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ARTICLE

State Child Care Regulations Regarding Infant Sleep Environment Since the Healthy Child Care America-Back to Sleep Campaign

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ABSTRACT

BACKGROUND. Despite overall decreases in sudden infant death syndrome deaths and prone sleeping, the proportion of sudden infant death syndrome deaths that occurs in child care settings has remained constant at ~20%. In 2003, the American Academy of Pediatrics' Healthy Child Care America program launched its own Back to Sleep campaign to promote the Back to Sleep message for those who care for young children.

OBJECTIVES. The purpose of this study was to evaluate the effectiveness of the first 2 years of the Healthy Child Care America-Back to Sleep campaign in improving child care regulations by assessing the inclusion of the elements of a safe sleep environment in the individual state regulations for child care centers and family child care homes.

METHODS. We examined regulations available in October 2005 for licensed child care centers and family child care homes in the 50 states and the District of Columbia for specific regulations pertaining to (1) sudden infant death syndrome risk-reduction training for child care providers, (2) infant sleep position, (3) crib safety, (4) bedding safety, (5) smoking, and (6) provision of information about sleep positioning policies and arrangements to parents before the infant is enrolled in child care.

RESULTS. Since 2003, when the Healthy Child Care America-Back to Sleep campaign began, 60 of the 101 state regulations for either child care centers or FCCHs have been revised. More than half of these regulations written since 2003 mandate a nonprone sleep position and restrictions on soft bedding in the crib, and the change in these regulations since 2003 is statistically significant. However, of the 101 existing state regulations, only 49 require that infants sleep nonprone, 18 mandate sudden infant death syndrome training for child care providers, 81 have ≥1 crib safety standard, and 43 restrict soft bedding in the crib. Only 4 regulations require that parents be provided with sleep policy information.

CONCLUSIONS. The initial 2 years of the Healthy Child Care America Back to Sleep campaign have been successful in promoting safe infant sleep regulations. Efforts must continue so that safe sleep regulations exist in all jurisdictions.

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Key Words
sudden infant death syndrome, risk reduction, regulation, child care, sleep position

Abbreviations
AAP—American Academy of Pediatrics
BTS—Back to Sleep
SIDS—sudden infant death syndrome
CCC—child care center
FCCH—family child care home
HCCA—Healthy Child Care America
CPSC—Consumer Product Safety Commission

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In 1992, THE American Academy of Pediatrics (AAP) recommended that infants no longer be placed to sleep prone.[1] Two years later, the National Institute of Child Health and Human Development, in conjunction with the Maternal and Child Health Bureau, the AAP, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs, launched a national Back to Sleep (BTS) campaign to educate the public about the importance of putting infants to sleep on their backs to decrease the risk of sudden infant death syndrome (SIDS). Since the inception of the BTS campaign in 1994, the number of infants in the United States dying from SIDS has declined from >5000 to <2500 each year.[2] The AAP most recently reinforced the importance of back sleeping at naptime and bedtime in its 2005 policy statement.[3]

In the United States, two thirds of infants <12 months of age are cared for by someone other than their parents, and half of these infants spend time in a child care center (CCC) or family child care home (FCCH).[4] Despite decreases in SIDS deaths and decreased frequency of prone sleeping overall, the proportion of SIDS deaths that occurs in child care settings has remained constant at ~20%.[5,6] Many child care providers continue to place infants in the prone position for sleep.[7,8] This is particularly problematic when infants are not accustomed to being placed prone for sleep, because unaccustomed prone sleeping significantly increases the risk of SIDS.[9,10] Primary reasons for child care providers to place infants prone include lack of awareness of the association between SIDS and sleep position, concerns about perceived risks and benefits of the different sleep positions, and lack of empowerment with regard to discussing sleep position with parents.[7,8,11] Educational efforts with child care providers have been effective in increasing knowledge and awareness of safe sleep guidelines, changing provider practice, and encouraging written policies.[12] The AAP has emphasized the importance of educating child care providers and other secondary caregivers of infants about safe sleep practices as being critical to the continued success of the BTS campaign.[3] Education of child care providers is often accomplished through the work of state licensing agencies and enforcement of regulations. In addition, licensing regulations that require use of the supine position by child care providers are associated with the desired behavior.[8]

In 2003, the AAP Healthy Child Care America (HCCA) program launched its own BTS campaign. The stated goals of the HCCA-BTS campaign are to reduce the number of SIDS deaths by offering technical assistance and resources, to promote the BTS message to those who care for young children, to raise awareness and change practices in child care settings, to disseminate new information on new national child care standards related to SIDS risk reduction, and to support states in establishing and improving child care regulations.[13] Since the beginning of the HCCA-BTS campaign, the AAP has promoted safe sleep practices in child care programs. In association with the American Public Health Association, the Maternal and Child Health Bureau, and the National Resource Center for Health and Safety in Child Care and Early Education, the AAP has published the national health and safety standards for children in child care within *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*[14] that pertain to reducing the risk of SIDS.[15] The AAP has also provided information about educating policy-makers on safe sleep practices, made available examples of new sleep regulations, and developed a training module, the "Reducing the Risk of Sudden Infant Death Syndrome" speaker's kit,[16] which has been used by health professionals, child care health consultants, public health educators, and others to educate caregivers around the country about safe sleep practices. More than 3000 copies of the AAP speaker's kit have been distributed to trainers and child care providers across the country. The AAP has created a Web-based system to track how many individuals have received this information. As of May 2006, 103 trainers had provided information and indicated that they had trained a total of 9674 individuals (data from the AAP Division of Developmental Pediatrics and Preventive Services, Early Education and Child Care Initiatives staff, written communication, 2006).

In 2001, 6 states had regulations requiring that infants be placed nonprone for sleep, 63% of states required cribs in CCCs to meet ≥1 safety standard, 6 states had provisions limiting the use of soft bedding in CCCs, and 71% prohibited smoking in CCCs during hours of operation.[17] Before the current study, there had been no evaluation of the effectiveness of the HCCA-BTS campaign in supporting states to establish and improve child care regulations related to SIDS risk reduction. The purpose of this study was, thus, to examine the inclusion of the elements of a safe sleep environment in the individual state regulations for CCCs and FCCHs after 2 years of the HCCA-BTS campaign. The key elements for reducing the risk of SIDS in child care, as described in the national safety and health standards,[14] include (1) training in SIDS risk-reduction practices for child care providers, (2) supine sleep position for infants, (3) safety of cribs, (4) avoidance of soft bedding, (5) avoidance of soft sleep surfaces, such as waterbeds and sofas, (6) provision of sleep positioning policies and arrangements to parents on enrollment of the infant in child care, and (7) a smoke-free environment.

METHODS

This study examined current regulations for licensed CCCs and FCCHs in the 50 states and the District of Columbia. The regulations were collected from individual state documents available in October 2005 on the

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National Resource Center for Health and Safety in Child Care and Early Education Web site (http://nrc.uchsc.edu) and data available from the 2004 Child Care Center Licensing Study[18] and the 2004 Family Child Care Licensing Study.[19] Information was collected regarding specific regulations pertaining to (1) SIDS risk-reduction training for child care providers, (2) infant sleep position, (3) crib safety, (4) bedding safety, and (5) smoking. In addition, reviewers looked for specific requirements that child care providers provide information about sleep positioning policies and arrangements to parents before the infant is enrolled in child care. Each document source was examined separately by 2 individuals. A regulation was considered to be in force if it was mentioned in any 1 of the 3 documents. Statistical analysis was performed to determine whether regulations enacted in 2003 (when HCCA-BTS was launched) and later were more likely to have safe sleep guidelines than those enacted before 2003.

RESULTS

All 50 states and the District of Columbia have designated agencies that set regulations for child care facilities. Nine states[20–28] have a single regulation for both CCCs and FCCHs, and 1[29] does not regulate FCCHs. Regulations evaluated were enacted from 1987 to 2005 (Tables 1 and 2). Four states[22,30–35] use regulations for either licensed CCCs or FCCHs that were written before the AAP initial 1992 policy statement regarding positioning and SIDS.[1]

Requirements for SIDS Risk-Reduction Training for Child Care Providers

Most states have ongoing training requirements for child care providers, and SIDS risk-reduction training can be used to fulfill these requirements. Currently, CCC providers in 7 states (13.7%)[20,27,36–40] and FCCH providers in 10 states (19.6%)[20,27,36,41–47] are specifically required to receive training in SIDS risk reduction if they care for infants. There was no significant difference in SIDS training requirements for states with regulations implemented in 2003 or later compared with those with regulations implemented before 2003 (11.9% vs 23.7%). Some states require that training occur at the time of licensing or orientation.[37,40–44,47] Several states[20,27,36,45] mandate that training be repeated periodically, with intervals ranging from 1 year[20,45] to 5 years.[36]

Infant Sleep Position Regulations

Compared with 2001, when only 6 states (11.8%) mandated a nonprone sleep position, 26 states (50.9%) now have some regulation regarding infant sleep position. CCCs in 23 states (45.1%)[20,21,27,37–40,48–63] are required to place infants supine; an additional 4[64–67] require side or supine position. All but 4 of these states allow the prone position if a physician or parent signs a waiver; 20 require a physician waiver,* and 3 (Iowa, Ohio, and Utah)[39,53,67] allow a parent waiver. Twenty-one states (42%) require FCCHs to place infants supine†; Mississippi and Ohio[79,80] allow side or supine position. Of these states, 18 allow an infant to be placed prone if there is a written physician or a parent waiver‡; 2 states (Colorado and Ohio)[21,80] allow a parental waiver. Virginia, South Carolina, and West Virginia require supine positioning in CCCs[51,60,63] but not in FCCHs. States are more likely to have sleep position regulations if their regulations were enacted in 2003 or later; 29.3% of regulations written before 2003 had provisions for sleep position compared with 63.3% of regulations written in 2003 or later ($P < .01$).

CCCs in 9 states (17.6%)§ and FCCHs in 9 states (18%)‖ are required to physically check on sleeping infants periodically, at a frequency ranging from "a few minutes"[28] to 2 hours.[86] North Carolina requires that each CCC and FCCH establish a policy stating how often sleeping infants will be checked.[27]

The AAP recommends that infants spend some time in the prone position while awake and supervised ("tummy time") to enhance motor development and reduce the risk of positional plagiocephaly.[3,87] Alabama, North Carolina, and Wisconsin require that infants spend awake time in the prone position while supervised[27,40,47,48,81]; Washington and Virginia require tummy time only for infants in CCCs.[60,62]

Crib Safety Regulations

The AAP recommends that cribs, bassinets, or cradles that conform to the safety standards of the Consumer Product Safety Commission (CPSC) be used.[88] Furthermore, infants should not be placed on waterbeds, sofas, soft mattresses, and other soft surfaces, and bed sharing, especially among children, should be avoided.[3,87] For both CCCs and FCCHs, 41 states (80.4%) have ≥1 specific regulation pertaining to crib safety.¶ States with regulations enacted in 2003 or later are no more likely to have ≥1 crib safety provision than those written before 2003 (87.8% vs 73.3%). The most common regulations pertain to distance between slats and firmness and fit of the mattress. In 46 states (90.2%), only 1 infant is allowed per crib in CCCs#; 44 states (88%) stipulate 1 infant per crib in FCCHs.** Cribs in most states include full-sized cribs, portable cribs, and playpens. Indiana,

* Refs 20, 27, 37, 38, 40, 48–52, 54–57, 60–64, and 66.
† Refs 20, 21, 27, 41, 43–48, 56, and 68–78.
‡ Refs 20, 27, 41, 43–45, 47, 68–74, 77–79, and 81.
§ Refs 24, 27, 28, 49, 54, 60, 61, 82, and 83.
‖ Refs 24, 27, 28, 41, 46, 73, 77, 84, and 85.
¶ Refs 20, 21, 23–27, 30, 31, 34, 35, 37, 38, 40–45, 47–58, 60–72, 74, 75, 77–82, 86, and 89–107.
# Refs 20–22, 24–28, 30, 32, 34, 37–40, 48–60, 62–67, 73, 82, 83, 89, 91, 93, 96, 99, 101, 103, 105, 108, and 109.
** Refs 20–28, 31, 35, 41–47, 68–70, 73–76, 78–81, 84–86, 90, 92, 94, 95, 97–99, 102–104, and 110–112.

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TABLE 1 **Summary of State Regulations for Licensed CCCs**

State and Ref. No(s).	Year	SIDS Training	Supine Sleep	Firm Mattress	Snug Mattress	No Pillows	No Comforters/Quilts	No Smoking
Alabama[48]	2001		X[a]	X	X	X	X	X
Alaska[20]	2002	X	X[a]	X		X	X	X[b]
Arizona[89]	2004				X	X		X[c]
Arkansas[49]	2004		X[a]		X	X	X	X
California[91]	2004							X
Colorado[21]	2004		X	X	X			X[b]
Connecticut[93]	2004			X	X			X[c]
District of Columbia[22]	1987							
Delaware[30]	1988							X[d]
Florida[50]	2004		X[a]	X	X			X[b]
Georgia[52]	2001		X[a]	X	X	X	X	X[b,c]
Hawaii[108,115]	2002							X
Idaho[29]	2004							
Illinois[64]	2004		X[a,e]	X	X	X	X	X[b]
Indiana[65]	2003		X[e]	X	X			X[b]
Iowa[53]	2003		X[a,f]	X	X			X[b]
Kansas[34,116]	2001							X
Kentucky[96]	2001			X				X[g]
Louisiana[98]	2000							X[b]
Maine[54]	2004		X[a]	X	X	X		X
Maryland[55]	2005		X[a]	X	X	X	X	X
Massachusetts[109]	1997					X		X
Michigan[100]	2003			X				X
Minnesota[23,36]	2004	X						X
Mississippi[66]	2004		X[a,e]		X			X
Missouri[101]	2002							X[h]
Montana[103,117]	2002				X			X
Nebraska[114]	1998							X[g]
Nevada[24]	2004			X				X
New Hampshire[25]	2000				X			X
New Jersey[56]	2005		X[a]	X	X	X		X[b]
New Mexico[26]	2005					X		X[b]
New York[57]	2005		X[a]	X				X[b]
North Carolina[27]	2004	X	X[h,i]	X		X[j]	X[j]	X[b]
North Dakota[105]	1999			X				X
Ohio[67]	2003		X[e,f]	X	X			X[b,c,g]
Oklahoma[37]	2005	X	X[a]	X	X	X	X	X
Oregon[58]	2001		X		X			X[b]
Pennsylvania[82]	2003							X[d]
Rhode Island[32]	1993							X
South Carolina[51]	2005	X[a]			X	X		X[b,c,d]
South Dakota[59]	2004		X					X
Tennessee[83]	2005							X
Texas[38]	2003	X	X[a]	X	X	X	X	X[b]
Utah[39]	2004	X	X[f]					X[b]
Vermont[61]	2001		X[a]	X	X	X	X	X
Virginia[60]	2005		X[a]		X	X	X	X
Washington[62]	2004		X[a]		X	X	X	X[b]
West Virginia[63]	2003		X[a]		X	X	X	X[b]
Wisconsin[40]	2005	X	X[a]	X	X	X	X	X[b]
Wyoming[28]	2001							X[d]

[a] Physician waiver allowed.
[b] Smoking also prohibited in vehicles if children present.
[c] Smoking only in designated areas.
[d] Smoking prohibited in areas used by children and in food preparation areas.
[e] Infants placed on side or back.
[f] Parental waiver allowed.
[g] Smoking prohibited in view or presence of children.
[h] Physician waiver required for infants <6 months old; parent waiver allowed if infants >6 months old.
[i] Copy of center's sleep policy must be provided to parents of infants before attendance in center.
[j] Written policy must specify whether pillows and blankets are allowed, and, if so, specifies the number and type of items allowed.

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TABLE 2 **Summary of State Regulations for FCCH**

State and Ref. No(s).	Year	SIDS Training	Supine Sleep	Firm Mattress	Snug Mattress	No Pillows	No Comforters/Quilts	No Smoking
Alabama[81]	2001		X[a]		X	X	X	X
Alaska[20]	2002	X	X[a]	X		X	X	X[b]
Arizona[90]	1999				X			X
Arkansas[68]	2004		X[a]		X	X	X	X[c]
California[92]	2004							X
Colorado[21]	2004		X	X				X[b]
Connecticut[94]	2004							X[c]
District of Columbia[22]	1987							
Delaware[31]	1994			X	X			X[c]
Florida[69]	2004		X[a]					X[b,c]
Georgia[70]	2001		X[a]	X	X	X	X	X
Hawaii[110]	2002							X[c]
Idaho	None							
Illinois[71]	2003		X[a]	X	X	X	X	X[b]
Indiana[95,113]	2001			X				X
Iowa[72]	2004		X[a]					X[b]
Kansas[35,116]	2001							X
Kentucky[97]	2003							X
Louisiana[99]	2003							X[b]
Maine[73]	1998		X[a]					X
Maryland[41]	2005	X	X[a]			X	X	X[c]
Massachusetts[84]	2003			X	X	X		X[c]
Michigan[42]	1999	X						X[c]
Minnesota[23,36]	2004	X						X
Mississippi[79]	2004		X[a,d]		X			X
Missouri[102]	2002				X			X[e]
Montana[103,118]	2002				X			X
Nebraska[111]	1999					X		X[c]
Nevada[24]	2004			X	X			X[c,f]
New Hampshire[25]	2000				X			X
New Jersey[43]	2004	X	X[a]			X		X[c]
New Mexico[26]	2005					X		X[b]
New York[74]	2005		X[a]	X				X[b]
North Carolina[27]	2004	X	X[g,h]	X		X[i]	X[i]	X[b]
North Dakota[104]	1999			X				X
Ohio[80]	2003		X[d,j]	X	X			X[c,f]
Oklahoma[44]	2004	X	X[a]	X	X	X	X	X[c]
Oregon[75]	2002		X		X			X[b]
Pennsylvania[86]	2003							X[c]
Rhode Island[33]	1990							X[c]
South Carolina[106]	1993							
South Dakota[76]	2004		X					X
Tennessee[85]	2005							X[c]
Texas[45]	2003	X	X[a]	X	X	X	X	X[b]
Utah[46]	2002	X	X					X[b]
Vermont[77]	2001		X[a]	X	X	X	X	X[k]
Virginia[112]	1993				X			X
Washington[78]	2004		X[h,l]	X	X		X	X[b]
West Virginia[107]	2003					X		X[b,c]
Wisconsin[47]	2005	X	X[a]	X	X	X	X	X[b]
Wyoming[28]	2001							X

[a] Physician waiver allowed.
[b] Smoking also prohibited in vehicles if children are present.
[c] Provider must disclose to parents if smoking occurs in FCCH.
[d] Infants placed on side or back.
[e] Caregivers shall not smoke when holding or feeding children, changing diapers, assisting with toilet, or when preparing food.
[f] Smoking allowed in designated areas, where children are not present.
[g] Physician waiver required for infants <6 months old; parent waiver allowed for infants >6 months old.
[h] Copy of center's sleep policy must be provided to parents of infants before attendance in center.
[i] Written policy must specify whether pillows and blankets are allowed and, if so, specifies the number and type of items allowed.
[j] Parent waiver allowed.
[k] Smoking allowed but not in view of children.
[l] Requires note from physician and parent to place in alternate sleep position.

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TABLE 3 **CPSC Standards for Cribs**[88]

1. Slats are spaced no more than 2 3/8 in (60 mm) apart
2. No slats are missing or cracked
3. Mattress fits snugly: <2 finger widths between edge of mattress and crib side
4. Mattress support is securely attached to head and foot boards
5. Corner posts or no higher than 1/16 in (1.5 mm) to prevent entanglement of clothing or other objects worn by child
6. No cut outs in the head and foot boards, which allow head entrapment
7. Drop-side latches cannot be easily released by infant
8. Drop-side latches securely hold sides in raised position
9. All screws or bolts that secure components of crib are present and tight

Utah, North Carolina, and Washington also allow bassinets.††

Many states have adopted the CPSC standards for cribs (Table 3)[88] by specifically referring to agency standards, stating federal requirements, or citing the specific standard (eg, distance between mattress and crib ≤2 finger widths). However, 9 jurisdictions‡‡ have no specific requirements for crib safety.

More states specifically ban the use of waterbeds and sofas in FCCHs than in CCCs. Although the use of waterbeds is implicitly forbidden in many states, 5 states (9.8%) expressly forbid it in CCCs,[37,38,40,61,89] and 10 states (20%) expressly forbid it in FCCHs.§§ Sofas in CCCs are explicitly forbidden in Oklahoma and Alabama,[37,48] and 6 states[44,45,77,81,107,111] forbid them for use as sleep surfaces in FCCHs. Nebraska also forbids the use of futons in FCCHs.[111] Alaska specifically allows sofas as sleep surfaces in FCCHs.[20]

Bedding Regulations

Both the AAP and the CPSC recommend avoidance of soft bedding and objects (quilts, comforters, pillows, and stuffed toys) in the infant sleep environment.[3] CCCs in 23 states|||| and FCCHs in 20 states¶¶ are prohibited from placing soft bedding or objects in the crib. Pillows, quilts, and bumper pads are the items most frequently named in the regulations. States with regulations enacted in 2003 or later are more likely to specifically ban soft bedding than those of which the regulations were enacted before 2003 (57.9% vs 20.5%; $P < .001$).

Bedding specifically allowed in the infant sleep environment is most frequently a thin blanket or sheet##; Georgia and Illinois[52,64,70,71] specifically indicate that such a covering should be tucked under the mattress at the foot and sides of the crib, with the infant's feet toward the foot of the bed, so that the covering cannot extend above the infant's shoulders ("feet to foot").[3] Oregon allows bedding that is culturally and seasonally appropriate for infants in FCCHs.[75] Nebraska requires that infants in CCCs have a toy in the crib.[114]

Bumper pads are prohibited in FCCHs or CCCs in 11 states (21.6%)***; however, Kansas and Missouri require bumper pads if crib slats are >2⅜ in apart,[34,35,101,102] and Nebraska requires them in all cribs.[111,114]

Smoking Regulations

Two states (3.9%) do not impose any restrictions on smoking in licensed CCCs.[22,29] Thirty seven (72.5%) prohibit smoking in the licensed CCC during hours of operation.††† Smoking is allowed in designated areas of CCCs in 7 states,[51,52,67,83,89,93,96] and 5 states[28,30,51,82,101] prohibit smoking in areas used by children and in food preparation areas. Kentucky and Nebraska prohibit smoking in front of children.[96,114] Twenty-one states (41.2%) also ban smoking while CCC children are in vehicles.‡‡‡ Tennessee requires that parents be informed if there is a designated area where CCC staff members can smoke.[83]

In FCCHs, smoking policies are often dependent on the presence of children who are being cared for. Forty-four states (88%) prohibit smoking in the FCCH while children are being cared for,§§§ and an additional 5[24,77,80,94,102] restrict smoking to areas away from children or while directly caring for children. The District of Columbia, Idaho, and South Carolina have no restrictions on smoking in FCCHs.[22,106] Sixteen states (32%) prohibit smoking when FCCH children are in vehicles.|||||| Seventeen states (34%) require that the FCCH provider inform parents if any smoking occurs within the FCCH, even after hours of care.¶¶¶ States with regulations enacted in 2003 or later are no more likely to have smoking restrictions than those written before 2003 (98.3% vs 92.6%).

Provision of Sleep Positioning Policies and Arrangements to Parents

The national child care standards from *Caring for Our Children*[14] recommend that parents, before infants are enrolled in child care, be provided with written information from the child care provider about sleep positioning policies and arrangements. North Carolina requires that parents of infants entering a CCC or FCCH be provided with a copy of the center's safe sleep policy and sign a statement acknowledging receipt and explanation of the policy.[27] Washington and Massachusetts require that FCCH providers give a copy of sleep safety requirements to parents of infants entering the FCCH for

†† Refs 27, 39, 46, 62, 65, 78, 95, and 113.
‡‡ Refs 22, 28, 29, 39, 46, 59, 76, 83, 85, 108, and 110.
§§ Refs 44, 45, 47, 68, 77, 81, 84, 104, 107, and 111.
|||| Refs 20, 21, 26, 27, 37, 38, 40, 48, 49, 51, 52, 54–56, 59–64, 67, 89, and 109.
¶¶ Refs 20, 21, 26, 27, 41, 43–45, 47, 68, 70, 71, 76–78, 80, 81, 84, 107, and 111.
Refs 52, 64, 70, 71, 82, 86, 91, 92, and 103.

*** Refs 20, 37, 38, 40, 41, 44, 45, 47, 48, 52, 55, 60, 62, 64, 67, 70, 71, 78, 80, and 81.
††† Refs 20, 21, 23–27, 32, 37–40, 48–50, 53–66, 91, 98–100, 105, 109, and 115–117.
‡‡‡ Refs 20, 21, 26, 27, 37–40, 50–53, 56–58, 62–65, 67, 98, and 99.
§§§ Refs 20, 21, 23, 25–29, 31, 33, 41–47, 68–76, 78, 79, 81, 84–86, 90, 92, 97–99, 104, 107, 110–113, 116, and 118.
|||||| Refs 20, 21, 26, 27, 45–47, 69, 71, 72, 74, 75, 78, 80, 98, 99, and 107.
¶¶¶ Refs 24, 31, 33, 41–44, 68, 69, 80, 84–86, 94, 107, 110, and 111.

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care.[78,84] No other states currently have similar requirements.

DISCUSSION

Since 2003, when the HCCA-BTS campaign began, 60 (59.4%) of the 101 state regulations for either CCCs or FCCHs have been revised. Many of these new regulations incorporate policies to create a safer sleep environment for infants. More than half of the regulations written since 2003 mandate a nonprone sleep position and restrictions on soft bedding in the crib, and the change in regulations since 2003 is statistically significant. Although it is not possible to determine a direct causal relationship between HCCA-BTS campaign activities and efforts of states to establish and improve child care regulations, these changes in regulations reflect initial successes for HCCA-BTS. However, of the 101 existing state regulations for CCCs and FCCHs, only 49 (48.5%) currently require that infants sleep nonprone (including 6 regulations[64–67,79,80] that allow side sleeping), 18 (17.8%) mandate SIDS risk-reduction training for child care providers, 81 (80.4%) have ≥1 crib safety standard, and 43 (42.6%) restrict soft bedding in the crib. Ninety seven (96.0%) of the regulations restrict smoking. Only 4 regulations (4.0%) require that parents be provided with sleep policy information.

It is essential that child care regulations be reviewed and revised on a regular basis so that they reflect the most current information about infant and child safety and well being. For example, 4 states (District of Columbia,[22] Delaware,[30] Kansas,[34,35] and Rhode Island[33]) continue to use regulations dated before the initial AAP policy statement in 1992.[1] Two states and the District of Columbia still do not have smoking restrictions in FCCHs[22,29,106] and/or CCCs,[22] and more than half of the child care regulations in the United States continue to allow prone position.

Many states are not consistent in their infant sleep regulations for CCCs and FCCHs. Although the FCCH is a more informal setting than is a CCC, both should be held to basic safety standards.

Licensing and regulations are important in assuring a minimum standard of care for children. However, all child care settings are not regulated. It is estimated that ≥30% of FCCHs in the United States are unlicensed.[119] In addition, care by relatives, friends, and nannies is not regulated. States also have established guidelines for what will and will not be licensed or regulated. For example, many states do not require religiously affiliated child care settings or FCCHs that care for <6 children to be licensed. Idaho does not license any FCCHs.[29] The proportion of SIDS that occurs while the infant is in unregulated care is increasing.[6] Those who provide unregulated care (relatives, nannies, and unregulated family child care providers) have no formal access to and may be unaware of training, education, and resources that are readily available through HCCA-BTS and the child care community at large.[120]

Currently, only 17.8% of state regulations require SIDS risk-reduction training for child care providers. It is essential that child care providers in all jurisdictions receive this information. Because any provider could potentially be asked to care for infants if the usual infant provider is ill, at lunch, or otherwise unavailable, all child care providers, not just those caring for infants, should be required to receive this training. In addition, the average annual turnover rate for CCC staff is 30%.[121] Therefore, it cannot be assumed that a single training session will be adequate in maintaining safe sleep practices in a center; SIDS risk-reduction training should be repeated on a regular basis to assure that all providers are knowledgeable about the most current safety information.

The limitations of this study are linked to the data itself and the difficulty in determining a direct causal relationship between campaign efforts and changes in licensing regulations. We reviewed both state documents and information available through the Children's Foundation.[18,19] All of the documents were reviewed at least twice by 2 separate persons, and if a regulation was mentioned in any of the 3 sources, it was included. No information was solicited from regulatory officials. In addition, we acknowledge that regulations may have been revised since our review or that states may be in the process of drafting new regulations. In some states, it can take years to change regulations, so it is likely that the HCCA-BTS campaign and related efforts have encouraged some changes that cannot be tracked within existing regulations. Finally, states not yet able to demonstrate a change in regulations may have made significant strides in educating caregivers using the AAP speaker's kit[16] and other resources.

It cannot be assumed that knowledge of safe infant sleep guidelines is universal among child care providers. In a 2003 study, 20% of nighttime CCCs reported that they placed infants prone, and only 18.2% reported a practice of placing infants in cribs without soft bedding.[7] Updated child care regulations may be helpful in increasing awareness of and adherence with safe sleep recommendations. We acknowledge, however, that the presence of regulations and attendance at training sessions do not guarantee compliance by individual child care facilities or providers.[122] In addition, whereas some states require that waivers indicate a medical reason for prone positioning, many do not. Child care providers or parents may request waivers from physicians, even when there is no medical condition necessitating prone positioning. It is hoped that, with continued education and training, such requests will decline in number and will be only for appropriate medical conditions. Furthermore, the presence of regulations does not ensure a lower incidence of SIDS. SIDS deaths in child care set-

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tings have occurred in sleep environments that were as safe or safer than those occurring at home.[6,123] However, the presence of regulations may make it more likely that child care providers will implement a safe sleep policy,[8] and implementation of such a policy will reduce the risk of SIDS. Regulations also can provide a venue for the education of child care providers and parents. The HCCA-BTS campaign has stressed the importance of child care providers and parents discussing consistent use of safe sleep practices. If a regulation is enacted, written information given to child care providers can inform them of the reasons for a policy and the safety risks if not followed. When policy dictates that this information must be shared with parents, there is even more opportunity for education and dissemination of information.

Although positive changes in child care regulations have occurred since the initiation of the HCCA-BTS campaign 2 years ago, efforts must continue so that safe sleep regulations exist in all jurisdictions. Regulations should be reviewed on a regular basis so that they reflect the most current information about infant and child safety and well being. In addition, specific efforts should be directed to those who provide unregulated care and/or who may be unaware of recommended practices and related resources. Pediatricians can play an important role in educating caregivers and parents about safe sleep practices and promoting necessary safety regulations for child care settings in their states. In addition, when parents request a medical waiver to allow prone sleep positioning, pediatricians should use this opportunity to educate the parents and child care providers about the importance of using the supine sleep position for every sleep.[3] Ongoing education about consistent use of safe sleep practices and adoption of new regulations should ultimately provide a safer environment for the millions of infants and children in child care.

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State Child Care Regulations Regarding Infant Sleep Environment Since the Healthy Child Care America-Back to Sleep Campaign

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