The Conversation

Essays on health: Australia is failing new parents with conflicting advice – it's urgent we get it right

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Every year, hundreds of thousands of Australians embark on a disorienting, life changing journey. They have a baby.

What happens after a woman gives birth should be a matter of serious public interest. Screaming babies, breast pain, baby weight-gain worries, breastfeeding issues, wind, colic, reflux, allergies, tongue tie, sleep deprivation, and parental anxiety and depression. These are common concerns at the beginning of the life of every Australian citizen.

In reflecting on these, we're actually considering the developmental origins of disease. This is so for many reasons, including that the infant gut microbiome affects metabolism and immunity even as an adult, and that postnatal depression has long-term effects on a child's cognitive potential and mental health.

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Throughout the developed world, non-communicable diseases are now the major cause of illness and death in children, mirroring trends in adults. Among these, immune, gut, developmental disorders and mental illness feature prominently. All are shaped by environmental factors in very early life.

Yet, our health professionals often recommend approaches to behaviour problems in infants - such as with breastfeeding, crying and fussing, or sleep - that have been demonstrated to be ineffective. Some recommendations actually risk worse health outcomes for both the mother and baby.

From the moment their baby is born, Australian parents receive vastly conflicting advice from different health disciplines, or even from different health professionals in the one discipline. Confusion during an already challenging life transition drives parents to seek opinions from multiple providers: the GP, paediatrician, midwife, child health nurse, pharmacy nurse, lactation consultant, dentist (yes dentist), and the emergency department. Many visit complementary and alternative medicine practitioners.

Yet less than 2% of the National Health and Medical Research Council funding goes to research into primary care, the first port of call for new parents. Research performed in hospitals or specialised settings, including concerning issues of early life care, often isn't relevant in the community. We must take primary care research seriously if we want to ensure parents are provided with consistent, evidence-based advice that is beneficial to the baby, themselves and society at large.

Breastfeeding confusion

Up to 96% of Australian women want to breastfeed at the time of the birth. Women want to breastfeed so much that not being able to do so affects their mental health. Yet multiple studies demonstrate serious gaps in health professional training in the two most common post-birth problems: breastfeeding difficulty and unsettled infant behaviour. Both increase a woman's risk of postnatal depression and are linked with poorer infant outcomes.

Undiagnosed problems with the baby latching on to the breast and finding a stable position during breastfeeding (which I call "fit and hold") can lead to a range of distressing infant behaviours. These include back arching, refusing or fussing at the breast, crying, poor weight gain and excessive night waking. These signs of positional instability are often thought to be signs of reflux and treated with acid medications. But evidence shows these medications don't help the problem.

Existing approaches used to support fit and hold, including letting the baby find their own way to the breast, don't improve outcomes for many. Common advice, such as using one hand on the back of the baby's neck while the other creates a particular shape of the breast, has been shown to increase nipple pain.

I commonly see women who have been told by multiple professionals their fit and hold is good, even though the baby's behaviour communicates inability to fit stably into the mother's body. That is, the baby is showing their position is uncomfortable or there is a drag of breast tissue pulling in another direction in the baby's mouth, in conflict with the inward pull created by the vacuum when the jaw drops.

Oral tie 'epidemic'

Then there's the issue with tongue tie, upper lip tie, and buccal (cheek to gum) tie. This is another way health professionals are dealing with breastfeeding problems and unsettled behaviour – by referring the child for oral surgery. A classic tongue-tie needs a simple scissors snip. But normal variations of the frenulum - the bits of connective tissue under the tongue and upper lip - are these days often labelled abnormal and blamed for problems.

If we put aside the situation of a classic tongue-tie, the belief cutting or lasering the frenula (called a frenotomy) helps breastfeeding is not supported by research. Our work suggests that diagnoses of normal variants of connective tissue as abnormal are based on an outdated and inaccurate model of how infants attach to the breast.

Read more: Deep cuts under babies' tongues are unlikely to solve breastfeeding problems

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Parents are sometimes warned if the baby doesn't have a frenotomy for the diagnoses of posterior tongue-tie or upper lip-tie, their baby is at risk of speech and swallowing problems, expensive orthodontic problems, sleep disorders and other developmental problems in later childhood, though there is no evidence to support these claims.

There are now studies demonstrating that the diagnosis of "oral ties" in breastfeeding babies has reached epidemic proportions in the United States and Canada. Exponential increases in frenotomy rates are also evident in our team's analysis of early Australian Medicare data (yet to be published). Many, if not most, frenotomies are performed by dentists using laser, and are not captured by Medicare.

I regularly see babies after laser surgery with worsened breastfeeding problems. Sometimes their wounds become infected. I often see pale cords of scarred tissue under the tongue. I have also seen the underbelly of a little tongue somewhat separated by a too-deep cut. I have seen suture knots hanging from a newborn's upper gum after scissors frenotomy.

The tongue-tie epidemic hasn't come from a sudden burst of new congenital abnormalities in the mouths of infants in the English-speaking world in the past ten years, as some proponents argue. The epidemic parallels broader international trends of medical overtreatment and is, in my mind, a painful sign clinical breastfeeding support is in crisis.

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The importance of sleep

Parents are also being advised their child's healthy development and their own wellbeing depends on implementing sleep training. This includes strategies such as: don't breastfeed your baby to sleep; don't let the baby get overtired or overstimulated; put the baby down in the cot at the first tired sign; teach the baby to self-settle in the cot; make sure the baby is getting big blocks of sleep instead of catnapping during the day; and use feed-play-sleep cycles.

Technically known as first wave behaviourism, these approaches arose in the 1950s and 1960s. Girls like me were taught them in the 1970s in compulsory mothercraft classes at high school – a long time before the emergence of evidence-based medicine.

But now, high-level evidence demonstrates these approaches do not decrease night waking or reliably improve women's mental wellbeing in the first year of life, and especially not in the first six months.

A small subgroup of babies with sleep problems go on to have sleep problems in later childhood. The evidence does not support the idea that applying sleep training in the first year will prevent this, yet I hear parents are often told if the baby doesn't get enough sleep, or if they let "bad habits" grow, their baby's development and capacity to learn in later childhood will suffer. The threat they are doing the wrong thing if they don't sleep train heightens parental anxiety.

In my experience in general practice, where I've had the privilege of following many families over months and years, first wave behavioural approaches cause parent-baby communication confusion, and also unnecessarily disrupted nights for many, due to disruption of the baby's circadian clock.

In Australia, many sleep-deprived mothers seek help from residential sleep schools. Some are even referred there by health professionals if the baby just catnaps during the day and doesn't go to sleep alone in the cot, due to fear of developmental implications. Yet only families with the most severe problems should require this hospital-based solution, which is extremely expensive to the health system.

So, what are the solutions?

We have enough evidence to show what works. For instance, latest research tells us it is important to respond to our baby's cues for the baby to develop secure psychological attachment. Babies should not be left to grizzle or cry as a pattern over time, and breastfeeding to sleep is one sensible tool for making the days and nights manageable.

It's also important to know about the young human's biological need for rich sensory nourishment. This means encouraging parents to enjoy a social life outside the house, trusting that the baby's biological sleep regulators will take whatever sleep he or she needs with minimal effort on the parent's part.

We've developed an alternative parent-baby sleep program. This repairs unnecessary disruption to night-time sleep either by identifying underlying breastfeeding problems in younger babies, or by helping to reset the circadian clock, which is commonly disrupted by the first wave behavioural focus on long blocks of sleep during the day.

And breastfeeding problems can resolve when women are helped to stabilise the way their and their baby's unique anatomies fit together. This is when the baby's breastfeeding reflexes are turned on, his or her face is symmetrically buried into the breast, and as much breast tissue as possible is drawn deep into the baby's mouth without a drag in another direction.

Our programs have a well-developed and published evidence base, and promising preliminary evaluations. Obviously, these require bigger trials. But there is too little funding available for clinical primary care research. The UK's Nuffield Trust recently issued a report advising that if we are to care for our children's health needs in a sustainable health system, models need to shift the focus from hospital-based care to integrated child health care in community settings.

Investing in primary health care has been demonstrated to be more effective, at a fraction of the price of treating problems in hospitals. Just a single visit to an Australian hospital's emergency department costs the tax-payer ten times the cost of a visit to a GP.

Read more: Medicare spending on general practice is value for money

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We can't expect hospital-based parenting support centres to improve outcomes when mothers and babies are seen there by health professionals who continue to offer conflicting advice. It would be much cheaper and more cost effective to invest in freely accessible, evidence-based, perinatal services in a family's own community, co-ordinated by their own GP.

In view of the health system costs and tsunami of mental health problems and chronic disease, this is a matter for urgent political and health system attention.

Pam responds to a comment:

Thanks for your reflections. Yes, if the old models are not demonstrated to help, then we need to start the process of innovating, building up an evidence-base for a new model. In our work at the Possums Clinic we are flipping traditional paradigms across a number of domains in the care of new families. Our programs comprise what is now known overall as Neuroprotective Developmental Care in the Community (NDCC) (or the 'Possums programs'). We have painstakingly developed up and published strong theoretical frames over the past 12 years, integrating the research literature across multiple disciplines (such as neuroscience, lactation science, evolutionary biology, and the psychologies of applied functional contextualism and parent-infant attachment). Our clinical breastfeeding support program, Gestalt breastfeeding, is based on a new model of the biomechanics of infant suck (article under review), derived from ultrasound studies in collaboration with the Human Lactation Research Group at the University of Western Australia, and contests the old model which is leading to overtreatment of oral connective tissues. Preliminary evaluations show that parents find what we are doing helps, but next step would be substantial trials, once we attract funding. We integrate simple psychological strategies for managing difficult thoughts and feelings into all our programs. NDCC can be delivered by health professionals across multiple disciplines, and Possums Education has upskilled around 1000 health professionals Australia-wide or overseas so far.