EVALUATION OF THE DEPARTMENT OF HEALTH WESTERN AUSTRALIA OPERATIONAL DIRECTIVE STATEWIDE CO-SLEEPING/BED-SHARING POLICY FOR WA HEALTH HOSPITALS AND HEALTH SERVICES

Prepared by: Dr Jennifer Dodd

Collaboration for Applied Research and Evaluation

Telethon Institute for Child Health Research
BACKGROUND

In 2008 the Coroner in response to a coronial inquest recommended the Department of Health of Western Australia develop a policy on co-sleeping/bed-sharing for use across all state maternity hospitals. The Operational Directive – Statewide Co-Sleeping/Bed sharing policy for WA health hospitals and health services was developed and approved. Please see attached link http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12410 (insert circular number 0139)

The aim of the policy is to reduce the risk of babies dying of Sudden Infant Death Syndrome (SIDS) and other fatal sleep accidents through improving education of health professionals and parents.

In 2010 the Deputy Coroner recommended WA Health demonstrate the implementation of the Operational Directive and support education of WA Health staff.

In response to this the Women’s and Newborns Health Network (WNHN) sponsored, with Department of Health funding, the Telethon Institute of Child Health Research (TICHR) to undertake an evaluation of the Department of Health WA Operational Directive – Statewide Co-Sleeping/Bed sharing policy for WA health hospitals and health services.

OUTCOMES OF THE REPORT

The Department of Health of Western Australia welcomes the completion and release of the TICHR Report. The Report makes 14 recommendations in key areas including the need:

- for ongoing education and training of health professionals to provide consistent messages about co-sleeping/bed sharing
- to improve access to education and resource material for parents; and
- development of culturally appropriate information

IMPLEMENTATION OF THE RECOMMENDATIONS OF THE REPORT

The Women’s and Newborns Health Network is taking lead responsibility for the implementation of the recommendations of the Report. A Working Group has been established made up of key stakeholders and experts from across health and community organisations. The Group will commence work on an Implementation Plan in March 2012.

For more information or to become involved in implementing the recommendations of the Report please email healthpolicy@health.wa.gov.au to register your interest.

Dr Simon Towler
Chief Medical Officer
Office of the Chief Medical Officer

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## CONTENTS

Acknowledgements, Abbreviations 5
Executive Summary 6-15
Introduction 16
Objectives, ethics, governance 17
Methodology and methods 18-23
Results of the review of the dissemination and content of co-sleeping resources 24-27
Maternity health services audit results 28-33
Interview and focus group results 34-49
Results of WA parent Interviews and focus groups 50-67
Combined findings, discussion and recommendations 68-76
Appendix 1: Literature review 77-89
Appendix 2: Evaluation research questions 90
Appendix 3: Invitation letter health professionals 91
Appendix 4: Invitation letter women 92
Appendix 5: Information sheet health professionals 93-94
Appendix 6: Information sheet women 95-96
Appendix 7: Health promotion audit 97-102
Appendix 8: Overview co-sleeping policy, guidelines 103-111
Appendix 9: Matrix 1, Co-sleeping used by health professionals and women 112-113
References 114-117

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**Study Sponsor and Project Reference Group Member**

Women and Newborn Health Network, Department of Health, Western Australia

**Project Reference Group Members**

Aboriginal Maternity Services Support Unit (AMSSU)

Area Health Service South

Child and Adolescent Community Health

King Edward Memorial Hospital

SIDS & Kids Western Australia

Consumer Representative (wished to remain anonymous)

**Project collaboration and guidance**

Aboriginal Council for Collaboration and Research Evaluation (ACCARE)

Aboriginal Health Council of Western Australia

WA Country Health Services

**ABBREVIATIONS**

ABA  Australian Breastfeeding Association

ACCHO  Aboriginal Community Controlled Health Organisation

CaLDB  Culturally and Linguistically Diverse Background

OD  Western Australian Operational Directive Statewide Co-sleeping/Bed-sharing policy

SIDS  Sudden Infant Death Syndrome

SUDI  Sudden Unexpected Death in Infancy

SUEND  Sudden Unexpected Neonatal Death

UNICEF  United Nations Children’s Fund

WNHS  Women and Newborn Health Service

**EXECUTIVE SUMMARY**

**INTRODUCTION**
The topic of co-sleeping is a controversial area where there can be polarised views and a wide range of perspectives articulated by health professionals, health educators, researchers and parents. Health professionals and workers based in maternity health system services are required by the Department of Health’s operational directive to implement co-sleeping education within contexts characterised by multiple tensions and challenges. These tensions arise from ‘top-down’ organisational cultures and expectations about how co-sleeping education should be delivered, as well as the need to respond to and negotiate the complex and diverse beliefs and attitudes of parents that may differ from those of health professionals.

The purpose of this evaluation was to assess the effectiveness of the implementation and dissemination processes of the Western Australian Operational Directive State-wide Co-sleeping/Bed-sharing policy OD0139/08 (OD) across state government maternity units, private hospital maternity units, child health and community health services in Western Australia. The evaluation also included the identification and analysis of other sources of co-sleeping information, policy, guidelines and directives used by health professionals/workers in maternity health system services [See Matrix 1, p.110].

**KEY OBJECTIVES**

The key objectives of this study include the following:

- To map the processes Area Health Services, maternity hospitals and other maternity system services use to disseminate the co-sleeping directive.

- To identify what individual health workers understand about the co-sleeping directive, how they interpret and respond to the recommendations in their everyday practice.

- To explore how health professionals and workers respond to the concerns of parents who wish to optimise the likelihood of skin to skin contact and the successful establishment of breastfeeding in light of the directive’s recommendations.

- To explore how Aboriginal women and women from Culturally and Linguistically Diverse Backgrounds (CaLDB) are provided with information about co-sleeping and determine the cultural appropriateness of the information and educational processes used.

- To determine how women receive information about the directive, in what form and how they respond to its recommendations (in hospital and on discharge). To explore what they understand about it, how they practice the recommendations and clarify their views on the usefulness and limitations of it.
HOW THE EVALUATION WAS CONDUCTED

Mixed research methods were used consisting of an audit, in-depth interviews and focus groups. These methods were used to elicit information about how the OD and other co-sleeping education strategies were implemented in a range of maternity system services.

A documentary overview of the co-sleeping resources and policies used by maternity health services was also compiled and analysed.

The sampling frame for the evaluation was drawn from maternity health service information internet pages, global email and contacts provided by project reference group members and other advisory groups to the evaluation. The researcher’s own networks and newspaper advertisements were also used to recruit health professionals/workers and mothers as participants.

This evaluation comprised an audit of 49 health worker participants including midwives from private and government maternity units, community midwives based in multicultural and community health services, child health nurses, nurses from private practice, hospital based social workers and health educators. Twenty-seven (27) health worker participants (including midwives, child health nurses hospital based social workers and health educators) participated further in the research through interviews and focus groups.

Twenty-four (24) mothers from metropolitan and regional areas of WA were also interviewed. These were participants who had birthed within the previous 2-12 months. Two focus groups, one with 4 women from an ‘attachment’ play group, the other with 6 Aboriginal mothers and a grandmother were facilitated.

WHAT THE EVALUATION FOUND

REVIEW OF THE CO-SLEEPING RESOURCES USED BY HEALTH PROFESSIONALS AND WOMEN

- The most consistent co-sleeping messages across the co-sleeping resources refer to smoking, excessive bedding, baby sleeping in their own cot in parents’ room, baby sleeping on their back and no soft surfaces

- There is inconsistency across the range of co-sleeping resources about the other risk factors (including swaddling and trapping) associated with co-sleeping deaths.
Health professionals/workers are implementing co-sleeping education in situations where they may experience multiple pressures, including organisational expectations, government policies, parental attitudes and beliefs in an area where there are diverse and contested views about the risks and benefits associated with co-sleeping. Whilst the majority of health professionals/workers acknowledged that the OD was effectively disseminated throughout private and government maternity units in particular, there was less agreement about how its recommendations were implemented or evaluated. A majority of health workers identified the need for follow up professional development about how to implement co-sleeping education to more effectively meet the needs of diverse women.

The OD, WNHS Co-sleeping/Safe sleeping and SIDS & Kids Co-sleeping brochures are referred to by a majority of midwives and were the most likely co-sleeping resources to be disseminated by health professionals in public and private maternity units. Community midwives, child health nurses and Aboriginal Health Workers were less likely to have received, or know about, the OD or the WNHS Co-sleeping/Safe sleeping brochures. Just under half of midwives and child health nurses questioned the scientific basis of the OD, pointing out that more clarity was needed about the absolute risk for co-sleeping deaths for healthy mothers and babies and when all other risk factors had been accounted for.

The SIDS & Kids Brochure was reported as being the most commonly disseminated co-sleeping brochure to mothers – although some health workers describe this as ‘ticking a box’ rather than providing effective co-sleeping education.

The audit also highlighted that implementing the OD recommendations created some tensions for health workers in the following situations:

- When women were well educated about attachment or bonding theories.
- Were concerned about the importance of bonding and breastfeeding, and
- The cultural background of women meant they were much more likely to normalise co-sleeping.

The audit also identified a lack of culturally appropriate and relevant co-sleeping information for Aboriginal and CalDB women.

The key findings from the interviews and focus groups identified that:

- Midwives working in government and private maternity units based in metropolitan and regional hospitals were the most likely to refer to the OD. The OD was less likely to be known about or used by the 3 lactation consultants (including hospital based) midwives in community health settings or the 6 midwives, Aboriginal health workers and social workers from Aboriginal Community Controlled Health Organisations
- A need for more consistent messages about co-sleeping risks that included information for parents about how to co-sleep more safely was identified by a majority of health
• A majority of health professionals/workers suggested that co-sleeping education should be presented and disseminated in a less directive way then was currently the case. They also described how implementing the OD in its current form, limited their ability to respond adequately to the diverse cultural, lifestyle and social circumstances of many of the women they cared for.

• Child health nurses and Aboriginal health workers maintained that co-sleeping education and information that is appropriate and relevant for fathers and other relatives and carers about safer co-sleeping requires development.

• A majority of health professionals/workers identified a need for professional development about co-sleeping to be included in university and college curricula. They also stated that the professional development about co-sleeping should be implemented in maternity health settings, be consistent and include ‘train the trainer’ modules as well as ‘e-learning’ case-studies that were interactive and accessible to a range of health workers.

• Several health professionals/workers referred to the range of safe sleeping aids and side cots available for sale in Australia and maintained that these should be assessed and a clear position from the Health Department and SIDS & Kids articulated, so that health workers can advise parents appropriately about their use. Parents and in some cases health professionals are currently advocating the use of these as a compromise for parents who intend to co-sleep.

• The issues of wrapping, babies sleeping in strollers and the use of second hand mattresses are key areas of confusion and contention for a range of health professionals/workers and were identified as ‘information gaps’ that the OD and SIDS and Kids education does not currently cover. Strategies and education about all of these should be more effectively informed by the cultural and social contexts within which they occur.

The following strategies were identified by midwives, child health nurses and social workers who were situated in community health services or who worked extensively with Aboriginal women as being more appropriate than current processes:

• Co-sleeping education that is culturally and language appropriate and that includes ‘safer’ co-sleeping messages (how to co-sleep more safely) should be developed and disseminated through multiple methods of story-telling, documentaries, face book, text messages and visual brochures.

• Local communities are consulted and involved in the design of new communication strategies about co-sleeping.

• Aboriginal women trained as co-sleeping educators are based in major maternity units to individually model and educate Aboriginal parents about the risks associated with co-
Community midwives working in multicultural health settings and child health nurses caring for CaLDB women all identified:

- A need for more culturally and language appropriate information for CaLD women.
- Appropriate language translators for CaLDB women attending major government maternity hospitals are available and used by maternity health staff, and
- The risk factor of over-heating associated with ‘wrapping’ is a key issue requiring more education, clarification and information for both health workers and CaLD women.

RESULTS OF THE WA PARENT INTERVIEWS AND FOCUS GROUP

The interviews and focus group consultations with mothers resulted in the following findings:

- Over half of the 34 women who participated in the study, co-slept with their babies at least once.
- The 6 Aboriginal mothers and grandmother consulted for the study all co-slept and described co-sleeping as ‘normal’ and an integral part of their culture.
- First time mothers were the most likely to recall receiving co-sleeping brochures and discussion about co-sleeping while in hospital, whilst most second time mothers received no information about co-sleeping while in hospital.
- Mothers who birthed in public maternity units were more likely to recall inconsistent responses to co-sleeping from midwives, with mothers birthing in private maternity units more likely to receive a consistent no co-sleeping message and structured education.
- Half of the women interviewed described fatigue, lack of sleep and pain medication as affecting their ability to remember or absorb information about co-sleeping.
- Several women stated that when they had accidentally co-slept with their babies in private and public maternity hospital beds they experienced feelings of fear when hospital midwives had advised them about baby deaths that had occurred as a consequence of co-sleeping.
- Aboriginal mothers who participated in this study stated they disagreed with midwives or child health nurses who advised them not to co-sleep and did not comply with this advice.
- About half of regular co-sleeping women described being supported by child health nurses and midwives in this decision.
- Four women recalled being told to not openly discuss co-sleeping either by midwives, lactation consultants or child health nurses.
• Women who had caesarean births in private and government maternity units were more likely than mothers who had not, to report difficulties establishing breastfeeding and being afraid of falling asleep with their babies in beds; they were also more likely to report not receiving adequate support in establishing breastfeeding.

• Women who co-slept and who wanted to maximise breastfeeding referred to the usefulness of the Australian Breastfeeding Association (ABA) pamphlet which illustrates a safe sleeping position for mother and baby in the same bed.

• Several women who stated they did not co-sleep in the early stages of the interview later revealed instances where they had co-slept, including on a couch, in a bed in a guest room and a partner co-sleeping with the baby. These were examples of where co-sleeping circumstances may be under-reported by parents, or are not considered co-sleeping because they did not occur in the parental bed.

• Several mothers related partners’ reluctance to room-share or co-sleep with baby due to fears about the effects on their sexual and intimate relationships.

• The Aboriginal mothers who participated in the study stated that their partners slept in other beds or rooms so that babies and children could sleep with mothers.

• Most of the women who co-slept from 3-6 months did so mainly as result of their own, or the baby’s illness, or because their baby was a restless sleeper. Women who were regular co-sleepers from the baby’s birth, usually did so to establish and continue breastfeeding, bonding and because they viewed not doing so as unnatural.

• The Aboriginal mothers and an Aboriginal grandmother maintained that larger families, lack of appropriate housing and the socio-economic circumstances of many Aboriginal families meant that co-sleeping was inevitable and viewed this as even more likely in rural areas.

• Women most commonly used SIDS & Kids brochures, parenting books and magazines and the internet as sources of co-sleeping information.

• Women who co-slept regularly and articulated knowledge of ‘attachment theories’ contrasted these positively with what they saw as ‘controlled crying’ sleeping advice and separation which they associated with current SIDS & Kids advice.

• More than half of the women interviewed wanted more information about how to co-sleep more safely from a centrally based and unbiased official web-site. Three women suggested that the current co-sleeping policy was too driven by the coronial process and that it contradicted other government policies that advocated parental bonding and breastfeeding.

• Aboriginal mothers viewed current information about co-sleeping as inappropriate for their needs, although did refer to information about not smoking, drinking or sleeping with other children and partner in the same bed as themselves and the baby as being more useful.

• Just under half of women interviewed suggested that SIDS & Kids include safer co-sleeping information on their brochures in line with the ABA and UNICEF brochures.
• Several women including Aboriginal mothers asserted that an official position and information on safe sleeper aids could provide a useful compromise for women who wanted to co-sleep more safely.

CONCLUSION

Overall the evaluation has shown that generally the OD is well disseminated throughout government and private maternity units, however, is less well distributed or known about in community health and Aboriginal Community Controlled Health Organisation (ACCHO) settings. The manner in which the OD has been interpreted and responded to by the health professionals/workers in this evaluation has shown that the implementation of its recommendations seems on the surface quite effective. Whilst many women and health professionals know and understand what the key messages about co-sleeping are, there are multiple reasons for non-compliance or only partial adherence to the OD recommendations. These may include the philosophical beliefs and attitudes about bonding and attachment by health professionals and women, pragmatic considerations such as lack of sleep, limited access to material resources such as cots, overcrowded living conditions experienced by mothers and cultural beliefs (co-sleeping is normalised) by both health workers and mothers. Some health professionals and women also question the scientific basis for the OD and require more clarity around the absolute risk for co-sleeping deaths when mothers and babies are healthy and all other risk factors have been taken into account.

The evaluation also identified key areas of confusion and information gaps that are not directly addressed by the OD, particularly around the use of safe sleeping aids and side cots, wrapping, stroller sleeping and mattress fumes. These were all issues identified by both health professionals and women as requiring clarification and the development of appropriate information.

RECOMMENDATIONS

The following recommendations have been informed and synthesised from audit, interview and focus group results from health professionals/workers and the women who used maternity health system services. They are organised under the key evaluation objectives and can apply to more than one area.

DETERMINE AND MAP THE PROCESSES AREA HEALTH SERVICES, MATERNITY HOSPITALS AND OTHER MATERNITY SYSTEM SERVICES UTILISE TO DISSEMINATE THE CO-SLEEPING DIRECTIVE.

R 1. The OD is distributed to diverse maternity health system services, including those not connected to the Department’s ‘global email’, such as: community, women’s health, multicultural and Aboriginal Community Controlled Health Organisations.
R2. The implementation practices of the OD are evaluated, followed up regularly, are ongoing and better informed by the ‘realities’ of health workers’ every day experiences of caring for women and babies within the individual and diverse contexts they occur.

R3. Professional development and more comprehensive education about co-sleeping are offered and embedded in educational/professional curricula for midwifery, child health nurse, teaching, social work and Aboriginal health worker training. Professional development about co-sleeping is ongoing, includes consistent and credible information about the risks and ‘safer co-sleeping’ perspectives, utilises a ‘train the trainer’ method and interactive ‘e-learning’ modules that enable health professionals in a range of maternity system services to collaborate and discuss diverse ‘case-studies’ and co-sleeping issues.

**IDENTIFY WHAT INDIVIDUAL HEALTH WORKERS UNDERSTAND ABOUT THE CO-SLEEPING DIRECTIVE, HOW THEY INTERPRET AND RESPOND TO THE RECOMMENDATIONS IN THEIR EVERYDAY PRACTICE.**

R4. Health professionals/workers across maternity and child health services are provided with the education, organisational and emotional support and resources to openly discuss the issue of co-sleeping with women, in ways that enable them to conduct individual risk assessments of parents and provide education about how to co-sleep more safely if this is appropriate.

R5. Co-sleeping information and education is provided to all birthing women at maternity hospitals, including those who have previously had children; midwives are supported to ensure that women who are fatigued or under pain medication have had the opportunity to absorb and discuss co-sleeping information with them.

R13. Health workers who care for CaLD women and their babies require an urgent review and guidance about to respond to the issue of ‘wrapping’ babies in some CaLD communities.

R14. The issue of ‘toxic mattresses’ and the association with SIDS is confusing for mothers and health workers, clear and coherent information about ‘mattress fumes’ is required.

**EXPLORE HOW HEALTH PROFESSIONALS AND WORKERS RESPOND TO THE CONCERNS OF PARENTS WHO WISH TO OPTIMISE THE LIKELIHOOD OF SKIN TO SKIN CONTACT AND THE SUCCESSFUL ESTABLISHMENT OF BREASTFEEDING.**

R4. Health professionals/workers across maternity and child health services are provided with the education, organisational and emotional support and resources to openly discuss the issue of co-sleeping with women in ways that enable them to conduct individual risk assessments of parents and provide education about how to co-sleep more safely if this is appropriate.
R6. Health professionals/workers are adequately resourced so that women who have caesarean births, are taking pain medication, or are fatigued, receive appropriate support to maximise skin to skin contact and the successful establishment of breastfeeding; appropriate co-sleeping information is developed for fathers and partners of women.

R7. Improved information and guidance about the range of ‘safe-sleeper’ aids available from the internet and credible sites such as the ABA is provided by the Health Department and SIDS and Kids; identification and approval of side-cots that can be used in hospitals and home is expedited.

EXPLORE HOW ABORIGINAL WOMEN AND WOMEN FROM CALD COMMUNITIES ARE PROVIDED WITH INFORMATION ABOUT CO-SLEEPING AND DETERMINE THE CULTURAL APPROPRIATENESS OF THE INFORMATION PROVIDED.

R8. Culturally appropriate processes and information about co-sleeping including the provision of consistent and credible information about risks and ‘safer’ co-sleeping messages are developed for CaLD women and Aboriginal women; Aboriginal women trained as co-sleeping educators are based in major maternity units to individually model and educate Aboriginal parents about how to co-sleep more safely. Peer education strategies are developed and owned by local Aboriginal communities so that Aboriginal women and girls are educated by Aboriginal people within their own communities about the risks and benefits of co-sleeping, particularly for those women living in remote and rural locations.

R9. Health professionals/workers are supported and trained to recognise and respond to the particular cultural and lifestyle conditions and contexts within which Aboriginal women and CaLD women live, including cultural and life-style practices associated with birth and child care in these communities such as ‘wrapping’ and ‘stroller sleeping.’ Recognition of the cultural sensitivities in broaching these subjects are acknowledged and addressed in the professional development, policies and strategies used.

R10. Co-sleeping education and messages are consistent about risks and include ‘safer’ co-sleeping information and are disseminated and presented through social media, documentary, storytelling and visually based methods that are informed, developed and owned by local communities.

DETERMINE HOW WOMEN RECEIVE INFORMATION ABOUT THE DIRECTIVE, IN WHAT FORM AND HOW THEY RESPOND TO ITS RECOMMENDATIONS (IN HOSPITAL AND ON DISCHARGE).

R6. Health professionals/workers are adequately resourced so that women who have caesarean births, are taking pain medication or are fatigued receive appropriate support to maximise skin to skin contact and the successful establishment of breastfeeding; appropriate co-sleeping information is developed for fathers and partners of women.

R7. Improved information and guidance about the range of ‘safe-sleeper’ aids available from the internet and credible sites such as the ABA is provided by the Health Department and SIDS
and Kids; identification and approval of side-cots that can be used in hospitals and home is expedited.

R10. Co-sleeping education and messages are consistent about risks and include ‘safer’ co-sleeping information and are disseminated and presented through social media, documentary, story-telling and visually based methods that are informed and owned by local communities.

R11. Co-sleeping education and information are presented by health professionals in ways that are more open to discussion and not as directive.

R12. Balanced, credible information about co-sleeping including a range of scientific studies that presents all the benefits as well as the risks of co-sleeping is accessible on one official website – with opportunities for mediated forum discussions involving other women and health professionals.

R13. Health workers who care for CaLD women and their babies require an urgent review and guidance about how to respond to the issue of ‘wrapping’ babies in some CaLD communities.

R14. The issue of ‘toxic mattresses’ and the association with SIDS is confusing for mothers and health workers, clear and coherent information about ‘mattress fumes’ is required.

INTRODUCTION

The topic of co-sleeping is a controversial area where there can be polarised views and a wide range of perspectives espoused by health professionals/workers, health educators, researchers and parents.

The development of a co-sleeping policy in Western Australia has been initiated following a coronial inquest and recommendations for a state wide co-sleeping/bed-sharing policy for use across all

This evaluation was commissioned by the Women and Newborn Health Service and was conducted by the Collaboration for Applied Research and Evaluation at the Telethon Institute for Child Health Research. The purpose of the evaluation was to assess the effectiveness of the implementation and dissemination processes of the Western Australian Operational Directive State-wide Co-sleeping/Bed-sharing policy (OD) across maternity system services.

The evaluation also included the identification and analysis of other sources of co-sleeping information, policy, guidelines and directives that health professionals/workers in maternity health system services used to educate the WA parents they cared for.

This report presents the findings and recommendations gleaned from audit, focus group, email submission, face to face and telephone interviews with a range of health professionals/workers and parents from urban, regional and rural Western Australia.

The report also discusses how health professionals/workers are supported in responding to the complex issues of co-sleeping. It presents the barriers and facilitators for health professionals and workers in providing co-sleeping information and highlights the complexities and dilemmas in interpreting the intent and practice of the OD and SIDS & Kids recommendations. The complexities of providing information that is culturally appropriate and adequately responds to the diverse lifestyles of socially, geographically and culturally diverse groups are also explored.

Finally, the report will present suggestions about how to improve knowledge about co-sleeping and how to offer more effective support for health professionals, in their everyday practices of providing co-sleeping information and education to WA parents. The views and perspectives of WA mothers and their families will also importantly inform suggestions and recommendations for consideration in developing and disseminating co-sleeping information.

A comprehensive literature review on co-sleeping and the definitions of commonly associated terms with co-sleeping such as SIDS, SUDI and SUEND is also attached [See Appendix 1].

OBJECTIVES

The following section describes the key objectives around which the evaluation was organised, followed by the methodology deployed and the methods used to explore these.

KEY OBJECTIVES
• Determine and map the processes Area Health Services, maternity hospitals and other maternity system services utilise to disseminate the co-sleeping directive. [Audit].

• Identify what individual health workers understand about the co-sleeping directive, how they interpret and respond to the recommendations in their everyday practice. [Interview and Focus Group].

• Explore how health professionals and workers respond to the concerns of parents who wish to optimise the likelihood of skin to skin contact and the successful establishment of breastfeeding. [Interview and Focus Group].

• Explore how Aboriginal women and women from CaLD communities are provided with information about co-sleeping and determine the cultural appropriateness of the information provided. [Audit, Interview, Focus Group].

• Determine how women receive information about the directive, in what form and how they respond to its recommendations (in hospital and on discharge). [Interview, Focus Group with Mothers].

ETHICS

The evaluation project research plan was submitted to and received ethics approval from:

- King Edward Memorial Ethics Committee
- Western Australian Aboriginal Health and Information Ethics Committee
- Western Australian Country Health Services Ethics Committee
- Child and Adolescent Community Health

GOVERNANCE OF PROJECT

The recruitment and overall directions of the research evaluation have been guided by the project management group and reference groups. These have included:

- SIDS & Kids
- Representatives for Area Health Services
- Representatives from major private and public maternity hospitals
- Aboriginal Health Council of WA
- Aboriginal Maternity Services Support Unit
- Aboriginal Council for Collaboration and Research Evaluation

METHODOLOGY & METHODS
The sampling frame for this project has included a purposive selection of state-wide maternity services, including government, private, community, child health and ACCHO health services. This has been used for the audit, interview and focus group samples of health professionals/workers.

MEANS OF RECRUITMENT

Health professionals and workers were identified from official Western Australian Department of Health on-line information pages and invited to participate in the study through letters sent to maternity health services, global email and by health networks and contacts provided by project reference group members and the researcher’s own networks. Health workers could contact the researcher directly if they wished to participate, or were able to indicate on completed audits that they were willing to participate in either interviews or focus groups. They were also provided with information sheets and consent forms about the study.

Recruitment of WA parents for interview and focus group participation was initially by written invitation to all women identified by maternity or child health services as meeting inclusion criteria. Although women who had experienced the death of a child were excluded from the study this was modified at a later date (with ethics approval) upon the request of women within this category who provided written requests to be included in the study. Women under the age of 18 were not included in the study.

Health professionals/workers from relevant services were provided with invitation letters and information sheets about the research [See Appendix 3]. These were then distributed by health workers to women who met the inclusion criteria. The women then contacted the researcher directly if they wished to participate. Some women were also recruited from local newspaper advertisements and these women contacted the researcher directly.

CHARACTERISTICS OF PARTICIPANTS

Health professional/workers participants included midwives, child health nurses, Aboriginal health workers, clinical nurse managers, midwife consultants, community midwives, lactation consultants, social workers and health educators from government, private, child, community and ACCHO health sectors.
The women who were interviewed included those from metropolitan Perth, regional and rural areas. Around half of the sample was first time mothers while the remainder were mothers who had more than one child and who had birthed in the previous 2-12 months. Women who have given birth in private and government maternity units were included as well as those who had given birth at home. Five women identified themselves as Aboriginal women and several of the women were from CaLDB.

AUDITS

One hundred email surveys (and follow up phone calls/emails or visits if necessary) were sent to maternity hospital units, child health services and community health services including: Area Health Services, public and private maternity hospitals, GP networks and child health centres from metropolitan and regional area.

A response rate of 49 per cent was achieved. The different kinds of services that responded are detailed in the Table 1 below.

<table>
<thead>
<tr>
<th>Table 1 Maternity health service audit type and response</th>
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<tr>
<td>Health service type</td>
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<td>---------------------------------------------------------</td>
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<td>Government maternity units</td>
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<tr>
<td>Private maternity units</td>
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<tr>
<td>Child health services</td>
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<tr>
<td>Women’s health services including multicultural women’s services</td>
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<tr>
<td>Community health services</td>
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<tr>
<td>Aboriginal community controlled health services</td>
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<tr>
<td>General Practitioners/GP networks</td>
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<tr>
<td>Area Health Service</td>
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<td>TOTAL</td>
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*Note: Several midwives and child health nurses expressed their concern about being completely ‘honest’ in responses to the audit, although anonymity and confidentiality was assured – this issue may have also affected the response rate to the audit.
The purpose of the audit was to map how the OD was disseminated to the range of health professionals/workers, how they implemented the recommendations of the OD and what other forms of co-sleeping education was used. The audit also asked respondents to identify key barriers and facilitators to implementing the recommendations of the OD and other forms of co-sleeping education. [See Appendix 7 Audit Tool].

HEALTH PROFESSIONAL/WORKER INTERVIEW AND FOCUS GROUP CHARACTERISTICS

The health worker focus group and interview samples have been combined to preserve the confidentiality of the participating organisations as well as the health professionals/workers who worked in them. Many of the health professionals/workers who participated in the study shared their concern about being ‘honest’ about what they thought.

Confidentiality of participation has not been possible for some organisations such as SIDS & Kids and services for young women, because of their unique roles in a relatively small population, however, the researcher has submitted this report for the perusal of these participants so they could comment, make changes if required and ensure that their contributions have been represented accurately and in ways that will not prejudice them.

The combined interview and focus group spread of organizations is presented in the tables below to illustrate the types of health occupations, geographical locations and service organisations that participated in the evaluation. Table 2 shows the numbers and kinds of health occupations represented in the evaluation.

Table 2 Type and numbers of health professional/worker participants

<table>
<thead>
<tr>
<th>Clinical Midwife Consultants Managers</th>
<th>Lactation Consultants</th>
<th>Midwives</th>
<th>Aboriginal Health Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Child Health Nurses</td>
<td>Paediatric Nurses</td>
<td>Community Educations</td>
<td>Social Workers</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Staff Development Manager/ Maternity</td>
<td>Maternal Health Program Manager</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3 shows the geographical reach of the evaluation and shows that maternity health services from diverse metropolitan and regional areas are represented.

Table 3 Geographical Areas of Participation
Table 4 shows that the evaluation has included the participation of different kinds of maternity system services including those that work with Aboriginal women, young women and women from culturally and linguistically diverse backgrounds.

**Table 4 Participation by type of service organisation**

<table>
<thead>
<tr>
<th>Category</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Community Controlled Health Organisations</td>
<td>3</td>
</tr>
<tr>
<td>Aboriginal Community Specific Services</td>
<td>2</td>
</tr>
<tr>
<td>Adolescent Maternity Services</td>
<td>1</td>
</tr>
<tr>
<td>Child Health Services</td>
<td>5</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>3</td>
</tr>
<tr>
<td>Government Maternity Hospital Units</td>
<td>6</td>
</tr>
<tr>
<td>Multicultural Women’s Health Services</td>
<td>2</td>
</tr>
<tr>
<td>Private Maternity Hospital Units</td>
<td>2</td>
</tr>
<tr>
<td>Women’s Health/Support Services</td>
<td>2</td>
</tr>
<tr>
<td>Non-government SIDS education</td>
<td>1</td>
</tr>
</tbody>
</table>

**HEALTH SERVICE FOCUS GROUPS (15 PARTICIPANTS)**

A focus group inviting participants to discuss their knowledge and use of the OD was co-convened by the TICHR Researcher and SIDS & Kids educators. Eleven participants from metropolitan Perth, including midwives, Aboriginal health workers, lactation consultants and health educators from public and private maternity units, multicultural health services, women’s and community health services and SIDS & Kids, described their knowledge and use of the OD. The discussion was jointly facilitated by the researcher and the Aboriginal Education Officer from SIDS & Kids.

A second focus group of 4 participants that included a midwife, Aboriginal health workers and social and emotional health educators was also conducted with an Aboriginal Community Controlled Health Service in a regional area. Both focus groups were facilitated and discussions organised about how health workers had obtained and used the OD, how they interpreted and practiced its recommendations in their everyday practice, the key barriers and facilitators to implementing the
OD and how appropriate the information and recommendations from the OD were for their particular client groups. [Questions used in the focus groups and interviews are attached in Appendix 2].

INTERVIEWS HEALTH PROFESSIONALS/WORKERS (12 PARTICIPANTS)

Twelve in-depth interviews were conducted with a range of health professionals/workers, including: midwives, lactation consultants, health educators and child health nurses from metropolitan, regional and remote WA. The maternity services included an Aboriginal antenatal clinic, community health service and an adolescent maternity unit. Half of the participants were from regional areas in WA including the Pilbara, the South West, Goldfields and Mid-west.

The results of the 2nd qualitative phase of the evaluation are presented below. As the same kinds of questions were asked whether health professionals were interviewed or participated in a focus group the results will be combined, however, where there are differences between the two methods these will be identified as appropriate and the findings presented separately. The themes and sub-themes arising from this analysis are arranged where appropriate under the key objectives of the evaluation. A combined discussion of the three phases of the study will follow this, combining the major findings from the audits, interviews and focus group consultations with health workers and women. [See also attached Matrix 1 of co-sleeping resources used across cohorts 1 & 2].

INTERVIEWS WA PARENTS (24 PARTICIPANTS)

Information collected through in-depth interviews and focus groups was used to investigate current understandings of co-sleeping, what types of information and education have been received, and how women used this information. The time frame used (birthed 2-12 months ago) enabled parents to describe their practice after discharge from hospital but was also recent enough for them to recall any information provided whilst in hospital. Women who have used regional maternity or child health services were interviewed by phone, if face to face interviews were not possible or were able to answer questions by email.

FOCUS GROUPS WA PARENTS (10 PARTICIPANTS)

Two focus groups with parents were convened. One of these was with a group of 4 women who belonged to the same play group and all of whom subscribed to attachment theories about child care. The other group were 5 Aboriginal mothers and 1 Aboriginal grandmother. Both groups were asked similar questions about how they received co-sleeping information, how they used it and how useful it was to them.

DATA ANALYSIS

METHODS OF DATA ANALYSIS AND INTEGRITY
Data was analysed according to the grounded theory approach, whereupon concepts, categories and themes were identified and developed while the research was being conducted. A constant comparative approach was utilised to elicit common themes and issues. Findings from all sources of data, including documentary evidence, health professional and women’s focus group and interview perspectives was compared and contrasted to identify points of difference and similarity about the effectiveness of the OD’s implementation and dissemination. A matrix was developed to illustrate key themes and sub-themes derived from the data about the implementation and dissemination of the co-sleeping operational directive [See Appendix 8]. Preliminary and emerging results of the evaluation were continuously disseminated to the project reference group members and key informants from Aboriginal and CaLD communities for feedback and comment. The women’s interviews and focus group findings were provided to a consumer representative for feedback and comment.

<table>
<thead>
<tr>
<th>LIMITATIONS OF SAMPLE, METHODS &amp; METHODOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>While the evaluation has incorporated a good cross-section of different health professionals and workers who provide services across public, private and community health settings the research was only able to gain very limited participation from general practitioners, despite numerous attempts to achieve this, including formal applications to key GP networks.</td>
</tr>
<tr>
<td>Another limitation which is common to all voluntary participation research may be that those health professionals, workers and women who feel strongly about the topic of co-sleeping may have been more likely to respond and participate.</td>
</tr>
<tr>
<td>Co-sleeping is a highly charged and controversial topic. The researcher was alerted to trepidation on the part of a significant number of health workers who worked in government and community health settings about responding ‘honestly’ to questions about how they viewed the OD and methods of dissemination and implementation of the recommendations. Although health workers were assured of confidentiality (and chose to participate) some of their views may have been modified particularly for those participating in focus groups. This tentativeness has also affected the response rate of the audits and the ways in which health workers responded to questions about their own practice, with two child health nurses expressing misgivings about participating.</td>
</tr>
</tbody>
</table>
RESULTS OF THE REVIEW OF THE DISSEMINATION AND CONTENT OF CO-SLEEPING RESOURCES

The co-sleeping information that was reviewed for this evaluation included brochures and magazines designed specifically for parents, as well as policies, guidelines and directives developed for health services staff in maternity, child health and community health settings. A detailed analysis of the content of these is provided in Appendices 8 and 9. The policies, brochures and resources that health professionals/workers referred to, how they were disseminated and those they provided to women are summarised below:

The Department of Health Western Australian Operational Directive State-wide Co-sleeping OD0139/08 (OD) was referred to most commonly by public hospital maternity staff and by about half of the child health nurses. It was most commonly accessed by global email. A significant number of child health nurses, community midwives, women’s health services and Aboriginal health workers who participated in the research had not heard of or used the Operational Directive. Lactation consultants, community midwives and child health nurses were the most likely to question the scientific basis for the OD recommendations and wanted more clarity about the absolute risk for co-sleeping deaths, when mothers and babies were healthy and when all other risk factors had been accounted for.

The Women and Newborn Health Service (WNHS) co-sleeping/bed sharing information for parents [brochure] was referred to most commonly by public hospital maternity units. Some child health nurses also reported using this but much less commonly than the SIDS & Kids brochure. Rural or remote health services were also much less likely to have received the WNHS brochure. One service stated they were waiting for the ‘up-dated’ version. Child health nurses were most likely to state they had not ‘heard’ of the brochure. Some Aboriginal and community health services had ‘heard’ of the brochure but did not use it because there ‘was too much writing and information’ for effective use in their client groups.

The WNHS Clinical Guidelines Section B: Obstetrics and Midwifery Guidelines 10.2, Care of Neonate 10.2, Care of Neonate in the ward [Guidelines for health/medical hospital staff] were referred to most commonly by government hospital maternity units. Government maternity units were more likely to refer to this than other kinds of maternity services. These guidelines direct readers to the OD and SIDS & Kids information on safe sleeping.

The SIDS & Kids Safe Sleeping: Reducing the Risk of Sudden Infant Death Syndrome (SIDS) [Brochure for parents] was most consistently referred to by public maternity hospital units, child health nurses and lactation consultants. All the health services that responded to the audit indicated that this brochure was used, although some services stated that dissemination to all the women that attended their service was not universal. It was not clear why some women were not given the brochure and was an issue subsequently explored through focus groups and/or interviews.

The SIDS & Kids Reducing the risk of SIDS in Aboriginal communities [Brochure for parents] was most commonly referred to by public hospital maternity units, Aboriginal health workers and some child
health nurses. This brochure was considered more appropriate for Aboriginal families than other forms of co-sleeping education because it uses visual representations and a clear message.

Community Health Policies, Procedures and Guidelines Birth to School Entry 3.3 Guidelines for universal meeting schedule 3.3.2 universal postnatal first contact [Guidelines for Child Health Nurses]. This was referred to by Child Health Nurses and is intended to prompt child health nurses to ask parents a range of questions about their intentions regarding sleeping arrangements for their babies.

The Metropolitan Public Hospital Practice Guidelines [A metropolitan public maternity unit guidelines for medical/hospital staff] was referred to by a public maternity hospital. These guidelines refer to the OD and the WNHS Co-sleeping/bed sharing brochure.

The Metropolitan Public Hospital Obstetrics and Gynaecology Manual Policy [A metropolitan maternity unit guideline for medical/hospital staff] refers staff to the OD, Midwifery Clinical Guidelines 10.2.5 and SIDS & Kids website and Australian Government Health Insite Website. This policy was submitted by a public maternity hospital.

The Metropolitan Public Hospital Acute Nursing Policy [Policy for medical/health staff in public maternity unit] includes recommendations for verbal advice and advocacy for preventing SIDS, refers to the OD, SIDS & Kids website, what to advise on discharge, provision of written information through the WNHS Co-sleeping/bed sharing brochure and SIDS & Kids brochure on Safe Sleeping. This was referred to by a public maternity hospital.

The Department of Health WA “Welcome to your new baby” magazine, provides information for parents about safe sleeping, referring to SIDS & Kids information. The magazine does not advocate co-sleeping but same room sharing in the baby’s own cot for the first 6-12 months. This was referred to by several child health nurses.

The Lactation Resource Centre & Australian Breastfeeding Association “Is your baby sleeping safely” [brochure] was referred to by a community health centre, two lactation consultants and identified as being useful by a child health nurse. This brochure does not advise against co-sleeping but does emphasise that all the ‘risk factors’ are addressed. It is detailed about the conditions under which co-sleeping can be ‘safer.’ This was also identified by a midwife working in an ACHHO as a more appropriate resource for Aboriginal Health Services.

The UNICEF “Sharing a bed with your baby. A guide for breastfeeding mothers” [brochure] was used by a lactation consultant and community health nurse located in a rural service. The brochure advocates co-sleeping for the first six months to maximise breastfeeding, however, is detailed about the conditions under which this occurs and highlights the key risk factors. It also emphasises the conditions under which co-sleeping should not occur, such as when parents are under the influence of alcohol or drugs, if the baby is pre-term or if the baby has a high temperature.

These twelve co-sleeping resources identified by health professionals/workers and submitted to the researcher have been analysed to highlight common risk factors that were identified, as well as consistencies and inconsistencies in the range of information used. The following two diagrams
highlight the risk factors emphasised by the 12 co-sleeping resources used and the consistency of information that is provided.

**RISK FACTORS HIGHLIGHTED IN THE CO-SLEEPING RESOURCES**

Chart 1 below illustrates the risk factors and issues emphasised in the 12 co-sleeping resources provided to the researcher by the health service provider respondents.

Chart 1 Consistency of co-sleeping risk factors highlighted across 12 co-sleeping resources

Chart 1 shows that the most consistent co-sleeping messages refer to smoking, excessive bedding, baby sleeping in their own cot in parents’ room, baby sleeping on their back and no soft surfaces. While all of the risk factors (except swaddling) are in the WNHS Co-sleeping brochure the other co-sleeping resources used by health services vary in the risk factors that they highlight. The risk factor of ‘swaddling’ was only directly referred to in two of the resources and these did not include the OD or WNHS Co-sleeping brochure. Only four of the resources use diagrams or illustrations in a way that is educational (most just show photos of parents with babies) [See Appendix 9].
CO-SLEEPING RISK AGES

The ages at which co-sleeping was considered less risky were also inconsistent, with 4 sources not stipulating these and others varying from 11 weeks to 4 months as shown in the Figure 1 below:

Figure 1 Co-sleeping risk ages across full range of co-sleeping resources supplied.

Co-sleeping was usually described as most risky for babies under 11 weeks, although there is some inconsistency between different sources of co-sleeping information. For example, the WNHS Co-sleeping bed-sharing brochure stipulates this as “under 4 months of age” whilst the Operational Directive states “11 weeks of age” and the WNHS Midwifery Clinical Guidelines stipulate “under 2-3 months of age.” The SIDS & Kids brochures do not identify any age for safer co-sleeping and this is in contrast with the Lactation Resource Centre and Australian Breastfeeding Association brochure which does not identify any age where co-sleeping may be more risky.
MATERNITY HEALTH SERVICES AUDIT RESULTS

The maternity health services audit identified the co-sleeping resources most commonly referred to and used by maternity and child health services. The audit also identified the key organisational barriers and facilitators to providing co-sleeping education to women.

THE USE OF THE OD AND OTHER CO-SLEEPING RESOURCES - GOVERNMENT MATERNITY UNIT AUDIT RESPONSE

Chart 2 below shows that although the OD is used by 15 of the 19 government maternity units it is not universally referred to, although the SIDS & Kids safe sleeping brochure is. Fifteen of these units also refer to the WNHS Co-sleeping brochure.

Chart 2 Government maternity units’ types and proportion of co-sleeping resources used

Co-sleeping resources used by WA government maternity units

![Graph showing the use of co-sleeping resources]

Chart 2 also shows that professional development regarding the use of the OD and other co-sleeping resources was identified as being available to only 11 of the 19 respondents. As can be seen by the results 15 of the respondents use other forms of co-sleeping information including on-line journals. Less than five services reported used follow up processes regarding co-sleeping after discharge.

CHILD HEALTH SERVICE RESPONDENTS

Child health services all reported using the SIDS & Kids brochures, with 13 using the OD and 8 the WNHS Co-sleeping Brochure. These results are presented in Chart 3 below.
The audit did not ask as specific question about the “Welcome to your new baby” magazine (as at the time this resource was unknown to the researcher). This and other community health policies were identified later in interviews and focus groups with child health nurses.

The issue of professional development about how to use the OD and other co-sleeping resources was identified as adequate by only 6 of the 16 child health nurse respondents. This issue was also raised consistently in the ‘additional comments’ across the range of health professionals/workers who stated that although dissemination processes were effective – the ‘how to’ implementation of the OD and other co-sleeping directives was not clear and that there appeared to be little follow up about how these directives and other policies worked on the ground, in both government maternity hospital and child health settings.

Twelve of the child health nurse respondents also use other forms of co-sleeping resources such as on-line journals.

**COMBINED HEALTH SERVICE RESPONDENTS**

The information that was provided to mothers about co-sleeping varied across the range of health service provider respondents. SIDS & Kids information was universally available at all health services and this is a resource that does not recommend co-sleeping for any age of infant. The policies and guidelines developed by the WNHS and the Health Department (which were the next most commonly referred to resources) whilst not advocating co-sleeping, particularly for babies under 11 weeks, do provide some information about ‘safer’ co-sleeping and also highlight the situations where it is particularly risky to do so. It was not clear from the audit results how child health nurses ensured follow up of women who were recently discharged from hospital.
Both of the private maternity units that responded to the survey indicated that they referred to the OD, one also referred to the WNHS co-sleeping brochure and both reported using the SIDS & Kids brochure. The community health services both reported using the SIDS & Kids brochures.

**HOW MUCH HEALTH PROFESSIONALS/WORKERS ARE SUPPORTED IN THE PROVISION OF CO-SLEEPING EDUCATION AND INFORMATION**

This section presents the results of the audit/survey questions about co-sleeping resources that asked health professionals/workers to reflect on how much their organisation supported them in disseminating and implementing the OD and other forms of co-sleeping education and advice. Chart 4 illustrates the extent to which government maternity health workers/professionals felt they were supported in various aspects of this and shows that most of the health professional/worker respondents agreed, or strongly agreed, they were supported in ensuring all workers knew about the OD.

Once again the SIDS & Kids brochure for parents seemed the most likely source of information to be disseminated, with health workers less often strongly agreeing that the WNHS Safe Sleeping Brochure was given to all women. Some workers were better placed than others in being able to offer adequate time and resources to respond to women’s questions about co-sleeping. Similar results were also reported for knowing where to refer women when workers were unable to answer questions about co-sleeping themselves. Areas where there was less agreement about being supported included in discharge strategies for following up co-sleeping practice and the provision of culturally appropriate co-sleeping information and education to women from culturally and linguistically diverse backgrounds.

**Chart 4 How much government maternity health professionals/workers agree that their organisation supports them in providing education about co-sleeping.**

![Chart 4](image)

In contrast, child health nurses were less likely to agree that all workers know about the OD and WNHS co-sleeping brochure as shown in Chart 5. A number of the child health nurses did comment on the audit that the WNHS co-sleeping brochure was ‘not known’ to them. Stronger areas of
agreement related to the dissemination of the SIDS & Kids brochure (although this was not universal).

Chart 5 How much child health nurses agree that their organisation supports them in providing education about co-sleeping

The issue of being provided with professional development and additional information about the OD was referred to as an area where child health nurses reported less support. They were also more likely to report less agreement about having adequate time and resources to respond to women’s questions about co-sleeping. In common with government maternity service workers child health nurses also expressed reservations about the adequacy of culturally appropriate co-sleeping information for culturally and linguistically diverse women. Child health nurses were also less likely to agree that all women were provided with the WNHS Co-sleeping brochure.

Audit respondents were also provided with space to write additional commentary about any issues they felt required further comment. The following points show the concerns and issues highlighted by health workers:

- Health professionals need to impart a lot of information to new parents and often have limited time and resources to do this.

- Midwives and child health nurses described the tensions in providing ‘no co-sleeping’ advice to women who they knew would co-sleep.

- A midwife manager of a major maternity unit stated that the ability to use side cots on maternity wards would resolve conflict or tension between midwives and women who wanted to co-sleep.
• Community midwives and lactation consultants were more likely to describe the OD as not reflecting the ‘reality’ of what went on in parents’ homes.

• Child health nurses and midwives highlighted how parents’ knowledge of ‘attachment theories’ and information about ‘bonding’ made it difficult to advocate a no co-sleeping position.

• Most health workers described the dissemination of the OD as effective but that there was little or no guidance about how to implement its recommendations, or evaluate what was being done.

• Child health nurses identified a need for more culturally appropriate information for CaLD women and that as both CaLD and Aboriginal women were the most likely to co-sleep, they should be able to provide them with ‘safer’ co-sleeping education and information.

• Midwives and child health nurses highlighted inconsistencies in information about co-sleeping including: women not realising sleeping on a chair or sofa with their baby was co-sleeping, women putting their babies to sleep on their tummies because this had been done in hospital and mothers using foam bolsters in cots and beds.

• Some midwives and child health nurses described the dissemination of SIDS & Kids brochures as ‘ticking a box’ that did not result in effective co-sleeping education for women.
**SUMMARY OF AUDIT RESULTS**

- The Operational Directive, WNHS Co-sleeping/Safe sleeping and SIDS & Kids Co-sleeping brochures are referred to by a majority of midwives involved in this study and were the most likely co-sleeping resources to be disseminated in public and private maternity units. The OD was most commonly received by global email. Community midwives, child health nurses in regional areas and Aboriginal Health Workers were less likely to have received or know about the OD or the WNHS Co-sleeping/Safe sleeping brochures. They were also least likely to use SIDS & Kids Brochures.

- The SIDS & Kids Brochure is the most commonly disseminated co-sleeping brochure – although some health workers describe this as ‘ticking a box’ rather than providing effective co-sleeping education.

- There is inconsistency across the co-sleeping resources about the age when babies are most at risk when co-sleeping.

- The most consistent co-sleeping messages across the co-sleeping resources refer to smoking, excessive bedding, baby sleeping in their own cot in parents’ room, baby sleeping on their back and no soft surfaces.

- There is inconsistency across the range of co-sleeping resources about the other risk factors (including swaddling and trapping) associated with co-sleeping deaths.

- A range of health workers identified difficulties in advising women not to co-sleep, particularly when women were well educated about attachment theories, and were concerned about the importance of bonding and breastfeeding, or when women’s cultural background meant they were much more likely to normalise co-sleeping.

- Health workers across services identified a lack of culturally appropriate and relevant co-sleeping information for Aboriginal and CaLD women.

- Child health nurses were most likely to express reservations about the availability of professional development to implement the OD recommendations.

The key audit results have informed the kinds of questions and themes explored in the health professional/worker focus groups and interviews which are presented in the following section.
INTERVIEW AND FOCUS GROUP RESULTS

The following section presents the results from the interview and focus group consultations with health professionals/workers. As the same kinds of questions were asked whether health professionals were interviewed, or participated in focus groups, the results will be combined, however, where there are differences between the two methods these have been identified as appropriate and the findings presented separately.

HOW DID HEALTH WORKERS KNOW ABOUT AND ACCESS THE OD?

The majority of health professional/worker participants recalled first knowing about the OD through the global email system. Less than half of the participants identified this as the way they first heard about the OD. Midwife managers or consultants from government maternity units were the most likely to say they had received the OD through the WA health global email system. Midwives from community health settings, Aboriginal and Multicultural Health Services were much less likely to recall the global email or other method. Several of these participants followed up the OD on-line as a result of the research participation request – although some re-called they had also paid more attention to the subject of co-sleeping as a result of the media coverage of a baby’s death in a Kalgoorlie Hospital. The child health nurses who were interviewed also referred to the global email as the method for obtaining the OD, although one child/community health nurse and a program manager who worked for an Aboriginal Community Controlled Health Organisation had not heard of the OD and were also not familiar with the term ‘co-sleeping.’

WHAT OTHER CO-SLEEPING EDUCATION WAS USED?

The majority of health professional/worker participants referred to the SIDS & Kids brochure as a ‘standard’ information source that was handed out to parents. Most of the midwives in government maternity units and child health nurses referred to the “little purple book” and assumed that the majority of mothers would have received the SIDS & Kids brochures on co-sleeping along with other brochures in the back of this.

Child health nurses were more likely to refer to the “Welcome to your new baby magazine” and would describe discussing the issue of co-sleeping with new parents usually within the context of talking about general ‘sleep’ and breastfeeding issues. Child health nurses who worked in regional and remote areas with Aboriginal and CaLD women most often used the SIDS & Kids brochures because of the clarity of the visual information provided, supplementing this with the UNICEF brochure, particularly if women stated an intention to co-sleep. One child health nurse who worked extensively with Aboriginal mothers described also using ‘no-smoking’ and ‘Asthma’ information on being ‘smoke-free’ to minimise the risks for mothers and babies who she considered would be likely to co-sleep.

Child health nurses were less likely to know about the Women and Newborns Co-sleeping/Bed Sharing Brochure. One child health nurse in a remote area who obtained a copy of this brochure as a consequence of this research found it useful because of the section on ‘safer’ co-sleeping, but then
described the difficulties in obtaining sufficient copies and also wanted to know whether this resource had been ‘officially endorsed’ by the WA Country Health Service.

Two midwives from different regional Aboriginal Community Controlled Health Organisations described the Women and Newborn Health Service Safe Co-Sleeping/Bed sharing Brochure and the SIDS & Kids Safe Sleeping Brochure as unsuitable for their client group. The Women and Newborn brochure was described as being “too wordy” and long, while the SIDS & Kids brochure with its emphasis on ‘cot’ sleeping was not culturally relevant for many Aboriginal women. These midwives did not consider the OD recommendations appropriate for their client groups. The SIDS & Kids Aboriginal specific SIDS Brochure with clear visual illustrations was identified as being more useful with its emphasis on a ‘safe sleeping site’ rather than a cot. The UNICEF and Australian Breastfeeding Association (ABA) Brochures were considered the most appropriate for their client group, because they depicted a visual representation of how women could sleep more safely with their babies in a bed.

Lactation consultants and community midwives were also more likely to refer to the UNICEF or ABA brochures as being more useful for their client groups because of the sections on how to co-sleep more safely and the illustration of the mother sleeping with the baby in the same bed. A paediatric nurse used the Women and Newborn Health Service Brochure, SIDS & Kids and also their own ‘in-house’ print outs compiled by another nurse about co-sleeping risks.

All health professionals described the importance of talking about co-sleeping as well as handing out of pamphlets (this is discussed further in the next section), although most also related to limitations in their ability to do this, either because of not having enough time, or because parents might bring up other pressing issues about the care of their baby, that were prioritised over this issue.

HOW USEFUL IS THE OD FOR HEALTH WORKERS AND PARENTS? HOW DO HEALTH WORKERS INTERPRET IT IN THEIR EVERYDAY PRACTICE?

The majority of health professionals/worked consulted for this study were unlikely to follow the recommendations of the OD to the letter. Several health professionals including midwife managers, lactation consultants, child health nurses and community midwives viewed the intent of the OD as being ‘legalistic’ and not reflecting the scientific evidence that was more supportive of the benefits of co-sleeping. A midwife who had worked in both government maternity and community settings summed this view up in the following way:

“I don’t like the fact that we’re just supposed to say don’t do it. You can’t say to somebody don’t do it. But you can show them how to do it safely. At X Government Maternity Hospital you know it’s everywhere [information about not co-sleeping]. It’s hanging on the cots and it’s all over the wall – you can’t just say to people, no don’t do that.”[Metro Focus Group Participant MW2].

A child health nurse who cared for a mother and family who had experienced the death of a baby was an exception to this general view and described the OD and associated co-sleeping education as not providing sufficient evidence about the absolute risks of co-sleeping. Claiming that not enough clear scientific evidence was provided to support a no co-sleeping stance, she reflected that it was
very difficult to dissuade women who intended to co-sleep about the risks as this was a very emotive issue and co-sleeping was considered ‘natural and nice’.

A paediatric nurse who claimed that she adopted the intent of the OD on co-sleeping at work, was herself a co-sleeping mother and described feeling ‘conflict’ about adhering to a no co-sleeping position with the women and babies she cared for. She also stated that it was difficult to insist on separation when mothers and babies came to the hospital for treatment after possibly establishing co-sleeping patterns at home.

Two thirds of the health professionals/workers interviewed or in focus groups would describe using a general ‘de-fault’ position of advising mothers about all the risks associated with co-sleeping, while at the same time being clear that this was their ‘official position’ and as a ‘midwife’ or ‘child health nurse’ this is what they had to tell them. If mothers explicitly stated they were going to co-sleep, or if they sensed mothers were likely to co-sleep, even if they did not state this intention, health professionals/workers would then go on to explain some of the benefits of co-sleeping and the conditions under which women could co-sleep more safely. Just over half of the health professional/worker participants framed these discussions within work-places where they described feeling that they were ‘legally’ vulnerable and pressured to ‘hold the no co-sleeping line’ rather than personally or professionally holding strong views on advising women against co-sleeping.

Several midwives, lactation consultants and child health nurses were also sceptical about the lack of scientific evidence for the absolute risks for co-sleeping deaths when other risk factors had been taken into account. Lactation consultants and community midwives in particular questioned why a particular selection of ‘scientific evidence’ seemed to be promoted over other scientific studies that were more supportive of the benefits of co-sleeping.

Health professionals/workers who worked predominantly with young women, Aboriginal or CaLDB women were more likely to describe using what they commonly referred to as a ‘harm minimisation approach.’ These health workers were more likely to view the OD as not reflecting the reality of their work-places and the client groups that they worked with. These health workers also seemed more comfortable than midwives in other maternity settings, about advising women about how they could co-sleep more safely. Typically this would involve telling women to sleep babies on their backs, to stay on beds and not move to sofas or bean bags, to not smoke or drink and for their partner to sleep in another room or bed if they had been smoking or drinking.

Hospital based midwives, community midwives, lactation consultants and some regionally based child health nurses identified a need for additional strategies to enable health professionals/workers to support women who stated an intention to co-sleep, this included options such as:

- Additional staff in hospitals to ‘oversee’ co-sleeping mothers and babies
- An official position and decision on the use of side-cots in hospital and options for home use, and
- Sufficient time to discuss options with mothers about how they could co-sleep more safely.
Several of the health professional/worker participants claimed that although the OD was useful as a starting point (alerting staff to the issue of co-sleeping and highlighting the risks) the practice of the OD recommendations were inconsistent with other health policy advice and policies, particularly those about encouraging and establishing breast-feeding and maximising skin to skin contact.

Health professionals who worked with Aboriginal women, women from CaLDB, or women who were well educated about ‘attachment theory’ described the OD as being less helpful and even irrelevant for responding to these women.

**THE DILEMMAS AND CONFLICTS DESCRIBED BY HEALTH PROFESSIONAL/WORKERS IN IMPLEMENTING THE OD AND OTHER FORMS OF CO‐SLEEPING EDUCATION.**

Nearly all of the health professionals/workers who participated in the evaluation described feelings of conflict about the OD, or that the OD placed them in positions where they experienced professional and ethical dilemmas. These ranged from their own misgivings about what they viewed as the limited scientific evidence for the OD recommendations, the sense that they were implementing the OD for ‘legal’ reasons and concerns that they would alienate women who they cared for by insisting on a strict no co-sleeping stance; or that women would just not tell them if they were, or intended to co-sleep.

Lactation consultants were more likely to describe the conflict in advocating and supporting breast-feeding while at the same time needing to adopt a position on co-sleeping that might contradict the likelihood of encouraging and sustaining optimum breast-feeding outcomes and affect the bonding between mother and baby.

“The OD presents a real dilemma, this policy is not driven by best science or even evidence, and it seems to revolve about legality issues. Why don’t they consider a whole raft of science that looks at how babies express themselves, want to be close to mothers. This is not just for breast-feeding; this is also psychological, for bonding and future long term behavioural factors. Why don’t they look at neuro-science? Very selective in the evidence they choose.” [Lactation consultant1, Regional].

Community based midwives and nurses were more likely to articulate the need for fully informing parents about all the risks and benefits associated with co-sleeping, supplying and informing parents about the full range of co-sleeping information available (including attachment theory and bonding) and enabling and supporting parents in their own decisions.

A community nurse and lactation consultant asserted the importance of fully discussing co-sleeping with parents as many who did not bed-share with their infants might co-sleep instead on couches or chairs. Over half of the health professionals/workers who participated in the research study described the dilemma of adopting the OD recommendations which might result in parents ‘shutting down’ about co-sleeping and prevent health professionals/workers from identifying risks and potentially dangerous practices.

Community midwives and child health nurses based in urban areas also described the dilemmas in providing co-sleeping education based on the OD and SIDS & Kids information, to what were described as ‘well-educated and articulate women’ who were knowledgeable about attachment
theories and psychological evidence about the short and longer term benefits of bonding and skin to skin contact.

**INCONSISTENCY AND GAPS IN THE OD, CO-SLEEPING APPROACHES AND INFORMATION**

Three regional child health nurses questioned the practices of midwives based in regional maternity hospitals, stating that when they advised women to put their babies to sleep on their back, many would respond that it was ‘okay’ to place their babies on their side or tummy because this is what midwives in hospital had done. One Perth based child health nurse described the difficulty in advising a woman, she was visiting for the first time, about sleeping her baby on their back, when tummy or side sleeping had already been modelled by some hospital-based midwives.

The metropolitan focus group comprising eleven maternity hospital and community based midwives, maternity unit managers, child health nurses, lactation consultants and community educators described the OD as inconsistent in the following areas:

- The OD referred to other co-sleeping pamphlets and sources of information that were inconsistent, mothers may not realise that sleeping with a baby on a couch or other surface was more dangerous than sleeping with the baby in the bed. The point was made that when talking with parents about co-sleeping or bed-sharing health professionals needed to be sure that the parents understood the definitions of this in the same way.

- Two participants pointed out that co-sleeping deaths that occurred on a couch should not be categorised as ‘bed-sharing’ or ‘co-sleeping deaths’ and that these needed to be separated out.

- Two health professionals/workers had prior to the focus group discussion, not understood what the term ‘co-sleeping’ meant. It was suggested that ‘bed-sharing’ or ‘sleeping with baby’ were less confusing terms.

- There was also some confusion and discussion about the definitions of SIDS, SUEND, and SUDI. It was pointed out that SIDS deaths should not be confused with those caused by suffocation or other causes. It was acknowledged that even amongst the health professionals in the group, there was frequent confusion about these definitions and the situations that they applied. It was also acknowledged that the absolute risk for co-sleeping deaths was unclear when mothers and babies were healthy and other risk factors had been taken into account.

- The different ‘safe-sleeper’ aids that are available on the market were also discussed at some length. Some of these are available from credible sites such as Australian Breastfeeding Association and are ‘Australian Standards Approved.’ It was generally agreed that there is no official stance from the Health Department on any of these and none of them have been approved by SID & Kids for use. It is considered a pressing topic with many parents buying and using these from the internet. Over two-thirds of the participants articulated their concerns about how to guide women who used, or were intending to use these aids and raised concerns about where they stood legally if they suggested their use.
The use of side-cots which are referred to in the OD was also raised and the point made that there needs to be an official ‘position’ on these by the Health Department as many women and health professionals view these as a compromise and safer option and are currently using them. The researcher also established through another study that these aids are being used in some women’s refuges.

### AREAS OF INCONSISTENCY AND CONFUSION IN HEALTH WORKER RESPONSES TO WRAPPING, STROLLERS AND SECOND HAND MATTRESSES

There were three key areas of contention identified through this evaluation. These relate to current strategies that are used by some health professionals/workers to respond to the issue of co-sleeping in ways that might be viewed as ‘controversial’ by other health professionals/workers. These have been highlighted to show that there are differences in viewpoints by health professionals and that the lack of clarity or guidance about these factors are ‘gaps’ or areas requiring greater clarity in the information currently provided by the OD and other co-sleeping resources.

### WRAPPING AND/OR SWADDLING

The first of these contentious issues relates to ‘wrapping’ or ‘swaddling’ as a method for encouraging babies to stay asleep on their backs. This issue was extensively referred to and explored in the metropolitan focus group and interviews with health professionals/workers who cared for CaLD women.

Midwives based in public maternity health settings, community health settings and child health nurses working in regional and metropolitan child health services all referred to the issue of ‘wrapping’ as being a concern that was not adequately addressed by the OD and other forms of co-sleeping education. SIDS & Kids currently have a position of supporting ‘wrapping’ as a method to encourage babies to remain sleeping on their backs.

Five midwives raised concerns about the danger of ‘over-heating’ babies when wrapped and also the additional danger of wrapping babies while they slept in the same bed as their mother. A lactation consultant pointed out that if babies were tightly wrapped they were unable to move or ‘alert’ mothers who may be breast-feeding their babies in bed and falling asleep with them. One midwife in particular who had midwifery experience working in a cooler climate where swaddling or wrapping was not recommended, expressed her surprise that it was a common practice in a hot country like Australia.

“I did most of my midwifery training in xxx and one of the big things there is - do not swaddle babies. I find coming to Australia it is very hot here and you go into a lot of these hospitals which are very hot in the summer. I am amazed about how many layers and swaddles they put on. It was so such a NO NO - you do not swaddle the baby in xxx. In the summer you know, our summers are really cool they are not swaddled. You come to a hot country and you know lots of people don’t have air conditioning. They go home to these really hot houses, so the whole thing about over-heating.” [Metropolitan Focus Group, Midwife 3, Public Maternity Unit].

39
A community educator maintained that ‘wrapping’ was sometimes necessary in maternity wards to ‘thermo-regulate’ babies temperatures but acknowledged this may not be ideal once mothers were at home with their babies. She stated that many mothers were only in hospital for 48 hours so that it was difficult to give that ‘transitional education’ in such a short time. She emphasised that the SIDS brochure on wrapping does recommend the use of muslin or cotton based wraps, rather than synthetic materials.

Five midwives and two child health nurses who cared extensively for women from African and Middle-Eastern backgrounds identified the issue of ‘wrapping’ as of particular concern for these groups.

“And obviously we’re doing post natal home visits and I feel like it’s a cultural thing. It’s almost like they’ve seen their friends and families and everyone else doing it. The layers that they’re swaddling their babies in! Even in summer when it is just baking hot.”[Interview,Midwife3, Public Maternity, Metro].

“The multicultural women have about 3 layers on, then have blanket on all the way round. It doesn’t matter what the weather is [Metro Focus Group, Community Midwife1, Metro].

The layers of wrapping were seen as a problem contributing to over-heating along with the kinds of material used for wrapping which included a lot of synthetic materials that did not ‘breathe.’ This problem was also identified by two midwives who worked in a metropolitan public maternity unit.

“There’s probably not enough [information], for some of the African and Muslim ladies who are very much into wrapping. There isn’t anything specific, not at all. There’s not specific SIDS stuff. We know, we know, that those two cultural groups are probably more at risk, don’t know about the stats, but from experience... I go to babies more from those cultures where babies are overwrapped, knitted things and heaps of stuff, they like an awful lot of artificial fabrics as well. They like lots of nylons, rayons, stuff that makes babies sweat, don’t use natural fabrics, use fleece like stuff or silky satiny stuff. We make sure we’ve reiterated, but I don’t think there is any specific literature.”[Interview, Midwife7, Public Maternity, Metro].

While the discussion by midwives and other health workers about ‘wrapping’ acknowledged the potential benefits of wrapping, such as assisting in settling the baby and encouraging the baby to sleep on their back, there were considerable misgivings expressed about the dangers of ‘over-heating’ particularly in the context of co-sleeping and the need to more clearly articulate this as a potential risk factor.

Several health professionals/workers also referred to the common use of sheepskin rugs in prams as also being an area where there was a gap in education.

**BABIES SLEEPING IN STROLLERS AND PRAMS**

A second key area where there were differences in opinions pertained to Aboriginal families and where babies were most likely to sleep. Health professionals/workers who cared for Aboriginal women described how many Aboriginal mums were often living with several other children and extended family members and that there may be little room for ‘separate’ beds or cots in rooms.
Two midwives who worked extensively with younger Aboriginal women described their concerns about young mums putting their babies to sleep in strollers all night and day.

“One of the biggest issues is babies sleeping 24/7 in strollers. You know those reclining strollers I’m talking about, not big prams, there is no air. You just see their tiny baby face all squashed in.” [Midwife7, Public Maternity Unit].

These midwives were concerned about the need to provide education to younger Aboriginal women about the dangers of babies sleeping day and night in strollers and currently strongly advise against this practice. They also suggested that pram and stroller manufacturers stipulate on their products that they are not suitable for babies to sleep in all night. This advice contrasts to that from another midwife who cares predominantly for Aboriginal mothers and instead views putting babies to sleep in prams as preferable to unsafe co-sleeping in a bed and as perhaps the only realistic option in situations of chronic over-crowding, or where smokers live in the same house:

“And I promote even the use of their pram if they don’t have anywhere else safe to sleep, so then they have a safe area. It can be controlled in some way...One of the issues for Aboriginal families is the housing and the overcrowding and things. That way if they can be mobile they can hear them or someone else can too.” [Midwife 2, Public Maternity, Metro].

This midwife while not entirely comfortable about this advice was also pragmatic about the realities for the mothers she was caring for and described this as a ‘harm minimisation approach.’

SECOND HAND MATTRESSES – TOXIC FUMES

The third area where there was some confusion related to the use of second hand mattresses, whether in beds or cots and perceptions that there were increased risks associated with the use of these. A SIDS & Kids publication does provide an overview of the scientific studies into this and reassures parents that ‘toxic fumes’ from mattresses have not been causally linked with SIDS, or co-sleeping deaths. The publication does stipulate that whatever mattresses are used it is most important that they are firm and that any coverings are tightly placed on the mattress.

The use of second hand mattresses was referred to by two Aboriginal health workers, three child health nurses and three midwives, all of whom cared predominantly for Aboriginal women. While most of the concerns around the use of these were about the potential lack of firmness of the mattresses, three of the health professional/workers also expressed concerns about ‘toxic fumes.’ These concerns are exemplified in the following quote by a midwife:

“I actually got a mattress you can get that is made from food safe plastic, because according to research from New Zealand there is research that shows heat from the mattress that causes the fumes to come up. It is really interesting because a lot of the mattresses that Aboriginal people use have been used, the more it is used the greater the increase of SIDS.” [Midwife3, public maternity unit, metro].

This is an area where there is confusion about the safety of mattresses whether on beds or cots. The ‘wrapping’ of mattresses with a ‘food-safe plastic’ that is purchased on-line was also referred to by mothers who were interviewed for the study.
INVOLVED DADS

A child health nurse based in a remote area discussed the consequences of involving dads as ‘equal parents’ and not providing appropriate information about co-sleeping risks. While this was only referred to by one health professional in any depth, the parent interviews demonstrate that this is an emerging issue that requires relevant policy responses. The child nurse interviewed described how partners may take on a ‘night-feed’ so that the mother can sleep and be ‘optimum’ during the day. She identified a need for fathers to be provided with appropriate co-sleeping education as they were also at risk of falling asleep on the couch with the baby.

PROFESSIONAL DEVELOPMENT AND OTHER SUPPORT NEEDS IDENTIFIED BY HEALTH PROFESSIONALS AND WORKERS ABOUT CO-SLEEPING

Both metropolitan and regional focus groups as well as individual interviews of health professionals/workers identified some common areas where additional support or professional development about co-sleeping was required. Education for health professionals/workers about co-sleeping was described as being needed during university or college training and then being provided at least annually within work-places. It was agreed across focus groups and interviews that consistent and standardised information and processes needed to be established so that health professionals/workers felt confident in their methods of providing advice and guidance to parents about co-sleeping, including the benefits as well as the risks.

Aboriginal Community Controlled Health Organisation health professionals and workers raised concerns that university and college curriculums currently did not include any information or education about SUDI at all. They also asserted that Aboriginal Health Workers needed much more education about what the different terms and definitions associated with co-sleeping meant, in particular terms such as: ‘SUDI’ ‘SUEND’ and ‘SIDS.’ Child health nurses and community midwives agreed that the university curriculum for midwives needed to include more information about co-sleeping risk factors, sleeping positions and how to respond to different cultural perspectives and lifestyles of WA parents, rather than just the current focus on the ‘anatomy of SIDS.’

The majority of health professional/worker participants agreed that midwives in regional and metropolitan maternity units needed to be educated consistently about modelling and showing women how to settle their babies so that they slept on their backs. This was particularly the case for mothers of premature or sick babies who may have spent some time in humidicribs in prone or side sleeping positions.

Health workers also described needing emotional and organisational support when dealing with the aftermath of a baby’s death. A child health nurse suggested a ‘legalistic context’ surrounded this issue and that there needed to be more support for health workers when a baby’s death occurred with more emotional support and guidance for health workers who were caring for grieving parents and families.
A midwife in an Aboriginal Community Controlled Health Organisation asserted that currently ‘adopting the middle line’ on co-sleeping was easier for health workers working with Aboriginal women because it was well recognised that Aboriginal women usually co-sleep with their babies, however, she stated that more support for the ‘middle line’ should be provided to health workers generally, acknowledging that many experienced distress about advising women how to co-sleep more safely when this was ‘against the OD policy.’

Nearly all of the health professionals and workers consulted for the study stated needing a lot more support and information about the raft of so-called ‘safe-sleeping aids’ such as in-bed bassinets, side cots and dividers. None of the health workers participating knew what the ‘official line’ was on any of these and this was identified as a significant gap in information and guidance. This was illustrated in the following statement,

“We need to know if these things [safe-sleeping aids] are an improvement, on what they’d do otherwise, we have fears of being legally responsible if something goes wrong. SIDS & Kids can’t possibly assess all these things available on-line and so on. I don’t think midwives are at all clear where we stand with those; we need some kind of position [from the HealthDepartment].” [Midwife3, Public Hospital, Metro].

The metropolitan and regional focus group participants agreed that although different methods could be used to educate both health workers and women about co-sleeping, the message needed to be consistent, adopt a harm minimisation approach and include ‘safer’ co-sleeping information. A ‘train the trainer’ method was considered the most effective, with the use of face-book and other social media tools so that health workers could have discussions about co-sleeping, discuss difficult or complex cases and exchange strategies for how to respond. A majority of health professionals maintained that while ‘e-learning’ was a useful component of co-sleeping education [See: www.sdc.qld.edu.au/ safe sleeping e learning package] that this needed to be interactive and supplemented by ongoing debate and discussion of case-studies in ‘live’ settings with a range of health professionals/workers from diverse maternity health settings.

**BALANCE – THE HARM MINIMISATION APPROACH**

There was some debate within both focus groups about how to deliver co-sleeping education. The issues involved in this discussion were about whether all women should be provided with all the information about the benefits and risks of co-sleeping and make their own decision, or whether information should be individually tailored to specific women depending on a risk assessment that considered their individual lifestyles and circumstances. Another view was that as co-sleeping is considered normal behaviour in many countries, why information in Western Australia was not based on the factors that enabled parents and babies to co-sleep safely in Australia.

While it was agreed that although different approaches might be needed in educating women, that the source of the information should be consistent and include ‘safer co-sleeping’ as a viable option. It was agreed that this approach was relevant for all women and not just women from different cultures. One child health nurse asserted that the current policy was questioned by many parents and there was a need for “a better body of evidence, information about actual rather than relative risks and more about the benefits.”
The metropolitan focus group, the regional focus group and over half of the individual interviewees described either currently using, or needing to use, what was often described as a ‘realistic’ or ‘harm minimisation approach.’ This was summed up by the following midwife participant,

“We are not saying don’t do it, but if you do – do it safe. We need to make sure parents know all the risk factors; they [health workers] need to consider whether or not these apply not only to the mother, but other carers, grand-parents, relatives and so on.”[Midwife 4, public maternity unit, Metro].

Another midwife who worked predominantly with Aboriginal mothers stated that:

*A brochure I would be okay to hand out would be one that accepted it is a happening thing [co-sleeping]. I believe in the mother nurturing thing but I also believe it has to be done safely [Midwife 6, Public Hospital, Metro].*

More than half of the health professionals/workers who were consulted for the study described how the underpinning philosophy of co-sleeping information and education needed to shift from ‘dictating’ which was how the current OD and SIDS & Kids information was perceived, to more positively responding to women’s needs and requirements for more information about how to co-sleep more safely.

**CONSISTENCY**

In both of the focus groups there was general agreement and discussion that the OD was potentially confusing because the supporting references to co-sleeping or bed-sharing brochures and information all define co-sleeping and bed-sharing differently, as one midwife manager noted,

*“even in this short discussion, there is different information, different leaflets, different definitions.” [Metro Focus Group, Midwife manager 1, Public Hospital].*

Both focus groups agreed that there was a need for one standardised brochure, saying the same thing. The SIDS & Kids brochure was the most consistently used across maternity services, with its visual clarity considered to be very important. There was a consensus that if one more page about how to co-sleep more safely was added to the general and Aboriginal specific SIDS brochure, there would be no need to then use different brochures and this would also ensure that the general brochure was more culturally appropriate for CaLD women.

The other area of inconsistency commonly described by health professionals as presenting particular challenges for them in insisting on “no co-sleeping” positions, was that there appeared to be no clear evidence for the absolute risk for co-sleeping deaths when all other risk factors had been addressed or responded to.

**OPTIMISING SKIN TO SKIN CONTACT AND THE ESTABLISHMENT OF BREAST-FEEDING**

Lactation consultants, child health nurses and community midwives were more likely than hospital based midwives to question the OD recommendations as they pertained to breastfeeding objectives.
One metropolitan based lactation consultant spent a lot of time with mothers and babies in hospital and on discharge establishing breast-feeding and described her feelings of conflict about the OD.

“I don’t want to go against policy, but I’m curious about how big the risk really is, it is not clear. It [OD] doesn’t tell women explicitly not to co-sleep, but also doesn’t tell them to co-sleep. Although I would rather they [women] did co-sleep I don’t actually state that.”[Lactation consultant1, public hospital, metro]

Another regionally based lactation consultant and child health nurse identified what they saw as incongruence between breastfeeding and co-sleeping information. These health workers in concurrence with most of the other participants identified a need to:

“Find safe, practical, middle ground for giving information to women. Midwives in maternity hospitals definitely need better information.”[Lactation consultant/community nurse1, regional]

A metropolitan based lactation consultant questioned why ‘clip-on cots’ could not be used on maternity wards as a compromise to improve breastfeeding due to proximity and closeness and referred to two scientific studies that advocated this position [See Ball, H 2007, 2006]. These studies provided evidence that ‘clip-on cots’ contributed to the successful establishment and longevity of breastfeeding.

HOW APPROPRIATE IS THE OD IN RESPONDING TO THE NEEDS OF ABORIGINAL AND CALD WOMEN?

Midwives who cared predominantly for Aboriginal women would describe the issue of co-sleeping as being sensitive, because it might be associated with child sexual abuse or child death, and was not something they would directly bring up. They would also refer to the oversaturation of brochures that were unlikely to be read. All of the health workers caring for Aboriginal women described their relationship with them as being paramount and that to build up trust and ensure continuity of service, they had to work very hard not to alienate women by, “appearing to judge or tell them what to do.” [Midwife2, ACCHO, Regional].

A maternity health services program manager from an ACCHO described the difficulties in engaging with Aboriginal women in the early post natal period for education purposes. Another issue was the short time Aboriginal women often spent in hospital (providing limited time for educating about co-sleeping) and the increased likelihood that Aboriginal women will also not attend regular antenatal clinics.

Community midwives and child health/community nurses who cared for women from culturally and linguistically diverse communities described the difficulties in educating these women about co-sleeping in ways that reflected the intent of the OD. Community midwives, Aboriginal health workers, child health nurses and hospital based midwives who worked with Aboriginal women or women from culturally diverse communities, overwhelmingly described the need to work on an individual ‘risk assessment’ [See Chart 7] basis with these mothers.

Although the SIDS & Kids brochure for Aboriginal women was considered somewhat useful (because it did not show a cot) the Women and Newborn Health Services co-sleeping brochure and other SIDS
& Kids information was viewed as being less appropriate for these groups. Community midwives, child health nurses and midwives who cared for Aboriginal women and CaLD women were more likely to advocate the use of the UNICEF or Australian Breastfeeding Brochures, with their discussions about safer co-sleeping identified as being a more realistic and appropriate option for their client groups.

“[1] The UNICEF one they’ve got that really nice picture. It shows the actual figure of a lady see the position, right hip over left, not here[points to illustration in pamphlet].

[2] The ABA one uses the same figure. It shows how to position so that the baby is then more likely to fall asleep on its back. So they’re the other two the child health nurses will use when the breastfeeding or co-sleeping comes into play.” [Metropolitan Focus group participants, educator1 & lactation consultant2].

Midwives, Aboriginal health workers and child health nurses who worked with Aboriginal women were also more likely to describe the dangers of alienating the women they worked with, if strict no co-sleeping stances were adopted by them. Rather they preferred what was often described as a ‘harm minimisation approach’ [See Chart 7, p. 53] so they could openly discuss co-sleeping and how to do it more safely. These health professionals/workers emphasised the need to ‘work with women where they are’ and instead provide information about putting the baby to sleep on their back, not smoking, how to make the bed safer for the baby to sleep and the avoidance of fluffy toys, overheating and polar fleeces.

One remote area child health nurse stated: “All Aboriginal mothers sleep with their babies. No use bullying them not to.” This view was shared by a lactation consultant and community nurse who described telling Aboriginal women about the OD ‘policy’ but then spending far more time providing information about how they could co-sleep more safely, “If they are exhausted at 3 am in the morning they are going to do it anyway.”

All the health workers who participated in the study who provided information about ‘safer’ co-sleeping would most commonly describe providing their clients with information about sleeping the baby on their back, no fluffy toys or pillows around the bed, promote the use of cotton, not smoking, straight sheets and not sleeping on couches or chairs. Four midwives also described advising women about ensuring a ‘safe sleeping site’ for babies, so away from partners who might sleep heavily due to substance use and not with other children or pets. A lactation consultant and two Aboriginal health workers advised women that if their partners had been drinking they should sleep in a separate room or on the couch, so that mum and baby could sleep safely in the bed.

A paediatric nurse maintained that it was difficult to insist on “no co-sleeping” with Aboriginal or CaLD women. She stated that rather it was better to document their decision and observe them more closely while they were in hospital, although remarked this was only possible while they were still in hospital and it was more difficult to follow up once they were home. A child health nurse stated that it was very difficult to maintain a no co-sleeping line with women from different cultures as many of them insist they will “never - not co-sleep.” In this situation she stated it was better to provide them with the UNICEF information about safer co-sleeping, but also acknowledged the lack of language specific co-sleeping information for CaLD women.
A midwife who cared for an Aboriginal woman who she knew used drugs and alcohol and also co-slept, suggested a ‘safe sleeper’ to prevent the mother from rolling on her baby in the bed. She described feeling ‘uncomfortable’ with this situation but also not seeing what else she could do. This was a major area of contention for most of the health workers consulted for this study, who while acknowledging the recommendations of the OD, would state that they needed to work with women in ‘realistic situations.’

A midwife, whose clients were predominantly Aboriginal women, developed a strategy of discussing with mothers how the incidence of SIDS was eight times higher for Aboriginal babies. This participant considered that not enough attention was paid to the increased risk for SIDS and co-sleeping deaths when mothers had been given pain relief medication, or were experiencing extreme fatigue. This participant’s response was to routinely give Aboriginal mothers iron tablets and multi vitamins as part of a preventative strategy that included advising mothers to ensure safe sleeping sites for themselves and their babies.

CONSIDERATION OF CULTURE, LEVELS OF LITERACY AND LIFESTYLES

The metropolitan focus group and midwives and Aboriginal health workers from two Aboriginal Community Controlled Health Organisations agreed that the Women and Newborn Health Service Brochure on safer co-sleeping was the least useful and relevant. This publication was described as being ‘too wordy’ and the lack of relevant visual cues made the pamphlet less appealing and accessible for Aboriginal and CaLD women.

Midwives working with younger women suggested that young women should be given some ownership, so that they could be referred to the SIDS & Kids web-site and read about the information for themselves. Two Aboriginal health workers agreed that young Aboriginal women also needed some kind of ‘ownership’ of the co-sleeping education and that methods for dissemination could include a mix of text messaging, social media and face-book. One suggestion was that maternity health services could design a face book page for young mums and babies where issues such as co-sleeping could be posted, along with photos of the mums with their babies. A major barrier to this was described by several health workers as the Health Department’s ‘ban’ on the use of face book in work-places.

Other strategies suggested by a regional ACCHO included a locale specific education documentary, featuring local actors who could ‘tell a story’ about aspects of caring for the baby, including about co-sleeping. It was also suggested that co-sleeping and other health education start in Primary School Year 7 for young Aboriginal women. A midwife manager of another ACCHO suggested that different ‘marketing strategies’ needed to be designed for different age cohorts of mothers. Those women who already had several children for example, would need different information and approaches to very young women.

A midwife who cared for Aboriginal women in a metropolitan based maternity unit described the difficulties in educating high risk groups and the need for sensitivity and non-confrontational communication with these women. Stating that in evaluating the reality of the situations in which some of these women lived it was better to,
‘advise of things like establishing sites of safety where they and their babies can sleep, then to give them a lecture about the dangers of co-sleeping.’ [Midwife2, Public Maternity Hospital, Metro].

Community midwives who cared for CaLD women in common with Aboriginal health workers caring for Aboriginal women, described the sensitivities in even broaching the subject of SIDS or co-sleeping deaths, in cultures where talking about these issues may result in considerable distress. Community midwives also described how women who were on ‘spousal visas’ were not connected into the general health system and were less likely to receive this kind of education.

A remote area nurse and a midwife from an Aboriginal maternity clinic suggested that ‘educating through respected women’s groups’ and ‘grannies’ was the most effective way to identify what kinds of information and support younger women needed. Younger women were also more likely ‘to take on board’ the information and guidance from these methods. A similar method was also suggested as being more useful by the regional ACCHO focus group who described ‘story telling’ by respected members of the community as having increased meaning:

“Use of stories – and stories told by xxxx people – so they have credibility. Real stories have real impact. May not stop co-sleeping - but maybe there will be harm minimisation and a reduction of the risks.”[Aboriginal Health Worker2, Regional]

A midwife who cared for Aboriginal women in an urban setting maintained that as Aboriginal women were unlikely to stay in hospital for very long, it was difficult to educate them about co-sleeping in ways that followed the OD recommendations. She suggested that as bed-sharing is culturally accepted, it might be more effective for Aboriginal women educators to facilitate co-sleeping education in hospital, promote and model safer co-sleeping practices and hand out culturally appropriate brochures. Another key informant advocated Aboriginal women ‘peer educators’ who could provide outreach education particularly to Aboriginal women living in rural and remote areas of the state.

The following summary highlights the key areas of concern about the OD and other current co-sleeping information and education identified by health workers, these and other areas are also explored in the next section reporting on the consultations with women.
The OD was most likely to be referred to by midwives working in government and private maternity units based in metropolitan and regional hospitals. The OD was less likely to be known about or used by lactation consultants (including hospital based) midwives in community health settings, child health nurses in regional settings, or Aboriginal Community Controlled Health Organisations.

A consistent message about co-sleeping that includes ‘safer co-sleeping’ education, and adopts a harm minimisation approach for health workers and parents needs to be developed and endorsed.

A consistent co-sleeping message that includes ‘safer co-sleeping’ education that uses multiple methods of dissemination and is culturally and language appropriate for Aboriginal women and women from culturally diverse backgrounds should be developed, including ‘story telling’ documentaries, face book, text messages and visual brochures. Local communities should be consulted and involved in the design of new communication strategies.

Co-sleeping education should be presented and disseminated in a constructive and collaborative manner. Information and education should not be directive, should highlight the benefits as well as the risks of co-sleeping and take full account of diverse cultural, lifestyle and social factors. Health professionals referred to the lack of certain information about the absolute risk for co-sleeping deaths when all other risk factors were accounted for.

A majority of health professionals/workers identified a need for professional development about co-sleeping to be included in university and college curricula. For the professional development about co-sleeping to be implemented in maternity health settings, be consistent and include ‘train the trainer’ modules as well as ‘e-learning’ case-studies that were interactive and accessible to a range of health workers.

The issues of wrapping, babies sleeping in strollers and the use of 2nd hand mattresses are key areas of confusion and contention. Strategies and education about all of these should be more effectively informed by the cultural and social contexts within which they occur.

The range of safe sleeping aids and side cots available for sale in Australia need to be assessed and a clear position from the Health Department and Sids & Kids needs to be articulated so that health workers can advise parents appropriately about their use.

Co-sleeping education and information that is appropriate and relevant for fathers and other relatives and carers about safer co-sleeping needs to be developed.

Aboriginal women trained as co-sleeping educators could be based in major maternity units to individually model and educate Aboriginal parents about how to co-sleep more safely. Aboriginal ‘peer educators’ should be used to educate Aboriginal mothers living in rural and remote areas.
RESULTS OF THE WA PARENT INTERVIEWS AND FOCUS GROUPS

This section outlines the key results from the parent interviews and focus groups. These results have been organised under the sub-themes derived from the key objectives of the evaluation.

HOW DO WOMEN UNDERSTAND, INTERPRET AND PRACTICE CO-SLEEPING EDUCATION?

The majority of women interviewed for the evaluation had, understandably, not directly heard about the OD. The effectiveness of this policy was evaluated by exploring how these women and their families received co-sleeping education and information from health professionals/workers whilst in hospital and after discharge. Three women did know about the OD and they have commented directly on their views about its effectiveness and relevance. The evaluation has then determined the kinds of co-sleeping information and resources that women use and how they practice co-sleeping guidance and advice in their every day practices of caring for their babies.

FOCUS GROUP WA PARENTS: ABORIGINAL MOTHERS AND GRANDMOTHER (6)

The focus group questions around which discussion was organized were similar to those used for face to face interviews and are attached in Appendix 2. Discussion was structured around questions about how women and their families received and interpreted co-sleeping education and information whilst they were in hospital and after discharge. They were also asked to describe other sources of information and their views on different kinds of information (such as SIDS & Kids and Australian Breastfeeding Association).

The focus group was conducted with 5 Aboriginal mothers and 1 Aboriginal grandmother. These were women who regularly attended an Aboriginal mothers’ community group based in a local neighbourhood centre that provided assistance with housing and child care and also regular support groups with a focus on art, craft and cooking activities.

FOCUS GROUP WA PARENTS: ATTACHMENT (4)

This focus group was conducted with four women who had formed their own ‘attachment’ play group. These were women who described themselves as not belonging in ‘main-stream’ play groups because they subscribed to the anthropological, biological and psychological theories that advocate bonding and skin to skin contact with babies from birth, what they termed ‘attachment parenting.’

INTERVIEWS WA PARENTS (24)

Over half of the interviews conducted with WA parents were face to face interviews that asked women questions about how they and their families received and interpreted co-sleeping education and information whilst they were in hospital and after discharge. They were also asked to describe other sources of information and their views on different kinds of information (such as SIDS & Kids and Australian Breastfeeding Association). The other interviews were conducted either by telephone
or through email discussion. Tables 5, shows where focus group and interviewed women had birthed.

Table 5 Place of birth for interviewee and focus group participants.

<table>
<thead>
<tr>
<th>Private Hospital</th>
<th>Public Hospital</th>
<th>Home Birth</th>
<th>Birthing Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>13</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Of the combined focus group and one-to-one interviews, 12 of the mothers had one child while the other 22 had more than one child. Twenty-six of the mothers were living in metropolitan Perth while eight lived in regional or rural locations.

Table 6 Numbers of mothers who co-slept and how often

<table>
<thead>
<tr>
<th>CO-SLEPT with baby 0-3 MONTHS</th>
<th>CO-SLEPT with baby &lt; 3 MONTHS</th>
<th>NEVER CO-SLEPT</th>
<th>REGULARLY CO-SLEPT (weekly)</th>
<th>OCCASSIONALLY CO-SLEPT (&lt; monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>12</td>
<td>11</td>
<td>17</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 6 below shows how many women co-slept and how regularly this was. Occasional co-sleepers have been categorised as those who co-slept less than once a month with their babies. Although some mothers would say they “never co-slept” they then sometimes went on to describe how they occasionally co-slept either in beds, couches or lounges and these have been included as ‘occasional co-sleepers.’ One mother has also been included in this category because although she did not co-sleep with the baby, her partner occasionally slept with the baby on the couch.

Of the 34 parents who participated in the study, 3 stated that either they or their partner occasionally slept with their babies on the couch.

Of the 17 women who co-slept regularly one stated that she used a ‘safe-sleeper’ in the bed and another used a side-cot attached to the bed. Both of these women’s babies were over 3 months old.
HOW WOMEN RECEIVED CO-SLEEPING INFORMATION AND EDUCATION IN HOSPITAL

First time mothers were much more likely than mothers who were having their second or third child to have received brochures in either public or private hospital maternity units about co-sleeping. Ten of the mothers who had private hospital births had attended pre-natal classes where the topic of co-sleeping was covered and while in hospital for the birth were encouraged to view a video about co-sleeping. These advised women to sleep babies on their backs and stressed that co-sleeping was particularly risky for babies under 6 months old.

The Aboriginal mothers who participated in the study did not recall receiving brochures and stated that although they were told not to co-sleep while in hospital they did not comply with this advice at home. They also had limited engagement with child health nurses preferring to learn about how to care for their baby from their own mothers, sisters, aunties and grandmothers. They also stated that co-sleeping was normal for Aboriginal families and that separate sleeping spaces were rarely considered.

Mothers who had birthed in private or public hospitals and who already had one child were much less likely to receive either brochures or advice from midwives about co-sleeping or other information relating to the care of their baby apart from the Women and Newborns ‘0-3 month’ brochure. This common experience is reflected in the following quote:

“No co-sleeping information or breast feeding. I think I got flyers but because it is my 2nd baby they don’t really bother. When it’s your 2nd baby they assume you know everything. Gave me a flyer for 0-3 months.” [Private Hospital C, Metro, 2nd occasional co-sleeper].

Mothers who birthed in public maternity hospitals were more likely to describe a greater range of responses to co-sleeping advice from midwives. One metropolitan based maternity unit in particular was viewed as having a strong policy against co-sleeping. Women who birthed at this unit were given SIDS & Kids brochures and midwives advised them not to co-sleep with their babies. The views of the nurses at this maternity unit were described as being more about ‘rooming-in’ than ‘bed-sharing.’

“I got lots of pamphlets, SIDS & KIDS, I was told I was not supposed to sleep with them when they are very young.” [Public Hospital A, Metro, 1st regular co-sleeper].

Another mother who regularly co-slept with her baby described her experience in another metropolitan public maternity unit as being similarly consistent with a no co-sleeping message, although she reflected that this may have been because of a recent death of a baby.

When I did it [co-slept] in hospital I was told not to – one of the midwives told me “don’t do that, you know about that baby who died in Kalgoorlie?” – she scared me. It had just happened apparently. [Public hospital E, Metro, 1st regular co-sleeper].

While just under half of the women birthing in public maternity units described being told very clearly not to co-sleep and/or receiving SIDS & Kids Brochures about co-sleeping others felt there were inconsistent messages and approaches from different midwives working in the same maternity units.
“There were different approaches from midwives; some said I’ll put the side up for you so he can sleep with you. Others would come in and quickly move him – and say, otherwise you will fall asleep with him. I definitely had this strong feeling, don’t tell anyone you co-sleep.” [Public Hospital G, Regional, 2nd occasional co-sleeper].

Another mother who birthed in a public maternity unit described slightly different approaches from midwives and the lactation consultant:

“I was given pamphlets during pre-natal appointments. I remember the midwives showing us how to swaddle and recommending that she was put to sleep in the bassinet on her back, and asking if I know about the SIDS risks. The lactation consultant also discussed the issues of co-sharing the bed with your baby, the risks and benefits of it. She seemed a bit more open to it although she didn’t say you should do it.”[Public Hospital B, Metro, 1st does not co-sleep].

Women who had birthed either at home or at birthing centres were more likely to state that the issue of co-sleeping while not actively encouraged by the midwives, who cared for them, was a topic they felt they could raise without being censured. Two of the mothers stated that they were encouraged to find out about co-sleeping and the associated risks and benefits for themselves and were then supported in their decisions. These two mothers also stated that they felt midwives who adopted this strategy were open to criticism from the Health Department and other health professionals who subscribed to the SIDS & Kids recommendations.

Over half of the mothers described how fatigue, lack of sleep, or pain medication, affected their capability to remember or take-in co-sleeping information or advice from midwives. These women were also more likely to describe having problems establishing breastfeeding.

“I was told co-sleeping is not on. I had such problems breastfeeding and I hadn’t slept for 3 days. I accidentally fell asleep with the baby in the bed and was told “it wasn’t allowed.” There was one midwife who disagreed; she knew I was on pain meds. When this midwife found out I had not slept she put the baby into bed with me.”[Private Hospital B, Metro, 1st occasional co-sleeper].

Another mother related how exhausted she felt after having a caesarean birth and also falling asleep with her baby in the bed – although she was told to be careful, it was not explicitly stated that she should not co-sleep. The midwife advised her to wrap the baby tightly and that because he had reflux “it was okay for him to sleep on his side.”[Public Hospital B, Metro, 1st occasional co-sleeper].

The responses to the question about the kinds of information and education women receive while in hospital show that first time mothers are more likely than second time mothers to receive any information. Most women are given brochures such as SIDS & Kids, although women who are cared for within community midwifery programs, or discuss the issue with lactation consultants, are more likely to be advised to read and consider a wider range of information.

The women who participated in this study and who birthed in private hospitals were more likely than those who birthed in public maternity units, to have received structured co-sleeping education through pre-natal classes run by the private maternity hospitals. Women described the message from these as being a strongly ‘no co-sleeping’ one and as being based on the SIDS & Kids safe sleeping brochure. Although some women described some health professionals/workers as being
more supportive of their decision to co-sleep, they also suggested that they felt midwives were reluctant to explicitly state this because of the prevailing ‘no co-sleeping’ contexts of maternity services.

**HOW WOMEN RECEIVED INFORMATION AND EDUCATION ABOUT CO-SLEEPING AFTER DISCHARGE**

Mothers’ experiences of receiving co-sleeping information and education after discharge from hospital varied from none at all, to being given brochures, discussions with child health nurses and midwives, to attending groups and classes where the topic was comprehensively covered. These group classes were held at some private hospitals (metropolitan) and with some metropolitan based child health nurses.

Aboriginal mothers described receiving some information from child health nurse about not co-sleeping, but maintained this was inappropriate, as this practice is a normal part of Aboriginal culture. They also stated that grandmothers, their own mothers, sisters and aunties were considered more credible sources of information about how to care for their child.

Several women described discussions with child health nurses or lactation consultants about sleeping or breastfeeding as providing the openers for guidance and advice about co-sleeping. Of these around half described their child health nurse as being supportive of their decision and providing them with guidance about how to co-sleep more safely.

> “The issue of co-sleeping comes up with the child health nurse—she is fine with it, she went through how to do it safely. OK as long as it is done properly on a firm mattress, no drugs that sort of thing.” [Public Hosp, E, Metro, 1st regular co-sleeper].

Others would state that although they did not receive any information about how to co-sleep more safely from their child health nurse, apart from sleeping the baby on their back, they were not told explicitly they must not do it. Instead co-sleeping became a subject that was not openly discussed.

> “The child health nurse did talk about co-sleeping, reinforced on the back message, but did not refer to bed-sharing at all.” [Private Hosp, M, Metro 1st does not co-sleep].

Apart from the several mothers who had made a decision about co-sleeping before the birth most of the mothers interviewed stated that co-sleeping was not usually prioritised by child health nurses, who were often more concerned about the establishment of breastfeeding,

*The child health nurse did come to visit once; she did talk about co-sleeping briefly and gave me the purple book and the SIDS pamphlet. She didn’t make a big thing of it though, she was much more concerned about breastfeeding and getting that established [Birthing Centre, Metro, A, 2nd regular co-sleeper].*

Three women who had made a conscious decision to co-sleep before the birth of their child described ‘scare tactics’ used by midwives or child health nurses. These responses resulted in strengthening the resolve of these mothers to co-sleep and also ‘keep quiet’ about the topic in any future consultations with the child health nurses.
“I remember going to the health nurse, the only reason she told me was to scare me, she didn’t even tell me how that baby died in Kalgoorlie. It wasn’t an educational thing it was to get her opinion across that it was dangerous. It didn’t change my decision, I was really angry.” [Public Hosp, L, Regional, 1st regular co-sleeper].

A mother who was also a paediatric nurse (and did make the decision to co-sleep) stated that she was not given any advice about co-sleeping from the child health nurse stating:

“I think this is because I am a Paediatric Nurse – they don’t want to tell you how to ‘suck eggs.’ I did not receive any info about SIDS or co-sleeping,” [Private Hosp, P, Metro 2nd regular co-sleeper].

Another second time mother described how she had changed her views about co-sleeping due to her experiences as a first time mother who birthed in a private hospital asserting:

“I had been drilled about co-sleeping, not to do it, I had lots of problems, breastfeeding and bonding with that child – I changed my views the second time after doing extensive research, I really believe I did that first child a disservice by not co-sleeping, I feel guilty that I did not co-sleep with both of them.” [Public Hosp, N, Regional, regular co-sleeper].

These excerpts show that the women’s experiences of receiving information about co-sleeping in hospital and on discharge varied and that health workers individually adopted different approaches and views about the topic.

There are four broad categories that incorporate the processes and approaches that health professionals/workers describe when providing co-sleeping education to women. These approaches were also described by the women who were interviewed about how they received co-sleeping education from a range of health professionals/workers. These approaches are illustrated in the Chart 7 below. Broadly, midwives from public maternity units and some child health nurses are positioned within category 1; community based midwives, lactation consultants, nurses and regionally based child health nurses were more likely to fit within category 2, with fewer lactation consultants and community midwives positioned under category 3. Finally, category 4, which was described by some women as how their midwife or child health nurse responded to them, was the least likely approach to disseminating and educating women about co-sleeping as described by health professional/worker participants themselves. The continuum of co-sleeping education can be viewed as ranging from directive to advocate as shown in the chart 7 below.
1. OD and SIDS & Kids - blanket statement, strong no-co-sleeping messages.

- Discussion about co-sleeping 'closed down' - risks highlighted
- Limited and qualified safer co-sleeping information for babies over 6 months
- Health professional as directive expert

2. Individual risk assessment - consideration of OD and SIDS & Kids, also UNICEF & ABA, assess individual cases according to risks/lifestyle. Position on co-sleeping contingent.

- Discussion about co-sleeping 'open' - risk benefit analysis
- Information about risks and benefits
- Assess individual and advise accordingly
- Health professionals as negotiating expert


- Discussion about co-sleeping 'open' does not explicitly advocate co-sleeping
- Information about risks and benefits of co-sleeping
- Enable and support consumer's decision
- Health professionals as supportive agent

4. Attachment theory/Continuum concept - co sleeping normalised - consideration of UNICEF, ABA and benefits of co-sleeping

- Discussion about co-sleeping normalises practice
- Information about risks and benefits, emphasises benefits
- Health professional as advocate for co-sleeping.
BREASTFEEDING AND CO-SLEEPING

The emphasis on the establishment and continuation of breastfeeding by international, national and state health policies has resulted in the encouragement of ‘skin to skin contact’ from birth and close proximity of the baby to the mother. Due to this emphasis the women who participated in the study were asked how they went about breastfeeding and what influence this had (if any) on where their baby slept.

The responses to this question were quite varied and also brought up other issues that are factors in the risks associated with co-sleeping including fatigue and pain management. Just under half of the women interviewed described at some point accidentally falling asleep with their babies while breastfeeding, or of being afraid of doing so.

“I would get up to feed him so I wouldn’t wake my husband up. I’d go to the lounge but I was very fearful that when I was breastfeeding in the lounge that I would fall asleep on the sofa. So would sit up with the TV on.” [Priv Hosp, D, Metro 1st does not co-sleep].

Several mothers described being told by their child health nurse or lactation consultant that at some point they were likely to fall asleep with their child while breastfeeding. Some of the mothers viewed this as tacit support for co-sleeping, however, were frustrated when health workers did not then want to discuss this openly.

“The lactation consultant told me at some point most breastfeeding women are going to co-sleep. She then said we won’t talk about it because you are not supposed to. It was annoying, I’d like to have known how I could do it more safely – I just found out by myself.” [Public Hosp, E, Metro 1st regular co-sleeper].

Over half of the mothers interviewed stated that they breastfed babies in the same room and then put them back in their own cot or bassinet next to their bed. Several of these mothers then described how once their babies were older (the youngest being 3½ months but most being around 5 months old) they then co-slept with their babies because it was easier and less tiring to breastfeed and that they all slept much better. These mothers also articulated a need for more information about breastfeeding and co-sleeping, as it was viewed as preferable to be informed about how to co-sleep safely, then to just fall asleep accidentally on the couch or in the bed, which they acknowledged was far more dangerous.

A mother who had a caesarean birth in a private hospital was frustrated at the lack of consistent support from midwifery staff while in hospital in establishing breastfeeding.

“I could have done with some help. It was too difficult to put my baby back in the bassinet on my own after the caesarean – I could easily have fallen asleep with him in bed. [Private Hosp Metro, R, 1st does not co-sleep].

Three other mothers who had birthed in private and public hospitals described similar experiences of extreme fatigue due to the birth and being affected by drugs used for pain management, to the extent they could not remember whether or not they had been advised about co-sleeping. Two of these mothers did not establish breastfeeding.
In contrast to these experiences a mother who had a home birth and had also joined the Australian Breastfeeding Association (ABA) described how breastfeeding and falling asleep with your baby “is normalised” by the ABA. This mother also referred to the work of James McKenna and Helen Ball:

“whose work has helped me most, particularly the position of the mother’s body” [while breastfeeding in bed], [Home Birth, B, Metro, 2nd regular co-sleeper].

The Aboriginal mother participates all normalised co-sleeping and breastfeeding as an integral part of mothering. They also maintained that if a child’s mother was unable to breast feed, or had to go away, other relatives including sisters and friends would breast feed their child for them.

Several of the mothers interviewed commented on what they viewed as inconsistent messages about co-sleeping and breastfeeding with one mother describing the current position on no co-sleeping as “flying in the face of all the breastfeeding advice.” [Attachment Group 1, Metro, 1st regular co-sleeper].

WHY MOTHERS CO-SLEPT, WHERE AND HOW OFTEN

The interview and focus group questions for the evaluation asked women what kinds of advice or guidance they had received about where to put their baby to sleep and mothers were only explicitly asked about co-sleeping if they did not mention it. Several of the women who stated they never co-slept at the beginning of the interview, would in the course of the interview then reveal circumstances where they had in fact co-slept with their baby. This included mothers or partners who slept with the baby on the couch, on another bed in a spare room, or in the parental bed with a ‘safe sleeper’ aid. Although these women would categorise or describe themselves as not being co-sleepers they have been included in the ‘occasional co-sleeper’ category for this evaluation.

Eleven of the mothers interviewed stated that they had never co-slept. Most, although not all, of these mothers were first time mothers and were also more likely to have birthed in a private hospital. Three of the mothers who never co-slept had very strong views about this and although they would refer to the SIDS & Kids brochures and demonstrate their knowledge of the dangers of suffocation, they would also describe other reasons for not co-sleeping. Two of the mothers stated they were very light sleepers and so put babies in separate rooms with monitors. One mother described herself as continually checking the baby in another room, but also maintained that she had good support from her husband and other family members.

Several mothers referred to their partner’s reluctance to co-sleep and in one case to room-share. In some cases this was due to their partners knowing about the SIDS education while for others it was more to do with concerns about how this would affect their intimate relationships with their partners. The ways in which those women who did co-sleep negotiated these issues with their partners will be further explored in the results about the regular co-sleepers.

Eleven of the mothers categorised as ‘regular co-sleepers’ while not co-sleeping with their baby every night, did so on at least a monthly basis or were mothers who started co-sleeping from 3½ to 5 months after the birth.
“With my first I used to bring him in after around 6.30 am. I used to bring him into the bed but that was when he was a bit older. I was always kind of awake; it was just so I could have that extra hour and just lay there. I didn’t do that at first – I only did that when he was over 6 months and could roll if he wanted to,” [Private Hosp, A, Metro 2nd regular co-sleeper].

There was diversity within this group of women about their motivations for co-sleeping. Around half of the women who co-slept described doing so after their baby become more restless after 3 months: “I didn’t want to co-sleep but after five months I did co-sleep because she kept waking up and was really restless.” [Private Hosp, Metro, G 1st regular co-sleeper].

Other women emphasised the importance of bonding and establishing and continuing breastfeeding, with six of the non-Aboriginal mothers describing sleeping separately from their babies as unnatural and even harmful to their babies’ physical and psychosocial development. The six Aboriginal mothers and grandmother participants also described co-sleeping as natural, as being part of their family and cultural traditions, ensuring adequacy of breastfeeding and closeness and enabling improved sleep for mothers and babies.

One mother who had not made a decision either way about co-sleeping before the birth of her child then determined to co-sleep after reading about attachment theory. She did qualify this, however, with the claim that when she was going through a lot of stress herself she did not co-sleep with the baby.

“I was pretty ignorant, I didn’t really know about co-sleeping or whether or not to breast-feed. I just assumed before birth he was going to sleep in the bassinet or cot. After the birth everything changed. I saw other info, read Dr William Sears on internet, I just googled co-sleeping. I read the book about the ‘continuum concept’. I’ve co-slept on and off for several months since his birth, but not when I’ve been stressed. Now I’ve sorted that out I pretty much co-sleep all the time.” [Public Hosp, Regional, D, 1st regular co-sleeper].

Most of the mothers who co-slept regularly had made the decision to do so before the birth and after reading and researching extensively. These mothers were generally proponents of the ‘attachment theory’ or ‘continuum concept.’ Women who had home births or who had birthed in family birthing centres were much more likely to describe co-sleeping as natural. All of the Aboriginal mothers described co-sleeping as being natural.

Five of the mothers interviewed have been categorised as occasional co-sleepers, so while they do not co-sleep every night or even every week they did co-sleep if their baby was restless or sick.

“I only started co-sleeping when my baby had his first cold at 6 months; I put him in the queen size bed and chucked my husband out! I was very conscious, no pillows or doona.” [Private Hosp, Metro, W, 1st occasional co-sleeper].

Two mothers described themselves as not co-sleeping, however one of them co-slept with her baby in the lounge occasionally and the other had a partner who co-slept with the baby on a couch. The mother who occasionally slept in the lounge did not view this as co-sleeping; her baby was six weeks old at time of interview:
“With this one (six weeks old) I do actually lay with her in the lounge, like 4 am it is her last feed, so I feed her and lay down (on the lounge). I got her wrapped up. I don’t tend to move.” [Private Hosp, Metro, F 2nd occasional co-sleeper].

For most occasional co-sleepers the reasons given were usually because they or their baby was sick, or was because they accidentally fell asleep while breastfeeding or resting with the baby in the same bed (or lounge). One mother maintained she co-slept even more if either she or the baby were sick.

**WHAT ARE THE MOST COMMON FORMS OF CO-SLEEPING INFORMATION USED AND HOW RELEVANT ARE THEY FOR WOMEN’S NEEDS?**

Most of the women interviewed for the evaluation used the internet, books and parenting magazines to research co-sleeping, although for some women this may have started as a search about how to maximise baby sleep rather than co-sleeping as a particular topic of interest. Aboriginal mothers described using other female relatives as their primary sources of information. They also referred to health information about not smoking or drinking as more useful for Aboriginal families.

Women who did not co-sleep generally referred to the SIDS & Kids brochures and discussions with their midwives or child health nurses as their key sources of information about co-sleeping.

Those mothers who subscribed to ‘attachment theory’ and who were most likely to co-sleep regularly would contrast this information with that of ‘controlled crying.’ These mothers were far less likely than mothers who did not co-sleep to bring up the subject with health workers. They were also more likely to articulate frustration about the lack of alternative and credible information about the benefits of co-sleeping. One woman who had conducted extensive research into the area of co-sleeping described this in the following terms:

“There really is this ‘controlled crying’ thing from X [parental support organisation] – they don’t call it that but that is what it is. Or you put your baby for hours to get them to sleep. Who is going to keep doing that after a week of not sleeping? We need to have information about how to co-sleep more safely a lot earlier. What about the psychology effects, all those other sleeping books are written by nannies, no references. If you are reading books, neurology, psychology they are supporting meeting your baby’s needs, there doesn’t seem to be much of a real debate! There is all this other government policy about responding to baby’s needs, bonding and so on – where does co-sleeping fit in with that? Seems to be a complete contradiction.” [Birthing Centre, Metro A, 1st regular co-sleeper].

Four of the other mothers who participated in the study also described the X[parental support organisation] ‘sleep therapy’ education as being very much like ‘controlled crying’ while co-sleeping was viewed as being far more beneficial and ‘natural.’

Other mothers acknowledged that the SIDS & Kids information was credible and consistent in its message but also felt it could be improved and made more relevant through a change in the language about co-sleeping. Several mothers questioned the use of ‘safe’ when talking about co-sleeping and instead asked why terms such as ‘benefits’ were not used in association with co-sleeping rather than ‘safety’ or ‘risk.’ These mothers questioned what they perceived to be an underlying assumption that co-sleeping was inherently unsafe.
More than half of the mothers interviewed, including those who did not co-sleep questioned why there was not more information about how to co-sleep more safely. The following two mothers illustrate why this is important to them:

“More information needs to be given to mums about how to sleep with your child safely. Mums feel pressured and unsure about it when it’s one of the most natural things in the world,” [Home Birth A, Metro, 2nd regular co-sleeper].

“Would be good to have something other than the SIDS brochure, about how to co-sleep more safely. I tend just not to discuss it, my parents are against co-sleeping. My dad was very against it so this makes me reluctant to talk to anyone about it.” [Public Hospital, Metro, S 1st occasional co-sleeper].

These views were shared by an occasional co-sleeper mother who was also a health worker, who stated that it was much better to have information about co-sleeping that adopted a ‘harm minimisation’ approach, as she contended that most new mums were going to co-sleep due to extreme fatigue. She also maintained that many of these new mums would not feel comfortable approaching their child health nurse given the current emphasis on the ‘no response.’

Limited opportunities to feel really comfortable about discussing co-sleeping issues with health workers were raised by several mothers. These mothers described feeling frustrated that they had read the SIDS guidelines and were then unable to discuss alternative perspectives with a health professional in an unbiased manner. Testing the waters with child health nurses were common terms used to assess whether or not they felt ‘safe’ to discuss the issue of co-sleeping. For those who had made the decision to co-sleep an inability to freely discuss the problems of co-sleeping with health professionals was also raised. Others described the ‘inconsistency’ of health worker views or what they described as ‘old-fashioned’ views on issues such as breastfeeding.

“The child health nurse would not discuss my decision to co-sleep with my 2nd baby. I was told off for still giving my baby a breastfeed at night at 5 months. I use the UNICEF brochure on co-sleeping – I found this more useful than the child health nurse saying no. What was most useful was learning about the safer position in the bed. Now my baby sleeps in the crook of my arm, with a cot next to the bed. I get exasperated with the child health nurses different views on co-sleeping – I think it is just their personal opinions. That child health nurse has a lack of credibility when she says don’t breastfeed your baby after 12 months. Inconsistency is very annoying particularly when you are a young mum. I want evidence based advice.” [Birthing Centre, Metro, A 2nd regular co-sleeper].

Most of the mothers who either regularly or occasionally co-slept stated a need for open and honest discussions with health professionals about co-sleeping. Many also pointed out that whilst they had researched how to co-sleep safely, many other mothers in their social circles had not. For example, one mother knew about parents who put pillows next to babies sleeping in beds. She also raised concerns about the stigma attached to parents whose babies die in bed, where there is far more social censure and professional condemnation than if the baby dies in a cot. Three mothers raised concerns about the severe limitations for parents who had experienced the death of a baby to discuss co-sleeping with a range of health professionals.

The mothers who participated in the evaluation described where and how they would like to obtain information. Generally this was described in terms of being consistent, unbiased, more about the
benefits and less judgemental. The majority of participants also wanted to be able to discuss the risks and benefits about co-sleeping with a range of health professionals and not feel that they were being judged. Some of the more commonly mentioned of these were:

- Official site on the internet with evidence based and refereed articles that covered the different points of view about co-sleeping in an unbiased manner.

- SIDS & Kids to include information about how to co-sleep safely in ways that reflect the UNICEF and ABA brochures.

- The ability to talk ‘on-line’ with other parents and health professionals in mediated and balanced forums about co-sleeping.

- An official position and discussion about various sleeping aids such as ‘safe-sleepers’ and side cots.

The following quote from a mother who did not co-sleep sums up the complexities of providing information to women about co-sleeping:

“I agree that the topic of co-sleeping is a hard one. A lot of cultures do it at low risk, there is a lot of information and it is very confusing. I’m especially concerned about the link between co-sleeping and breastfeeding, you know maybe it would have helped me [did not breast feed]. The information needs to be centralised and not biased either way. To me there seems to be two extremes, those who are really against co-sleeping, the health establishment and then the internet mum’s forums that are really for it and not always very well informed. There is a need for a harm minimisation approach; we need more pragmatic information for the sleep deprived!” [Private Hosp, Metro, T 1st does not co-sleep].

One mother who had experienced depression touched on the mental health aspect of co-sleeping, stating that there should be information that presents it as a viable option because sleep deprivation can lead to severe emotional mental health issues and even relationship breakdown. Another mother who never wanted to co-sleep asserted that there were mixed messages about co-sleeping stating:

“Although I never wanted to co-sleep, I know other people have had problems with their kids so they do it out of necessity I think, so they can survive. I mean I don’t know what the Department recommends, but I know there is those capsule things that they make a lot of those, little safe sleepers, it’s pretty much like a cot or bassinet isn’t it? I suppose if I had to I’d use one of those, why isn’t there more information about those?” [Private Hosp, K, Metro 2nd does not co-sleep].

A co-sleeping mother questioned the simplicity of the ‘putting babies on their back to sleep’ message as glossing over the real difficulties that some parents experience in ensuring a good night’s sleep for themselves and their baby. This mother maintained that as co-sleeping babies sleep very well why were the health and psychosocial benefits of sleeping well for parents and babies not highlighted or better known. This was also a point raised by the Aboriginal mothers who participated, all of whom stated that their babies slept well because they co-slept with their mothers.
USE OF SAFE SLEEPER AIDS

One of the strategies suggested by health workers and taken up by mothers themselves who want to co-sleep but are afraid of suffocating or lying over their babies, is to use ‘safe-sleeping’ aids. These may include side-cots (that are referred to in the OD) as well as in-bed bassinets, bolsters and baskets that women find out about from health workers, relatives, friends, various parenting organisations and the internet.

While only three of the women interviewed had at any time used these, many more, including Aboriginal mothers, stated that they required more information about them and wanted either the Health Department, or SIDS & Kids, to evaluate and recommend the ones that were safest to use. One of the mothers interviewed stated that she had co-slept with her baby after five months because her mother bought her a ‘safe-sleeper’, an in-bed bassinet made with rigid material and mesh air flow sides. Later on in the interview (re-assured that the interviewer was not judging her) she then stated that she had in fact co-slept with her baby earlier than this because she had the ‘safe-sleeper.’ Other mothers had heard of ‘safe-sleepers’ but were confused about whether or not they were safe. Some asked why they were approved to “Australian Standards” and sold, if they were not safe.

Two mothers highlighted that ‘safe-sleepers’ were available from the Australian Breastfeeding Association’s web-site on-line shopping and furthermore were ‘approved to Australian Standards.’ They expressed their confusion about why these were not approved by the Health Department, or SIDS & Kids, if they had been approved by Australian Standards and were available through the Australian Breastfeeding Association.

Mothers whose babies slept in cots also used aids to prevent their baby from tummy sleeping. One mother used a bolster type of sleeping aid that was loaned from a friend; while another stated that her daughter slept on a sheepskin and that she used cot bumpers.

Three participants also referred to Helen Ball’s (2006) research that correlated improved breastfeeding rates with women who either co-slept, or whose babies slept in side-cots. They questioned why the Health Department did not have a position on the use of these when the OD referred to side-cots as a possible compromise for women who wanted to co-sleep.

INVOLVED DADS

Several women discussed how consideration of their partner’s attitudes to co-sleeping and care of the baby more generally influenced their decisions about whether or not to co-sleep. The Aboriginal mothers were the least likely to be influenced by their partner stating that they just ‘told their partner that the children come first.’

Partner’s concerns about co-sleeping described by non-Aboriginal women, included those relating to SIDS or suffocation, but also the effects on their sexual relationships with their partner and ability to sleep. Four of the mothers who regularly co-slept with their babies described how they needed to negotiate with their partners and reassure them that the co-sleeping would be for a defined time. One mother saw co-sleeping as potentially positive for the marital relationship:
“Co-sleeping doesn’t destroy the marital relationship – sleep deprivation does though! You can always put your kids in their own beds, have time with your husband and then they come in. There are ways around if you have the resources, sleep with your husband for the first few hours then sleep with the baby in a guestroom on a bed.” [Public Hospital, Metro, R, 1st regular co-sleeper].

Another woman who was an occasional co-sleeper stated that she had initially argued with her husband about co-sleeping because he had been an advocate, while she was against it. This was because both of their babies had taken a long time to settle. When she had fallen asleep with them occasionally in the bed she described waking up with her “heart pounding, very worried she had squashed them.” She also referred to the ‘safe-sleeper’ aids claiming that if one had been approved officially she would have felt more comfortable using one of these. She reflected this would have been a good compromise in their situation and would have prevented a lot of arguing and stress in the relationship.

Another woman described her resentment about what she termed the ‘rise of the involved dad’ claiming there were advantages and disadvantages to this. Touching on the potential power imbalances in some relationships she asserted the pressing need for information that was designed specifically for ‘involved dads’ about co-sleeping:

“I’m against co-sleeping and I really did have a worry with her [baby’s] dad – he is an ‘involved father’. There are plusses and minuses to this. He used a traditional African carry sac to walk baby around with (close to body) because he had heard about how Western mothers ‘separate’ children and he didn’t like it. I really used to worry because sometimes he would walk around the house with baby like this [in the sac] and then once he and baby were tired would lie down on the couch. I would be frantic and have to get up to make sure my daughter was okay. Dad’s can sometimes think ‘they know so much more.’ It was hard because I felt grateful that he was doing his bit, but I was also worried about the baby being rolled over on. I also was so tired that I couldn’t fight about it all the time, I really feel as though the crashing fatigue I experienced and this issue took away from my mothering experience.” [Private Hosp, Metro, L 1st partner co-slept].

Four other women who co-slept regularly also described how they needed to negotiate the ‘involved dad’ role and resist feeling disempowered in their mothering role. They also highlighted the need for information specifically designed for fathers as well as other relatives and carers about safer co-sleeping.

TOXIC MATTRESSES

Several women from one playgroup in suburban Perth touched on the issue of ‘toxic mattresses’ and the association of these with SIDS. One of the mothers who were interviewed described the playgroup’s response to this:

“Some of the information from SIDS is bitty – like they don’t actually know. I looked on-line and everyone in New Zealand is wrapping their mattresses in plastic because there’s a theory that there is bacteria in the mattresses. They reckon there is a drop in SIDS because of that. All the mums are doing that (in playgroup) wrapping mattresses in plastic. [Private Hospital, Metro, T 1st does not co-sleep].
This issue was not generally referred to by other interview participants, however, does demonstrate how for one group of women there was a need for more coherent information.

**Knowledge of the Operational Directive and State Policy**

Most of the women interviewed did not know about the Operational Directive and were not asked any direct questions about this. Instead the researcher asked them questions about the range of co-sleeping information they used and how they had been educated about co-sleeping in hospital and after discharge. Three mothers did refer directly to the OD and the coroner. One woman questioned the philosophy underpinning the directive and SIDS & Kids policy on co-sleeping.

“I feel that the coronial process is driving this policy. They just assume that all bed-sharing is dangerous, even though babies do just die sometimes and no-one knows why. If you have been co-sleeping they will blame it on that. That is even though you may have done everything right, no loose bedding the right position and everything. If you make the choice and if you have a death, it’s your fault. They don’t provide much information about rare events.” [Private Hosp, Metro, C, regular co-sleeper].

Two other women who were regular co-sleepers also questioned the evidence and what they saw as the lack of balance in the information and education from the majority of midwives and child health nurses. Citing a need for more extensive research they questioned why current policy seemed predicated on a minority of high risk communities. Acknowledging the higher rates of SIDS and child deaths in Aboriginal communities’ one woman commented:

“For me there’s a real risk benefit continuum. A lot of deaths in Aboriginal populations occur in remote communities – what other factors are at play here, all sorts of things could have gone wrong besides the fact they were next to their mum.” [Public Hosp, Regional, D regular co-sleeper].

A focus group of mothers who were knowledgeable about and based their child care practices around ‘attachment theory’ did not refer directly to the OD but did state that Health Department policy should acknowledge co-sleeping as “just another parenting practice not as something deviant.” These women also questioned why only particular scientific evidence was privileged over other biological, psychological and anthropological theories that supported co-sleeping and provided evidence for short, medium and long term benefits, including:

- Improved establishment and longevity of breastfeeding
- Enhanced bonding and connection between parents and children, and
- Potentially improved psychological wellbeing and mental health outcomes for their children in the medium to longer term.

These women were also aware of other government policies that advocated ‘bonding’ with children and babies and asked why Health Department Policy and co-sleeping education generally seemed to contradict this advice.

The Aboriginal mothers and grandmother who participated in the study were quite critical of health professionals advising them not to co-sleep. They stated there were many more pressing concerns
for Aboriginal families including the provision of appropriate housing, more space and room for larger families, the raising of living standards and adequate nutrition.

CONCLUSION

The interviews and focus groups with women show that the co-sleeping education they receive while in hospital is not consistent and far less likely to occur for mothers who have already had a child. The need for greater clarity about what co-sleeping means (including sleeping on couches and other surfaces) is also an area that requires improved processes. A majority of the mothers interviewed also stated that they required more balanced information about co-sleeping that included the evidence for the benefits of this and opportunities to discuss co-sleeping without feeling they were being censured by health professionals. Many women were also confused about the inconsistency and contradictions in different forms of advice about breastfeeding and bonding with their babies and how these related to co-sleeping advice. Aboriginal mothers were the least likely to engage or comply with mainstream co-sleeping education and advice and more likely to listen to other family members about how to care for their baby.
SUMMARY OF WA PARENT INTERVIEW AND FOCUS GROUP RESULTS

- Over half of the 30 women interviewed, co-slept with their babies at least once. The 6 Aboriginal mothers and grandmother consulted for the study all co-slept and described co-sleeping as ‘normal’ and an integral part of their culture.

- First time mothers were the most likely to recall receiving co-sleeping brochures and discussion about co-sleeping while in hospital, whilst most second time mothers received no information about co-sleeping while in hospital.

- Mothers who birthed in public maternity units were more likely to recall inconsistent responses to co-sleeping from midwives, with mothers birthing in private maternity units more likely to receive a consistent no co-sleeping message and structured education.

- Half of the women interviewed described fatigue, lack of sleep and pain medication as affecting their ability to remember or absorb information about co-sleeping.

- About half of regular co-sleeping women described being supported by child health nurses and midwives in this decision.

- Four women recalled being told to not openly discuss co-sleeping either by midwives, lactation consultants or child health nurses.

- Women who had caesarean births in private and government maternity units were more likely than mothers who had not, to report difficulties establishing breastfeeding and being afraid of falling asleep with their babies in beds; they were also more likely to report not receiving adequate support in establishing breast feeding.

- Women who co-slept and who wanted to maximise breastfeeding referred to the usefulness of the Australian Breastfeeding Association (ABA) pamphlet which illustrates a safe sleeping position for mother and baby in the same bed.

- Several women who stated they did not co-sleep in the early stages of the interview later revealed instances where they had co-slept, including on a couch, in a bed in a guest room and a partner co-sleeping with the baby.

- Several mothers related partners’ reluctance to room-share or co-sleep with baby due to fears about the effects on their sexual and intimate relationships.

- The Aboriginal mothers who participated in the study stated that their partners slept in other beds or rooms so that babies and children could sleep with mothers.

- Women who co-slept from 3-6 months did so mainly as result of their own, or the baby’s illness, or because their baby was a restless sleeper. Women who were regular co-sleepers from the baby’s birth, usually did so to establish and continue breastfeeding, bonding and because they viewed not doing so as unnatural.

- Aboriginal women maintained that larger families, lack of appropriate housing and the socio-economic circumstances of many Aboriginal families meant that co-sleeping was inevitable and viewed this as even more likely in rural areas.

- Women most commonly used SIDS & Kids brochures, parenting books and magazines and the internet as sources of co-sleeping information.

- Women who co-slept regularly and articulated knowledge of ‘attachment theories’ contrasted these positively with what they saw as ‘controlled crying’ sleeping advice and separation which they associated with current SIDS & Kids advice.

- More than half of the women interviewed wanted more information about how to co-sleep more safely from a centrally based and unbiased official web-site. Three women suggested that the current co-sleeping policy was too driven by the coronial process and that it contradicted other government policies that advocated parental bonding and breastfeeding.

- Aboriginal mothers viewed current information about co-sleeping as inappropriate for their needs, although did refer to information about not smoking, or drinking when they co-slept, as being more useful.

- Just under half of women interviewed suggested that SIDS & Kids include safer co-sleeping information on their brochures in line with the ABA and UNICEF brochures.

- Several women including Aboriginal mothers asserted that an official position and information on safe sleeper aids could provide a useful compromise for women who wanted to co-sleep more safely.
COMBINED FINDINGS AND RECOMMENDATIONS

The key findings from the mixed methods of audits, interviews and focus groups with health professionals/workers and women utilised for the evaluation are summarised under the main objectives of the evaluation. The text boxes emphasise the main areas identified by the participants and synthesise their suggestions (S1-S12) for more effective responses to co-sleeping education. These suggested actions are numbered and may also appear under one or more objectives as they apply.

DETERMINE AND MAP THE PROCESSES AREA HEALTH SERVICES, MATERNITY HOSPITALS AND OTHER MATERNITY SYSTEM SERVICES UTILISE AND DISSEMINATE THE CO-SLEEPING DIRECTIVE

Generally the OD was disseminated effectively across government and private maternity units through clinical midwife managers and midwives. Most had accessed the OD through the global email. Follow up about how to implement the OD and a lack of professional development and evaluation about how to practice it in different maternity health settings and with diverse communities were commonly mentioned as processes that required further development. Lactation consultants based in government maternity settings were the most likely to question the appropriateness of the OD and described adopting a ‘neutral’ position, neither explicitly supporting co-sleeping, nor rigorously enforcing the OD recommendations. One of the major criticisms of the OD is, that it is unclear to health professionals what the absolute risk of co-sleeping deaths are, when other risk factors have been addressed or are not a factor.

Community Midwives, midwives based at ACCHOs and child health nurses were less likely to have received the OD, of if they had received it, were less likely to view it as appropriate for their client groups. They were also more likely to use other sources of co-sleeping education. This was identified by focus groups as leading to some inconsistency in approaches and understandings.

RECOMMENDATIONS

R1. The OD is distributed to diverse maternity health system services, including those not connected to the Department’s ‘global email’, such as: community, women’s health, multicultural and Aboriginal Community Controlled Health Organisations

R2. The implementation practices of the OD are evaluated, followed up regularly, are ongoing and better informed by the ‘realities’ of health worker’s every day experiences of caring for women and babies within the individual and diverse contexts they occur

R3. Professional development and more comprehensive education about co-sleeping are offered and embedded in educational/professional curricula for midwifery, teaching, social work, child health nurse and Aboriginal health worker training; Professional development about co-sleeping is ongoing, includes consistent and credible information about risks and ‘safer co-sleeping’ perspectives, utilises a ‘train the trainer’ method and interactive ‘e-learning’ modules that enable health professionals in a range of maternity system services to collaborate and discuss diverse ‘case-studies’ and co-sleeping issues
The language of the OD was perceived by the majority of health professional/worker participants as being legalistic and not flexible enough to respond to the ‘realities’ of their everyday practice. This was also evidenced by women who had described receiving ‘scary’ information about co-sleeping while in hospital. Although this did prevent some women from co-sleeping, it also angered others who perceived that health professionals’ were promulgating their own views rather than providing balanced information about the risks and benefits of co-sleeping.

Midwife managers and midwives in metropolitan public and private hospital based settings were most likely to provide structured education and develop policies that reflected the recommendations of the OD. While the majority of public hospital maternity units adopted an official “no co-sleeping” position informed by the OD, mothers and midwives described inconsistent approaches to co-sleeping in some public maternity units. While the majority of midwives would firmly endorse the “no co-sleeping” position, several of the women interviewed reported at least one or two midwives (or lactation consultants) in maternity hospital settings being more supportive of co-sleeping with the baby in the bed, acknowledging that this was generally against the prevailing view of the majority of other midwives.

Perceptions that the OD was ‘legalistic’ were reflected in numerous comments in the interviews with health professionals/workers who would differentiate their ‘personal’ views about co-sleeping and acknowledge that these were often contradictory to the OD recommendations. The dissonance that a majority of health professionals/workers in audits, interviews and focus group described seemed often to result in them attempting to adopt a ‘neutral’ position, where they did not openly advocate co-sleeping, but neither did they categorically adopt a ‘no’ position. In part, this is due to the lack of information about ‘absolute risks’ for co-sleeping deaths when all other risk factors are accounted for. This position was most often adopted by lactation consultants, child health nurses and midwives based in community settings (including ACCHOs). The women who were interviewed for the evaluation described ‘inconsistent’ or ‘non-committal’ approaches by midwives and child health nurses, as frustrating and this often led to them either ignoring co-sleeping advice, or finding out for themselves (without health professional guidance).

These inconsistencies in approach were also reflected in women’s descriptions about how they received co-sleeping education in hospital, with second time mothers and those who were fatigued or under pain medication reporting they were far less likely to receive any information about co-sleeping. Several mothers also described inconsistent approaches by midwives (particularly in public maternity units) with a majority being described as adopting no co-sleeping positions and a significant minority enabling co-sleeping.
R3. Professional development and more comprehensive education about co-sleeping are offered and embedded in educational/professional curricula for midwifery, teaching, social work, child health nurse and Aboriginal health worker training; Professional development about co-sleeping is ongoing, includes consistent and credible information about risks and ‘safer co-sleeping’ perspectives, utilises a ‘train the trainer’ method and interactive ‘e-learning’ modules that enable health professionals in a range of maternity system services to collaborate and discuss diverse ‘case-studies’ and co-sleeping issues.

R4. Health professionals/workers across maternity and child health services are provided with the education, organisational and emotional support and resources to openly discuss the issue of co-sleeping with women in ways that enable them to conduct individual risk assessments of parents and provide education about how to co-sleep more safely if this is appropriate and particularly with Aboriginal and CaLD women.

R5. Co-sleeping information and education is provided to all birthing women at maternity hospitals, including those who have previously had children; midwives are supported to ensure that women who are fatigued or under pain medication have had the opportunity to absorb and discuss co-sleeping information with them.

R13. Health workers who care for CaLD women and their babies require an urgent review and guidance about how to respond to the issue of ‘wrapping’ babies in some CaLD communities.

R14. The issue of ‘toxic mattresses’ and the association with SIDS is confusing for mothers and health workers, clear and coherent information about ‘mattress fumes’ is required.

EXPLORE HOW HEALTH PROFESSIONALS AND WORKERS RESPOND TO THE CONCERNS OF PARENTS WHO WISH TO OPTIMISE THE LIKELIHOOD OF SKIN TO SKIN CONTACT AND THE SUCCESSFUL ESTABLISHMENT OF BREASTFEEDING.

The difficulties in following the OD recommendations to the letter were particularly acute for health professionals/workers who cared for clients who were articulate and knowledgeable about ‘attachment theories’ bonding and breastfeeding. The evidence base for the OD was often questioned by health professionals who stated that only a limited selection of ‘scientific evidence’ was used and that other evidence particularly about the benefits associated with co-sleeping was not referred to. Lactation consultants and community based nurses and midwives also experienced professional boundary conflicts and tensions, such as how to be a breastfeeding advocate while actively discouraging women to co-sleep. The women who participated in the evaluation also reported similar tensions, with some describing feelings of frustration when they were unable to openly discuss co-sleeping with lactation consultants, midwives or child health nurses. The dangers of women ‘going underground’ or ‘closing down’ about co-sleeping were highlighted by both women and health professionals/workers who emphasised the importance for open and free discussion about the risks and benefits of this.
R4. Health professionals/workers across maternity and child health services are provided with the education, organisational support and resources to openly discuss the issue of co-sleeping with women in ways that enable them to provide consistent information about risks and ‘safer’ co-sleeping information when appropriate and particularly with Aboriginal and CaLD women.

R6. Health professionals/workers are adequately resourced so that women who have caesarean births, are taking pain medication, or are fatigued, receive appropriate support to maximise skin to skin contact and the successful establishment of breastfeeding; appropriate co-sleeping information is developed for fathers and partners of women.

R7. Improved information about the range of ‘safe-sleeper’ aids available from the internet and credible sites such as the ABA are clarified by the Health Department and SIDS and Kids; identification and approval of side-cots that can be used in hospitals and home is expedited.

TO EXPLORE HOW ABORIGINAL WOMEN AND WOMEN FROM CALDB COMMUNITIES ARE PROVIDED WITH INFORMATION ABOUT CO-SLEEPING AND DETERMINE THE CULTURAL APPROPRIATENESS OF THE INFORMATION PROVIDED AND THE PROCESSES UTILISED.

Midwives and child health nurses who cared for Aboriginal and/or CaLDB women, who were located in regional areas, or cared for women who were knowledgeable about attachment or bonding theories, were most likely to adopt pragmatic approaches to providing co-sleeping education, including information about how to do so more safely. These participants identified the need for ‘safer co-sleeping’ information and used UNICEF and ABA resources in place of the OD, SIDS & Kids and Women and Newborn Health Service brochures. Health professionals/workers who cared for Aboriginal and CaLD women were less likely to report feeling so pressured about adopting the OD recommendations with their clients groups because of expectations that their clients were much more likely to co-sleep and that it was culturally normalised.

These health professionals/workers also identified that current co-sleeping education strategies for CaLDB and Aboriginal women needed to include culturally appropriate language, visual representations and multiple dissemination processes. Information gaps in current co-sleeping information that were commonly referred to included culturally appropriate information about ‘wrapping’ and ‘stroller sleeping.’
R8. Culturally appropriate processes and information about co-sleeping including the provision of consistent and ‘safer’ co-sleeping messages are developed for CaLD women and Aboriginal women; Aboriginal women trained as co-sleeping educators are based in major maternity units to individually model and educate Aboriginal parents about how to co-sleep more safely. Peer education strategies are developed and owned by local Aboriginal communities so that Aboriginal women and girls are educated by Aboriginal people within their own communities about the risks and benefits of co-sleeping, particularly for those women living in remote and rural locations.

R9. Health professionals/workers are supported and trained to recognise and respond to the particular cultural and lifestyle conditions and contexts within which Aboriginal women and CaLD women live, including cultural and life-style practices associated with birth and child care in these communities such as ‘wrapping’ and ‘stroller sleeping,’ recognition of the cultural sensitivities in broaching these subjects are acknowledged and addressed in the professional development, policies and strategies used.

R10. Co-sleeping education and messages are consistent about risks and include ‘safer’ co-sleeping information and are disseminated and presented through social media, documentary, story-telling and visually based methods that are informed and owned by local communities.

TO DETERMINE HOW WOMEN RECEIVE INFORMATION ABOUT THE DIRECTIVE, IN WHAT FORM AND HOW THEY RESPOND TO ITS RECOMMENDATIONS (IN HOSPITAL AND ON DISCHARGE).

The women who participated in the study were not asked any direct questions about the Operational Directive, but rather how they received information and education about co-sleeping. Women who had been private hospital patients were most likely to have received structured education and had read the SIDS & Kids information, they were also the least likely to co-sleep with babies under 3 months old. They would most often describe fears of squashing or lying over the baby or their partner doing so. Second time mothers were also more like to co-sleep with their babies and were the most likely to have not received any information about this.

Three women were unaware they had been co-sleeping when describing how they occasionally slept on couches or lay in the bed with babies in the early hours of the morning. Women who did regularly co-sleep with their babies, described being unable to discuss that they did this with their child health nurse or midwife. The importance of enabling open discussion about co-sleeping was raised by a majority of women and health professionals/workers who described how the emphasis on ‘bed-sharing’ may result in women co-sleeping un-safely on chairs or lounges. Aboriginal women were firm in their resolve to co-sleep, received more of their information from other Aboriginal women and were also more interested in receiving health related information about smoking and alcohol.

Some women also referred to ‘involved fathers’ and highlighted the importance for developing co-sleeping information for this group. This was particularly for women who may have been in relationships where there was a power imbalance, or where they felt unable to challenge or
question their partner. Another topic raised by women that did not co-sleep was their concerns about the effects this may have on their intimate relationship with their partner.

**AREAS OF CONSISTENCY AND AGREEMENT – WHAT INFORMATION AND HOW?**

A majority of health professionals/workers and women agreed that there needed to be a consistent co-sleeping message that included ‘safer co-sleeping’ or ‘safer bed-sharing.’ It was also agreed by interview and focus group health worker participants that while the message needed to be consistent, multiple methods of dissemination and presentation of the message including, social media, documentaries, story-telling and visually based information were all forms of dissemination that could be considered. There was a consensus from a majority of health workers and women that the SIDS & Kids brochures were the most effective, due to their visual appeal and clarity, however, that these also needed to include information about how to co-sleep more safely.

A majority of women including those who did and did not co-sleep identified a need for more balanced information, from an official web-site (such as Health Department or SIDS & Kids) that presented unbiased information about all the benefits as well as the risks of co-sleeping.

A majority of health professionals/workers and women agreed that there needed to be more information and an ‘official position’ about ‘safe-sleeper’ type aids, side-cribs, Moses baskets and other ‘in-bed’ co-sleepers that women could use while in hospital and upon discharge. This was particularly emphasised by Aboriginal women.

About half of the health professional/workers and the majority of the women identified a need for co-sleeping information and education to be presented in ways that were negotiable, less directive and non-judgemental.

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**R7.** Improved information about the range of ‘safe-sleeper’ aids available from the internet and credible sites such as the ABA is provided by the Health Department and SIDS and Kids; identification and approval of side-cots that can be used in hospitals and home is expedited.

**R10.** Co-sleeping education and messages are consistent about risks and, include ‘safer’ co-sleeping information and are disseminated and presented through social media, documentary, story-telling and visually based methods that are informed and owned by local communities.

**R11.** Co-sleeping education and information are presented by health professionals in ways that are more open and not as directive.

**R12.** Balanced, credible information about co-sleeping including a range of scientific studies that presents all the benefits as well as the risks of co-sleeping is accessible on one official web-site with opportunities for mediated on-line discussion with other women and health professionals.
A number of key areas were raised in the evaluation by health professionals/workers and women where there seemed to be a lack of consistent or limited information, or where official responses were questioned.

The wrapping of babies was one area that health professionals/workers identified as requiring more discussion and consideration with respect to co-sleeping education. Community midwives and child health nurses caring for CaLD women and midwives caring for young women also expressed concerns about some CaLD communities wrapping babies too warmly in synthetic materials and the danger of ‘over-heating’ was viewed as particularly risky. Currently SIDS & Kids advocate the wrapping of babies to encourage ‘back’ sleeping and several health professionals/workers identified this as a recommendation that requires urgent review.

Babies sleeping in strollers on a permanent basis was viewed as dangerous by two midwives caring for Aboriginal women, while for another midwife the baby sleeping on their own sleep surface was seen as safer in crowded living conditions and viewed as ‘harm minimisation.’ None of the Aboriginal mothers who participated in this study used strollers or prams as permanent sleeping spaces, with most stating they placed their babies in the bed at night and only used these briefly during the day.

‘Toxic mattresses’ and the association with dangerous fumes and an increased risk for SIDS, was one of the most confusing issues for health professionals/workers and the women interviewed for this evaluation. The SIDS & Kids information about this issue is questioned as not being coherent or certain. Currently women and health professionals are acquiring information about this from the internet and in some cases purchasing plastic wrapping for mattresses.

**R8. Culturally appropriate processes and information about co-sleeping including the provision of consistent information about risks and ‘safer’ co-sleeping messages are developed for CaLD women and Aboriginal women; Aboriginal women trained as co-sleeping educators are based in major maternity units to individually model and educate Aboriginal parents about how to co-sleep more safely. Peer education strategies are developed and owned by local Aboriginal communities so that Aboriginal women and girls are educated by Aboriginal people within their own communities about the risks and benefits of co-sleeping, particularly for those women living in remote and rural locations.**

**R9. Health professionals/workers are supported and trained to recognise and respond to the particular cultural and lifestyle conditions and contexts within which Aboriginal women and CaLD women live, including cultural and life-style practices associated with birth and child care in these communities such as ‘wrapping’ and ‘stroller sleeping,’ recognition of the cultural sensitivities in broaching these subjects are acknowledged and addressed in the professional development, policies and strategies used.**

**R14. The issue of ‘toxic mattresses’ and the association with SIDS is confusing for mothers and health workers, clear and coherent information about ‘mattress fumes’ is required.**
CONCLUSION

The evaluation has shown that health professionals/workers are situated in contexts that present particular challenges and pressures that affect their ability to implement the OD recommendations on co-sleeping. There are top-down pressures from organisations that emphasise the legal contexts and multiple risks associated with co-sleeping. Simultaneously health professionals may experience feelings of conflict about the advice they give, particularly to parents who they know will co-sleep whether for cultural reasons, because of particular beliefs about the benefits of attachment and bonding, or simply due to lack of sleep and fatigue. Health professionals/workers also grapple with how to ensure consistent engagement with women who may otherwise not attend essential maternal and child health appointments. The fears about alienating women either from services or from having a fully open and honest relationship with their health professional are forefront and these situations at times result in more ‘middle of the road’ or modified information being given about co-sleeping and other sensitive issues. Throughout the interviews and focus group consultations the majority of health professionals/workers described feelings of conflict and vulnerability about how to respond to the issue of co-sleeping. Even those who were strongly supportive of a ‘no co-sleeping’ position cited a need for more substantive evidence about the absolute risks associated with co-sleeping.

Many of the issues raised by health professionals/workers were also described by the women who were interviewed. The importance of having relationships with health professionals that were open and frank enabling women to discuss co-sleeping issues honestly was emphasised. Perceptions of being ‘judged’ or that health professionals sometimes used ‘scare-tactics’ were also barriers to women interpreting and considering co-sleeping education. The interviews also showed that many women obtained information about co-sleeping, bonding and breast-feeding from different sources including scientific, neurological, psychological and anthropological approaches. For many of these women there was often frustration at the lack of opportunity to discuss these viewpoints with health professionals/workers who were implementing a strongly no co-sleeping position, or who refused to discuss the topic.

The evaluation has also shown a number of areas where there is confusion and misunderstanding experienced by both parents and health professionals/workers about co-sleeping and associated issues such as wrapping, stroller sleeping, toxic mattresses and the use of ‘safe-sleepers’ and side-cots. Gaps in information were also identified with several health professionals describing confusion or lack of clarity around terms such as SIDS, SUEND and SUDI. The need for co-sleeping as a topic to be embedded in health professional/workers educational curriculum was also identified with two of the health worker participants for this study not understanding what the term ‘co-sleeping’ meant.

The suggested actions informed by the evaluation’s findings are designed to create education opportunities that enable health professionals/workers to provide advice about co-sleeping that includes how to do it more safely as an option, in particular situations, where either due to cultural reasons or beliefs and attitudes about bonding and breast-feeding women are unlikely to subscribe to the current position on co-sleeping as stated in the OD and SIDS & Kids brochures. The suggested actions also make recommendations about different methods for providing more culturally and age-
appropriate co-sleeping information utilising social media, documentary and community specific methods.

The provision of co-sleeping education and information occurs within highly contested and emotive contexts. A topic that is returned to repeatedly in both health worker and parent interviews is the need for ‘harm minimisation’ or ‘middle of the road’ approaches. Whilst not overtly advocating co-sleeping, this approach is viewed as preferable for responding to women who will otherwise co-sleep and who may potentially do so in a particularly risky manner if they are not educated about ways in which it may occur more safely.
**LITERATURE REVIEW**

**DEFINITION OF CO-SLEEPING**

Co-sleeping is a term used in a range of health science, medical and social scientific research literature that analyses risk factors in sudden infant deaths and in studies that outline the benefits of bonding and breast-feeding when mothers co-sleep with their infant. It can be used to describe bed-sharing or room-sharing with an adult, infant or child in the same bed, sleeping surface, or room. Given the multiplicity of interpretations McKenna and Volpe (2007) recommend that researchers who are investigating adult carers who are co-sleeping with infants should be clear about what they mean: “infant and caregiver sleeping side by side on a shared surface, usually a mattress surrounded by a wooden or metal frame” (McKenna & Volpe, 2007, p. 1). Co-sleeping is not always used in the same way in the literature to describe whether it is the mother, both parents or other family members or care-givers who are sleeping with the infant. Mesich (2005) asserts the importance for studies to be clear about whether they are referring to the mother and infant sharing mutual sleep, or if they include other family members or care-givers.

The Western Australian Operational Directive (2008) (the directive) defines co-sleeping in the following way: “co-sleeping refers to a mother or her partner/support person (or any other person) being asleep on the same sleep surface as the baby. Bed-sharing may include co-sleeping, whether intended or not and should therefore be considered in the same way.”

**DEFINITION OF SIDS**

Sudden infant death syndrome (SIDS) is defined as “The sudden death of an infant under 1 year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history” (Willinger et al. 1999). The ways in which SIDS is categorised and used by researchers in a number of studies is challenged by Fremantle and colleagues (2005) who assert that diagnosis of SIDS has undergone several changes in definition since first being used to describe a cause for death and that changing autopsy practices and the use of different definitions make comparing death rates difficult over time. Burnell and Byard (2002) similarly caution about the number of studies that have been published on infants whose deaths are associated with SIDS without the ‘appropriate diagnostic steps occurring.’ SIDS may also be described as “cot-death” in some studies, as well as by parents.

**DEFINITION OF SUDI**

The term SUDI (Sudden Unexpected Death in Infancy) has been adopted in some studies to describe when infants die “suddenly and unexpectedly and do not fulfil diagnostic criteria for SIDS,” or in
circumstances where there has been no examination of the death scene or documentation of the full clinical history or where this is incomplete (Escott, 2009).

The term SUDI is less commonly used in the literature and the term SIDS is more usually used to describe infant deaths associated with co-sleeping. This may be even where there may be a strong association with overlying or suffocation which might be more accurately described as SUDI. The term SUDI is used by the Public Health Association of Australia to describe “the sudden and unexpected death of an infant, usually occurring in sleep, in which a cause of death is not immediately obvious.” SIDS is described in the PHAA’s policy as a ‘sub-set’ of SUDI (PHAA 2009). SUDI refers to a broad category of sudden and unexpected deaths which include Sudden Infant Death Syndrome (SIDS), infections or anatomical or developmental abnormalities not recognised before death, sleep accidents due to unsafe sleep environments and sudden unexpected deaths that are revealed by investigations to have been the result of non-accidental injuries (QLD Health 2008).

DEFINITION OF SUEND

Sudden unexpected neonatal death (SUEND) is used to describe infant deaths that occur unexpectedly in the first week of life. A study about SUEND advocates the clear delineation between SUEND from SUDI due to the differences in frequencies and aetiologies of underlying causes of death, contending that significantly more explained deaths occur with SUEND than with SUDI due to congenital abnormalities and metabolic disease. The authors also highlight that it may be particularly risky for co-sleeping to occur in this patient group (Weber et al. 2009).

CONTEXT

The benefits and risks associated with co-sleeping give rise to a highly contested and complex array of issues. As the discussion about the key terms above demonstrates, there is some inconsistency in how the descriptors “co-sleeping” and “SIDS” are used. The association between co-sleeping and SIDS or SUDI is not always clearly articulated, rather any infant death associated with co-sleeping is more often conflated under the general category of “SIDS” rather than suffocation, asphyxiation or overlying. This overview of the literature identifies the key themes, debates and conundrums that are presented in consideration of co-sleeping information, education and association with infant deaths. In acknowledging the difficulties associated with these definitions and the ongoing ambiguity of the area, this review will focus on the discussions of risk factors associated with co-sleeping, the efficacy of co-sleeping education and information provided to women and how the literature describes different cultural, ethnic and socio-economic groups and health professionals engaging with co-sleeping advice and education.

78
The two positions most often adopted in the literature and by health experts very broadly fall into
the following two positions and there are further variations within each of these:

1. Co-sleeping in the same bed for infants under 3 months should not occur, even though it
may be argued that it is less dangerous or even benign in some circumstances. This is
because it is too difficult and complicated to explain or ensure the conditions under which it
may be practiced without some risk. Given the dilemma of trying to provide information that
takes account of all the complexity and that can adequately explain key risk factors; a
blanket statement advising parents not to co-sleep with infants under 3 months is the
preferred option. This is in recognition of the unavoidable ‘high risk’ factors that may be
present in some settings due to socio-economic, parental smoking, over-crowding,
environmental, health or cultural factors (AAP 2008; SIDS & Kids 2009; Department of Health

2. Co-sleeping is natural and intrinsic to human existence- anthropological, psychological and
biological studies show that ‘bonding’ results in functional ‘attached parenting’ styles that
are better for the infant’s psychological and physiological health both in the short and long
term. Co-sleeping also results in the skin to skin contact necessary for successful breast-
feeding and has been practiced safely in many cultures. As long as parents are advised about
risks and ensure that co-sleeping occurs in beds with flat mattresses, with safe and
appropriate bed clothes, ensuring they are not under the influence of drugs or alcohol, do
not smoke and that the infant is not overheated or at risk of being covered with bedding.
Parents should be enabled to make their own ‘informed choice’, as to whether or not they
co-sleep with their infant. The short-term benefits of co-sleeping (improved breast feeding)
and longer term bonding and emotional advantages outweigh the risks (Ball, Hooker & Kelly
1999; Germo et al. 2000; Mace 2006; Mesich 2005; McKenna & McDade 2005).

Within these two key themes are a number of issues and factors that contribute to the challenges of
developing appropriate information and guidelines for educating parents and health professionals
accurately about the benefits and risks of co-sleeping. These may include factors such as the home
environment of families, cultural attitudes and traditions, as well as naturalistic discourses that
challenge bio-medical responses informing current guidelines such as SIDS Safer Sleeping and the
WA Co-sleeping Directive. A recent study found that in popular magazines geared toward women of
child-bearing age over a third of the images of infants sleeping, portrayed inappropriate sleeping
positions and that two thirds of pictures were inconsistent with bio-medical recommendations
(Joyner, Gill-Bailey & Moon 2009). An internet search on the topic brought up a number of web-sites
advocating co-sleeping referring to selections of key scientific studies and ‘experts’ in support of the
benefits associated with co-sleeping including the establishment of breastfeeding, emotional and
www.askdrsears.com; www.Australianbreastfeeding.com). Other co-sleeping information available
on the internet while acknowledging the benefits of co-sleeping highlight the risks, recommending
that if bed-sharing is to occur it is done safely and with full consideration of the risks (www.RaisingChildrenNetwork).

**STATISTICS OF SIDS, SUDI AND CO-SLEEPING RISK FACTORS**

Deaths associated directly with co-sleeping may be difficult to disentangle from broader statistics about SIDS, SUDI, SUEND and deaths that have been reported as ‘unverifiable’ in cause and child neglect or abuse (NSW 2005). Fremantle and colleagues (2005) maintain that changing autopsy practices and definitions may also result in ambiguity in assessing deaths associated with SIDS, for example, deaths that are currently categorised as ‘unascertainable’ may have, in previous years been attributed to SIDS. The authors of this study raise concerns about these shifting diagnostic categories and suggest these may lead to misinterpretations of data and inaccurate policy advice (Fremantle et al. 2005). The ABM Protocol (2008) describes how concerns about co-sleeping are due to the association with SIDS and studies that have reported on unverifiable death certificates which conclude that these are the result of asphyxiation caused by unsafe sleeping environments or co-sleeping with other adults or children.

A decrease in deaths associated with SIDS is acknowledged in much of the literature although some do raise concerns about an increase in infant deaths associated with sudden and unexpected deaths and co-sleeping (ABM Protocol, 2008; Blair et al. 2009; Lawrence 2008; Nelson et al. 2005). Wilson and colleagues (2010) note that SIDS deaths in Australia have decreased from 168.1 per 100 000 live births in 1991 to 63.2 per 100 000 live births in 2002. This decrease is positively associated with guidelines that advise parents to put babies to sleep on their back (rather than on their side) and advice about safe bedding and surfaces where infants sleep. SIDS & Kids estimated that there were 0.3 deaths per 1,000 births in Australia due to SIDS in 2007 (http://www.sidsandkids.org/wp-content/uploads/SIDS-and-Kids-Fast-Facts-20091.pdf).

A number of co-sleeping studies report that bed-sharing increases the risk for SIDS in infants aged 0-3 months (ABM Protocol 2008; Blair 1999; Carpenter et al. 2004; Fu et al. 2008; Tappin et al. 2005; Ruys et al. 2007). The Child Death Review Committee of Western Australia has completed a total of 14 reviews since the inception of the committee in 2003. Two cases were reported during 2007-08 whereby children who were less than 6 months of age died in circumstances of co-sleeping. Furthermore, co-sleeping was associated with 16 (24%) of the 68 cases reviewed to date, indicating that unsafe co-sleeping practices have contributed to the deaths of these children. Maternal smoking in particular, sleeping position and co-sleeping are most often cited as key risk factors associated with SIDS (Abel, 2001; Aslam, 2009; Wilson et al 2010). While rates of SIDS have reportedly decreased worldwide, deaths associated with accidental asphyxiation or undetermined (SUDI) have increased (Escott 2009).
Key national health statistics report that Aboriginal populations have an increased risk for SIDS; however, it is not clear whether this is due to a greater likelihood for genetic risks, environmental or cultural factors (Wilson et al. 2010). Death from SIDS amongst Aboriginal children is reported to be around 4 times as common as that in non-Aboriginal populations (AIHW 2010). The highest mortality rates from SIDS is reported for the age of 1–2 months for Aboriginal and non-Aboriginal infants (0.36 and 0.06 per 1,000 live births respectively). Aboriginal infants of this age died at almost six times the rate of non-Aboriginal infants. Mortality rate ratios between Aboriginal and non-Aboriginal infants among those aged less than 1 month show that Aboriginal infants died from SIDS at 12 times the rate of non-Aboriginal infants (AIHW 2005). The highest mortality rates for SIDS are at around the age of 2–3 months for Aboriginal and non-Aboriginal infants (0.24 and 0.06 per 1,000 live births respectively). Mortality rate ratios between Aboriginal and non-Aboriginal infants were highest among those aged 4 months, where Indigenous infants died from SIDS at 16 times the rate of non-Indigenous infants (AIHW 2006). Promoting an Aboriginal “Safer Sleeping Brochure” a media statement from the Ministry of Community Services (NSW) asserts that between January 2005 and December 2007, 35 infants died while sleeping in the same bed as their parents and Aboriginal children were over-represented in these numbers, comprising 40 per cent of the total. Aboriginal infants in Queensland were reported by Queensland Health to die at 3.5 times the rate for non-Aboriginal infants (Queensland Health, 2005). The Northern Territory has the highest SIDS rates in Australia (2.07) deaths per 1,000 births (ABS 2003).

The incidence of SIDS for Australian Aboriginal, New Zealand Maori and Native American people are higher than for non-Indigenous and Asian peoples in the same communities. Blackwell and colleagues (2004) posit that higher rates of maternal smoking in Indigenous groups may increase the risk of other infections in infants and contribute to the higher incidence of SIDS for these groups. This study describes how between the ages of 2-4 months infants express an antigen “Lewis” which acts as one of the receptors for three types of bacteria associated with SIDS. However, the increased risk of infection was considered by the authors as less influential than the modifiable prevention of SIDS such as prone sleeping, head covered or maternal smoking. The authors maintain that further research into the effects of the environmental, genetic and developmental risk factors for specific ethnic groups may be more effective than just focussing on the risk factors themselves and that there is currently insufficient evidence to support blanket recommendations for all groups of people (Blackwell et al. 2004). Another study also cautions against this stance acknowledging that whilst infant mortality in isolated Aboriginal communities throughout Australia is high, accurate evaluations of these deaths are required rather than the current practice of placing inadequately investigated infant deaths under an overarching category of SIDS (Chatzimichail, Pietrobelli & Boner 2002).

The SIDS incidence in Asian countries is reportedly lower than that in Western Countries. One study found that the SIDS incidence in Hong Kong was 0.3 per 1000 live births in 1987 (Lee et al. 1989), lower than for Western countries at the same period (2–4 per 1000). The Hong Kong SIDS incidence decreased to 0.16 per 1000 in 1999–2002 while the SIDS incidence in the USA for the same period was 0.56 per 1000 (AAP 2008). A more recent study has estimated the incidence of SIDS in Germany as 0.12 per 1000 births and the Netherlands as 0.1, reported to be the lowest in Europe (Sperhake,
Zimmerman, Puschel, 2008). A study of Thai infant and mother co-sleeping found an increased prevalence of co-sleeping rates in Asian countries compared to Western countries and a decreased incidence of deaths associated with SIDS as a result of this practice. The authors note that there are a number of cultural and socio-economic factors that differ in Asian countries. Co-sleeping in Thailand is more likely to be practiced by women who are professional, from higher socio-economic groups and who sleep in different sleeping environments to Western mothers and infants. The authors contend these factors may decrease risk factors associated with SIDS deaths in Western Countries (Anuntaseree et al. 2007). This is supported by a study examining the experiences of Indian migrant mothers and infants in Australia where lower rates of maternal smoking and other cultural practices are associated with a reduced risk of SIDS associated with co-sleeping (Aslam 2009).

Several studies have demonstrated an increased risk of SIDS when either or both parents smoke and particularly when infants co-sleep with mothers who smoke cigarettes (ABM Protocol, 2008; Alm 2007; Aslam 2009; Fu et al. 2008; Paneretto et al. 2002). A higher prevalence of smoking in Aboriginal populations compared to non-Aboriginal has been documented and the increased likelihood for Aboriginal women to continue smoking during pregnancy and after birth (Gilchrist et al. 2004; Paneretto et al. 2002). Eades and colleagues (1999) discuss the increased likelihood of tobacco smoking exposure in Aboriginal households and suggest that advising and encouraging mothers and families not to smoke rather than discouraging co-sleeping would be more effective in reducing the risk of SIDS for these families. Increased rates of smoking in pregnancy and post-birth are also reported in New Zealand for Maori and Pacific mothers (Hutchinson, Stewart & Mitchell 2006). One study has suggested that Aboriginal infants may also be more susceptible to an infection associated with SIDS and exposure to cigarette smoke due to a TT genotype found more often in Aboriginal populations (Moscovis et al. 2004). Another study whilst not Aboriginal specific highlights an increased risk for co-sleeping and death in infants of low birth-weight noting that low birth-weight is also associated with maternal smoking and premature births (McGarvey et al. 2008).

In a study of SIDS deaths in South West England, Blair and colleagues (2009) compared a cohort of infants who had died from SIDS with two randomised control groups of infants who had not, concluding that co-sleeping in association with other risk factors contributes to a much higher incidence of SIDS. These included where co-sleeping occurred in conjunction with the use of alcohol or drugs (31% v 3% random controls), when infants had co-slept on a sofa (17% v 1%) where one fifth of SIDS infants used a pillow for the last sleep (21% v 3%) were swaddled (24% v 6%), where mothers smoked during pregnancy (60% v 14%), where infants were preterm (26% v 5%) or were in fair or poor health for the last sleep (28% v 6%). A significant proportion of SIDS infants were still found in a prone sleeping position (29% v 10%).

Cohen and colleagues (2010) identified that the re-breathing of asphyxial gases, reduced heat loss and overlying may contribute to SIDS which was also associated with an unsafe sleeping environment. These authors contend that these risk factors may contribute to inhibited reflexes affecting breathing and an infant’s ability to gasp. The association of these risk factors and SIDS deaths are also acknowledged by Fu and colleagues (2008) who attribute nearly half of all sudden and unexpected infant deaths in the US with shared sleeping. Other risk factors identified in the literature include co-sleeping with infants and the use of duvets; sleeping prone on a sheepskin;
sleeping in the house of a friend or a relative (compared with sleeping in the parental home); and sleeping in the living room (compared with sleeping in the parental bedroom (Vennemann 2009).

The influence of low birth weight on infant deaths associated with co-sleeping has also been estimated up to three times as high as for those within the normal weight range (McGarvey 2006). A New Zealand study has described how the immature physiology of the jaw bone in infants may be a factor in infant deaths associated with co-sleeping. The authors suggest that pressure on the jaw may lead to obstruction of the airway, particularly in infants who are pre-term or small. They suggest that co-sleeping could lead to SIDS through inadvertent pressure being applied to the infant’s jaw, either by bedding, or the arm of the carer (McIntosh, Tonkin & Gunn 2009).

Increased risk for SIDS has also been reported for babies of mothers under 20 years old, as well as mothers who have poor or delayed prenatal care. Socio-economic disadvantage is also strongly associated with SIDS. Infants who have not been immunised are also at increased risk (Queensland Health 2008).

**BREAST FEEDING, DUMMIES AND SIDS**

Although meta-analyses have found a significant association between breastfeeding and the prevention of SIDS no causal link has yet been established (ABM Protocol, 2008). However, the study did find that infants who co-slept with mothers who breastfed were more likely to be breastfed more often and the authors recommend that the advantages of this need to be weighed against the risks of co-sleeping. Breast-feeding of infants was also a reason given by parents in a British study for co-sleeping with their infants (Ball 2002). Whilst several studies have positively associated co-sleeping with more frequent breast-feeding Mace (2006) has questioned whether this results in reduced sleep time for the mother with possible negative outcomes for maternal well-being.

The Royal Australasian College of Physicians (2007) acknowledges the associations between co-sleeping and improved breast-feeding rates. However, they also highlight the association between co-sleeping and SIDS if the mother smokes, or is affected by fatigue, alcohol or drugs. They recommend that all mothers be informed about how to co-sleep safely and refer to the UNICEF UK Baby Friendly Initiative. The positive association between co-sleeping and breastfeeding is discussed in other studies, which also caution about the risk factors of co-sleeping (Buswell & Spatz 2007). One study raises concerns about the funding of a program by the Gates Foundation to buy cribs that separate mothers and babies and describe this as a ‘new assault on breastfeeding’ (Lawrence 2008). The use of dummies or pacifiers is controversial in the literature with some studies advocating their use in reducing the risk of SIDS and others cautioning against the encouragement of their use (Fleming et al. 2006; Haycock & Greenough, 2007).

**CO-SLEEPING EDUCATION AND INFORMATION**
A number of factors may influence parents’ decisions to adopt co-sleeping with their babies. Studies show that while for some parents co-sleeping is a conscious decision; most do not plan to co-sleep with their infant before the birth. The reasons that parents do adopt co-sleeping, reflect opinions that it is: easier to breastfeed, increases the frequency and length of parental sleep, promotes parent/infant bonding, reduces infant crying, makes it easier to tend to sick children and may even serve as a prevention to SIDS (Ball, Hooker & Kelly, 1999; Germo et al. 2007; Mace 2006; McKenna & McDade, 2005; McKenna & Volpe, 2007).

Co-sleeping is often reported as being more common in Scandinavian countries such as Norway and Sweden; however, these are often referring to infants 3 months of age and older (Lindgren 1998; McKenna, Ball and Gettler 2007). Co-sleeping or bed-sharing is described in one study as one of the oldest human sleeping arrangements with many variations and that to attempt to adhere to any single public health edict that does not support parental decisions about co-sleeping will be problematic. This complexity may be cited by public health officials as a reason for a blanket statement against all forms of co-sleeping because it is too difficult to individually educate parents properly about the conditions under which it may be safer (McKenna & Volpe, 2007). In a review of SIDS cases the authors reveal the prevalence of multiple risk factors stating this underscores the need for education that provides comprehensive and multi-layered risk reduction education not only to parents, but also to other care-givers involved in infant care (Ostfield et al. 2010).

In contrast to these more qualified views, the American Academy of Paediatrics (2005) and the Department of Health (UK) (2009) have cautioned against the practice of co-sleeping, maintaining the safest place for babies to sleep is in their own cot. The Public Health Agency of Canada advocates room-sharing for babies under the age of 6 months as a preventative measure against SIDS but strongly advises parents not to co-sleep with the infant in the same bed at any time (http://www.phac-aspc.gc.ca/hp-ps/dca-dea/stages-etapes/childhood-enfance_0-2/sids/index-eng.php). The Public Health Association of Australia supports the SIDS (2009) advice about safe-sleeping, including the recommendation that babies sleep in a safe sleeping environment next to the parents’ bed for the first six to twelve months (PHAA 2009).

Co-sleeping education in Western Australia similarly reflects the more cautious of the two perspectives. Between 1985 and 2005, deaths from SIDS in Australia declined by 83%, from 523 deaths in 1985 to 87 in 2005 (CYH, 2005). This decline in deaths has been positively associated with the promotion of safe sleeping practices (such as placing babies to sleep on their back). Similarly, SIDS and Kids Safe Sleeping brochure (Western Australia) for parents recommends a number of measures for safer sleeping, including placing babies on their back for sleeping, flat, firm mattresses and safe ways to use bedding, how to dress the baby and the cessation of parental smoking which has been associated with an increased risk of SIDS. Caution is also raised about bed-sharing with an adult, including concerns about the baby being caught under adult bedding or pillows, being trapped between the wall and the bed, falling out of bed, being rolled on by a heavy sleeper, or an adult affected by drugs or alcohol (Sids and Kids Safe Sleeping, Western Australia).

The SIDS and Kids Safe Sleeping information statement further recommends that babies sleep in their own safe sleeping environment next to the parents’ bed, for the first six to twelve months of life. The information statement refers to the debate about co-sleeping, stating that some studies show babies that sleep closer to their mothers are more likely to be successfully breastfed. The SIDS
and Kids Safe Sleeping information statement maintains that an increased risk of SIDS has been associated with co-sleeping, in conjunction with a number of other key risk factors, such as, when it is with: babies who are younger than 4 months, born preterm or small for gestational age and those who co-sleep with parents who smoke. Furthermore, SIDS and Kids maintain their Safe Sleeping Program is based on scientific evidence that has resulted in an 87% drop in SIDS deaths. The WA information is consistent with the directives about safer co-sleeping from NSW, South Australia and Queensland (CYH, 2005; NSW 2005; Queensland Health 2005).

The Women and Newborn Health Service has produced a booklet for parents about co-sleeping that outlines the association between SIDS and co-sleeping particularly when other factors are present such as: the baby being younger than 3 months, being preterm or small, either parent is a smoker, mother smoked in pregnancy, either parent is very tired, or under the influence of drugs or alcohol, sleeping on soft surfaces, excessive bedding and when other children or pets are sharing the sleeping surface. The booklet also outlines the conditions which contribute to safer co-sleeping suggesting that parents carefully assess these against the risk factors, finally, the booklet outlines the benefits of room-sharing which is presented as the safest option. The Clinical Guidelines for care of the neonate in the ward (10.2) (2007) recommends the same measures as those previously mentioned, including ensuring that new parents are provided with the Sids and Kids safe sleeping booklet. Midwives are referred to Clinical Guidelines, Section B, 10.2.5.1 for information regarding bed-sharing and co-sleeping.

The development of a co-sleeping policy in Western Australia has been initiated following a coronial inquest that requested information on the development and implementation of a state wide co-sleeping/bed-sharing policy for use across all state maternity hospitals (Operational Directive, 2008). The aims of the WA Health state wide co-sleeping/bed-sharing policy are:

- To ensure the safest possible sleeping environment for mothers and babies;
- To reduce the risks of sudden unexpected infant death associated with co-sleeping/bed-sharing in high risk situations;
- To ensure that parents are provided with all the information required to make an informed choice; and,
- To be sensitive to the emotional, cultural and physical needs of the mother and her family, including the importance of skin to skin contact and optimal conditions for the initiation of breastfeeding (Operational Directive, 2008).

Co-sleeping and bed-sharing for babies under 11 weeks is described as high risk in the directive. If women choose to co-sleep with their infant in hospital to facilitate breastfeeding, close supervision and documentation of the decision in the medical records is recommended. The directive does not recommend bed-sharing or co-sleeping, on discharge from hospital for the first three months of the baby’s life (Operational Directive 2008). Each Area Health Service is charged with the responsibility of ensuring that health workers “receive appropriate and timely education to assist them in effectively identifying and responding to co-sleeping, bed-sharing.” The Operational Directive (2008) states that parents and caregivers be provided with the Women and Newborn Health Service Co-
HEALTH WORKERS AND CO-SLEEPING EDUCATION

Health professionals articulate different views about the risks and benefits associated with co-sleeping, particularly those who may prioritise breast-feeding or bonding with the baby. One study highlights the inconsistency of ‘safe-sleeping’ messages between health professionals and suggests that GPs are well placed to provide advice to parents about safe-sleeping practices (Wilson, Quine & Lewis 2010). The capacity for midwives to educate mothers about the prevention of SIDS is highlighted in a study that recommends that midwives inform and encourage mothers to comply with SIDS guidelines about co-sleeping. Whilst room-sharing is positively associated with breast-feeding and bonding, co-sleeping or bed-sharing is not recommended (Bredemeyer 2004).

A study that examined the risk factors associated with SIDS asserts that while educating about safe sleeping environments is important, health professionals need to consider that some families may not be able to afford the purchase of firmer mattresses or separate bedding for infants. This study advocates the use of multi-agency and method approaches to educate vulnerable (in this case black) families about the risks associated with co-sleeping, including the use of brochures, posters, media messages, video presentations, direct parental education and education for health providers (Hauck et al. 2003). McKenna & McDade (2005) contend that while co-sleeping in impoverished urban environments may increase the risk for SIDS, these findings should not result in blanket statements against co-sleeping which may, in other circumstances be less harmful and even benign. Other studies suggest that while health professionals may not feel comfortable about a blanket statement advising parents not to co-sleep with infants under any circumstances, health professionals should ensure that mothers are well informed about the risks, particularly if they smoke or drink alcohol, or the infant is under 8 weeks of age (Mace 2006; Paneretto 2002).

In another study the positive association between co-sleeping and improved breast feeding is highlighted, however, this is qualified with the recommendation that paediatric nurses find out about sleeping arrangements from mothers and insure that risky lifestyle factors will not endanger co-sleeping arrangements. The authors also provide a check-list for safer co-sleeping, including the avoidance of soft beds, loose chords, heavy or loose bedding, parental smoking, drugs and alcohol and recommend that parents who are overweight do not sleep with infants in the same bed. This study also calls for increased research and awareness about the incidence of SIDS in different ethnic groups and more effective means of educating culturally diverse groups (Buswell & Spatz 2007).

In a meta-analysis examining the risks associated with co-sleeping and smoking the authors concluded that more effective education was needed about the increased risk of infant death when babies co-slept with mothers who smoked. The study also found that infants under the age of three months who co-slept with mothers who did not smoke were also at increased risk. The authors recommended that health professionals find new ways of educating women about the risks associated with co-sleeping and smoking (Lahr et al. 2005). This view is shared by Paneretto and colleagues (2002) who advocate for more effective and culturally appropriate smoking cessation programs for Aboriginal parents and extended family members.
Sobralske & Gruber (2009) emphasise that health professionals enable parents to assess all the risks associated with co-sleeping and to be prepared to advise parents against co-sleeping if the risks are too high. They advocate the need to distinguish between safe and unsafe bed sharing and to be clear about the conditions under which co-sleeping may be considered particularly risky. The authors also highlight the importance for health professionals to consider the parent’s culture, religion and health beliefs and the necessity to gather information about the parent’s lifestyle habits and economic status as a basis from which to assess and provide information to parents that is individually appropriate.

Socio-economic status may also increase the likelihood for parents to co-sleep with their infants due to a lack of rooms, beds, bedding or adequate heating (Sobralske & Gruber 2008). A similar view is espoused by Mesich (2005) who maintains that nurses should ensure they are well educated about the risks and benefits of co-sleeping and that they should respect mothers’ decisions about co-sleeping in a non-judgemental manner. Rather than a blanket statement that is against co-sleeping Mesich (2005) advocates informing parents as much as possible about all the benefits and risks and respond by guiding and supporting parents to establish safe sleeping environments regardless of their decision.

**HOW DO WOMEN INTERPRET AND PRACTICE ADVICE ABOUT CO-SLEEPING AND SIDS EDUCATION AND INFORMATION**

Cultural differences in infant care practices and beliefs are factors affecting how culturally and ethnically diverse groups may take up western bio-medical advice. Co-sleeping is viewed as normal and common practice in countries such as Sweden, Norway, China and Hong Kong (Sobralske & Gruber 2009). Abel and colleagues (2001) describe how in their study of Maori and Pacific Islanders infant care practices (including co-sleeping) parents were negotiating a series of issues, between traditional and Western notions of care, between the advice of older family members and younger relatives and friends, between these groups and a range of expert advisors, between what they instinctively felt and ‘doing it by the book.’ There were also tensions in how parents negotiated the economic, physical and social realities of their lives resulting in a wide range of practices. This study discussed how co sleeping was far more prevalent in Maori and Islander cultures and that many parents adhered to the guidelines provided by health professionals about safe sleeping advice. The compliance of younger parents with co-sleeping education at times resulted in tensions and arguments with older family members who thought they should continue co-sleeping in more traditional ways.

The ABM Protocol (2008) on co-sleeping and breastfeeding refers to studies that describe how co-sleeping arrangements in Asian and Pacific Island countries differ to those in Western countries. These demonstrate that mothers who co-sleep with their infants in these countries are more likely to be on top of a bed, on a firm mattress and at arm’s length from their mother. Co-sleeping on sofas
or water beds has been identified as particularly risky and this is far less likely to occur with these groups (Alm, 2007). The ABM Protocol also highlights that in areas where there is malaria, co-sleeping may be the most effective way of protecting infants because of more efficient use of mosquito nets, or may be the only option where bedding or housing is inadequate (ABM Protocol 2008).

In a study of Indian migrant mothers living in Australia, Aslam (2009) describes how these mothers while not explicitly disagreeing with the SIDS advice (and who demonstrated their knowledge and understanding of SIDS) do still co-sleep with their infants from birth. Indian migrant mothers rather frame their resistance to the SIDS advice as a personal choice, as something they have always done and articulate that the advice is not relevant to them because they are responsive and alert mothers who do not smoke or drink alcohol.

African mothers who live in Australia may have different views and practices about pregnancy, birth and breast-feeding management to those shared by health professionals. Many of these women may not be literate in either English or their first language, therefore the importance for providing education and information through the use of interpreters has been emphasised as essential in avoiding misunderstanding about information and education provided by health professionals to these women (Carolan & Cassar, 2010).

**SUMMARY OF LITERATURE**

This review of the literature on co-sleeping demonstrates the complexity and difficulties for both health professionals/workers and parents in assessing and making decisions about co-sleeping. Those health professionals who are breast-feeding advocates or who prioritise the importance of infant and maternal bonding may prefer a more qualified stance to co-sleeping, emphasising the importance for parents to be fully informed about all the risks and advantages of co-sleeping. Others may argue that it is too difficult to properly assess the lifestyle factors and living arrangements of parents, or may feel they do not have the time or resources to adequately educate individual parents and other potential carers of the infants to ensure ‘informed’ education. They may conclude therefore that a ‘blanket statement’ such as that reflected in the WA Co-sleeping directive and SIDS and Kids information is the preferred and safest option.
Appendix 2

EVALUATION RESEARCH QUESTIONS: HEALTH PROFESSIONALS/WORKER INTERVIEW AND FOCUS GROUP QUESTIONS 1-5; QUESTION 6 & 7 INTERVIEW AND FOCUS GROUP QUESTIONS FOR WOMEN.

1. What are the processes area health services and maternity hospitals have in place to implement and disseminate the operative directive on co-sleeping.

2. What professional development, information and education for health professionals have been completed or is being undertaken about the information in the directive.
3. What are the understandings of health professionals about the directive, how do health professionals educate women and other carers of the infant, about co-sleeping in hospital and on discharge, what are the processes – handing out of brochures, other information, discussion or a combination of all these.

4. How do health professionals respond to different viewpoints about co-sleeping?

5. What (if any) are the organisational barriers and facilitators to disseminating and educating women about the recommendations of the directive.

6. How do women receive information on co-sleeping, is it appropriate for their needs (including cultural relevance and appropriateness), easy to understand, and how do they and other carers of the infant, interpret it in the daily practice of caring for their baby.

7. How do women respond to, and raise concerns (if any) to the information and/or education they receive about co-sleeping.

Appendix 3

INVITATION LETTER TO COMPLETE EMAIL/POSTAL SURVEY FOR HEALTH PROFESSIONALS/WORKERS ABOUT THE CO-SLEEPING OPERATIONAL DIRECTIVE.

Dear

I am writing about a research project being undertaken by the Telethon Institute of Child Health Research and the Women and Newborns Health Network in partnership with organisations such as ...... I have attached to this letter an information sheet about the project “An evaluation of the implementation and dissemination processes for the Western Australian Operative Directive for co-sleeping.”

As you may be aware the development of a co-sleeping policy in Western Australia has been initiated following a coronial inquest that requested information on the development and
implementation of a state wide co-sleeping/bed-sharing policy for use across all state maternity hospitals.

To this end we are seeking your views about how your organisation implements and disseminates information from the Western Australian Operative Directive for co-sleeping (2008) (the directive).

We would appreciate if you could reflect on the processes you use and identify these on the questionnaire. If there is insufficient room for you to document all of these, or we have not anticipated all the processes or resources you use, please provide details of these in the additional space left at the end of the questionnaire.

Upon receipt of the questionnaire we may follow up with some supplementary questions either by email or phone in the event we need to clarify or confirm the information you have provided.

We would also like to talk to a selected group of health professionals/workers in a facilitated focus group to explore in more depth, the resources, support and professional development needs required by health professionals and workers to more effectively implement and disseminate the recommendations from the directive. If you are willing to participate further in this way you may indicate this in the space provided on the questionnaire.

Please do not hesitate to contact the researcher: Jenny Dodd on if you require any further information about this research or your participation in it.

Appendix 4

INVITATION LETTER TO WOMEN FOR PARTICIPATION IN “AN EVALUATION OF THE IMPLEMENTATION AND DISSEMINATION PROCESSES FOR THE WESTERN AUSTRALIAN OPERATIONAL DIRECTIVE FOR CO-SLEEPING.”

Dear

The Telethon Institute for Child Health Research is currently conducting a study that is investigating how women are given information and education about co-sleeping or bed sharing with their babies while in hospital and after they have been discharged.

We would like to find out how useful you find the information and how you have used it particularly after you have gone home with your baby.
We would like to talk to you and other women so that we can try and find out what works well and also how the information and education that is provided to women about co-sleeping might be improved.

We would like to invite you to talk to one of our researchers for about 30 minutes at a suitable time and place that is most convenient for you. The researcher will ask you some questions about how you were provided with the information, what you think about it and how you have used it.

An information sheet that gives you more information about the project is attached to this letter. If you would like to take part your time and effort will be greatly appreciated and may help to improve the way the information about co-sleeping is provided in the future.

Please tick the box below if you are willing to be contacted by the researcher, who can arrange a suitable time and place and can also answer any further questions you have.

Yours sincerely

☐

Please tick this box if you are willing to be contacted and provide a contact phone number or email.

Thank you. Phone/email: ________________________________

Appendix 5

AN EVALUATION OF THE IMPLEMENTATION AND DISSEMINATION PROCESSES FOR THE WESTERN AUSTRALIAN OPERATIVE DIRECTIVE FOR CO-SLEEPING.

INFORMATION SHEET FOR HEALTH WORKER RESEARCH PARTICIPANTS

Why are we doing the study?

We are evaluating how effectively the Western Australian Operative Directive for Co-Sleeping is implemented and disseminated. We want to know about the processes your organisation uses to inform health workers who care for women in maternity hospitals about the co-sleeping directive. We also want to explore how the information is provided to women, the availability of booklets and how else you and the women you care for are educated about co-sleeping.

Who is carrying out the study?
The study is being carried out by researchers from the Telethon Institution of Child Health Research in partnership with a range of organisations including Area Health, Child Health and Maternity Hospital Services and includes the participation of women who have recently been discharged from maternity hospital, so we can also obtain their views on the directive.

**What will the study tell us?**

The findings from the study will be written up into a report that can help identify the effectiveness of the implementation and dissemination of the co-sleeping operational directive. It may also help identify improvements that can be made to organisational processes to better support you in providing information and education to women about co-sleeping.

**What will you be asked to do if you decide to take part in this study?**

We will ask you if your organisation has any documented guidelines or protocols about providing co-sleeping education to women. We will do this through short email surveys, followed up by phone calls and visits if necessary to clarify, or obtain more detailed information. You may then be invited to participate in a focus group comprising a range of health workers from metropolitan and regional maternity health organisations. The focus group discussion will be about how you provide education to women about co-sleeping, how your organisation supports you to do this and how you respond to diverse views about co-sleeping arrangements.

**Is there likely to be a benefit to other people in the future?**

The research will help identify organisational processes, protocols and guidelines that are working well in the provision of information about co-sleeping. It may also identify areas of difficulty or gaps in knowledge and how appropriate the information is for women from diverse backgrounds. The research may also identify professional development or resource needs to more effectively assist health workers in providing education and advice to women about co-sleeping.

**What are the possible discomforts and/or inconveniences?**

You may not feel comfortable about sharing in a focus group situation, your reservations or concerns about the implementation or dissemination of the co-sleeping directive. Whilst anything you say shall remain confidential and all participants will be advised of this, you may if you still wish to participate, choose to be interviewed individually at a suitable location chosen by you.

**Where is your information kept?**

All study information is kept in a secure facility at the Telethon Institute of Child Health Research.

**What about my privacy?**

Your privacy (and your organisation’s privacy) is assured and no identifying information will be released to any person or other organisation in a way that either you or your organisation can be identified.
Who has approved the study?

The study has been approved by the WA Aboriginal Health Information and Ethics Committee and the King Edward Memorial Ethics Committee.

Who to contact for more information about this study:

If you would like any more information about this study, please do not hesitate to contact one of the research team. They are very happy to answer your questions.

Name  Title  Contact Number

Who to contact if you have any concerns about the organisation or running of the study?

If you have any concerns or complaints regarding this study, you can contact the Director of Medical Services at KEMH (Telephone No: (08) 9340 8221). Your concerns will be drawn to the attention of the Ethics Committee who is monitoring the study.

What to do next if you would like to take part in this research:

If you would like to take part in this research study, please read and sign the consent form provided.

THANK YOU FOR YOUR TIME

Appendix 6

AN EVALUATION OF THE IMPLEMENTATION AND DISSEMINATION PROCESSES FOR THE WESTERN AUSTRALIAN OPERATIVE DIRECTIVE FOR CO-SLEEPING.

INFORMATION SHEET FOR WOMEN/CARER RESEARCH PARTICIPANTS

Why are we doing the study?

We are doing this research because we are interested to know how you received information about co-sleeping or bed-sharing with your baby. We want to find out how useful you think the information is and what you understand about it.

Who is carrying out the study?

The study is being carried out by researchers from the Telethon Institution of Child Health Research in partnership with a range of organisations including Area Health, Child Health and Maternity Hospital Services. We are also consulting with women like you, who have recently been discharged
from maternity hospital, so we can obtain their views about how they received information about co-sleeping.

**What will you be asked to do if you decide to take part in this study?**

We will be asking you to meet with the researcher at a time and place that is convenient for you and talk about what you know about the information on co-sleeping, how you received the information and what you think about it. The conversation will be taped with your permission, or the researcher will take some notes.

**Is there likely to be a benefit to other people in the future?**

By talking to women and health workers about co-sleeping information and how it is provided, we can find out if there needs to be any improvements in how this is done. We can find out how useful the information is and if there are better ways to present it.

**What are the possible discomforts and/or inconveniences?**

You may not wish to talk to the researcher in your own home. If this is the case, the interview can be arranged to take place at another suitable location, and if required, transport can be provided for you to attend the interview location.

**Where is your information kept?**

All study information is kept in a secure facility at the Telethon Institute of Child Health Research.

**What about my privacy?**

Your privacy is assured and no identifying information will be released to any person or other organisation in a way that you can be identified.

**Who has approved the study?**

The study has been approved by the WA Aboriginal Health Information and Ethics Committee and the King Edward Memorial Ethics Committee.

**Who to contact for more information about this study:**

If you would like any more information about this study, please do not hesitate to contact one of the research team. They are very happy to answer your questions.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Contact Number</th>
</tr>
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</table>

**Who to contact if you have any concerns about the organisation or running of the study?**
If you have any concerns or complaints regarding this study, you can contact the Director of Medical Services at KEMH (Telephone No: (08) 9340 8221). Your concerns will be drawn to the attention of the Ethics Committee who is monitoring the study.

What to do next if you would like to take part in this research:

If you would like to take part in this research study, please read and sign the consent form provided.

THANK YOU FOR YOUR TIME

Appendix 7

Health professional/worker questionnaire audit

An evaluation of the implementation and dissemination processes for the Western Australian Operative Directive for co-sleeping.

We are interested in your views about how you and your organisation implement and disseminate information and recommendations about co-sleeping to women in your care. The findings of this research will help identify the current
processes used and may inform future strategies for supporting health professionals and workers to more effectively respond to the needs of women, including women from Aboriginal and CALD communities.

The survey will take approximately 5 minutes to complete.

NO individual, identifiable information will be released about you or your organisation without your permission. Your name will be number coded, your organisation will be coded by type (e.g. hospital, women’s health service, community health service) and the location as (metropolitan, regional, remote).

Please answer all questions that apply to your situation and either highlight or circle numbers. You may complete as a word document and email back - or complete with biro and post or fax to Jenny Dodd (please see details at the end of the survey) by 18 April 2011.

NAME: _______________________________________________________

GEOGRAPHICAL LOCATION OF YOUR SERVICE:

(Please circle one number that most closely represents where your service is).

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<tbody>
<tr>
<td>a</td>
<td>Inner Metro</td>
</tr>
<tr>
<td>b</td>
<td>Outer metro</td>
</tr>
<tr>
<td></td>
<td>i.e. North of Burns Beach Road.</td>
</tr>
<tr>
<td>c</td>
<td>Rural/Regional</td>
</tr>
<tr>
<td>d</td>
<td>Remote</td>
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</table>

1. Please select the appropriate service type to describe where you work:

(Please highlight or circle one box)

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<tbody>
<tr>
<td>a</td>
<td>Government maternity hospital/unit</td>
</tr>
<tr>
<td>b</td>
<td>Private maternity hospital/unit</td>
</tr>
<tr>
<td>c</td>
<td>Area Health Service</td>
</tr>
<tr>
<td>d</td>
<td>Aboriginal health service</td>
</tr>
<tr>
<td>e</td>
<td>Child Health Service</td>
</tr>
<tr>
<td>f</td>
<td>Women’s Health Service</td>
</tr>
<tr>
<td>g</td>
<td>Other, please describe below</td>
</tr>
</tbody>
</table>
2. Please describe your occupation and role, e.g. midwife, Aboriginal health worker, nurse, doctor, below:

3. Does your organisation have documented guidelines or protocols for providing information and education about the co-sleeping directive to workers in your organisation

(Please highlight or circle one number)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>a</td>
<td>1</td>
<td>2</td>
</tr>
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</table>

If possible please attach a copy of these to email jdodd@ichr.uwa.edu.au or indicate your willingness for the researcher to obtain a copy by ticking this box.

4. Does your organisation have documented guidelines or protocols for providing information and education about co-sleeping to the women you care for in your organisation

(Please highlight or circle one number)

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

5. Please indicate what processes and resources you and/or your organisation uses to disseminate, inform and educate you, other appropriate workers in your organisation and women in your care, about co-sleeping

(Please highlight or circle one number for each statement that applies)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women’s and Newborns’ Health Network Operational Directive</td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>State wide co-sleeping/bed-sharing policy for WA Health hospitals and health services OD 0139/08</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>WNHS Co-sleeping/Bed Sharing</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Brochure Information for Parents (July 2009)</td>
<td></td>
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<tr>
<td>---</td>
<td>---------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>Own organisational documented protocol/guidelines on how to provide women with information about co-sleeping</td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>Own organisational protocol/guidelines on how to respond to women’s questions and concerns about co-sleeping</td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>SIDS &amp; Kids Western Australia Brochure on Safe Sleeping</td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>Professional development for staff on co-sleeping and how to respond to women’s questions and concerns about co-sleeping</td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>Protocols for follow up information for women after discharge from hospital about co-sleeping</td>
<td></td>
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<tr>
<td>h</td>
<td>Access to and knowledge about, other publications, journal articles, reports, internet sites on co-sleeping that can be used by staff and women</td>
<td></td>
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</tbody>
</table>
6. Please rate how much you agree your organisational processes support the following statements. Rating 1 as least agreement to 5 most agreement.

<table>
<thead>
<tr>
<th></th>
<th>Do not agree</th>
<th>Agree a little</th>
<th>Agree somewhat</th>
<th>Agree a lot</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>My organisation ensures that all appropriate workers are knowledgeable about and have access to the Operational Directive on Co-sleeping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b</td>
<td>My organisation provides additional complementary information and professional development support to appropriate workers about the co-sleeping directive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c</td>
<td>All women using our service/s are provided with a copy of the Women’s and Newborns Health Service Co-sleeping/bed sharing brochure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d</td>
<td>All women using our service/s are provided with a copy of the SIDS and KIDS Western Australia Brochure on Safe Sleeping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e</td>
<td>My organisation provides culturally appropriate information and education about co-sleeping to Aboriginal women</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<td></td>
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<tr>
<td>f</td>
<td>My organisation provides culturally appropriate information and education about co-sleeping to women from culturally and linguistically diverse communities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>g</td>
<td>I have adequate time and resources to educate women about co-sleeping and respond to their questions and concerns about co-sleeping.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>h</td>
<td>I know where to refer women when I am unable to answer their questions or concerns about aspects of co-sleeping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i</td>
<td>There are strategies in place to follow up co-sleeping information and education after women have been discharged from hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

7. Please write down any additional thoughts, comments and feedback (if any) you have about this issue, particularly about facilitators and barriers to providing information to women about co-sleeping.

...............................
We would like to talk to a selection of workers in more depth – if you are willing for the researcher to contact you please tick the box below and provide an appropriate contact phone number:..................................................

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY

Please can you attach it to a return email to: jdod@ichr.uwa.edu.au by 18 April 2011

Or print off and post back to:

Jenny Dodd
100 Roberts Road
Subiaco WA 6008

Or fax to:

Attention: Jenny Dodd. CARE: 9489 7700.

Appendix 8

Overview: Policy, guidelines and brochures used by maternity/health services in Western Australia and submitted to researcher: High Risk Factors/Cautions emphasised in Co-sleeping Bed-sharing Information

<table>
<thead>
<tr>
<th>Source</th>
<th>Type</th>
<th>High risk age for babies co-sleeping</th>
<th>Baby must sleep on back all times</th>
<th>Baby sleeps in own cot in parents room</th>
<th>Reference to mother smoking</th>
<th>Reference to household/partner smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source</td>
<td>Type</td>
<td>High risk age for babies co-sleeping</td>
<td>Baby must sleep on back all times</td>
<td>Baby sleeps in own cot in parents room</td>
<td>Referenced to mother smoking</td>
<td>Reference to household/partner smoking</td>
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</tr>
<tr>
<td>WNHS (KEMH)</td>
<td>Brochure for parents</td>
<td>Under 4 months of age</td>
<td>✓</td>
<td>Recommend for first 6-12 months</td>
<td>✓</td>
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<tr>
<td>Department of Health Operational Directive OD0139/08</td>
<td>State wide co-sleeping/be d sharing policy for WA Health hospitals and health services for health staff</td>
<td>Under 11 weeks of age</td>
<td>✓</td>
<td>Strongly recommende d for first three months after hospital discharge</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>WNHS (KEMH) Clinical Guidelines Section B: Obstetrics &amp; Midwifery Guidelines 10 Care of Neonate 10.2 Care of Neonate in the ward</td>
<td>Obstetric and Midwifery Guidelines for use in maternity hospital ward for health staff</td>
<td>Under 2-3 months of age</td>
<td>X</td>
<td>Refer to SIDS &amp; Kids shared room not sleep surface. In hospital use of clip on cots may be used under supervision (not available at KEMH).</td>
<td>✓</td>
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</tr>
<tr>
<td>Community Health Policies, Procedures and Guidelines Birth to School Entry 3.3</td>
<td>Policy with recommended verbal question to ask parents/car</td>
<td>X</td>
<td>✓</td>
<td>Refers to Women and Newborn and SIDS &amp; Kids brochure</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Source</td>
<td>Guidelines for universal meeting schedule. 3.3.2 Universal Postnatal First Contact</td>
<td>Practice Guidelines for medical staff in maternity hospital setting – verbal and written information provided -</td>
<td>Under 11 weeks of age</td>
<td>✓</td>
<td>Refer to SIDS &amp; Kids recommendation, that is, do not recommend sharing sleeping surfaces with baby</td>
<td>✓</td>
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<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
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<td>Metropolitan Public Hospital Practice Guidelines (P1)</td>
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<td></td>
</tr>
<tr>
<td>Source</td>
<td>Type</td>
<td>High risk age for babies co-sleeping</td>
<td>Baby must sleep on back all times</td>
<td>Baby sleeps in own cot in parents room</td>
<td>Referenced to mother smoking</td>
<td>Reference to household/partner smoking</td>
</tr>
<tr>
<td>Source</td>
<td>Description</td>
<td>Under 11 weeks of age</td>
<td>Refers to SIDS &amp; Kids recommendation</td>
<td>Does not stipulate</td>
<td>Recommendations that baby shares a room for at least first 6 months, supports co-sleeping as long as risk factors are considered</td>
<td></td>
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<tr>
<td>------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Metropolitan Public Hospital Acute Nursing Policy (P3)</td>
<td>Acute – mother and baby co-sleeping bed sharing policy for use in maternity hospital ward for health staff</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Department of Health Western Australia “Welcome to your new baby.”</td>
<td>Information magazine for parents disseminated by Child Health Nurses</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation Resource Centre &amp; Australian Breastfeeding Association</td>
<td>“Is your baby sleeping safely?” Brochure for parents</td>
<td>✓</td>
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<td></td>
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<tr>
<td>UNICEF Sharing a bed with your baby. A guide for breastfeeding mothers</td>
<td></td>
<td>✓</td>
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</tr>
<tr>
<td>Source</td>
<td>Type</td>
<td>Caution against co-sleeping when fatigue and/or illness</td>
<td>Caution against co-sleeping when using alcohol or other substance</td>
<td>No soft surfaces/sofas/sagging mattress, bean bag</td>
<td>No excessive bedding</td>
<td>No other children or pets</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td>WNHS (KEMH) Co-sleeping/Bed-sharing Information for Parents</td>
<td>Brochure for parents</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Department of Health Operational Directive OD0139/08</td>
<td>State wide co-sleeping/bed sharing policy for WA Health hospitals and health services for health staff</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>WNHS (KEMH) Clinical Guidelines Section B: Obstetrics &amp; Midwifery Guidelines 10 Care of Neonate 10.2 Care of Neonate in the ward</td>
<td>Obstetric and Midwifery Guidelines for use in maternity hospital ward for health staff</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>SIDS &amp; Kids Safe Sleeping Reducing the risk of Sudden Infant Death Syndrome (SIDS)</td>
<td>Brochure for parents</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>SIDS &amp; Kids Reducing the risk of SIDS in Aboriginal Communities</td>
<td>Brochure for Aboriginal parents</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Source</td>
<td>Type</td>
<td>Caution against co-sleeping when fatigue and/or illness</td>
<td>Caution against co-sleeping when using alcohol or other substance</td>
<td>No soft surfaces/sofas/sagging mattress, bean bag</td>
<td>No excessive bedding</td>
<td>No other children or pets</td>
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</tr>
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<td>Metropolitan Public Hospital Practice Guidelines (P1)</td>
<td>Practice Guidelines for medical staff in maternity hospital setting – verbal and written information provided –</td>
<td>✓</td>
<td>✓</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Metropolitan Public Hospital Acute Nursing Policy (P3)</td>
<td>Acute – mother and baby co-sleeping bed sharing policy for use in maternity hospital ward for health staff</td>
<td>X</td>
<td>X</td>
<td>✔</td>
<td>✔</td>
<td>X</td>
</tr>
<tr>
<td>Department of Health Western Australia “Welcome to your new baby.”</td>
<td>Information magazine for parents disseminated by Child Health Nurses</td>
<td>X</td>
<td>✓</td>
<td>✔</td>
<td>✔</td>
<td>X</td>
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<tr>
<td>Lactation Resource Centre &amp; Australian Breastfeeding Association</td>
<td>Brochure for parents</td>
<td>X</td>
<td>✓</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Source</td>
<td>Type</td>
<td>Caution against trap between wall/pillows/cushions</td>
<td>Parental sleeping position (on side facing baby)</td>
<td>Cautions about partner in same bed</td>
<td>Caution against baby being too hot</td>
<td>Caution against swaddling</td>
</tr>
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<td>WNHS (KEMH) Co-sleeping/Bed-sharing Information for Parents</td>
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<td>✔</td>
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<tr>
<td>Department of Health Operational Directive OD0139/08</td>
<td>State wide co-sleeping/bed sharing policy for WA Health hospitals and health services for health staff</td>
<td>X</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>WNHS (KEMH) Clinical Guidelines Section B: Obstetrics &amp; Midwifery Guidelines 10 Care of Neonate 10.2 Care of Neonate in the ward</td>
<td>Obstetric and Midwifery Guidelines for use in maternity hospital ward for health staff</td>
<td>X</td>
<td>✔</td>
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<td>X</td>
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<td>Brochure for parents</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td>SIDS &amp; Kids Reducing the risk of SIDS in Aboriginal Communities</td>
<td>Brochure for parents</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Source</td>
<td>Type</td>
<td>Caution against trap between wall/pillows/cushions</td>
<td>Parental sleeping position (on side facing baby)</td>
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<td>Caution against baby being too hot</td>
<td>Caution against swaddling</td>
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<td>Metropolitan Public Hospital Practice Guidelines (P1)</td>
<td>Practice Guidelines for medical staff in maternity hospital setting – verbal and written information provided</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<td>✔</td>
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<tr>
<td>Metropolitan Public Hospital Acute Nursing Policy (P3)</td>
<td>Acute – mother and baby co-sleeping bed sharing policy for use in maternity hospital ward for health staff</td>
<td>X</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>Department of Health Western Australia “Welcome to your new baby.”</td>
<td>Information magazine for parents disseminated by Child Health Nurses</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>✔</td>
<td>X</td>
</tr>
<tr>
<td>Lactation Resource Centre &amp; Australian Breastfeeding Association “Is your baby sleeping safely?”</td>
<td>Brochure for parents</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<td>Source</td>
<td>Type</td>
<td>Use of informational diagrams/illustrations/photos</td>
<td>Avoidance of plagiocephaly</td>
<td>Verbal and documentary information</td>
<td>Safety tips for cot sleeping/cot meets Australian standards</td>
<td>Document parental decisions to co-sleep</td>
</tr>
<tr>
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<td>----------------------------------------</td>
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<tr>
<td>WNHS (KEMH) Co-sleeping/Bed-sharing Information for Parents</td>
<td>Brochure for parents</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>√</td>
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<tr>
<td>Department of Health Operational Directive ODD0139/08</td>
<td>State wide co-sleeping/bed sharing policy for WA Health hospitals and health services health staff</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>√</td>
</tr>
<tr>
<td>WNHS (KEMH) Clinical Guidelines Section B: Obstetrics &amp; Midwifery Guidelines 10 Care of Neonate 10.2 Care of Neonate in the ward</td>
<td>Obstetric and Midwifery Guidelines for use in maternity hospital ward for health staff</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
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<tr>
<td>SIDS &amp; Kids Safe Sleeping Reducing the risk of Sudden Infant Death Syndrome (SIDS)</td>
<td>Brochure for parents</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>X</td>
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<tr>
<td>SIDS &amp; Kids Reducing the risk of SIDS in Aboriginal Communities</td>
<td>Brochure for Aboriginal parents</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Source</td>
<td>Type</td>
<td>Use of informational diagrams/illustrations/photos</td>
<td>Avoidance of plagiocephaly</td>
<td>Verbal and documentary information</td>
<td>Safety tips for cot sleeping/cot meets Australian standards</td>
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<tr>
<td>Metropolitan Public Hospital Acute Nursing Policy (P3)</td>
<td>Acute – mother and baby co-sleeping bed sharing policy for use in maternity hospital ward for health staff</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>Department of Health Western Australia “Welcome to your new baby.”</td>
<td>Informatio n magazine for parents disseminated by Child Health Nurses</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Lactation Resource Centre &amp; Australian Breastfeeding Association “Is your baby sleeping safely?”</td>
<td>Brochure for parents</td>
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## MATRIX 1: CO-SLEEPING RESOURCES USED ACROSS HEALTH PROFESSIONAL/WOMEN COHORTS

<table>
<thead>
<tr>
<th>Source</th>
<th>ACCHO Midwives</th>
<th>Midwives Public Maternity</th>
<th>Midwives Private Maternity</th>
<th>Child Health Nurses</th>
<th>Lactation Consultants</th>
<th>Community Midwives/Nurses</th>
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</thead>
<tbody>
<tr>
<td>Operational Directive</td>
<td>Rarely</td>
<td>Most often</td>
<td>Most often</td>
<td>Less often</td>
<td>Quite often</td>
<td>Rarely</td>
</tr>
<tr>
<td>WNHS Brochure on Co-sleeping</td>
<td>Rarely</td>
<td>Most often</td>
<td>Quite often</td>
<td>Less often or DNR</td>
<td>Rarely</td>
<td>Rarely</td>
</tr>
<tr>
<td>WNHS Hospital Guidelines/policy</td>
<td>Rarely</td>
<td>Most often</td>
<td>Most often</td>
<td>DNR</td>
<td>Rarely</td>
<td>DNR</td>
</tr>
<tr>
<td>Own Hospital Guidelines/policy</td>
<td>DNR</td>
<td>Quite often</td>
<td>Quite often</td>
<td>DNR</td>
<td>DNR</td>
<td>DNR</td>
</tr>
<tr>
<td>SIDS &amp; Kids Brochure (general)</td>
<td>Rarely</td>
<td>Most often</td>
<td>Most often</td>
<td>Most often</td>
<td>Quite often</td>
<td>Quite often</td>
</tr>
<tr>
<td>SIDS &amp; Kids Brochure (Aboriginal)</td>
<td>Quite often</td>
<td>Most often</td>
<td>DNR</td>
<td>Most often</td>
<td>Quite often</td>
<td>Most often</td>
</tr>
<tr>
<td>UNICEF – Sharing a bed with your baby leaflet</td>
<td>Most often</td>
<td>Rarely</td>
<td>DNR</td>
<td>Rarely</td>
<td>Most often</td>
<td>Most often</td>
</tr>
<tr>
<td>Australian Breastfeeding Association</td>
<td>Quite often</td>
<td>Rarely</td>
<td>DNR</td>
<td>Rarely</td>
<td>Most often</td>
<td>Most often</td>
</tr>
<tr>
<td>Welcome to your new baby magazine</td>
<td>Rarely</td>
<td>DNR</td>
<td>DNR</td>
<td>Most often</td>
<td>DNR</td>
<td>DNR</td>
</tr>
<tr>
<td>McKenna J</td>
<td>DNR</td>
<td>Rarely</td>
<td>DNR</td>
<td>Rarely</td>
<td>Quite often</td>
<td>Quite often</td>
</tr>
<tr>
<td>Ball H</td>
<td>Quite often</td>
<td>Rarely</td>
<td>DNR</td>
<td>Rarely</td>
<td>Most often</td>
<td>Most often</td>
</tr>
<tr>
<td>‘Attachment Theory’ ‘Continuum Concept’</td>
<td>Quite often</td>
<td>Rarely</td>
<td>DNR</td>
<td>Rarely</td>
<td>Quite often</td>
<td>Quite often</td>
</tr>
<tr>
<td>Internet web-sites</td>
<td>Quite often</td>
<td>Quite often</td>
<td>Rarely</td>
<td>Rarely</td>
<td>Quite often</td>
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### MATRIX 2 WOMEN’S USE OF CO-SLEEPING RESOURCES

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<tr>
<th>Source</th>
<th>Women co-sleep never</th>
<th>Women co-sleep occasionally</th>
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<tbody>
<tr>
<td>Operational Directive</td>
<td>DNR</td>
<td>DNR</td>
<td>Rarely</td>
</tr>
<tr>
<td>WNHS Brochure on Co-sleeping</td>
<td>DNR</td>
<td>DNR</td>
<td>DNR</td>
</tr>
<tr>
<td>WNHS Hospital Guidelines/policy</td>
<td>DNR</td>
<td>DNR</td>
<td>DNR</td>
</tr>
<tr>
<td>Own Hospital Guidelines/policy</td>
<td>DNR</td>
<td>DNR</td>
<td>DNR</td>
</tr>
<tr>
<td>SIDS &amp; Kids Brochure (general)</td>
<td>Most often</td>
<td>Most often</td>
<td>Most often</td>
</tr>
<tr>
<td>SIDS &amp; Kids Brochure (Aboriginal)</td>
<td>DNR</td>
<td>DNR</td>
<td>Rarely</td>
</tr>
<tr>
<td>UNICEF – Sharing a bed with your baby leaflet</td>
<td>DNR</td>
<td>Rarely</td>
<td>Most often</td>
</tr>
<tr>
<td>Australian Breastfeeding Association</td>
<td>DNR</td>
<td>Rarely</td>
<td>Most often</td>
</tr>
<tr>
<td>Welcome to your new baby magazine</td>
<td>Rarely</td>
<td>Rarely</td>
<td>Rarely</td>
</tr>
<tr>
<td>McKenna J</td>
<td>DNR</td>
<td>DNR</td>
<td>Quite often</td>
</tr>
<tr>
<td>Ball H</td>
<td>DNR</td>
<td>DNR</td>
<td>Quite often</td>
</tr>
<tr>
<td>‘Attachment Theory’</td>
<td>DNR</td>
<td>Rarely</td>
<td>Most often</td>
</tr>
<tr>
<td>‘Continuum Concept’</td>
<td>DNR</td>
<td>Rarely</td>
<td>Most often</td>
</tr>
<tr>
<td>Internet web-sites</td>
<td>Quite often</td>
<td>Quite often</td>
<td>Most often</td>
</tr>
</tbody>
</table>

Legend:  
Most often = over 2/3 of cohort  
Quite often = more than ½ but less than 2/3 of cohort  
Rarely = 1-3 of cohort  
DNR = No participants referred to resource/Did not know/Never used
AAP (2008)
American Academy of Paediatrics
A Parent’s Guide to Safe Sleep
http://www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf


AIHW (2005)
Australian Institute of Health and Welfare (2005)
A picture of Australia's children. AIHW cat. no. PHE 58. Canberra: AIHW.

AIHW (2006)
Australia’s Health 2006
Canberra: AIHW.


Chatzimichail, Pietrobelli & Boner (2002)


Children Youth and Women’s Health Service: Parenting and Child Health. Sudden Unexpected Deaths in Infancy including SIDS. Child and Youth Health,South Australia.


PHAA (2009)


SIDS & Kids Safe Sleeping, pamphlet (n.d.) Western Australia.


Women and Newborn Health Service (2007). Clinical Guidelines, Section B: Obstetrics and Midwifery Guidelines. 10.2.5. Strategies to reduce sudden infant death syndrome (SIDS). King Edward Memorial Hospital, Perth, Western Australia.

Women and Newborn Health Service (2008). Co-sleeping/bed-sharing information for parents. King Edward Memorial Hospital, Subiaco, Western Australia.

**Web-sites**


