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Childcare Providers' Possession or Use of Marijuana, Tobacco, or Alcohol While Caring for Children: A Comparison of US State Regulations

Elyse R. Grossman, JD, PhD, Sarah Gonzalez-Nahm, PhD, MPH, RD, Natasha Frost, JD, and Sara E. Benjamin-Neelon, JD, PhD, RD

Objectives. To evaluate US state regulations regarding marijuana, tobacco, and alcohol to determine the extent to which states attempt to govern these substances in early care and education (ECE) settings.

Methods. Two independent reviewers assessed regulations enacted by December 2016 for all states and the District of Columbia. Reviewers compared regulations to national standards on the possession or use of marijuana, tobacco, and alcohol in ECE settings.

Results. Fewer states regulated marijuana than tobacco or alcohol in ECE settings. More states restricted the use of these 3 substances than they restricted the possession of them.

Conclusions. Most states address alcohol or tobacco possession or use in their regulations but should consider updating these provisions to align with national standards.

Public Health Implications. Updating and strengthening state childcare regulations regarding marijuana, tobacco, and alcohol possession and use may help protect children in ECE settings, where many children spend a substantial portion of time. As more states legalize marijuana, they may consider updating their regulations and including precise language to better protect children from unintended pediatric marijuana exposure or impaired childcare providers. (*Am J Public Health.* Published online ahead of print April 19, 2018: e1–e6. doi:10.2105/AJPH.2018.304351)

Increasingly more US states have softened or even reversed their stance on the illegality of marijuana. As of 2017, 8 states and the District of Columbia (DC) have legalized recreational marijuana and 29 states and DC have legalized medical marijuana. Although the impact on child health outcomes has not been fully evaluated, previous research indicates that these laws may have unintended deleterious effects on young children.

First, children may be harmed directly by either consuming marijuana or being exposed to marijuana smoke. Marijuana use or exposure can interfere with cognitive function, decrease reflex time, inhibit good decision-making, and cause lethargy, agitation, vomiting, or the need for hospitalization.[1,2] Researchers analyzed 10 years of records from French hospitals for 235 children younger than 6 years admitted for cannabis intoxication—14 had respiratory failure, 8 required ventilation, and 38 were comatose.[3] A similar study of US children younger than 6 years found 1969 marijuana exposures between 2000 and 2013.[4] Most were attributable to either unintentional ingestion (75%) or secondhand inhalation (14.5%). Nearly 41% of children had 1 or more exposure-related clinical effects. A growing body of evidence demonstrates the harmful impact of marijuana exposure on young children.

Second, children can also be affected indirectly by adult caregivers impaired by marijuana use. Not surprisingly, as states have legalized recreational and medical marijuana, use among adults has increased steadily.[5] Between 2002 and 2016, the National Survey on Drug Use and Health found increases among both US adults aged 18 to 25 years (up by 20% to 7.2 million) and US adults aged 26 years and older (up by 80% to 15.2 million), who reported past-month marijuana use.[5] Among adults, marijuana may interfere with motor function (e.g., coordination) and cause memory impairment and anxiety or panic reactions.[2,6] Marijuana intoxication also affects reaction time and increases the risk of accidents.[7,8]

Because potential child exposure to marijuana is an understudied area of inquiry, researchers have not examined the relation between caregivers' marijuana use and children's risk of unintentional injuries although a relation exists between parents using illegal drugs and higher reported rates of child abuse and neglect.[9] However, similar concerns with caregivers possessing or using tobacco or alcohol have previously arisen. When caregivers possess these products, young children may suffer accidental poisoning by accessing them.[10–12] Similarly, when caregivers use tobacco around young children—thereby exposing them to secondhand or thirdhand smoke—children suffer a range of health problems (e.g., increased acute respiratory infections, acute asthma exacerbation, and ear infections).[13] When caregivers consume alcohol, children are at higher risks of sustaining unintentional injuries.[14]

These caregivers may be parents, relatives, teachers, or even out-of-home childcare

ABOUT THE AUTHORS

Elyse R. Grossman, Sarah Gonzalez-Nahm, and Sara E. Benjamin-Neelon are with the Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD. Natasha Frost is with the Public Health Law Center, Mitchell Hamline School of Law, St. Paul, MN.

Correspondence should be sent to Elyse R. Grossman, JD, PhD, Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health, 624 N. Broadway St., Suite 291, Baltimore, MD 21205 (e-mail: egrossman@jhu.edu).
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providers. Nearly 12.5 million children younger than 5 years (61% of children in this age group) are in some form of nonparental childcare,[15] and states have enacted licensing and administrative regulations governing these early care and education (ECE) settings. Regulations cover a wide range of areas, from child sleeping to infant feeding. State regulations also govern childcare providers' possession or use of alcohol, tobacco, and drugs. These regulations are often in addition to more general state laws or statutes governing the possession and use of marijuana, tobacco, and alcohol.

As states have legalized recreational or medical marijuana or both, it is unclear whether policymakers have considered the impact of these laws on ECE settings and have updated their state ECE regulations accordingly. For example, many states have regulations limiting providers' use of illegal drugs while caring for children. Under federal law, marijuana possession and use remains illegal in the United States, as marijuana is classified as a Class I controlled substance under the Controlled Substances Act. However, in some states, marijuana possession and use are now legal under state law. This creates an inherent conflict, worsened by the fact that state regulations often fail to define the term "illegal drugs." We examined state regulations regarding marijuana, tobacco, and alcohol possession and use in ECE settings.

METHODS

Two independent reviewers compared ECE regulations through 2016 for all states and DC (hereafter "states") to national standards, focusing on regulations governing the possession or use of marijuana (recreational and medical), tobacco, and alcohol. The National Health and Safety Performance Standards were included in *Caring for Our Children*, third edition.[16]

Standard 3.4.1.1 of *Caring for Our Children* provides that "tobacco use, alcohol, and illegal drugs should be prohibited on the premises of the program"[16(p118)] and that written policies should specify that "all of these substances are prohibited inside the facility [or] on facility grounds."[16(p363)] We used these same standards for marijuana (although not specifically mentioned) and coded regulations using the words "marijuana," "cannabis," "controlled substances," "scheduled substances," or "drugs." We did not include the terms "illegal drugs" and "illegal substances."

As with previous reviews,[17,18] we used a combination of key word searches and full-text reviews and coded regulations for both childcare centers (hereafter "centers") and family childcare homes (hereafter "homes"). Agreement for the 2 reviewers was greater than 83% for all standards.

RESULTS

We present regulations related to ECE providers' possession and use of recreational marijuana, medical marijuana, tobacco, and alcohol (Table 1). We included regulations related to the cultivation or distribution of marijuana in the "possession" category. If a state's regulation did not define marijuana, we counted that state as having regulations for both recreational and medical marijuana. Of note, Louisiana regulates only centers—and thus we coded Louisiana as "not applicable" for homes for all standards.

Recreational Marijuana

Possession by early care and education providers. Thirteen states regulated the possession, cultivation, or distribution of recreational marijuana in ECE settings (Table A, available as a supplement to the online version of this article at http://www.ajph.org). Seven of these states' regulations used the terms "marijuana" (2 states) or "controlled substances" (5 states), with some states—such as Oregon—regulating recreational marijuana, its derivatives, and paraphernalia related to it (including marijuana plants). The other 6 states' regulations used the terms "drugs," "impairing drugs," or "detrimental drugs." In centers, 9 states (of 12) regulated its possession. The other states regulated the possession, cultivation, and—in 2 states—distribution of recreational marijuana. In homes, 5 states (of 8) required recreational marijuana to be stored safely or in its original containers and kept inaccessible to children or in a safe location. Two states' regulations prohibited the possession (Nebraska) or the possession and distribution (New Mexico) of recreational marijuana in homes. Similar to its regulations for centers, Oregon's regulations for homes prohibited the cultivation or distribution of recreational marijuana but allowed the possession of it if stored with a child safety lock.[19]

Use by early care and education providers. Approximately 40% of states regulated ECE providers' recreational marijuana use in centers (22 states) or homes (20 states). Half of these states' regulations used the terms "marijuana" (2 states) or "controlled substances" or "scheduled drugs" (10 states). The rest of the states used the term "drugs" or referenced substances that impaired caregivers or adversely affected their ability to do their jobs. States varied in the breadth of their regulations. For example, Oregon regulations stated that "no adult shall use or be under the influence of marijuana" on the premises.[20] Georgia, on the other hand, prohibited the consumption of marijuana either on the premises during operating hours or "at any other time or place where there are children present for whom the Center Staff is responsible."[21] Sixteen states similarly regulated the use of recreational marijuana for both centers and homes. Five states regulated its use only in centers; 4 states regulated its use only in homes.

Medical Marijuana

Possession by early care and education providers. Ten states regulated medical marijuana possession, cultivation, and distribution in ECE settings (Table B, available as a supplement to the online version of this article at http://www.ajph.org). States often had the same regulations governing both recreational and medical marijuana. Three states had regulations specifically governing medical marijuana in ECE settings. Arizona prohibited the possession of medical marijuana in centers. Illinois prohibited the possession of medical marijuana on center premises, in vehicles used to transport children or parked on the grounds, anywhere state law already banned smoking, or anywhere a child could observe or smell it.

Illinois also prohibited a medical marijuana cultivation center or dispensary from being within 2500 feet or 1000 feet of a center's property line, respectively. Oregon allowed medical marijuana to be kept on the center premises if medically necessary to treat a child, but it had to be "kept in its original container if purchased at a dispensary, and . . . under child safety lock."[20] Whereas Illinois had the same

TABLE 1—States With Regulations Prohibiting or Restricting the Possession or Use of Recreational Marijuana, Medical Marijuana, Tobacco, and Alcohol by Childcare Providers in Childcare Centers and Family Childcare Homes: United States, December 2016

	Prohibiting or Restricting Possession		Prohibiting or Restricting Use	
Substance	Centers	Homes	Centers	Homes
Recreational marijuana	12 (AZ, CO, DE, FL, HI, IL, KY, NE, NM, NY, OR, WI)	8 (DE, HI, NE, NM, NY, OR, RI, WI)	22 (AK, AZ, CO, DE, FL, GA, HI, IA, ID, KS, MA, MD, NE, NJ, NY, OH, OR, SC, TX, VT, WI, WV)	20 (AK, CO, FL, ID, IL, KS, KY, MA, MD, ME, NE, NJ, NY, OH, OR, RI, SC, TX, VT, WI)
Medical marijuana	9 (AZ, CO, DE, FL, HI, IL, NY, OR, WI)	7 (DE, HI, IL, NY, OR, RI, WI)	18 (AK, AZ, CO, DE, FL, GA, HI, IA, ID, MA, NJ, NY, OH, OR, SC, TX, VT, WV)	15 (AK, CO, FL, ID, IL, KS, MA, NJ, NY, OH, OR, RI, SC, TX, VT)
Tobacco	11 (AZ, DC, IL, KY, NC, NH, OK, PA, SC, UT, WV)	16 (AK, CT, DC, IL, KS, KY, MD, NC, NH, NJ, OK, PA, SC, UT, WA, WV)	49 (AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY)	47 (AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, HI, IA, ID, IL, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY)
Alcohol	15 (AR, CO, FL, HI, IN, KY, MO, NE, NM, OR, RI, TN, UT, WA, WY)	14 (AR, DE, HI, KY, MD, MN, MO, NE, NM, UT, VA, WA, WV, WY)	36 (AK, AL, AR, AZ, CO, DC, DE, FL, GA, HI, IA, ID, IN, KS, KY, LA, MA, MD, MO, MS, ND, NE, NJ, NY, OH, OR, RI, SC, TN, TX, UT, VT, WA, WI, WV, WY)	36 (AL, AK, AR, CO, DC, DE, FL, HI, ID, IL, KS, KY, MA, MD, ME, MO, MS, ND, NE, NJ, NM, NY, OH, OK, OR, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY)

prohibitions for both centers and homes, Arizona and Oregon had more relaxed regulations for homes. In Arizona, homes were prohibited from cultivating medical marijuana on the premises. In Oregon, all medical marijuana obtained from a dispensary and any medical marijuana derivatives and associated paraphernalia had to be kept in a locked receptacle.

Use by early care and education providers. Eighteen states regulated ECE providers' use of medical marijuana in centers; 15 states regulated its use in homes. All but 1 state (Arizona) had the same regulations governing both recreational and medical marijuana. Although we coded both New York and Vermont as prohibiting or restricting the use of medical marijuana, both of these regulations relied on a subjective opinion by the provider or the provider's doctor. In New York centers and homes, a childcare provider could not use a controlled substance "unless the controlled substance is prescribed by a health care provider[,] is being taken as directed, and does not interfere with the person's ability to perform his or her child day care functions."[22] In Vermont homes, providers could take medications prescribed by a physician if "in the opinion of the physician, [the medicine] does not impair the ability to provide adequate care and supervision during the hours of care."[23]

Tobacco

Possession by early care and education providers. Few states restricted the possession of tobacco in ECE settings (Table C, available as a supplement to the online version of this article at http://www.ajph.org). In the 11 states that did restrict it in centers, these restrictions focused on preventing children's access to used and unused tobacco products. Many states' regulations—including those of Illinois, Kentucky, Oklahoma, South Carolina, and Utah—broadly stated that tobacco and tobacco products shall not be accessible to children. Illinois limited its restriction to cigarettes, and Oklahoma and Utah expanded their restrictions to also cover "related items, such as ashtrays and cigarette butts" and "e-cigarettes, e-juice, e-liquids," respectively. In DC, North Carolina, and West Virginia, the "tobacco products" or "smoking materials" had to be out of the reach of children and, sometimes, out of their sight as well. The restriction was more specific in Pennsylvania and prohibited "ashes and cigarette or cigar butts . . . in a child care space, a play space or a food preparation area."[24]

Arizona required that childcare providers "remove all ashtrays from all areas where smoking is prohibited,"[25] and New Hampshire required that containers of tobacco products be "clearly labeled with the name of the product they contain."[26] More states restricted the possession of tobacco in homes (16 states). In 8 of these, the states restricted tobacco in homes in the same manner and using the same language as they had for centers. Oklahoma limited its restriction for homes to include smoking materials. By contrast, West Virginia expanded its restriction for homes to also include "all tobacco products, smoke abatement products, ashtrays, butts, [and] ashes." Another 6 states—Alaska, Connecticut, Kansas, Maryland, New Jersey, and Washington—restricted tobacco (including cigarettes, cigars, pipes, ashes, and butts) in homes but not centers.

Use by early care and education providers. Almost all the states prohibited or restricted the use of tobacco in ECE settings. The majority did not differentiate on the basis of products and instead just regulated "smoking," "smoking tobacco," "using tobacco," or "using nicotine products"—often without defining these terms. Only 5 states had more specific regulations: Arizona prohibited smoking or using tobacco (defined as "smoking materials such as cigars, cigarettes, or pipe tobacco"); Arkansas prohibited smoking and using e-cigarettes; Oregon prohibited "smok[ing]/carry[ing a] lighted smoking instrument, including e-cigarette[s] or vaporizer[s]" and using smokeless

tobacco; Pennsylvania prohibited smoking cigarettes, pipes, and cigars; and Vermont prohibited using tobacco and tobacco substitutes. Forty-nine of the states (not including Minnesota or South Dakota) prohibited the use of tobacco in centers. Forty-seven of the states (not including Georgia, Indiana, South Dakota, or Louisiana [which does not regulate homes]) prohibited the use of tobacco in homes.

Alcohol

Possession by early care and education providers. Less than 30% of states regulated the possession of alcohol in ECE settings (Table D, available as a supplement to the online version of this article at http://www.ajph.org). Only 15 states regulated the possession of alcohol in centers, with 11 of these states prohibiting it. Kentucky, Missouri, and Utah required alcohol to be inaccessible to children. Wyoming required any cupboards or drawers containing alcohol to have childproof locks. Six states—Colorado, Florida, Indiana, Oregon, Rhode Island, and Tennessee—prohibited the possession of alcohol in centers without similar prohibitions for homes. Fourteen states restricted the possession of alcohol in homes; none of the states prohibited it. Nine of the states that regulated the possession of alcohol in homes also had regulations for centers. Five states—Delaware, Maryland, Minnesota, Virginia, and West Virginia—restricted the possession of alcohol in homes but did not have similar regulations for centers.

Use by early care and education providers. Most states prohibited childcare providers' alcohol use in either centers (36 states) or homes (36 states). Arizona, Georgia, Indiana, Iowa, and Louisiana prohibited the use of alcohol only in centers. However, these prohibitions varied across states. Alabama's broader regulation prohibited alcohol consumption on the center's premises.[27] Wyoming's narrower regulation prohibited the consumption of alcohol "in all licensed care facilities anytime during hours of operation."[28] In Alaska, the owner of the center shall "ensure that the ability of an employee or other caregiver to perform assigned duties is not impaired by alcohol . . . while that person is in contact with children or performing other job responsibilities."[29] Although the same number of states prohibited the use of alcohol in homes, these were not the same states that prohibited alcohol in centers. For example, 5 states—Illinois, Maine, New Mexico, Oklahoma, and Virginia—prohibited the use of alcohol in homes but not in centers.

DISCUSSION

We compared state ECE regulations regarding the possession and use of marijuana, tobacco, and alcohol to national standards. Although the national standards recommended prohibiting the possession or use of these substances in ECE settings, the state regulations varied from full prohibitions, to restrictions, to no regulations at all.

In general, fewer states regulated marijuana than tobacco or alcohol in ECE settings, with the marijuana regulations varying by recreational versus medical use of marijuana, by state, and by center versus home setting. For all 3 substances, states were more likely to restrict use than possession and to have more comprehensive regulations for centers than homes.

Specifically, the states varied in how they protected children from exposure to or consumption of these products. Almost all states prohibit tobacco usage in ECE settings, thereby reducing children's exposure to secondhand or thirdhand smoke. Many fewer states restricted the possession of marijuana (13 states), tobacco (17 states), or alcohol (20 states) in ECE settings. Without these regulations, young children may accidentally find and consume these products, potentially resulting in the need for calls to poison control centers or hospital visits. From 2005 to 2011, calls to poison control centers for children younger than 9 years increased by 30.3% per year in states that had decriminalized marijuana, compared with states that had not.[30] Additionally, in Colorado, rates of marijuana-related hospital visits or poison control center cases among young children increased by up to 150% after the state legalized the sale of recreational marijuana.[31]

States' regulations prohibiting ECE providers from experiencing alcohol or marijuana impairment while performing their duties also varied. Whereas 80% of states prohibit providers from consuming alcohol in ECE settings, only 51% of states prohibit providers from using either recreational or medical marijuana in ECE settings.

As of 2017, 9 states have legalized recreational marijuana, but only 5 regulate it in ECE settings. Fifteen of the 30 states that legalized medical marijuana regulate it in ECE settings. Because the 2016 national standards omitted marijuana and addressed only alcohol, tobacco, and illegal drugs, states that have legalized recreational or medical marijuana may not have considered the impact on ECE settings. *Caring for Our Children* has since updated their online standards; it now recommends the prohibition of "tobacco, electronic cigarettes (e-cigarettes), alcohol and drugs . . . [and] the use of legal drugs (e.g. marijuana, prescribed narcotics, etc.) that have side effects that diminish the ability to proper[ly] supervise and care for children."[32] More states should follow this lead and prohibit marijuana possession or use in ECE settings.

States may have more alcohol and tobacco regulations than marijuana regulations because of the current conflict between state and federal laws. Although some states have legalized recreational or medical marijuana or both, marijuana is still classified as a Class I controlled substance under the Controlled Substances Act. This inherent conflict of laws could result in litigation with debate arising over the Supremacy Clause of the Constitution.

It is important that states also examine the larger context. Most states already regulate the possession and use of alcohol and tobacco in ECE settings to varying degrees. However, these regulations often do not fully adhere to the national standards and use vague and undefined language. For example, most states do not distinguish between different types of tobacco products, and only 4 states restrict e-cigarettes. Exposure to different types of tobacco products will have different types of injury risks.

Therefore, states cannot simply insert the word "marijuana" into these preexisting regulations. Instead, we recommend that states consider updating and strengthening their regulations for all 3 substances to better match the recommended national standards. States should draft these regulations using more precise well-defined nonsubjective language. Currently, the weakest regulations

that we coded used undefined terms such as "drugs" and "substances that impaired a provider's ability to care for children," with some regulations relying on the "opinion of the physician" to determine if a medicine impairs a provider.

Some states used the undefined terms "controlled" or "scheduled" drugs or substances in their regulations. This creates confusion because marijuana is a Class I controlled substance under federal law but has been legalized for recreational or medical purposes or both by some states. Even the state regulations that specifically mentioned marijuana need more precise language. For example, Colorado's regulations prohibit the presence of marijuana in centers. Does the regulation, therefore, not permit use, cultivation, and distribution? Alternatively, Georgia prohibits only the consumption of marijuana in centers. Is it, therefore, acceptable to possess, cultivate, or distribute it?

Limitations

This study has limitations. States may regulate marijuana, alcohol, and tobacco through other state laws. States have different laws that already regulate alcohol possession and use and apply to all individuals in the state, for example, minimum legal drinking age laws and driving while impaired laws. States may choose to not reiterate these laws in their ECE regulations. Similarly, tobacco use is often regulated through state clean air laws. For example, Minnesota's smoke-free statute specifically prohibits smoking in childcare centers and limits when smoking can occur in family childcare homes. Many clean indoor air and smoke-free laws are being amended to include smoking marijuana in public places and workplaces. Moreover, marijuana possession or usage also may be addressed by general restrictions on the use of illegal or prescription drugs around children that would also cover an ECE setting.

We do not explain how state laws legalizing recreational or medical marijuana interact with existing childcare regulatory language. For example, Washington home providers must not "have or use illegal drugs on the premises . . . [or] be under the influence of . . . illegal drugs or misused prescription drugs when working with or in the presence of children in care."[33] Although marijuana is legal in Washington, this regulation has not been updated to specifically exclude being under the influence of marijuana when in the presence of children in care.

Also, states may enact new ECE regulations at any time, and our results are current only through 2016. Finally, regulations may not reflect actual practice in ECE settings. Previous research has indicated that new state regulations may improve child health outcomes.[34,35] Researchers may want to examine whether the consequences of violating these regulations vary across states.

Public Health Implications

States may want to consider updating their ECE regulations to prevent unintended pediatric marijuana exposure and to match their alcohol or tobacco provisions to national standards. States also may wish to consider regulations related to recreational and medical marijuana differently in the context of ECE settings. For example, because home-based care typically occurs in the provider's home (vs centers, which are often in designated [nonhome] buildings), it is conceivable that the provider or resident might be prescribed medical marijuana.

It might be reasonable to allow medical marijuana in a home versus a center, but states should still require that the marijuana be kept inaccessible to children. Moreover, states should continue to develop regulations for packaging and storing edible marijuana products (e.g., cookies, brownies), as these products are attractive to children. Regulating marijuana, tobacco, and alcohol possession and use may help protect children in ECE settings, where large numbers of children spend a substantial portion of time. AJPH

CONTRIBUTORS

E. R. Grossman drafted the article. E. R. Grossman and S. Gonzalez-Nahm conducted the regulations review. S. Gonzalez-Nahm, N. Frost, and S. E. Benjamin-Neelon reviewed and edited the article. N. Frost helped design the study and oversaw the coding of state regulations. S. E. Benjamin-Neelon designed the study and oversaw the regulations review. All authors approved the final article as submitted.

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This was a regulatory review that did not involve human participants, so approval was not required.

REFERENCES

1. Volkow ND, Baler RD, Compton WM, Weiss SRB. Adverse health effects of marijuana use. *N Engl J Med*. 2014;370(23):2219–2227.

2. Committee on Substance Abuse, Committee on Adolescence. The impact of marijuana policies on youth: clinical, research, and legal update. *Pediatrics*. 2015;135(3): 584–587.

3. Claudet I, Mouvier S, Labadie M, et al. Unintentional cannabis intoxication in toddlers. *Pediatrics*. 2017;140(3): e20170017.

4. Onders B, Casavant MJ, Spiller HA, Chounthirath T, Smith GA. Marijuana exposure among children younger than six years in the United States. *Clin Pediatr (Phila)*. 2016;55(5):428–436.

5. Center for Behavioral Health Statistics and Quality. *Key Substance Use and Mental Health Indicators in the United States: Results From the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). 2016. Available at: http://www.samhsa.gov/data. Accessed March 15, 2018.

6. Karila L, Roux P, Rolland B, et al. Acute and long-term effects of cannabis use: A review. *Curr Pharm Des*. 2014; 20(25):4112–4118.

7. Goodwin Gerberich S, Sidney S, Braun BL, Tekawa IS, Tolan KT, Quesenberry CP. Marijuana use and injury events resulting in hospitalization. *Ann Epiemiol*. 2003: 13(4): 230–237.

8. Elvik R. Risk of road accident associated with the use of drugs: a systematic review and meta-analysis of evidence from epidemiological studies. *Accid Anal Prev*. 2013;60: 254–267.

9. Freisthler B, Wolf JP, Wiegmann W, Kepple NJ. Drug use, the drug environment, and child physical abuse and neglect. *Child Maltreat*. 2017;22(3):245–255.

10. Lando HA, Hipple BJ, Muramoto M, et al. Tobacco control and children: An international perspective. *Pediatr Allergy Immunol Pulmonol*. 2010;23(2):99–103.

11. Bronstein A, Spyker D, Cantilena L, Green J, Rumack B, Heard S. Annual report of the American Association of Poison Control Centers' National Poison Data System (NPDS). *Clin Toxicol (Phila)*. 2007;45(8):815–917.

12. Young-Hee Y, Stinson FS, Hsiao-ye Y, Dufour MC. Accidental alcohol poisoning mortality in the United States, 1996–1998. *Alcohol Res Health*. 2003;27(1): 110–118.

13. US Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke. A Report of the Surgeon General: Secondhand Smoke: What It Means to You*. Atlanta, GA: Centers for Disease Control and Prevention; 2006.

14. Damashek A, Williams NA, Sher K, Peterson L. Relation of caregiver alcohol use to unintentional childhood injury. *J Pediatr Psychol*. 2009;34(4):344–353.

15. Laughlin L. *Who's Minding the Kids? Child Care Arrangements: Spring 2011*. Washington, DC: US Census Bureau; 2013.

16. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and*

Education Programs. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2011.

17. Benjamin Neelon SE, Duffey K, Slining MM. Regulations to promote healthy sleep practices in child care. *Pediatrics*. 2014;134(6):1167–1174.

18. Benjamin-Neelon SE, Gonzalez-Nahm S, Grossman E, et al. State variations in infant feeding regulations for child care. *Pediatrics*. 2017;140(6):e20172076.

19. OAR 414-350-0090. Oregon Department of Education, Chapter 414: Early Learning Division; Division 350: Certified Family Child Care Homes; 0090: General Requirements.

20. OAR 414-300-0070. Oregon Department of Education, Chapter 414: Early Learning Division; Division 300: Certified Child Care Centers; 0070: General Requirements.

21. Ga. Comp. R. & Regs. 591-1-1. Rules of Bright From the Start: Georgia Department of Early Care and Learning. Rules and Regulations for Child Care Learning Centers. Chapter 591-1-1. Authority: O.C.G.A. §20-1A-1 et seq. (November 16, 2012).

22. N.Y. Comp. Codes R. & Regs. §418-1.11(10). New York Codes, Rules and Regulations, Child Day Care Centers, 418-1.11 Health and Infection Control.

23. Vt. Code R. 5.10.1.11.2. Vermont Codes. Licensing Regulations for Center Based Child Care and Preschool Programs; 5.10.1.11: Use of Tobacco, Alcohol and Illegal Drugs (Effective September 1, 2016).

24. 55 Pa. Code §3270.68. Pennsylvania Code. Title 55; Chapter 3270: Child Day Care Centers; §68: Smoking.

25. Ariz. Admin. Code §R9-2-104. Arizona Administrative Code. Article 1. Smoke-Free Arizona; R9-2-104. Proprietor Responsibilities (2007).

26. N.H. Code Admin. R. Lab. He-C 4002.14. New Hampshire Code of Administrative Rules. Chapter He-C 4000: Child Care Licensing Rules. He-C 4002.14: Health and Safety in the Child Care Environment (2017).

27. Ala. Admin. Code II-C-4-k-9.

28. 8 Wyo. Code R. §12(d).

29. Alaska Admin. Code tit. 7, §57.220(b)(5). Alaska Administrative Code. Title 7: Health and Social Services, Part 4 Children's Services and Juvenile Justice; Chapter 57: Child Care Facilities Licensing, Article 1; 7 AAC 57.220: Child Care Facility Operation and Management.

30. Wang GS, Roosevelt G, Le Lait M, et al. Association of unintentional pediatric exposure with decriminalization of marijuana in the United States. *Ann Emerg Med*. 2014;63(6):684–689.

31. Wang GS, Le Lait M, Deakyne SJ, Bronstein AC, Bajaj L, Roosevelt G. Unintentional pediatric exposures to marijuana in Colorado, 2009-2015. *JAMA Pediatr*. 2016;170(9):e160971.

32. American Academy of Pediatrics. Health promotion and protection. In: *Caring for Our Children*. Available at: http://cfoc.nrckids.org/StandardView/3.4.1.1. Accessed March 19, 2018.

33. WAC 170-296A-4025. Washington State Legislature. Drugs and Alcohol (2012).

34. Benjamin Neelon SE, Finkelstein J, Neelon B, Gillman MW. Evaluation of a physical activity regulation for child care in Massachusetts. *Child Obes*. 2017;13(1):36–43.

35. O'Neill JR, Dowda M, Benjamin Neelon SE, Neelon B, Pate RR. Effects of a new state policy on physical activity practices in childcare centers in South Carolina. *Am J Public Health*. 2017;107(1):144–146.