American Academy of Pediatrics

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Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

Policy Statement—Tobacco Use: A Pediatric Disease

abstract

Tobacco use and secondhand tobacco-smoke (SHS) exposure are major national and international health concerns. Pediatricians and other clinicians who care for children are uniquely positioned to assist patients and families with tobacco-use prevention and treatment. Understanding the nature and extent of tobacco use and SHS exposure is an essential first step toward the goal of eliminating tobacco use and its consequences in the pediatric population. The next steps include counseling patients and family members to avoid SHS exposures or cease tobacco use; advocacy for policies that protect children from SHS exposure; and elimination of tobacco use in the media, public places, and homes. Three overarching principles of this policy can be identified: (1) there is no safe way to use tobacco; (2) there is no safe level or duration of exposure to SHS; and (3) the financial and political power of individuals, organizations, and government should be used to support tobacco control. Pediatricians are advised not to smoke or use tobacco; to make their homes, cars, and workplaces tobacco free; to consider tobacco control when making personal and professional decisions; to support and advocate for comprehensive tobacco control; and to advise parents and patients not to start using tobacco or to quit if they are already using tobacco. Prohibiting both tobacco advertising and the use of tobacco products in the media is recommended. Recommendations for eliminating SHS exposure and reducing tobacco use include attaining universal (1) smoke-free home, car, school, work, and play environments, both inside and outside, (2) treatment of tobacco use and dependence through employer, insurance, state, and federal supports, (3) implementation and enforcement of evidence-based tobacco-control measures in local, state, national, and international jurisdictions, and (4) financial and systems support for training in and research of effective ways to prevent and treat tobacco use and SHS exposure. Pediatricians, their staff and colleagues, and the American Academy of Pediatrics have key responsibilities in tobacco control to promote the health of children, adolescents, and young adults. *Pediatrics* 2009;124:1474–1487

COMMITTEE ON ENVIRONMENTAL HEALTH, COMMITTEE ON SUBSTANCE ABUSE, COMMITTEE ON ADOLESCENCE, AND COMMITTEE ON NATIVE AMERICAN CHILD HEALTH

KEY WORDS

tobacco, smoke, cigarette, environmental tobacco, nicotine, secondhand, smoke free, cigar, smokeless

ABBREVIATIONS

SHS—secondhand tobacco smoke
AAP—American Academy of Pediatrics
DoD—Department of Defense

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BACKGROUND

Tobacco use is the leading preventable cause of death and illness in the United States, causing more than 443 000 deaths each year.[1] The consequences of tobacco use include harms to the health of the fetus, such as low birth weight and sudden infant death; harms to children from tobacco use and secondhand tobacco-smoke (SHS) exposure, including respiratory illness, infection, and decreased lung function; the uptake and establishment of tobacco use and nicotine addiction by the

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next generation; fires attributable to smoking; the economic costs of purchasing tobacco and tobacco-use materials; litter and debris from tobacco products; additional cleaning and maintenance of facilities in which tobacco is used; the health care and emotional costs of diseases associated with tobacco use and SHS exposure; and the costs to families and society because of poor health and lost productivity.[2]

Most tobacco users (~80%) started using tobacco products before 18 years of age.[3] Initiation of tobacco use is often instigated by exposure to tobacco use by parents or peers, depiction in movies and other media, advertising targeting children and adolescents, and other environmental and cultural factors.[3–12] The connection between children and tobacco use is so strong that the commissioner of the US Food and Drug Administration declared tobacco use a "pediatric disease" in 1995.[13]

Tobacco use is a pediatric disease because of the extent of harms to children caused by tobacco use and SHS exposure, the relationship of pediatric tobacco use and exposure to adult tobacco use, the existence of effective interventions to reduce tobacco use,[14] and the documented underuse of those interventions.[15] This statement provides guidance for providers of pediatric services, including the American Academy of Pediatrics (AAP) and its members, and summarizes other AAP policies that have addressed tobacco use and control.

Because tobacco use has significant effects on children and families, its management has been reviewed in many AAP policies and official documents.[16–18] The information and recommendations described in this statement are consistent with recommendations in the other AAP publications cited as well as with tobacco policies from other clinical professional membership organizations, including the Academic Pediatric Association,[19] the American Academy of Allergy Asthma & Immunology,[20] the American Academy of Family Practice,[21] the American Academy of Pediatric Dentistry,[22] and the American Medical Association.[23,24] The policy is accompanied by 2 technical reports: "Secondhand and Prenatal Tobacco Smoke Exposure"[25] and "Tobacco as a Substance of Abuse."[26]

The AAP recognizes the dangers of tobacco use and SHS exposure to children's health. Tobacco control was named a strategic priority by the AAP in 2005, and the Julius B. Richmond Center of Excellence (www.aap.org/richmondcenter), dedicated to the elimination of children's exposure to tobacco and SHS, was established in 2007 to foster tobacco-control initiatives at the AAP.

TERMS USED AND THEIR DEFINITIONS

The term "tobacco" includes all smoked and smokeless forms. The term "tobacco control" refers to any and all aspects of efforts to reduce or eliminate tobacco use in any form, except ceremonial uses, where legal. The term "parent" is meant to include anyone acting in the role of parent, including legal guardians and foster parents. "Community" is used broadly and includes local-, city-, county-, state-, national-, and international-level groups and organizations.

THE ROLE OF PEDIATRICIANS IN TOBACCO CONTROL

Pediatricians have important roles in efforts to reduce family tobacco use and SHS exposure. In their practices, they can (1) provide counseling to expectant parents to quit using tobacco products and avoid SHS exposure during and after pregnancy, (2) assist new parents in their efforts to continue their tobacco use-abstinence or -cessation efforts after delivery, (3) counsel parents to prevent and eliminate children's exposure to SHS, (4) counsel preadolescents and adolescents to prevent initiation of tobacco use, and (5) counsel adolescents and parents to quit using tobacco. Important adjuncts to these efforts include quitlines and pharmacotherapies for tobacco-use cessation.[14,27,28] Quitlines (toll-free telephone-based tobacco use-cessation services that offer evidence-based information and counseling support, including referral of the tobacco user to his or her primary care provider for pharmacotherapies) are an effective way to deliver tobacco use-cessation services.[28] Quitlines are available throughout the United States, Canada, and many other countries. Pharmacotherapies approved for adult use, including nicotine-replacement products and medications such as varenicline and bupropion, are extremely effective in promoting tobacco-use cessation when used in conjunction with cessation counseling.[14]

AAP members are uniquely positioned to disseminate information about the effects of tobacco use and effective tobacco-control methods through their practices and other efforts. In addition to practice-based efforts in tobacco control, other roles for pediatricians include participating in community, advocacy, and media campaigns that inform the public of the harms of tobacco use, SHS exposure, and the risks of tobacco-use initiation; promoting treatment; and helping to enact and enforce laws and regulations that limit access to tobacco and promote tobacco control.

TOBACCO CONTROL AND PUBLIC POLICY

Legislative and regulatory efforts that have been effective in controlling and eliminating tobacco use include clean indoor-air legislation, taxes on tobacco products, restricting youth access to

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tobacco products, mass-media campaigns, tobacco-advertising restrictions, and comprehensive community interventions.[29] Interventions in single arenas have not been sufficient to achieve tobacco control. The most effective strategies use multiple interventions that target different aspects of tobacco control, including school-based programs, anti–tobacco-use advertisements, and enforcement of existing tobacco-control policies.[30] Many successful public-policy changes have begun with the efforts of individuals—including pediatricians—who initiated, supported, and led tobacco-control efforts in their practices, communities, professional organizations, and legislatures. A promising effort, supported by the AAP, is the recent federal law that grants the US Food and Drug Administration regulatory control over tobacco.

ECONOMICS OF TOBACCO USE AND SHS EXPOSURE

Tobacco use is costly, and the resulting harms are completely preventable. Health care costs attributable to tobacco use and SHS exposure are estimated to be in the billions of US dollars annually.[31–34] Other costs attributable to tobacco use and SHS exposure include loss of life and productivity,[35,36] income diverted to purchase tobacco-use materials,[37,38] and fires.[39–43] Treatments for tobacco use and dependence are among the most efficacious and cost-effective preventive services in both the short-term and long-term[2,14,44] and are second only to childhood immunization in terms of cost-effectiveness.[2,45–48]

THE TOBACCO INDUSTRY

The goal of the tobacco industry is profit, not health. Tobacco industry–sponsored research programs have been designed to gain an air of legitimacy and produce results favorable (or less unfavorable) to tobacco use.[49] The tobacco industry has attempted to present the evidence of harms from tobacco use and SHS exposure as "controversial."[50] Youth exposure to tobacco industry–sponsored prevention advertising does not prevent tobacco use, and industry-sponsored prevention programs that target parents may actually promote youth tobacco use.[51]

SOCIOECONOMICALLY DISADVANTAGED CHILDREN AND ADOLESCENTS

The prevalence of cigarette smoking is greatest among adults who live below the poverty line and those who have not completed high school[52]; accordingly, SHS exposure disproportionately affects children who live in low-income households.[52] Use of other forms of tobacco is similarly distributed according to income and education levels.[53] The costs associated with tobacco use exacerbate the health harms to children by decreasing available family funds while increasing the likelihood of poor health in their parents, which can lead to decreased family income[54] and stratification of tobacco use in the population that is least able to afford the consequences.[55]

TOBACCO USE AND PSYCHIATRIC AND SUBSTANCE USE DISORDERS

People with psychiatric and substance use disorders, including youth and young adults, are far more likely to use tobacco than those in the general population,[56–61] yet they are less likely to have a diagnosis of and receive treatment for nicotine addiction.[62–64] These people deserve treatment of their nicotine addiction and can successfully quit using tobacco.[14] Although people with psychiatric and substance use disorders are more likely to relapse in their tobacco-cessation efforts than the population at large, there is little evidence that nicotine withdrawal will escalate psychiatric symptoms.[14] One study of patients in a maximum-security forensic hospital showed a decrease in sick calls, total disruptive behavior, and verbal aggression after a smoking ban was implemented.[65] Several psychiatric facilities, including facilities for adolescents, have successfully eliminated tobacco use.[66,67] Because nicotine withdrawal may unmask psychiatric symptoms or disorders, this potential should be anticipated, and treatment of these symptoms or disorders should be considered an adjunct to treatment of tobacco use and dependence.[68]

TOBACCO AND ALASKA NATIVE AND AMERICAN INDIAN PEOPLE

Tobacco-use and smoking rates are highest among Alaska Native and American Indian people.[69–73] In addition to the high prevalence of smoking in these groups, the use of smokeless tobacco is common, even among adolescents and children.[74,75] Smokeless tobacco has been used by Alaska Native parents to calm their children while they are teething.[76] It is important to note that traditional ceremonial use of tobacco does not include smoking cigarettes, the use of smokeless tobacco, or the use of other commercial tobacco products.[70,77] Although traditional ceremonial uses of tobacco still play a role within many American Indian tribes, every effort should be made to prevent nontraditional uses.

TOBACCO USE AND MILITARY SERVICE

Historically, tobacco use and smoking have been accepted, even encouraged, by the military services. More recently, the US Department of Defense (DoD) took an active approach to reducing tobacco use by members of the military services. Subsidized sales of tobacco products were eliminated in 1996,[78] most DoD-operated facilities are smoke free (see DoD instruction No. 1010.15, January 2, 2001, for exceptions), and resources for tobacco-use

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prevention and cessation are widely available.[79] These and other efforts have contributed to a decline in cigarette use by military personnel from 51% (1980) to 32% (2005).[80] Despite these efforts, the prevalence of tobacco use remains higher in military personnel than in comparable civilian populations.

ORGANIZATION OF THE POLICY STATEMENT

Because of the effects of tobacco use on children and their families and the extent to which tobacco permeates our society, the recommendations in this policy statement are numerous and detailed. The recommendations to pediatricians address personal and professional behavior as well as clinical practices. The recommendations to government and policy makers include public actions needed to eliminate SHS exposure, support prevention and treatment of tobacco use and dependence, support control of tobacco product-distribution, and expand research. Three overarching principles can be identified: (1) there is no safe way to use tobacco; (2) there is no safe level or duration of exposure to SHS[81]; and (3) the financial and political power of individuals and organizations should be used to support tobacco control and eliminate tobacco use. Many AAP statements have tobacco-related content and provide additional detail on specific topics (Table 1), and additional resources are available (Table 2).

TABLE 1 AAP Policy Statements With Tobacco-Related Content

AAP Statement	URL
Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention and Management of Substance Abuse	www.pediatrics.org/cgi/content/full/115/3/816
Tobacco's Toll: Implications for the Pediatrician	www.pediatrics.org/cgi/content/full/107/4/794
Breastfeeding and the Use of Human Milk	www.pediatrics.org/cgi/content/full/115/2/496
Secondhand and Prenatal Tobacco Smoke Exposure	www.pediatrics.org/cgi/content/full/124/5/e1017
Tobacco as a Substance of Abuse	www.pediatrics.org/cgi/content/full/124/5/e1045
Health Care for Children and Adolescents in the Juvenile Correctional Care System	www.pediatrics.org/cgi/content/full/107/4/799
Indications for Management and Referral of Patients Involved in Substance Abuse	www.pediatrics.org/cgi/content/full/106/1/143
Health Supervision for Children With Sickle Cell Disease	www.pediatrics.org/cgi/content/full/109/3/526
Health Supervision for Children With Turner Syndrome	www.pediatrics.org/cgi/content/full/111/3/692
Sexual Orientation and Adolescents	http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/6/1827#R3#R3
Reducing the Number of Deaths and Injuries From Residential Fires	www.pediatrics.org/cgi/content/full/105/6/1355

RECOMMENDATIONS TO PEDIATRICIANS

1. Personal Behavior
   A. Maintain a tobacco-free environment at home, at work, at play, and in vehicles. Do not smoke or use tobacco in any way. Encourage family members and friends to do the same. Do not wear or display tobacco products, advertisements, or promotional items on your person or property.
   B. Consider tobacco control when making financial decisions. Support smoke-free restaurants, hotels, and other venues as well as print and electronic media companies that decline tobacco advertising. Review your personal financial holdings and divest or avoid tobacco stocks (Table 2).
2. Professional Behavior
   A. Patronize tobacco- and smoke-free venues. Hold conferences and meetings at smoke-free locations in smoke-free jurisdictions (Table 2).
   B. Support comprehensive tobacco control and prevention, education, and cessation programs and policies in schools and your community. Participate in education of community leaders and elected officials about tobacco control. Promote linkages among community resources and organizations related to tobacco control. Serve as a conduit for information about the harms of tobacco use and common challenges to prevention and cessation and as an advocate for tobacco control in your community. Be available to provide profes-

TABLE 2 Resources

Resource	URL
Listing of tobacco stocks	www.famri.org/tobacco_co_list/index.php
Smoke-free hotels	www.smokefreeaccommodations.com; www.freshstay.com/?gclid=CIPY_dr9j5QCFQuwGgodOhvMew; www.smoke-freehotels.com
Smoke-free jurisdictions	www.smokefreeworld.com
Pediatric clinical practice systems that support tobacco control	www.aap.org/richmondcenter
Tobacco-free magazines	www1.tobaccocme.com/PageReq?id=940:20998
Antitobacco messages to children	www.healthywomen.org/b2s/pg10.html
Coding for tobacco-related diagnoses and treatments	www.kidslivesmokefree.org/pdf/CodingCorner_AAPnewsarticle.pdf (AAP Coding Corner); www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf (*Treating Tobacco Use and Dependence: 2008 Update*)
Global strategies	www.who.int/tobacco/framework/en (World Health Organization Framework Convention on Tobacco Control)

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sional consultation for these programs. Advocate for community-based tobacco-use prevention and treatment services, including services in residential facilities (see Table 1 for related AAP policy statements with more extensive discussions of these facilities).

C. Support clean-air and smoke-free–environment ordinances and legislation in your community and state, particularly for environments in which children learn, live, and play, such as schools, multiunit housing, public parks, child care settings, public beaches, sidewalks, restaurants, and sporting arenas. These environments should be smoke free even when children are not present.

3. Clinical Practice

A. For the office, clinic, or hospital facility

i. Provide tobacco-free environments in all work settings, indoors and outdoors, and in all vehicles, including employees' vehicles used professionally or on work property. Enforce this policy. Some employers insist on no tobacco use by their employees during work hours and while performing official duties; some employers do not hire tobacco users.[82] Consider implementation of these or similar policies.

ii. Encourage and provide support for your employees' efforts to quit tobacco use, including fostering their use of prescription and nonprescription medications, counseling, and other evidence-based methods. When selecting a health insurer for employees, contract with one that provides tobacco-use and -dependence treatment benefits, including coverage for tobacco-use–cessation counseling.

iii. Use office systems that promote cessation and prevention of tobacco use. The most effective way to change clinical practice is to change the "system" of care delivery to one that promotes best practices in cessation and prevention of tobacco use. Resources that facilitate such office-systems changes are available (Table 2). One of the most important changes is to use paper or electronic health records that require documentation of tobacco use and SHS exposure status. This information should be readily available, easy to use, and easy to find. The use of cues to promote counseling in tobacco-use prevention and cessation in the clinical encounter is very effective.[14]

iv. Eliminate tobacco advertising from all materials associated with your clinical practice, including magazines and other media in patient care and waiting areas (Table 2).

v. Do not accept funding from the tobacco industry. The tobacco industry is defined as companies that support or engage in manufacturing, advertising, promotion, exportation, or importation of tobacco or tobacco products.

B. For patients and their family members

i. Ask about and document tobacco use and SHS exposure at all clinical encounters, including prenatal visits, nursery visits, and well- and sick-child visits, whether inpatient or outpatient. Include prenatal exposure as well as SHS exposure from in-home child care providers and family and other household members in these inquiries. Responses should be prominently recorded in the patient's record. This is more likely to be successful if all members of the staff are included in this effort.[14]

ii. Know the harms of tobacco use and SHS exposure and educate patients and their families about those harms.

a. Counsel children and parents about the harms of tobacco use and SHS exposure.

b. Include tobacco in all discussions of substances of abuse and risky behaviors. Discussion and anticipatory guidance about tobacco use should ideally begin by 5 years of age and emphasize resisting the influence of advertising and rehearsal of peer-refusal skills. Be aware of confidentiality issues related to tobacco use and other substance abuse, including testing for nicotine and its metabolites.

c. Encourage parents to start discussions of tobacco use with their children early in their life and continue to do so throughout childhood and adolescence; these discussions should include delivery of clear messages disapproving of tobacco use. Both parents and children should be counseled that

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it is not safe to "experiment" with tobacco, because nicotine is so highly addictive and there is no safe way to use tobacco. Tobacco dependence can begin almost as soon as use begins, with some users exhibiting signs of dependence with only occasional or monthly use.[83,84] As a result, prevention of tobacco use is one of the most important messages you can deliver.

d. When discussing safety, instruct parents and caregivers that cigarettes and other lighted tobacco products are the cause of a significant proportion of residential fires that result in fatalities. All smoking materials are dangerous and should be kept out of the reach of children.

iii. Advocate for tobacco-free homes, cars, schools, child care programs, playgrounds, and other venues.

a. Advise avoidance of SHS exposure and suggest ways to eliminate SHS exposure. Counsel all families to make their homes and cars completely "smoke free." The dangers of SHS and the risk of modeling tobacco use should be discussed with parents and caregivers, particularly those who smoke, and reinforced with culturally and ethnically appropriate resources and cessation referrals.[25]

b. Advise parents to inquire about policies on tobacco use when selecting schools, child care programs, and other venues for their children. There should be no tobacco use in or around the premises, regardless of whether children are present.

C. For patients or family members who use tobacco or who are exposed to SHS

i. Advise all families to make their homes and cars smoke free, and urge all tobacco users to quit. Provide appropriate advice and counseling to foster tobacco users to quit. Routinely offer help and referral to those who use tobacco—even if the person is not your patient. Be familiar with evidence-based guidelines for treatment of tobacco use and dependence and apply them to patients and their families.[14] There is a growing body of literature on the effectiveness of pediatric clinician-provided treatment for parental nicotine addiction that demonstrates a role for pediatricians in this effort.[14,85,86]

a. Pharmacotherapy is an effective component of tobacco use-cessation treatment in adults.[14] Encourage tobacco users to include these medications in their quit plan, whenever appropriate. Be familiar with and offer information and instruction on correct use. Many nicotine-replacement products are available without a prescription, although prescriptions are required for any nicotine-containing product if the patient is younger than 18 years.

Most (85%) parents who smoke consider it acceptable for their child's pediatrician to prescribe a smoking-cessation medication for them,[87] but few pediatricians do so.[88] Liability concerns, record-keeping challenges, and lack of insurance reimbursement are cited as barriers to prescribing these products to parents.[89] In response to these concerns, the American Medical Association adopted a policy statement in 2005 supporting the practice of pediatricians addressing parental smoking.[90]

Pediatricians who choose not to prescribe pharmacotherapies should make referrals to cessation services and recommend that parents discuss pharmacotherapies with their health care providers or purchase over-the-counter products.

b. Be familiar with tobacco-use–cessation services in your community and provide referrals to these programs for your patients and their families. Memorize the national quitline telephone number (1-800-QUIT NOW), prominently post it, and provide it to all tobacco users. Whenever possible, proactively enroll tobacco users in cessation programs, using "fax-back" or similar programs. Such referrals are more effective in connecting the tobacco user to the resource than referrals that

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require the tobacco user to initiate the contact.

ii. Counsel all parents, including those who smoke, on how to deliver antitobacco messages and ways to discuss the addictive nature of nicotine.

   a. When parents or caregivers use tobacco, their children are more likely to experiment with tobacco and to begin to use tobacco regularly. Maintain a high index of suspicion for early onset of tobacco use by these children. It can be a particularly powerful message when the parent or caregiver who uses tobacco advises the child never to start using tobacco[91] (Table 2).

   b. Help patients and families understand that even casual use of tobacco by children and adolescents, regardless of amount or frequency, is illegal and associated with adverse health consequences.

iii. Code for tobacco use and SHS exposure and bill for treatment. Consider SHS exposure a risk factor when justifying immunizations, respiratory syncytial virus prophylaxis, and other care. The additional time needed to counsel families about tobacco use should be documented and billed as the counseling that it is (Table 2). Whenever appropriate, list on death certificates that tobacco use or SHS exposure was the cause of or a contributor to death.

iv. Tobacco use by mothers is not a contraindication to breastfeeding, but tobacco use immediately before and during breastfeeding is strongly discouraged. Nicotine and its metabolites are present in human milk, and all tobacco users, including breastfeeding mothers, should make their home smoke free immediately and quit using tobacco products as soon as possible. Infants of mothers who smoke and breastfeed are more likely to be weaned at a younger age and to experience other adverse effects. For a more complete discussion of tobacco use by breastfeeding mothers, see specific AAP policy statements (Table 1).

v. SHS exposure may arise as a concern when children are involved in custody disputes. The AAP supports a healthy environment for children, meaning that the physical, emotional, and educational environment should provide support, nourishment, and education. Custody arrangements are complex agreements that should be decided on the basis of the best interests of the child, and all aspects of the child's well-being should be considered. All parents should be encouraged to eliminate their child's exposure to SHS; however, custody arrangements based solely on tobacco use or SHS exposure may not be in the overall best interests of the child.

D. Special considerations for populations at high risk of harm from tobacco or of tobacco use

   i. Emphasize the significant health harms of tobacco use and SHS exposure when treating children with chronic diseases or health risks such as preterm birth, low birth weight, asthma, diabetes, cystic fibrosis, and sickle cell disease. Several AAP policy statements have addressed tobacco use and SHS exposure in children with chronic diseases (Table 1), including sickle cell disease and Turner syndrome. When preparing future AAP policies, guidelines, and other products, authors should consider and mention the effects of tobacco use and SHS exposure on the subject addressed. Whenever relevant, AAP products should provide information on or access to information about treatment of tobacco use and dependence and SHS exposure.

   ii. When assessing mental health and substance abuse, include assessment of tobacco use and SHS exposure. Urge adolescent substance abuse treatment programs to treat tobacco dependence in their patients and their families. Treatment for nicotine addiction, if indicated, should be part of any inpatient or outpatient treatment plan. Closely monitor such individuals for changes in their symptom and adverse-effect profile during early nicotine withdrawal.

   iii. The following groups of people are more likely to use tobacco than those in the general population and should be counseled accordingly:

      a. Lesbian, gay, bisexual, and transgender children and youth[92,93] (Table 1).

      b. Alaska Native and American Indian people. Respect for

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ceremonial tobacco use should be demonstrated.

c. Current or former military personnel.

RECOMMENDATIONS FOR GOVERNMENT AND ADVOCACY

Whenever new public policy is developed or existing policy is revised, the wide range of consequences of tobacco use on children and their families should be considered. Local, county, state, and federal policies should support and enforce tobacco control. The AAP, through its chapters, committees, councils, sections, and staff, can provide information and support for public-policy advocacy efforts. See www.aap.org/advocacy.html for further information or contact chapter leadership.

1. Tobacco-Free Environments
   - A. The use of tobacco products in all indoor and outdoor public places should be prohibited. Federal, state, and local governments should enact and enforce laws that mandate the provision of smoke-free environments in all public places and require employers to provide smoke-free work environments for their employees.
   - B. Health care and educational facilities should be completely tobacco free, inside and outside, at all times. This includes all buildings, grounds, parking lots, satellite facilities, vehicles, and temporary venues. Tobacco-dispensing machines and sale of tobacco products should be banned from schools, hospitals, affiliated clinics, and pharmacies. The only exception to this ban would be legitimate research centers that study tobacco use or cessation.
2. Treatment of Tobacco Use and Dependence
   - A. Clinicians should be trained and skilled in counseling to prevent tobacco use and SHS exposure and the treatment of tobacco use and dependence. Medical schools, nursing schools, residency training programs, fellowship programs, and continuing medical education programs should include training in tobacco-use treatment and the prevention of tobacco use and SHS exposure.
   - B. Treatment of tobacco use and dependence should be available to patients and their families in both inpatient and outpatient settings. Children's hospitals and pediatric inpatient and outpatient facilities should specifically address the tobacco use of parents and other family members.
   - C. Proactive enrollment in cessation programs such as "fax-back" quitlines should be implemented in every jurisdiction and be available through all clinical settings, including pediatric settings.[28] The additional staff and resources needed to implement a proactive program should be supported.
   - D. Public and private employers should develop or provide access to tobacco-use–cessation programs for their employees and provide employee incentives for participation in these programs. Incentives, such as tax exemptions, should be offered to public and private employers who offer tobacco-use–cessation programs for their employees.
   - E. All public and private health insurance should provide coverage for comprehensive tobacco-cessation treatment, including counseling (individual and group) and medications (both prescription and over-the-counter) that have been shown to be effective. Health insurance should provide adequate reimbursement for services related to the treatment of tobacco use and SHS exposure of children and families, including behavioral modification treatments and US Food and Drug Administration–approved pharmacotherapies.
3. Tobacco-Use Prevention. Local, state, and federal authorities should promote programs that contribute to the prevention and decrease of tobacco use by youth, including programs that discourage tobacco use, support antitobacco advertising, and teach skills to resist peer and advertising influences. Evidence-based antitobacco education, as recommended by the Centers for Disease Control and Prevention,[30] the US Surgeon General,[94] and the Institute of Medicine,[95] should be provided to students at all levels of education, including early childhood, elementary, secondary, and higher. It is important to differentiate between genuine effective tobacco-prevention curricula and those developed and supported by the tobacco industry, which have been shown to encourage tobacco use.[96,97]
4. Tobacco Product Control
   - A. Control access to tobacco products.
     - i. Sales and distribution of tobacco to youth should be strictly prohibited. Venues for unsupervised purchase of tobacco products, such as vending machines and online merchants, should be eliminated. All tobacco products should be placed behind sales counters to reduce

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shoplifting. Provision of tobacco products to youth by adults should be made illegal, with significant consequences for noncompliance. Sales of tobacco products should be eliminated from schools, including secondary schools; health care facilities; military bases; and other sites that serve youth and young adults. The promotional distribution of tobacco products should be prohibited.

   ii. The sale of tobacco products on the same premises as pharmacies should be eliminated, including pharmacies located in supermarkets.

B. Control marketing of tobacco products.

   i. All tobacco products should be labeled to warn users of the health hazards of tobacco use. Warnings should use clear wording, in the strongest possible terminology, and be in the primary language of the country in which the product is sold. Warnings should be prominently displayed on packaging (occupying >50% of the front), on advertisements, and on displays at tobacco sales facilities. These warnings should be rotated to present a new warning on a regular basis.[98]

   ii. Advertising of tobacco products should be banned from all media, events, and venues, including the Internet. Products such as t-shirts, sports equipment, and other items should not bear messages or images that depict tobacco products or promote tobacco use. All forms of advertising and media, especially advertising and media aimed at children, adolescents, and young adults, should not contain messages that promote tobacco use or images of tobacco or tobacco use. The single exception is historically accurate depictions of real people who used tobacco.

   iii. Sales of candy cigarettes, cigars, and other products that imitate tobacco products or smoking should be banned. These products have been shown to promote tobacco use by children and youth.[99,100] The sale or dispensing of electronic or e-cigarettes, which imitate smoking while delivering nicotine to the user, should also be banned.

   iv. Exposure to and depiction of tobacco use should be reduced in films, videos, DVDs, and television programs. The evidence is very strong that depiction of tobacco use in films, videos, DVDs, and television programs is a significant factor in the uptake of tobacco use by children and youth.[9] The following 4 steps should be taken:

      a. Any new film that shows or implies tobacco use should be given a Motion Picture Association of America† rating of R. The only exceptions should be when the presentation of tobacco clearly and unambiguously reflects the risks and consequences of tobacco use or the depicted tobacco use is necessary to represent that of a real historical figure who actually used tobacco.

      b. It should be certified that no one working on or associated with the production received anything of value (money, gifts, publicity, loans, or anything else) in exchange for using or displaying tobacco products. The closing credits of every film depicting tobacco use or displaying images of tobacco products should contain such a declaration.

      c. Definitive and unambiguous antismoking ads (not produced or funded by a tobacco company) should be required to preview before any film with any tobacco presence. This should occur in any distribution channel and regardless of the rating for the film.

      d. Tobacco brand identification and tobacco brand imagery (such as billboards) should be eliminated from movies.

C. Use tax policies, funding, and evidence to control tobacco.

   i. Local, state, and federal tax policies should support tobacco control. Higher taxes have been shown to deter the purchase and use of tobacco and prompt cessation attempts; accordingly, local, state, and federal taxes on tobacco products should be implemented and/or increased. The revenue from these taxes can be used to support evidence-based tobacco-control programs. Tax deductions for advertising tobacco

†The Motion Picture Association of America (MPAA) is the organization that provides the G, PG, PG-13, R, and NC-17 ratings for movies.

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products and tobacco-farming price supports and subsidies should be eliminated. Alternative revenue sources should be developed for and promoted to tobacco farmers.

ii. The evidence-based recommendations of *Best Practices for Comprehensive Tobacco Control Programs*[30] should be funded and implemented. Proceeds of the Tobacco Master Settlement Agreement[101] should be used for tobacco-control activities, as intended. More information about state expenditures of funds from the Tobacco Master Settlement Agreement is available from the AAP Division of State Government Affairs.

D. Other aspects of tobacco-control recommendations

i. Foster families should provide smoke-free environments to children whenever possible but specifically in the home and in vehicles used to transport children. These spaces should remain smoke free even when children are not present to reduce the exposure via off-gassing or "thirdhand smoke."‡ Although the smoking status of foster parents need not be a barrier to program participation, smoking-cessation treatments should be made available to foster parents. Evidence of smoking in the home or in vehicles should be assessed during required inspections. Evidence of smoking in the home or in vehicles should be considered a possible reason for removal of foster families from the program and for selecting alternative, smoke-free environments for children.

ii. Traditional sacred tobacco use by American Indian and Alaska Native people should be preserved while preventing nicotine addiction. Images, names, and icons from American Indian culture, such as "Noble," "Geronimo," "Red Man," and "American Spirit," should not be used to "brand" and market tobacco products to US and international markets.

iii. All cigarettes should be required to use "fire-safe" technology, which makes them less likely to cause fires (Table 1).

5. Research

B. Funding should not be accepted from the tobacco industry.

C. Pediatric tobacco-control research should be considered a high priority and funded accordingly. Priorities include development of evidence-based curricula to educate pediatric clinicians on the health effects of SHS exposure, nicotine addiction, and tobacco use as well as effective treatments for tobacco use and nicotine addiction. The spectrum of pediatric tobacco control includes prevention of youth tobacco use and dependence, treatment of youth tobacco dependence, prevention and treatment of SHS exposure of children, and prevention and treatment of tobacco use and SHS exposure of pregnant women.

i. Research in basic science, clinical outcomes, behavior, family structure and tobacco use, health services, underserved populations, health education, and policy analysis must be included in this comprehensive research effort.

ii. Funding for training the next generation of investigators in pediatric tobacco control should be supported.

iii. Translation of research on effective interventions to promote smoking cessation and reduction of SHS exposure from adult to pediatric settings is needed. Transdisciplinary efforts to maximize the positive effects on children of these research endeavors should be encouraged and supported.

6. International Tobacco Control

A. The World Health Organization Framework Convention on Tobacco Control should be ratified by the United States (Table 2). However, any resulting federal legislation to implement the Framework Convention should expressly not preempt stronger state or local restrictions.

B. As an exporter of tobacco, the United States should conform to all domestic policies when making treaties, agreements, and other arrangements with other governments. Tobacco products sold on American Indian reservations and tobacco products manufactured for export markets should be required to conform to the same requirements as tobacco products intended for the US market, except when the destination country has stronger requirements.

‡Thirdhand smoke is the smoke residue that is left in an environment after smoking has ceased. Some components of thirdhand smoke persist for weeks and provide a lasting source of exposure.

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CONCLUSIONS

Tobacco use is the leading preventable cause of death and illness in the United States. Pediatricians and other clinicians who care for children are uniquely positioned to assist patients and families with prevention and treatment. Pediatricians and the AAP have key responsibilities in tobacco control and place a high priority on these goals for the health of children.

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