NATIONAL PARTNERSHIP FOR CHILD SAFETY

Center for the Helping Professions

PRACTICE & POLICY BRIEF

Safely to Their First Birthday

Overview

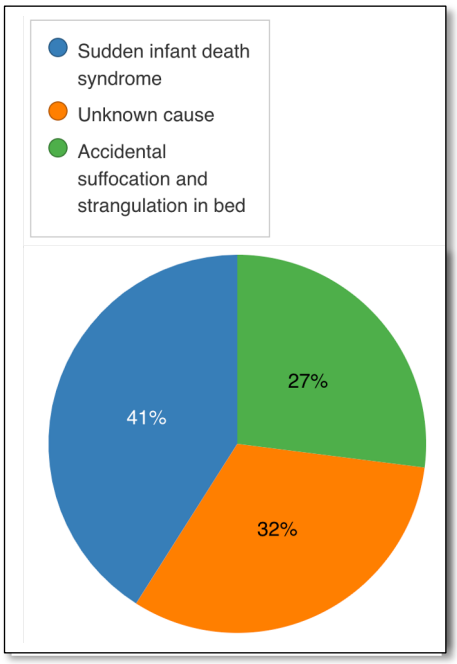
> *"**Safety science** in the context of child protection means using an evidence-based approach to inform preventive and responsive actions, rather than basing policy and practice decisions on emotion or assumption. When we employ safety science, we identify and apply lessons learned based on the best available research and evidence."*
>
> *– Casey Family Programs*

The Center for the Helping Professions (CHP) is a nonprofit, 501(c)(3) organization based in Nashville, Tennessee, which specializes in the application of safety science and the accompanying sciences of improvement and implementation. CHP adapts and applies safety science and evidence-based approaches to enhance safety and address systems improvement across safety-critical sectors such as child welfare. CHP works in support of The National Partnership for Child Safety (NPCS), a quality improvement collaborative of more than 35 state, county and tribal child-serving jurisdictions. Since 2018, the NPCS has been working across jurisdictions to focus on applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities. Members of the NPCS have a shared goal of strengthening families, promoting innovations and a public health response to reducing and preventing child maltreatment and fatalities. This concept integrates a broad spectrum of partners and systems to identify, test, and evaluate strategies to provide upstream, preventative, and earlier intervention supports and services that can strengthen the building blocks of healthy families. NPCS is working to build a child protection system that both helps families before a crisis occurs as well as acts decisively when children are not safe.

Safely to Their First Birthday

Safely to their First Birthday is one of several NPCS affinity groups which are formed around key areas to provide a space for jurisdictions with shared experience to come together, learn, and generate innovative solutions. The focus of this affinity group is on the development of consistent, equitable, and compassionate child welfare responses to sudden unexpected infant deaths (SUIDs), as well as the identification of upstream practices for SUID prevention.

Background



According to the Centers for Disease Control (CDC), approximately 3,400 infants die from SUIDs each year. These deaths occur among infants less than 1 year old. The three causes of death that comprise the umbrella term of SUID are:

- Sudden infant death syndrome (SIDS).
- Unknown cause.
- Accidental suffocation and strangulation in bed.

Demographics of infants who died of SUID include:

- Ethnicity: 35% - Black; 16% - Hispanic; 3% - Native American; 55% - white
- Age: 79% - 0 to 4 months; 21% - 5 to 11 months.
- Sex: 42% - female; 58% - male.

Several risk factors have been identified which can increase the risk of an infant dying from SUID. Those risk factors include: infants who are preterm or low birth weight; exposure to cigarette smoke in gestation or after birth; and use of unsafe sleep surfaces, such as a sharing a sleep surface, soft bedding, or use of pillows.

While SUID is largely preventable, child welfare agencies can default to thinking of caregivers as "causing" SUID, while the reality is that a constellation of factors can contribute to SUID. Researchers use the Triple-Risk Model, which is based on three risk factors which, when combined, makes the chances of SUID high:

- **At-risk infant.** An infant has an unknown problem—such as a genetic change or a brain defect—that puts him or her at risk for SIDS. Health care providers, parents, and caregivers don't know about these problems, so they don't know the infant is at risk.
- **Important time in infant's development.** During the first 6 months after birth, infants go through many quick phases of growth that can change how well the body controls or regulates itself. Also, infant's bodies are learning how to respond to their environment.
- **Stressors in the environment.** All infants have stressors in their environments—sometimes called external stressors because they are outside the body. Being placed to sleep on the stomach, overheating during sleep, and exposure to cigarette smoke are all examples of external stressors. Infants who have no problems like those explained above can usually correct or overcome external stressors to survive and thrive. But an infant who has an unknown problem and whose body systems are immature and unstable might not be able to overcome these stressors.

Conversely, protective factors include breastfeeding (data shows that, of those babies who experienced SUID at 3 months of age or older, only 4 percent were still being breastfed) and adherence to the ABCDs of Safe Sleep, which, according to the American Academy of Pediatrics' Back to Sleep education campaign, advocates that babies need to sleep… **A**lone, on their **B**ack, in a **C**rib, and with caregivers who **D**on't Smoke.

This guidance originated with The Safe to Sleep® campaign, which began in 1994 as the Back to Sleep campaign, launched by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), part of the National Institutes of Health, and other collaborating organizations. The campaign was expanded and renamed Safe to Sleep® in 2012 to address not only SIDS, but also other sleep-related infant deaths. This updated campaign included the

entirety of unsafe sleep environments such as co-sleeping and over bundling, that, in addition to prone sleeping increased the risk of SUID.

After the initial recommendations were released in 1994, the rate of deaths decreased by 60 percent. Those gains have waned in recent years, and evidence suggests many-to-most parents sleep with their babies at some point during their child's infancy. The most effective action to prevent sleep-related deaths is placing infants on their backs to sleep, and the Safe to Sleep campaign championed those national efforts. Since the campaign began, data shows the rate of babies placed on their backs to sleep has increased from approximately 25 percent to 70 percent.

This led the American Academy of Pediatrics (AAP) to revise their guidance in 2022 to reflect the persistent racial and ethnic disparities that exist, with SUIDs among Black and American Indian/Alaska Native infants more than double and almost triple, respectively, that of white infants (85 per 100 000 live births) in 2010-2013.

The revised recommendations include:

- The baby should sleep on a firm, flat non-inclined surface that must meet existing federal safety standards for cribs, bassinets, play yards, and bedside sleepers.
- Sitting devices, such as car seats, strollers, swings, infant carriers, and infant slings, are not recommended for routine sleep in the hospital or at home, particularly for infants younger than 4 months.
- Breastfeeding reduces the risk of sleep-related infant deaths.
- AAP recommends that parents sleep in the same room – but not in the same bed as a baby, preferably for at least the first six months.
- Avoid parent and infant exposure to nicotine, alcohol, marijuana, opioids, and illicit drugs.
- Make sure the baby receives routine immunizations.
- Pacifier use is associated with reducing risk.
- Avoid the use of commercial devices that claim to reduce the risk of SIDS or other sleep-related deaths.

- Supervised, awake tummy time is recommended to facilitate infant development and to minimize development of positional plagiocephaly.
- There is no evidence to recommend swaddling as a strategy to reduce the risk of SIDS. If infants are swaddled, always place them on the back.
- Parents need to be made aware of the most dangerous shared sleep surface environments (e.g., soft bedding, impaired parent) for babies.

SUIDs and The Child Welfare System

Child welfare agencies often investigate suspected SUID as potential child maltreatment. Child abuse hotline screening decisions fall into various maltreatment categories ranging from "Lack of Supervision" to "Environmental Neglect." While numerous factors can be involved in SUID, including those beyond caregiver action, the differential diagnosis as well as unexplained and severe nature of these deaths challenge child welfare agencies to consider how to best respond.

Allegheny County Office of Child, Youth and Families Field Screen Policy

When CYF receives a General Protective Services (GPS) report alleging that an infant died of suspected SUID but there is no clear allegation of abuse or neglect, a Field Screening Unit caseworker conducts a home visit. If the caseworker does not observe any safety concerns with the home or the sibling, the report is screened out, and the caseworker provides the family with information about grief support groups, family support centers, and any other helpful referrals. The Field Screen Unit does this when reports are without clear maltreatment allegations but certain risk conditions (i.e., a child age 3 or younger, multiple reports on a family within 2 years, the child is remote or home-schooled) are present. The assigned Field Screen Caseworker responds within 24 hours to assess the safety of each child in the family. The caseworker then provides a recommendation on whether the report should be screened in for further assessment or screened out. In either decision, prompt community resources can be offered.

Screening

Most child welfare agencies are not designed – due to policy or statute or both – to meet and assess an incident or family without formally opening a maltreatment investigation. The decision to open an investigation into potential maltreatment is decided at screening, based on information from the reporter. As it relates to suspected SUID, law enforcement and medical professionals are very common reporters. Amidst the uncertainty, public child welfare agencies often screen-in suspected SUID to give themselves an opportunity to meet and assess the family personally, as agencies are held highly accountable to ensuring the safety of surviving children.

One consideration for child welfare jurisdictions is to screen out suspected SUIDs when there are no other concerns like potential drug exposure that would warrant screening in a maltreatment investigation. Jurisdictions should also ensure reporters are promptly made aware of screened out referrals, so they know to re-engage if new information arises that could contribute to concerns of maltreatment. Alternative non-maltreatment-alleged pathways may also be appropriate child welfare engagements, as well as prompt referral to supportive non-governmental agencies.

Safety Threat Identification

The absence of clear policy regarding safety planning after suspected SUID can exacerbate family trauma and create an environment where parents and surviving children are forced to separate or have someone move into their home to supervise caregiving. These actions may take place despite no observable danger threats to surviving children, who are often older siblings and not at risk of SUID.

Child welfare agencies experience many unknowns at the onset of an investigation into suspected SUID, as the official cause of death can take months to determine and is sometimes found to be linked to other factors, such as drug ingestion (e.g., Fentanyl) or abusive head trauma. Child welfare agencies can feel compelled to mitigate risk by restricting parents access to their surviving children while these differential diagnoses occur, yet safety planning on the absence of information – instead of the presence of information – likely deepens the divide between public child protection agencies and the communities they serve. While in many cases, the family is reunified once the cause of death is confirmed as SUID, the long-term impact and trauma due to separation can remain.

Project CHILD – Cook County, IL

Project CHILD of Cook County Health was part of a national demonstration initiative to address child maltreatment fatalities called Child Safety Forward. Cook County leaders understood going in that child welfare cannot do this work alone. In fact, data indicated that 50% of infants who died from maltreatment in Cook County, including SUIDs, were unknown to the child welfare system. This led to Project CHILD convening a multi-disciplinary group of stakeholders and partnering with the Child Protection Training Academy to utilize a simulation training model. The simulation was structured around training to recognize elements of unsafe sleep practices based on a fictional family with numerous underlying conditions including domestic violence, unaddressed mental health and substance use disorders, and suspicions of sexual and physical abuse. What the simulation training revealed was that unsafe sleep issues were often not the primary concern of law enforcement, who are often called to homes for other reasons and are rarely trained to look for unsafe sleep practices. This led to the development of new trainings and resources targeting those audiences so they can identify risk factors

One consideration for jurisdictions is that the presence of suspected SUID alone does not constitute a need for safety planning where parental autonomy is impacted. For example, separating surviving children from their parents, even in the context of a temporary safety plan, impacts parental autonomy. Instead, formal and informal parental supports should be engaged, not only around parenting and basic family needs, but also family supports to process the loss. An additional consideration is that regardless of when safety planning is warranted, helpful resources are coordinated or provided urgently (e.g., Narcan provided if opioid use is suspected, community counseling referrals, concrete resources to alleviate economic distress) to respond to some of the extraordinary stressors that contribute to potentially present or impending danger threats.

Maltreatment Dispositions

Similar to other decision-making points across the continuum of child welfare involvement, maltreatment dispositions can perpetuate disparities and trauma as some families choose bed-sharing as part of their heritage.

Another important factor to note is that child welfare agencies are not first responders to child fatalities, as this role belongs to emergency medical services and law enforcement. As a result, child welfare agencies often receive referrals several hours or days after first responders became involved, and this places child welfare agencies in a particularly challenging role – where they are potentially pressed with a responsibility to "re-investigate" the incident from a lens of child safety and maltreatment dispositions, while also assessing the family's needs to determine next steps. Child welfare agencies are concerned about the integrity and usefulness of their investigation in such contexts, and they are concerned about the additional trauma to families. Medical examiner reports can take months or even years to reach public child welfare agencies, and if the cause of death was something unexpected and dangerous, such as opioid ingestion, the public outcry about child welfare having not responded earlier to the family can be intense and contribute to child welfare agencies adopting less risk tolerant strategies in family preservation.

After screening-in a suspected SUID report, child welfare's role is to investigate and make dispositional findings, often in 60 days or less. Local statutes governing child welfare can broadly allow substantiation

when the caregivers' behavior led to severe harm. Though criminal charges are unlikely in such situations, child welfare agencies often make maltreatment determinations on lesser legal thresholds. This threshold is less burdensome to prove and generally requires maltreatment to be more likely than not. Though the field of public child welfare is uniquely and regularly charged to make these dispositional decisions, which affect family's lives and livelihoods, such decisions – especially in the face of such loss, may perpetuate psychological harm, traumatize families, increase unhelpful family oversight and court action, and contribute to overall distrust in public child welfare.

One consideration for jurisdictions is that parents' intentional or unintentional action to share a sleep surface with their child does not warrant substantiation, even if the parents have been previously educated on the ABCDs of infant safe sleep. Also - if concurrent maltreatment allegations are under investigation, such as those related to caregivers' substance use problems – engage a team-approach to thoughtfully consider if the caregiver's behavior rose to the level of maltreatment, despite the outcome. This promotes mindful child welfare practice and guards against substantiating on the basis of outcome bias.

Safety Science and SUIDs

The National Partnership for Child Safety has a shared commitment of adopting a family-centered approach grounded in the applications of human factors, safety science, implementation and improvement science into public child welfare work. Central to that effort is the collaborative sharing of insights across critical incident reviews – particularly child fatality reviews – to improve the systems-of-care supporting safety and wellbeing. This also lessens the potential for child welfare agencies to get stuck in cycles of blaming families or child welfare professionals for child fatalities, often accidental ones. The NPCS adopts a systems approach to learning from child fatalities in the interests of sharing accountability for child safety and family wellbeing. The NPCS is uniquely positioned to describe the landscape of public child welfare prevention and response, related to child fatalities like SUID, and be candid about opportunities for systems improvement.

Based on a safety science approach, the NPCS offers the following considerations regarding safe sleep:

- Compassionately inform all families of the ABCDs of infant safe sleep and provide access to no-cost safe sleep surfaces. Consider offering caregivers choices about the safe sleep surface they are provided, as a bedside bassinet versus pack-in-play may be preferable within certain social and cultural contexts. For those who intend or have experienced falling asleep on a shared surface with their baby, provide responsive harm reduction education.
- Problem-solve with families. If a baby's care is shared across multiple homes, ensure safe sleep furniture is easily transferable or – better yet – provided to all homes where the baby will be. If a family is homeless or living in poverty and does not have a safe sleep environment for their child, provide them with one but also help them access a safe, secure space for their family while more permanent housing is sought and connect the family with resources and economic supports available through community-based organizations.
- Support access to human milk for babies by helping parents access lactation consultants and donor milk banks, and destigmatizing medication for treatment of opioid use disorders. Under the advisement of a medical professional, parents with substance use problems can sometimes still safely breastfeed, especially those stabilized on medication (e.g., buprenorphine, methadone) for opioid use disorders.

A Human Factors Approach to Parent-Infant Sleep

From a systems perspective, what is missing from the conversation around SUID prevention in child welfare work is the need to adopt a "human factors approach" to understanding caregiver-infant care decisions broadly and sleep decisions specifically. A human factors approach, which is grounded in safety science, examines the wide range of factors that influence humans' actions and decisions and can lead to system changes defined by a clearer understanding of the capabilities and limitations of human decision-making.

What does this look like in practice as it relates to SUID? Consider the trajectory of the Safe to Sleep campaign. As the number of deaths began to decrease in the 1990s, policymakers and public agencies doubled down on advocating for the ABCDs in safest sleep practices without acknowledging or accounting for social and cultural differences in bed-sharing. This contributed to greater punitive action across child protection agencies against families who were not following safest sleep guidance.

In their updated guidance, the AAP, while still advocating that families do not engage in bed-sharing, did identify specific risk reduction steps for those who do, noting: "It is also important for parents, pediatricians, other physicians, and nonphysician clinicians to know that the following factors increase the magnitude of risk ten-fold when bed sharing or surface sharing:

- Bed sharing with someone who is impaired in their alertness or ability to arouse because of fatigue or use of sedating medications (e.g., certain antidepressants, pain medications) or substances (e.g., alcohol, illicit drugs).
- Bed sharing with a current smoker (even if the smoker does not smoke in bed) or if the pregnant parent smoked during pregnancy.
- Bed sharing on a soft surface, such as a waterbed, old mattress, sofa, couch, or armchair."

In addition to the above, the revised guidance also described increased SUID risk when bed-sharing or surface-sharing in these following conditions:

- Term, normal weight infant aged less than 4 months, even if neither parent smokes and even if the infant is breastfed.
- Bed sharing with anyone who is not the infant's parent, including nonparental caregivers and other children.
- Preterm or low birth weight infant, even if neither parent smokes.
- Bed sharing with soft bedding accessories, such as pillows or blankets.

Despite this updated AAP guidance on harm reduction conversations, child welfare systems struggle to help caseworkers navigate these conversations in practical and nuanced ways. The ABCDs of safest sleep are easy to teach, but integrating person-centered assessment and harm reduction education – especially when a parent describes intentions or experiences sharing a sleep surface with their child – is not difficult. Child welfare professionals are routinely charged with much more complex assessment and decision-making. Making high-consequence family assessments and safety determinations in the context of complex and interdependent societal and social factors is their routine work. Child welfare professionals have every desire to serve their communities well — wanting the best information and resources to support families in

the ways they most need. Their work is complicated by the fear of moral injury, damning media headlines, the potential of losing their job, and rare but well-publicized prosecution for their decisions which in turns leads to greater risk aversion. Equipping them with life-saving knowledge of the ABCDs of safest sleep alongside some simple harm reduction talking points is achievable and likely to prevent more SUID deaths.

Educating the child welfare workforce only on the ABCDs of infant sleep, which represent the safest sleep approach, could risk alienating the already stigmatized and disadvantaged community often reached by public child welfare agencies. While education is paramount, it must be accessible and responsive to those in the community for which the education is intended to serve.

From a human factors perspective, falling asleep with an infant is a biologically rewarded practice. Research shows physical touch between parents and children increases oxytocin and effects dopamine levels. Many parents report bedsharing contributes to easier and longer breastfeeding, improved sleep and decreased rates of postpartum depression. Co-sleeping (defined in the study as either room-sharing or bedsharing) has predicted lower infant cortisol reactivity, and breastfeeding has predicted quick cortisol recovery. Mothers with opioid use disorder also describe unique factors that influence sleep behaviors, such as efforts to keep babies under close monitoring and to ease infant behaviors they perceive to be the result of drug withdrawals.

One recent study found that higher odds of bed-sharing among U.S. mothers was linked to a high prevalence of worries regarding basic needs, family relationships, and health. And while the prevalence of bed-sharing is higher among mothers of color, it remains a practice across all ethnicities. For example, over half of respondents study using Pregnancy Risk Assessment Monitoring Systems (PRAMS) data, reported bed sharing with their infant. Other data found almost half of all babies bed-shared at some time with their parents, and on any one night in the first month over a quarter of parents slept with their baby. Bed-sharing was not related to younger mothers, single mothers, or larger families, and was not more common in the colder months, at weekends, or among the more socially deprived families; in fact, bed-sharing was more common among the least deprived in the first months of life. Breastfeeding was strongly associated with bed-sharing, both at birth and at 3 months.

Social Current and Evaluation Plus, which provided technical assistance for Child Safety Forward, a five-year demonstration initiative funded by the Department of Justice, Office for Victims of Crime, developed a Safe Sleep conversation guide based on learnings from the five demonstration sites. The guide offers practical advice for how providers can have equitable conversations with caregivers that foster trust around safe sleep advice. The guide is set up to offer providers a tool based on Child Safety Forward learning to help think through how bias shows up at the individual, relational, and institutional level and helps re-design our work with community so that we stand a far greater chance of finding solutions in partnership with them around the universal goal of child safety.

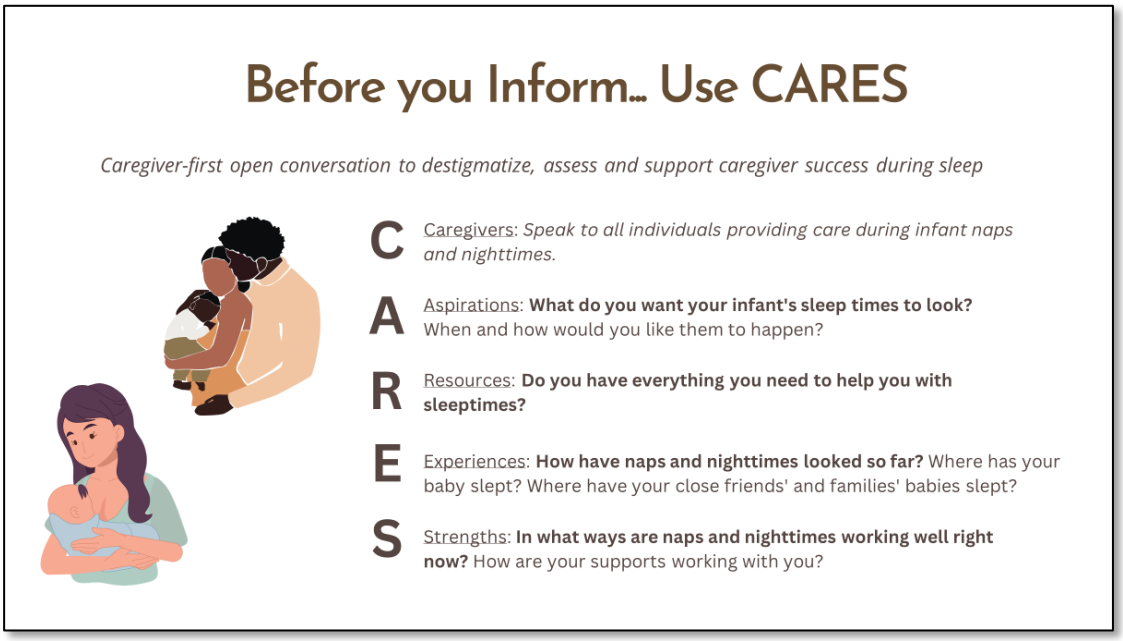
A Person-Centered Approach to Reducing SUID

An integrative and person-centered approach to reducing SUID starts with destigmatizing conversations with caregivers to honor both the ABCDs of Safest Sleep as well as bed-sharing being both well-intentioned and compassionate caregiver practices. Every family needs education and support to practice the ABCDs of safest sleep. Building person-centered context and offering culturally relevant information is key to education being accessible and well-received. Prior to educating families on Safest Sleep, a loosely structured conversation could start with identifying the caregivers' aspirations, resource needs, experiences and strengths.

To support child welfare professionals in having such conversations, the Safe Systems Team at the University of Kentucky Center for Innovation in Population Health in collaboration with The Safely to Their First Birthday affinity group created the acronym CARES. It exists to help child welfare professionals have person-centered conversation and information-exchanges with caregivers of infants:

Following a CARES conversation, child welfare professionals should always provide the ABCDs of safest sleep and provide resources to encourage the family to adopt those practices. When caregivers describe any experiences or intentions to share a sleep surface with their infant, responsive harm reduction information can additionally be provided.

While influencing behavior in families with infants at risk of SUID has traditionally focused on “getting messages across,” a recent NIH study found that moving from “information giving” to “information exchange” using personalized, longer term relationship-building models improved how infant sleep advice is implemented. We suggest engaging parents in a discussion about why they choose certain sleep practices with the goal of understanding the "why" in order to intervene in an appropriate way. (I.e., 1. Ask what they do, 2. ask why they do it.)



In addition to CARES, there are several key strategies that reflect a person-centered approach to SUID prevention, such as:

- Engage in holistic SUID prevention strategies by making the most of Plans of Safe Care. Plans of Safe Care offer opportunities for child welfare agencies to work in tandem with other family-serving entities to co-create plans for parents with substance use problems who have newborns. It is important for other first responders, including medical professionals, to engage with CPS on Plans of Safe Care. These plans do not require maltreatment allegations, certain dispositions, or court involvement. They are an opportunity for candid, person-centered, collaborative care.

- Use simulation strategies, such as dolls with visible respiratory systems, to help caregivers understand the importance of placing their baby on the baby's back on a safe surface.
- Use funding streams to support health-related agencies in giving small, frequent, timely incentives to caregivers who are learning new skills and/or are engaged in services or treatment. Especially in recovery from substance use problems, contingency management offers great evidence for helping adults adhere to treatment.
- Support breastfeeding as it is proven that human milk has uniquely protective properties — human milk even once daily makes a difference. Child welfare agencies and their partners can offer access to lactation support in partnership with Family Resource Centers.

Indiana Department of Child Services Safe Sleep Simulation Kit

The Indiana Department of Child Services introduced its Safe Sleep Simulation Kit in 2023, purchasing kits for each of its 95 offices. The kits include an anatomical doll that pulls apart so that families can see the anatomical difference if a baby spits up on their back versus on their stomach. It also shows the difference in the opening of the windpipe when the baby is flat on their back versus in a swing or car seat. The kit comes with access to an application that allows teams to enter the family's individual risk factors and then simulates the baby's oxygen saturation level based on these individualized risk factors.
The 3D infant model allows educators to address the common misconception surrounding infant choking on vomit or spit up in the back to sleep position by utilizing visual and auditory cues in

- Destigmatize medication for treatment of opioid use disorders and emphasize human milk for infants by supporting healthcare-led conversations around breastfeeding for mothers in stabilized medication adherence for substance use. For those whose substance use prevents them from safely breastfeeding, create supportive, destigmatizing systems for access to free human donor milk.
- Encourage parents to understand different types and reasons for crying, known as purple crying, and destigmatize the need for caregivers to leave an infant in a safe location temporarily to reduce caregiver stress.

Child welfare does and can continue to coordinate resources for the families they come into contact with. Available resources include:

- Tailored, comprehensive, and integrated supports that respond to family needs, such as lactation support for mothers, is available via Family Resource Centers or in-home consultation as funded by the Affordable Care Act. Family Resource Centers' resources have been linked to a decrease in SUID rates based on the Child Safety Forward Strengthening Indiana Families demonstration project.

- Support healthcare connections for smoking reduction or cessation. For support resources, dial 1-800-quit-now.
- The Nurse-Family Partnership is one example of a home visiting program that empowers first-time moms to transform their lives and create better futures for themselves and their babies. The Nurse-Family Partnership works by having specially trained nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy and continuing through the child's second birthday.
- Healthy Families America (HFA), is another example of a home visiting program developed by Prevent Child Abuse America. As one of the leading family support and evidence-based home visiting programs in the United States, HFA promotes positive parenting and child wellbeing and prevents the abuse and neglect of children in communities around the world through family-focused and empathic support provided in the home.
- Concrete economic supports to families have a direct impact on reduced involvement with child welfare systems. A study out of Georgia found that the monthly Child Tax Credit payments made to families during 2021 resulted in fewer children visiting the emergency room with abuse- and neglect-related injuries. Chapin Hall at the University of Chicago also developed a brief on the impact of concrete, economic supports for families and its correlations to reducing involvement with the child welfare system. Their research identified poverty as a key driver of child welfare system involvement and suggested that even modest economic supports could help stabilize families and prevent the need for removing children from the home.
- Care Coordination for Pediatrician Appointments, which entails organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.
- Distribution of safe sleep products, including furniture, sleep sacks, and resources that support infant sleep (i.e. use of white noise, slow-tempo music, infant night lights).
- Support recall and/or replacement of unsafe sleep items.
- Safe Baby Court Teams help minimize trauma and its impact on early development by improving how the courts, child welfare agencies, and related child-serving organizations work together to support young children and their families.

Conclusion

Drawing on human factors and a person-centered approach to families at risk of SUID is a respected public health approach that child welfare agencies can employ to improve outcomes among infants. A multifactorial approach to prevention that improves the safety of infant sleep environments while also encouraging other protective factors such as: human milk for babies, medication for caregiver opioid use disorders, support for smoking reduction or cessation, and concrete economic supports to reduce caregiver stress is crucial to reducing SUIDs while also increasing family well-being and preservation.

Evidence supports that biological, social, and cultural differences may lead families to not fully comply with the ABCDs of safest sleep guidance. Responsive information-exchanges between child welfare professionals and families can impact caregiver practices, and CARES conversations may be able to help professionals operationalize person-centered conversation. While all caregivers need education and support on the ABCDs of safest sleep, harm reduction conversations are additionally important for families who describe experiences or intentions to share sleep surfaces. Every act a family takes to improve the safety of their baby's environment can matter. Creating open dialogue with families is crucial.

In the fortunately rare (but not rare enough) event of SUID, lack of adherence to the ABCDs of safest sleep does not singularly warrant screening-in a maltreatment investigation, development of a restrictive safety plan, or substantiating maltreatment, even on the instance an infant has died from suspected SUID.

Alternative response programs can assess and support families without having to identify and formalize dispositions on allegations of maltreatment. Using these programs to engage families and support assessment and safeguarding may be a better approach than screening-in suspected SUID for a maltreatment investigation. Also, restrictive safety plans are likely inappropriate in circumstances where the caregivers' behavior does not constitute a clear risk to surviving siblings, given their age and development. Lastly, substantiating maltreatment for intentional or accidental surface-sharing with an infant has the potential to perpetuate trauma and deepen social and racial disproportionalities.

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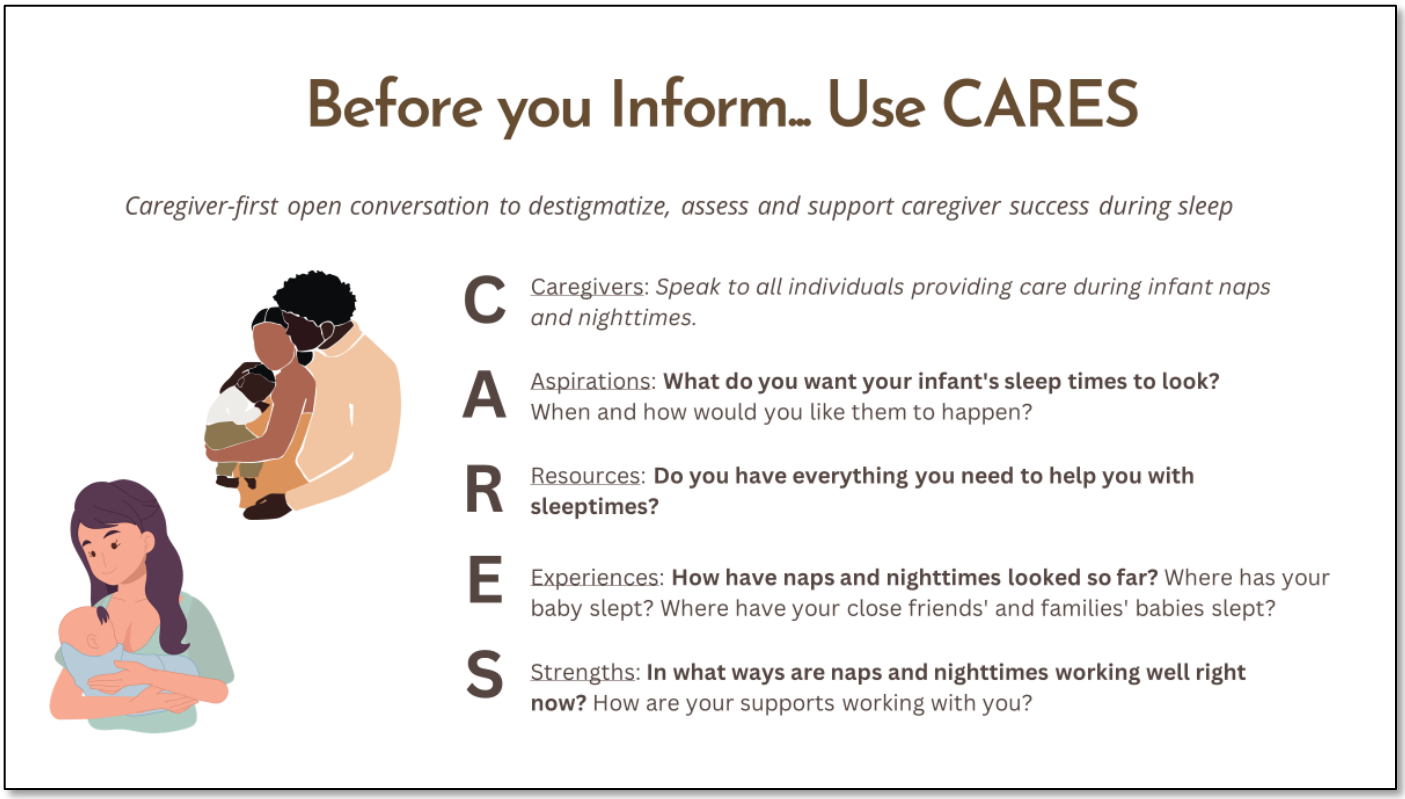
Appendix

This graphic can be printed and shared as a flyer to represent the CARES conversation approach to SUID: