17 J. HEALTH CARE POOR UNDERSERVED 328 (2006).

See Neal Halfon et al., Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child, 149 ARCHIVES OF PEDIATRIC & ADOLESCENT MEDICINE 386 (1995).
45 C.F.R. § 1355.20 (2000). Foster care is defined as "twenty-four-hour substitute care for children placed away from their parents or guardians and for whom the State Agency has placement and care responsibility." Id. (emphasis added).

See infra “Duty to Protect the Foster Child.”


Although all states must comply with federal regulations to receive Title IV-E funding, each state determines how services are provided to children in foster care. The structure of foster care systems varies from state to state, and often within states. Some have state-administered systems in which the state directly provides foster care services to children. Other states have county-administered systems in which the state retains responsibility for the safety and well-being of children in foster care, while counties provide the services. To make it even more complicated, some state and county-administered programs contract a portion of or all foster care services to private agencies.


See infra “Michigan’s Study on Foster Parents and Secondhand Smoke” (discussing Michigan’s assessment of health care costs for children in foster homes where parents smoke).

See Susan Weisman, Public Health Law Center, Kids, Cars and Cigarettes: Policy Options for Smoke-free Vehicles 9 (2010), available at http://publichealthlawcenter.org/sites/default/files/resources/phlc-policybrief-kidscarssmoke-2010_0.pdf. “Four states — Arkansas, Louisiana, California and Maine — and the Commonwealth of Puerto Rico prohibit smoking in private cars when children are present. . . . Several municipalities have also enacted policies and statewide legislation has been proposed, but not yet enacted, in at least 20 states, plus the District of Columbia.” Id. A growing number of countries have passed legislation requiring smoke-free cars for children, including South Africa, Cyprus, Tasmania, several Australian territories, and Canadian provinces and communities. Id.

See, e.g., Doe v. New York City Dep’t of Social Servs., 649 F.2d 134, 141—42, 145 (2d Cir. 1981) (finding that the state has an affirmative duty of care in overseeing a child in a foster home and analogizing the New York Department of Social Services’ failure to protect a foster child to a state prison’s failure to protect an inmate). But see DeShaney v. Winnebago County Dep’t of Social Services, 489 U.S. 189 (1989) (holding that a state’s failure to protect a child from private violence of which the county was aware was not a violation of the child’s rights under due process clause of the fourteenth amendment). Even after DeShaney, however, it is arguably proper to impose liability on the state for having acted affirmatively in placing foster children in homes in which they are later harmed. Such children are in the quasi-custody of the state if the state has continuing obligations to assess the quality of the foster home in which it placed them and to act to protect the children if its quality deteriorates. See, e.g., Garrett M. Smith, DeShaney v. Winnebago County: The Narrowing Scope of Constitutional Torts, 49 MD. L. REV. 484, 504 (1990).

See Weisman, supra note 60 at 8 (discussing “parens patriae” doctrine with respect to smoke-free vehicle legislation). The term “parens patriae” is Latin for “parent of the nation.”

See Dachille & Callahan, supra note 63.

45 C.F.R. § 1355.20 (2000). State and local governments have also implemented smoke-free policies for other “wards of the state,” such as prisoners. See, e.g., American Nonsmokers’ Rights Foundation, 100% Smoke-free Correctional Facilities Fact Sheet (2012), available at http://www.no-smoke.org/pdf/100smokefreeprisons.pdf.

Applicants must meet several state requirements, such as a minimum age; verification of income; a criminal background check at local, state and federal levels, including finger printing and no prior record of child abuse or neglect; medical certification to ensure all household members are free from diseases risky to children and in sufficient health to parent a child; and letters of reference. Most states also require classes and home visits as part of the foster parent application process. See, e.g., NATL FOSTER FAMILY ASS’N, http://www.nfpainc.org/. Also, foster care licensing applications typically inquire if the foster parent or other adults in the household smoke (in case of allergies). See Sample Foster Care Application, fosterparenting.com, http://www.fosterparenting.com/foster-care/application.html (last visited Nov. 13, 2012).


See Graff, supra note 70, at 2—5.


See Dachille & Callahan, supra note 63 at 1.

See Weisman, supra note 60.

See Graff, supra note 70 (discussing why smoking is not a specially protected liberty or privacy right). See also In re Julie Anne, 780 N.E.2d 635-36, 659 (Ohio Com. Pl. 2002) (holding that the fundamental right to privacy “does not include the right to inflict health-destructive secondhand smoke upon other persons, especially children who have no choice in the matter.”)

For example, foster parents could still smoke outdoors and in other locations apart from the foster home or vehicle when transporting a foster child.

Hennepin County (Minnesota) Human Servs. & Public Health Dep’t, Public Health Promotion, Effects of Other States’ Smoking Prohibitions on Child Foster Care (2011) [hereinafter Hennepin County Survey], available at http://www.hennepin.us/files/HennepinUS/HSPHD/Community%20Services/Public%20Health%20Promotion/Health%20at%20the%20Community%20Level/Report%20on%20Smoking%20in%20Child%20Foster%20Care%20Facilities.pdf. In 2010, fifteen states were surveyed out of sixteen states with smoke-free foster care legislation or regulations. Interviewers were unable to obtain an interview with a manager from the sixteenth state. Id. See infra “Experiences with Smoke-free Foster Care Policies.”

Hennepin County Survey, supra note 78, at 2-3.

Hennepin County Survey, supra note 78, at 7.
81 Hennepin County Survey, supra note 78, at 2-6.
82 Hennepin County Survey, supra note 78, at 3-4.
83 See id.; see also Margalit Weinblatt, Legal Resource Center for Tobacco Regulation, Litigation & Advocacy, University of Maryland School of Law, Written Testimony in Support of HB 661 (2008) (supporting Maryland’s smoke-free foster policy bill).
84 Id.
86 See id. at 11-13 (discussing key principles and recommendations regarding enforcement of smoke-free measures).
88 See Hennepin County Survey, supra note 78. No state managers said they were aware of problems in recruiting foster parents because of the smoke-free policy; two states indicated that there were more complaints about the smoke-free policy from kinship care providers than other providers, but the kinship care providers still complied with the policies. Id.
89 See id. Several respondents indicated the following factors could affect the availability of foster homes: economic pressures; more households where both parents are working; some high profile cases of foster parenting problems; and policy introduction at the same time other regulations were imposed (for example, window size and fenced areas), so they were unable to attribute any decline to the non-smoking policy alone. Id. See also Position Statement 122.07, Smoking & Secondhand Smoke, NAT’L FOSTER PARENT ASSN, http://www.nfpainc.org/Default.aspx?pageId=1020551#ps122.07 (last visited Nov. 13, 2012). (“There has been no diminution in the number of available placement homes in states that limit the use of tobacco products in their foster homes.”) Id.
90 See Americans for Nonsmokers’ Rights website, for information about predictions related to the adverse economic effect of smoke-free laws on businesses, such as local bars and restaurants, and subsequent peer-reviewed economic studies that prove these fears were largely unfounded. ANR, Economic Impact, http://www.no-smoke.org/getthefacts.php?id=14 (last visited Nov. 13, 2012).
92 Id. at 7. Findings also indicated that in 92 percent of the homes where one or more adults smoke, smoking was restricted. Id. at 52. For example, in 46 percent of the foster homes, smoking is not allowed anywhere in the home; in 45 percent, smoking is allowed only in some places inside the home or at certain times. Id. at 7. Thus, only 8.4 percent allow smoking anywhere inside the home at any time. Id.; see also Ctr. for Tobacco Regulation, Univ. of Maryland School of Law, Michigan Abstract: Secondhand Smoke and Foster Children in the State of Michigan (2007) (attachment to Testimony in Support of HB661).
93 See MICHIGAN DEPT OF HUMAN SERVS., supra note 91, at 6-7 (explaining methodology on assessment of costs and other statistical findings). Conditions considered tobacco-related included low birth weight, respiratory syncytial virus and bronchiolitis, acute otitis media, otitis media with effusion, asthma, and burns. Id. at 7.
Id. at 6 (asking “Would you still be a foster parent if not allowed to smoke around children?”). See table summarized below. Id. at vii.

<table>
<thead>
<tr>
<th>Overall Households</th>
<th>Yes %</th>
<th>No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-smoking</td>
<td>97.9</td>
<td>2.1</td>
</tr>
<tr>
<td>Smoking</td>
<td>85.6</td>
<td>14.4</td>
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</table>

<table>
<thead>
<tr>
<th>Licensed foster</th>
<th>Yes %</th>
<th>No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-smoking</td>
<td>95.7</td>
<td>4.3</td>
</tr>
<tr>
<td>Smoking</td>
<td>82.8</td>
<td>17.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relative care provider</th>
<th>Yes %</th>
<th>No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-smoking</td>
<td>96.9</td>
<td>3.1</td>
</tr>
<tr>
<td>Smoking</td>
<td>91.2</td>
<td>8.8</td>
</tr>
</tbody>
</table>


Id.

As of February 2011, at least twenty-three states prohibit smoking at all times in commercial child care centers, while eleven prohibit smoking only when children are on the premises.


For updated information on the status of smoke-free legislation, visit the Americans for Nonsmokers’ Rights website at www.no-smoke.org.

See Hennepin County Survey, supra note 78.


See Appendix A. Summary of U.S. Smoke-free Foster Care Regulations.

Statutes are state laws passed by the legislature. Administrative codes, rules and regulations have the force and effect of law; are enacted by an office or agency of the state under authority granted by the legislature; and often interpret the requirements of an office or agency.


See id. at 92.


OKLA. STAT. ANN. Tit. 21, § 1247 (2007).

111 N.D. ADMIN. CODE, 75-03-14-04 (2007).

112 North Dakota, N.D. ADMIN. CODE, 75-03-14-04 (2007) and Illinois, 410 ILL. COMP. STAT. 82/10 (2010).


114 See MD. CODE REGS. 07.02.25.08 (2008).


118 See ALASKA ADMIN. CODE tit. 7 § 10.1085 (2007).

119 See Letter from James W. Payne, Dir., Ind. Dep’t of Child Services to Reg’l Managers, Directors, Local Offices, Dep’t of Child Services (Oct. 1, 2009), available at http://www.in.gov/dcs/files/Smoking_in_ReSource_Homes.pdf.

120 See Hennepin County Survey, supra note 78.


123 See Appendix C. Select Resources.


125 See Foster Care Fact Sheets, NAT’L RESOURCE CENTER FOR PERMANENCY AND FAMILY CONNECTIONS.


130 Id.

131 See Hennepin County Survey, supra note 78; see also Smoke-free Foster Homes — 6/3/10, Tobacco Control Network, supra note 121.

132 Although, as mentioned earlier, the state cannot as a general rule compel parents not to expose their children to secondhand smoke in their homes, a growing number of courts have been willing to craft custody and visitation orders that protect children from smoke, especially if the child suffers from an illness exacerbated by secondhand smoke. See Dachille & Callahan, supra note 63.

133 See Smoke-free Foster Homes — 6/3/10, Tobacco Control Network, supra note 121.