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Rapid scoping review of protective factors for parent and child wellbeing

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Australian Institute of Family Studies

April 2026

The Australian Institute of Family Studies acknowledges the Traditional Owners of Country throughout Australia and recognises their continuing connection to lands and waters. We pay our respects to Aboriginal and Torres Strait Islander cultures, and to Elders past and present.

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Cover image: © gettyimages/FatCamera

ISBN (online): 978-1-76016-443-0
ISBN (PDF): 978-1-76016-444-7

Suggested citation: Truong, M., & Gahan, L. (2026). *Rapid scoping review of protective factors for parent and child wellbeing*. Melbourne: Australian Institute of Family Studies.

Edited by Katharine Day
Typeset by Rachel Evans

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Acknowledgements

This scoping review was commissioned by the Australian Government Department of Social Services.

This report has been prepared by Mandy Truong and Luke Gahan. Catherine Andersson and Liz Neville reviewed drafts of this report. The authors acknowledge the work of Gillian Lord in assisting with developing the search strategy and conducting the literature search.

Overview

This rapid scoping review sought to identify the volume and breadth of recent research on the protective factors for parent and child wellbeing in the early years.

This report summarises the research evidence on protective factors[1] for parent and child wellbeing in the early years (pre-birth to when children are 5 years old), including programs and interventions that support families.

It focuses on research exploring the factors that support parents to meet the needs of their children. It covers child outcomes in so far as they are associated with parent outcomes. The report is based on evidence published in Australia and similar countries (the United Kingdom (UK), Denmark, Norway, Sweden, New Zealand, Germany and Ireland) between 2018 and 2025.

Key messages

- There is a highly diverse body of literature that has explored protective factors for parent and child wellbeing in the early years of childhood.
- This review summarises the findings from studies that focus on parents; however, child outcomes are also included when studies report both.
- Of the 136 studies included in this review, 51 (38%) were from Australia.
- The majority of the included studies (60%) focused on the positive impacts of parenting programs and interventions. The remaining studies (40%) focused on the relationship between protective factors and parent and child outcomes.
- Most studies focused on general populations or families with parents (often mothers) experiencing mental health challenges or children with behavioural or developmental challenges. A small number of studies examined protective factors specifically for fathers and cohorts such as families from refugee backgrounds, Aboriginal and Torres Strait Islander families, families with children with disability and families experiencing disadvantage.
- Research showed that programs and interventions for pregnant women, early intervention programs, parenting programs, parent wellbeing programs and parent-mediated interventions in the early years can be effective in improving a range of child, parent and family outcomes. The research has mainly focused on parental mental health and wellbeing, parenting self-efficacy, parenting confidence and the parent–child relationship.
- Across the subset of studies that examined the relationships between protective factors and parent and child wellbeing, positive parenting practices and supportive parent relationships emerged as important protective factors for parent and child outcomes. Family and social supports (including community supports) also positively contributed to parent wellbeing.
- Research on factors (i.e. moderators and mediators) that buffer the impacts of negative experiences on child and parent outcomes is emerging. Nevertheless, the studies that focused on moderators and mediators collectively highlight the complex interplay of potential factors influencing child and parent outcomes. These factors may be at the individual child or parent level or broader, such as the home environment and social supports.

Research gaps and limitations

The majority of available research about protective factors for parents, caregivers, families and kin was focused on parents. Further research is needed on caregivers other than parents who support children in their early years.

Research focusing on priority populations including (but not limited to) Aboriginal and Torres Strait Islander families, families from refugee backgrounds, families with children with disability, LGBTQA+ families, separated parents and families living in rural and remote locations is also lacking. Further, more research is needed on long-term outcomes and protective factors for fathers.

1 Protective factors are experiences, behaviours, characteristics or contexts that are either associated with a reduced likelihood of a negative outcome or with an increased likelihood of a positive outcome.

The findings in this review are largely consistent with similar previous reviews; however, the strength of the included research is variable. Many studies were feasibility, pilot and qualitative studies that included small sample sizes. Additionally, most studies involving a program or intervention did not have a comparison group, making the generalisability of those findings unclear. There is also a need to examine whether programs and interventions can work at scale.

Many studies were also cross-sectional (meaning they only examine a single point in time) and short term. Hence, the long-term effects of programs are relatively unknown and evidence on the cause-effect relationship between factors and child and parent outcomes is currently limited.

This review did not seek to examine the effectiveness of programs and interventions. The highly diverse nature of early years programs and the diversity of research (e.g. study designs, methods and measures) in this area make this challenging to assess through a scoping review.

There is a large volume of research in this area; therefore, we took a pragmatic approach in consultation with the Department of Social Services (DSS) to narrow the review's scope to ensure the review was completed within the desired time frame. This resulted in the review being limited to peer-reviewed academic literature published in the past 7 years, and to populations based in Australia and similar countries. Therefore, this review may have omitted earlier relevant studies and insights from other countries.

Finally, risk of bias assessment and quality appraisal of studies were not conducted. Therefore, the quality of the studies in this review was not assessed and considered in the synthesis of findings. This should be kept in mind when considering the review's findings.

Introduction

The early years is an important developmental period in a child's life. This period provides a critical opportunity to positively influence a child's development, health, learning and resilience and to set children up to have good health and wellbeing for their whole life (Department of Social Services [DSS], 2024a).

A child's development is influenced by the people and relationships that surround them. Children's relationships with their parents are the building blocks for positive growth and development (Britto et al., 2017; Newland, 2015). The early years of childhood provide a window of opportunity to promote nurturing, strong and caring family relationships. Supporting and empowering parents and families to meet the health, social, emotional and developmental needs of children in the early years is critical.

Protective factors play a vital role in achieving positive outcomes for children, parents and families and can minimise the impact of any adverse childhood experiences (Draper et al., 2024; Spearman et al., 2023). Positive factors including strong family relationships can buffer the impacts of stress and adversity in the short and long term (Fritz et al., 2018).

The Australian Government has developed the *Early Years Strategy 2024–2034* (the Strategy) to outline its vision for supporting young children and their families (DSS, 2024b). The Strategy adopts a holistic, socio-ecological and strengths-based approach to the early years. Released in December 2024, the Strategy's First Action Plan 2024–2027 details the practical steps the Government is taking to support children and families during the early years (DSS, 2024c). Additionally, an Outcomes Framework has been established to measure progress against the Strategy's eight outcomes (DSS, 2024d).

The aim of this rapid scoping review is to identify the protective factors that support and empower parents, caregivers and families to meet the needs of children in the early years.

This review focuses on parents and covers child outcomes in so far as they are associated with parent outcomes. The focus on parents, rather than including other caregivers (e.g. non-parental family members and kin) was necessary as the vast majority of research is focused on parents.

This review examined:

- parent outcomes related to health, social, emotional and mental health, empowerment, connection and support (e.g. psychological stress, social connection and wellbeing)
- child outcomes related to health, social, emotional and mental health (e.g. emotional functioning, social competence), as well as developmental and educational needs (e.g. school readiness).

This report presents a synthesis of the relevant literature and a narrative account of the findings. It maps existing research according to 2 main categories: intervention studies and other studies.

This report begins by outlining the key research questions guiding the review, the review methods used and the literature search results. It then provides a summary of the nature and characteristics of the included literature, followed by a synthesis of the findings by topic/thematic area. Studies conducted in Australia have been highlighted to show evidence that may be most relevant to the Australian context. The report concludes with a summary of findings.

Research questions

The following research questions guided this review:

- What are the protective factors associated with parent and child outcomes related to families being empowered, connected and supported?
- What factors (i.e. mediators and moderators) buffer the impacts of negative experiences/factors (e.g. adverse childhood events) on parent and child outcomes?

These questions were used to inform the search strategy and the approach to selecting and synthesising the literature.

Note: this review focuses on parents with child(ren) aged 0–5 years as well as expecting parents. Studies that focus on parents but also report child outcomes are included. Further details are provided below.

Review methods

In this section, we outline the methods used for conducting the scoping review, including the approach to sampling and screening the relevant literature, as well as how the information was extracted and synthesised.

This scoping review project was conducted from June to August 2025.

This project followed a scoping review method, guided by Mak and Thomas (2022) and Arksey and O'Malley (2005). This method uses a systematic and iterative approach to identify and synthesise existing literature and knowledge. This approach enabled us to map the extent, range, nature and any possible gaps in the literature (Mak & Thomas, 2022; Munn et al., 2018).

There are 5 steps for conducting a scoping review:

1. identifying the research question(s)
2. identifying relevant studies
3. study selection and screening
4. charting and extracting the data
5. collating, summarising and reporting the results.

The review began with identifying the specific research questions that the DSS wished to answer. This initial process was done to confirm that the research questions provided sufficient literature for the scoping review or whether a more targeted approach was necessary due to the large volume of content (Mak & Thomas, 2022). The research questions are provided in section 2 above.

The search strategy aimed to identify relevant studies that addressed the research questions. The search strategy, including the list of search terms (Table 1 and 2[2]) and the inclusion and exclusion criteria (Table 3), was then developed in consultation with the AIFS librarian and with the DSS. As the project is underpinned by a strengths-based approach, search terms did not solely focus on adverse or negative experiences and outcomes.

Table 1: Search terms (inclusion)

Domain	Inclusion search terms (limited to the title, abstract and subject fields)
Population	Infants or infancy or baby or babies or pre-school* or preschool* or toddler or "young child*" or "early childhood" or "children aged 0" or pregnancy or pregnant or prenatal or antenatal
Impact	Protective or buffer* or strength* or "positive relationship*" or "positive association*" or "positive effect*" or mitigat* or ameliorat* or moderate or mediate or mediated
Outcomes	"Mental health" or "mental illness" or wellbeing or well-being or externali* or internali* or developmental or "child development" or "psycho-social development" or "socio-emotional development" or "school readiness" or resilien* or "positive childhood" Or parent* N3 (behavio* or skill* or practic* or efficacy or self-efficacy or engag* or involve* or confidence or stress* or connect* or support or interact* or relations* or empower*) Or emotional N1 (functioning or problem* or difficult* or compet* or development) Or social N1 (functioning or problem* or difficult* or compet* or connect*) Or behavio* N1 (problem* or difficult* or compet*) Or Famil* N3 (functioning or support or connect* or empower* or health)

2 The initial database search using search terms from Table 1 yielded over 14,000 references for screening; therefore, search terms for exclusion were added to narrow the search results to ensure the scoping review was completed within the desired time frame.

Table 2: Search terms (exclusion)

Exclusion search terms (limited to the title field)
China or Uganda or Ethiopia* or africa or Hispanic or latin or Indonesia* or Singapore* or Pakistan or india or asia or Bangladesh or Africa* or "south America*" or "developing countries" or "developing nations" or "middle income" or "Systematic review" or "narrative review" or "scoping review" or "literature review" or meta-analysis or meta-analyses or "scoping study" or "Integrative review" or "rapid review" or "umbrella review"

To identify relevant academic literature, the following databases were used to conduct the search: Australian Family and Society Abstracts (AFSA), Education Resources Information Center (ERIC), the Australian Education Index (AEI), Psychology and Behavioral Sciences Collection, SocIndex, and PsycINFO. Among other inclusion criteria (Table 3), the literature was limited to articles published in English and published in the past 7 years (i.e. between January 2018 and May 2025).

Screening of relevant references for inclusion in the review was conducted in 2 stages: title and abstract screening and the screening of the full text. Screening was conducted by 2 researchers. An initial pilot screening of 50 references was conducted to establish inter-rater reliability. The reviewers met to discuss any disagreements and whether the eligibility criteria needed to be refined. Once agreement was reached, the remaining titles and abstracts were screened independently. References that were an unclear 'yes' or 'no' were flagged and discussed by the 2 reviewers to reach consensus on eligibility.

Following completion of title and abstract screening, full texts of included references were uploaded into Covidence (an online systematic review management tool) and screened using the same procedure (i.e. pilot screening, discussion and refinement as needed), followed by single full-text screening until all references were screened. A final list of included studies was then created.

Table 3: Inclusion and exclusion criteria for literature screening

Inclusion	Exclusion
Published between January 2018 and 26 May 2025 (the day of search)	Published 2017 or earlier
• Focuses on parents with children aged 0–5 years of age • Focuses on expecting parents (prenatal, antenatal)	• Focuses only on children • The mean age of the children of parent participants is 6 years or older. • Focuses on educators, nannies, babysitters, child care workers
Outcomes • Parent outcomes related to health, social, emotional, mental health, empowerment, connection and support (e.g. psychological stress, social connection and wellbeing) • Child outcomes related to health, social, emotional, mental health (e.g. emotional functioning, social competence), developmental and educational needs (e.g. school readiness)	Focuses on negative factors and outcomes (e.g. risk factors) only. For example, poor parental mental health, harsh parenting practices, intimate partner violence
Study populations are based in Australia and the similar* OECD countries of New Zealand, United Kingdom, Ireland, Norway, Sweden, Denmark, Germany **Similar in terms of culture, economy, education and/or health, welfare and early childhood policies and programs.*	Conference abstracts, editorials/commentaries, theses/dissertations, policy briefs, grey material, study protocols, literature reviews and meta-analyses
Published in English	Clinical, medical, psychiatric, genetics, pharmacological or in laboratory/experimental settings (including trials on animals)
Original research articles published in peer-reviewed journals	COVID-19 or pandemic specific and not generalisable to non-pandemic times/situations
	Negative or null findings (i.e. focused on negative outcomes, or the intervention/study had no significant impact on parent/child outcomes)

The next stage, 'charting the data,' involved synthesising and interpreting the literature by sifting, charting and sorting material according to key issues, themes and topics – also known as 'data extraction' (Arksey & O'Malley, 2005). Extraction categories were developed to capture the data relevant to the research questions and included items such as year, geographical location, study population and main results (Mak & Thomas, 2022). This charting of the literature provided an overview of the breadth and depth of the knowledge base and of any information gaps.

Due to the heterogeneity of study methods, design, sample characteristics, exposure and outcome measures, a narrative synthesis was conducted where both qualitative and quantitative data were tabulated together and categorised according to the themes emerging from the data. The development of themes was informed by the social ecology model of child development (DSS, 2024a). A descriptive comparison between studies reporting on the same theme was performed, with similar and divergent findings reported.

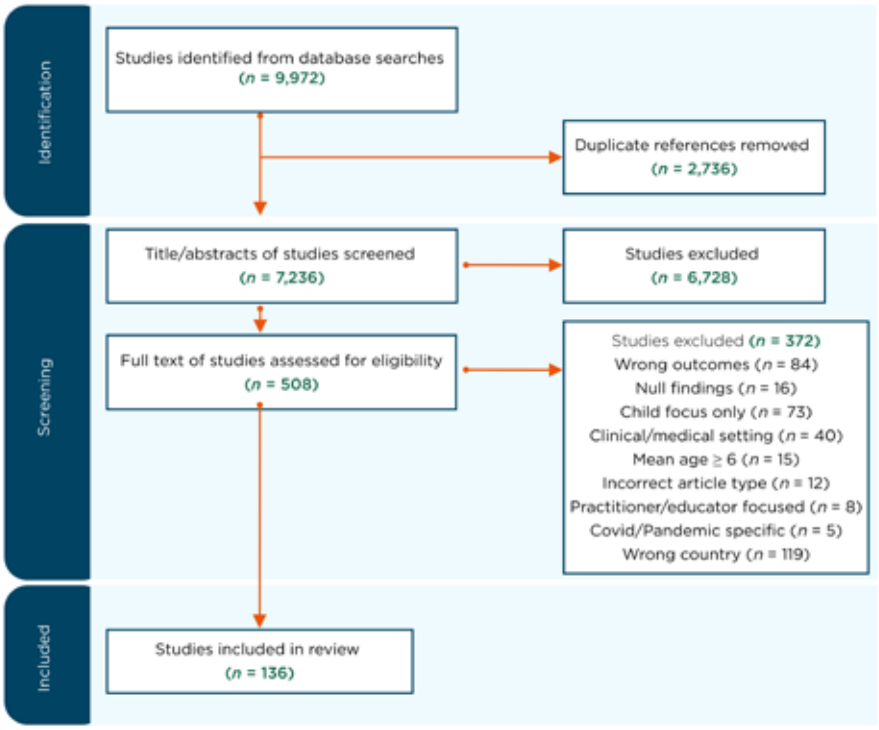
Literature search results

In this section we outline the results of the search and screening process and provide an overview of the nature and volume of research articles included in the review, such as their location, method and study type.

Screening

The database searches identified a total of 9,972 items of literature. After removing 2,736 duplicates, 7,236 unique articles remained. After titles and abstracts were screened, 508 references remained for full-text screening. Of these, 372 studies were excluded, resulting in 136 studies that met the inclusion criteria to be in the review (see Figure 1).

Figure 1: Flow chart of the search and screening process



During the screening process, it was identified that the existing literature in this area was extensive. At the full-text screening stage, the research team in consultation with DSS agreed to further refine the scope of the review to ensure the most relevant studies were synthesised and reported. This included a decision to exclude studies that reported child outcomes only.

Note: The search strategy and search terms used for this review were initially designed to capture primary caregivers of children aged 0–5 years, the majority of which are parents. Other family primary caregivers, such as grandparents, were not explicitly excluded in the search. However, during the screening process, it was identified that the vast majority of studies meeting the eligibility criteria for inclusion in the review were focused on parents.

The next section presents the final stage of the scoping review – a synthesis of the literature, themes and key areas of research related to the research questions, including where research has been undertaken within the Australian context.

Overview of studies

Overall, the existing evidence base is highly diverse and broad in terms of study populations (e.g. demographics), programs and interventions, study designs and parent and child protective factors and outcomes examined. For analysis, the research was divided into 2 categories: intervention studies and other studies.

Of the 136 studies included in the review, the country with the largest number of studies was Australia (*n* = 51, 38%), followed by the United Kingdom (*n* = 34, 25%) and the Scandinavian nations of Denmark, Norway and Sweden (*n* = 26, 19%). Most of the studies were evaluations of programs and interventions (*n* = 82, 60%) using study designs including quantitative methods (i.e. randomised controlled trials (RCT)), mixed methods (e.g. feasibility, pilot studies) and qualitative methods. A majority of both the intervention and other studies used quantitative methods such as surveys, longitudinal and cohort study designs (see Table 4).

Studies that used qualitative methods mostly used interview and focus group methods while a few used participatory methodologies such as co-design or yarning circles.

Table 4: Included studies' locations, types and methods

		n	%
Study location	Australia	51	38
	United Kingdom	34	25
	Scandinavia (Denmark, Norway, Sweden)	26	19
	New Zealand	11	8
	Germany	8	6
	Ireland	6	4
Study type	Intervention	81	60
	Other	55	40
Study method	*Intervention studies*		
	• Quantitative	40	29
	• Qualitative	22	16
	• Mixed methods	20	15
	Other studies		
	• Quantitative	35	26
	• Qualitative	17	12.5
	• Mixed methods	2	1.5

The studies examined a range of family types from families as a single unit to studies focusing specifically on one parent type (often mothers). Studies that included mothers explored a range of groups including pregnant women, first-time mothers and mothers living with a mental illness or depressive symptoms including postnatal depression (PND). Few studies specifically explored fathers' experiences; some focused on fathers from refugee backgrounds, First Nations fathers and first-time fathers.

Furthermore, studies included a range of family types and experiences including refugee and migrant families, families that have children with medical conditions or disabilities, and families involved in specific programs such as singing therapy or PND support groups. Studies that examined the impact of programs and interventions designed to support families in the early years were also diverse and explored a range of parent and child outcomes. The studies are discussed in more detail below, with Australian studies highlighted.

Findings

This section summarises the findings from the studies included in this review. It groups the findings into 2 main sections: impacts of early years programs and interventions, followed by the protective factors for parent and child wellbeing.

Impacts of early years programs and interventions

Eighty-two of the included studies (60% of the total) reported findings from programs and interventions designed to support parents and their children in the early years. Twenty-seven of the 82 studies were from Australia.

There was a variety of early years programs and interventions reported in the research literature. In this report, they are grouped according to the following program/intervention types:[3]

- programs for pregnant women – focused on promoting health and wellbeing during pregnancy
- early intervention programs[4] – primarily focused on promoting positive parent–infant attachment
- parenting programs – a variety of programs aimed at improving parenting skills and knowledge, child development and behaviours and parent–child relationships.
- parent wellbeing programs – focused on promoting positive mental health and wellbeing in parents
- parent-mediated interventions – involve parents but focus on improving child outcomes. Parents are trained by practitioners or other professionals to develop the necessary skills, knowledge and resources to be able to provide primary support and intervention to their child.

Key findings:

- Most programs for pregnant women were targeted at those with existing mental health issues or at risk of postpartum depression. Thus, the programs aimed to enhance the mental health and wellbeing of pregnant women.
  - Overall, these programs led to reduced symptoms of depression and anxiety and improvements in mood among pregnant women.
- Early intervention programs mostly involved families with children aged 0–24 months and focused on promoting positive parent–child attachment and relationships.
  - Many of the early intervention programs focused on families experiencing vulnerability or adversity (e.g. socio-economic disadvantage), parental mental health issues and parent–child relationship challenges. Some early intervention programs focused on families with pre-term babies.
  - Research indicated that early intervention programs resulted in multiple positive outcomes for families including improvements in mother–child attachment and interactions, maternal mental health, parenting self-efficacy[5] and parenting confidence.
- Parenting programs generally involved families with children aged 2–5 years. These programs covered a wide range of programs and interventions aimed at improving parenting skills and knowledge, child development and behaviours and parent–child relationships.
  - Some parenting programs focused on supporting families with children with particular conditions such as autism, attention deficit hyperactivity disorder (ADHD) and speech and language needs. Other programs sought to address the needs of socially disadvantaged families or families at risk of child maltreatment. Several studies examined the impact of universal parenting support programs on family wellbeing.

3 There is some overlap between the 5 types of programs/interventions discussed in this report. Some programs may fit in more than one program type. For example, an intervention may be targeted at supporting maternal mental health during pregnancy and continue into early parenthood (see e.g. O'Dea et al., 2024; Waters et al., 2020).

4 Early intervention programs are often designed for families with children at risk of poor social and emotional development but some are designed for universal implementation (Izett et al., 2021).

5 Parental self-efficacy refers to a parent's belief in their ability to influence their child in a positive, healthy and success-promoting manner (Albanese et al., 2019).

  - Overall, parenting programs resulted in positive parent and child outcomes, including improvements in parental mental health and wellbeing, parenting self-efficacy and confidence, child behaviour and development and parent–child relationships. There are benefits for the general population as well as specific cohorts including families experiencing challenges (e.g. parental mental health difficulties, social disadvantage) and families with children experiencing developmental and behavioural challenges (e.g. conduct problems).
- Parent wellbeing programs focused on promoting positive parental health and wellbeing across the early years.
  - Some programs were designed specifically to support mothers with mental health issues (e.g. postpartum depression).
  - Programs provided several benefits for parents in relation to their mental health and wellbeing, parental self-efficacy and parenting confidence.
- Parent-mediated interventions helped parents to support their child with particular needs, such as sleep problems and behavioural challenges. Some interventions were designed to enhance healthy dietary and physical activity behaviours and language skills in children.
  - Both children and parents appear to benefit from parent-mediated interventions. Studies found benefits to children's behaviours (e.g. externalising and internalising behaviours), development and levels of anxiety and parents' parenting knowledge and skills.

Programs for pregnant women

Eight studies included programs focused on women during their pregnancy, 2 of which were based in Australia (Table 5). Some were targeted at women with mental health issues (e.g. Evans et al., 2021, Townshend et al., 2018) and others were available to the general population (e.g. Haga et al., 2021). Most of these programs aimed to support pregnant women's mental health and wellbeing.

The pregnancy wellbeing programs varied in terms of format, content and duration. For example, an Australian study evaluated the effectiveness of an 8-week mindful parenting program – Caring for Body and Mind in Pregnancy (CBMP) – for pregnant women at risk of perinatal depression and anxiety (Townshend et al., 2018). Participants of the CBMP program attended in-person sessions once a week for 8 consecutive weeks. The program is based on mindfulness-based cognitive therapy, modified for pregnancy, and comprised teachings related to attachment theory, reflective functioning and transition to motherhood.

Another example of a pregnancy wellbeing intervention was a mobile phone app for social and emotional wellbeing during pregnancy called *Positively Pregnant* (Barber & Masters-Awatere, 2022). The app provided structured self-reflection and prompts for consideration of the psychosocial changes relevant to becoming a parent. Participants from New Zealand were involved in a pilot study of the app over a 24-week period, with access to the app varying from 6 to 142 days (Barber & Masters-Awatere, 2022).

Table 5: Australian studies of pregnancy wellbeing programs

Program name	Population characteristics	Overview of program	Key findings
Caring for Body and Mind in Pregnancy (CBMP) (Townshend et al., 2018)	109 pregnant women from an Australian hospital dataset who were at risk for perinatal depression and anxiety; mean age 33.52 years; 46.8% Anglo-Saxon Australians, 27.4% non-English speaking background, 1.6% Aboriginal or Torres Strait Islander background; 66.7% had at least completed a bachelor's degree.	8-week mindful parenting program for pregnant women at risk of perinatal depression and anxiety. The program uses mindfulness-based cognitive therapy, modified for pregnancy, and comprised teachings related to attachment theory, reflective functioning and transition to motherhood.	CBMP intervention significantly reduced depression, anxiety, perinatal depression, perinatal anxiety and general stress scores, while significantly increasing self-compassion and mindfulness with moderate to strong effect sizes.
Mum2BMoodBooster (Gemmill et al., 2022).	27 pregnant women (18 from Australia and 8 overseas); most Australian participants were metro and urban areas; mean age 32.19 years; Edinburgh Postnatal Depression Scale score 11–22. Most had completed university, were married/de facto and had a family income ≥ 80,001 ($AUD).	Online antenatal program targeting depression and anxiety. Utilises cognitive-behavioural therapy techniques to target depression and comorbid anxiety, including mood monitoring, relaxation training and behavioural activation.	The intervention resulted in significant decreases in depression scores and anxiety.

Across the 8 studies, the programs and interventions reduced parent participants' symptoms of depression, anxiety and distress (Barber & Masters-Awatere, 2022; Gemmill et al., 2022; Lönnberg et al., 2020; Townshend et al., 2018). One study that followed up participants in the post-partum period found that reduced levels of depressive symptoms were maintained at 3 months follow up (Gemmill et al., 2022). Some studies also found improvements in mindfulness, self-compassion, affect and mood among participants (Evans et al., 2021; Haga et al., 2021; Townshend et al., 2018).

Studies also found that participants generally found pregnancy wellbeing programs to be helpful and useful. For example, the Mum2BMoodBooster intervention had a high rate of program usage, with 74% of women visiting all 6 sessions and acceptability ratings at moderate to high (Gemmill et al., 2022).

Early intervention parenting programs

Twenty-six studies included early intervention parenting programs for families with a child aged 0–24 months. Some studies included children up to age 3 (Armstrong & Ross, 2023; Osbourne et al., 2023; Palmer et al., 2023; Risholm Mothander et al., 2018). Eleven of the 26 studies were based in Australia (Table 6).

Most programs focused on strengthening parent–infant attachment. Some studies focused on other outcomes such as healthy eating habits for infants (Helle et al., 2019; Gelmini et al., 2024) and sleep hygiene (Quin et al., 2024).

The majority of early intervention parenting programs involved families with vulnerability or adversity (e.g. Bergsund et al., 2024, Cooke et al., 2023), parental mental health issues (e.g. Ericksen et al., 2018; Fisher et al., 2024) and parent–child relationship challenges (e.g. Risholm Mothander et al., 2018). For example, an Australian study evaluated the impact of a collaborative group intervention called 'Together in Mind' for mothers with moderate to severe perinatal mental illness and their infants (Irvine et al., 2021). The intervention aimed to support the developing parent–infant relationship by providing psychoeducation sessions and support for mothers and their infants.

Some early intervention parenting programs focused on pre-term babies (e.g. Gibbs et al., 2019; Holm et al., 2019) and others involved children with conditions such as early regulatory disorders (Georg, 2021, 2022) and infants at risk of obesity (Gelmini et al., 2024).

Table 6: Australian studies of early intervention parenting programs

Program name	Population characteristics	Overview of program	Key findings
Antenatal Dads and First Year Families program (Parry et al., 2019)	16 fathers and 6 staff; located in Murraylands region of South Australia (Demographic information about the fathers was restricted due to ethical concerns.)	Antenatal Dads is a weekly program that provides fathers with information on topics including infant communication, attachment, postnatal depression and birthing. First Years Families is a follow-up program that explores the needs and concerns of fathers in their first year of fatherhood.	Fathers in the Antenatal Dads and First Year Families programs gained valuable insights on infant development, attachment and parenting techniques. This helped them feel more prepared and engaged in their role as fathers. Fathers appreciated the safe space to discuss these issues of concern. Fathers developed social networks and were more likely to engage with other services.
Birthing in Our Community (BiOC) (O'Dea, 2024)	1,988 women who gave birth at the Mater Mothers' Public Hospital, Brisbane. 944 received the intervention versus 1,044 receiving standard care. Most mothers identified as Indigenous and most were educated beyond or equal to grade 10.	First Nations-led, culturally informed, community-based service designed specifically for Aboriginal and Torres Strait Islander families. It provides holistic, wraparound services underpinned by a cultural safety framework and First Nations workforce providing continuity of care throughout pregnancy, birth and up to 6 weeks postnatal.	The 'Birthing in our community' (BiOC) model significantly reduced the likelihood of child protective services removals at birth.

Program name	Population characteristics	Overview of program	Key findings
Cognitive behavioural therapy for insomnia (CBT-I) (Quin et al., 2024)	127 first-time mothers in Australia, recruited in their 3rd trimester; mean age 32.62 years; majority had completed university education, were white, worked full-time, had a household income ≥ 130 k AUD and were married or in a de facto relationship.	CBT-I is a maternal sleep intervention involving therapist-assisted self-help to address unhelpful sleep-related thoughts, beliefs and behaviours, delivered from pregnancy to 6 months postpartum.	CBT-I was effective in both reducing prenatal insomnia (large effect) and preventing postpartum insomnia (medium effect).
Community HUGS (CHUGS) (Ericksen et al., 2018)	74 women from Melbourne with postnatal mental health difficulties. Most were first-time mothers with an age range of 18–50 years (average 31.52), had a partner and English as their primary language.	A mother–infant intervention involving 10 weekly playgroup sessions targeting 4 areas: parent–infant relationship and interactions, parenting skills, maternal self-efficacy and maternal health	Reductions in parenting stress, depression and anxiety symptoms and improvements in observer-rated mother–infant interactions occurred.
Early parenting program (Fisher et al., 2024)	1,220 women with postnatal depression admitted to a private hospital early parenting centre in Melbourne, mean age 35.2 years. Most were married, from high socio-economic status areas and born in Australia or other high-income English-speaking countries.	Five-night residential stay involving a psychoeducation early parenting program for women with postpartum depression symptoms. Private sector setting.	Significant and rapid reduction in depressive symptoms among participants from pre-admission to pre-discharge and continued improvement at 6 weeks post-discharge
Mother–Baby Nurture R (MBN) (Cooke et al., 2023)	Study One: 69 mother–infant dyads, mean age 31.72 years, metro region in Western Australia. Study Two: 27 dyads (experiencing adversity or vulnerability), mean age 32.15 years, almost half were Australian or Caucasian ethnicity.	Community-based, relationship-focused group intervention for mothers and infants (0–6 months)	Significant reduction in depression, anxiety, parenting stress and significant increase in parenting confidence and reflective functioning among participants
Mother–Infant Dialectical Behavior Therapy (MiDBT) (Osborne et al., 2023)	32 mothers with borderline personality disorder, from metropolitan Adelaide; mean age 29.33 years. On average, the women reflected a moderate-high level of disadvantage.	Group intervention involving weekly sessions over 24 weeks covering areas including maternal skill development, emotional regulation and child development. Designed for mothers with borderline personality disorder	Significant improvement in the Interest and Curiosity subscale of the Parental Reflective Functioning questionnaire. No improvement in mother–infant relationship quality. Qualitative interviews with participants indicated highly positive feedback on skills and knowledge learnt.
Parent-mediated infant intervention (Cleary et al., 2022)	13 families of women in early pregnancy, Joondalup, Perth, Western Australia. All had a relatively high level of education and household incomes above average. More than half identified as being of British ethnicity.	Video-aided intervention focusing on parent–infant interactions. Families receive 2 antenatal sessions and 7–10 postnatal sessions within a home setting. Topics include: psychoeducation around infant development, strengthening parent–child relationships.	Feasibility assessment shows that the intervention was acceptable. All participants reported that they had benefited from the program, including increased understanding of and communication with their infant.
Together in Mind (Irvine et al., 2021)	84 mothers with moderate to severe mental health challenges and their infants; located in Queensland; mean age 30 years; most were married/de facto, Australian and 55% did not have any post-school education	Perinatal and infant mental health day program involving psychoeducation sessions and support for mothers with moderate to severe mental health problems	Statistically significant improvements in all clinical measures of maternal mental health symptomatology (e.g. depression, anxiety, stress). Improvements in infants' social-emotional development and parent–infant responsiveness also occurred.

Program name	Population characteristics	Overview of program	Key findings
Triple P discussion group (Gelmini et al., 2024)	82 parents of infants meeting at least 2 risk factors for early childhood obesity were randomised to intervention or control group. Location was Greater Brisbane region. Mean age 32.4 years; majority were mothers, married/de facto, Australian, held a degree and were employed.	Brief 2-hr parenting intervention focused on increasing protective factors against and reducing risk factors for infant obesity	No significant intervention effects on parent-reported responsive feeding practices, mealtime environment or parent self-efficacy in responsive feeding. Parents reported that the intervention had a positive influence on some parental feeding practices.
Web-based intervention (Treyvaud et al., 2022)	103 infants and their primary caregiver from a Melbourne hospital, randomised to intervention (*n* = 50) and control (*n* = 53) groups. The mean ages were 32.2 years (intervention) and 32.5 years (control). Most participants in both groups were tertiary educated, employed, part of a couple and spoke English at home.	Clinician-supported, web-based intervention consisting of 8 age-dependent modules (5–10 topics each) that focused on education about preterm infant development, strengthening parent–child relationships, and supporting parental mental health.	Weak evidence that mothers had lower odds of being in the elevated category for depression at 12 months post-intervention. Higher scores in parent–child relationship outcomes in mothers in the intervention compared with the control group at 24 months (child's corrected age).

The programs varied in terms of format, content and duration. Some programs were delivered online (e.g. Helle, 2019; Treyvaud et al., 2022), in neonatal intensive care units (NICU) (Gibbs et al. 2019) or via playgroups (Ericksen et al., 2018). One study involved residential stays (away from home) (Fisher et al., 2024).

Some programs used a video-interaction guidance format to promote positive parent–child attachment and interactions (e.g. Barnicot et al., 2024; Chakkalackal et al., 2021; Greaves et al., 2024). This involved practitioners or parents filming parent–child interactions (e.g. engaging in activities such as reading or playing), which practitioners or researchers evaluated. Parents then received feedback on their interactions and guidance on ways to enhance their responses to their baby's cues and improve their emotional regulation.

Overall, early intervention parenting programs had positive outcomes for parents and the parent–child relationship. Studies that examined program impacts on parental mental health and wellbeing found significant reductions in levels of depression, anxiety and stress (Cooke et al., 2023; Eriksen et al., 2018; Fisher et al., 2024).

For example, an RCT study based in Germany involving families with infants aged 4–15 months who were experiencing early regulatory disorders (e.g. excessive crying, sleeping challenges) compared parent and child outcomes among families receiving psychodynamic-based focused parent–infant psychotherapy (fPIP) and families receiving standard paediatric care (Georg et al., 2021).

The intervention aim was to strengthen the quality of the parent–infant relationship, reduce infants' symptoms and improve parents' mental health and wellbeing outcomes. The study reported that mothers in families who received the fPIP intervention had significantly greater decreases in maternal psychological distress and depression, compared to mothers receiving standard treatment (Georg et al., 2021).

Some studies also reported significant increases in maternal sensitivity,[6] parenting confidence and self-efficacy (Barnicot et al., 2024; Eriksen et al., 2018). A feasibility study of a brief online group intervention for parents with anxiety, based in the United Kingdom, found increases in parenting confidence as well as reductions in depression, anxiety and stress at the 8-week follow-up (Palmer et al., 2023).

Qualitative data from parents also highlighted the positive impacts of the programs on their wellbeing; participants described feeling supported and safe and that their confidence in their parenting increased as a result of the program (Bergsund et al., 2024; Cooke et al., 2023; Holm et al., 2019; Parry et al., 2019).

A Denmark study explored the views of parents with preterm infants involved in a neonatal tele-homecare program delivered by specialist neonatal intensive care unit staff (Holm et al., 2019). It found that the program was a useful method for supporting families in the home and parents reported greater privacy and independence, less stress and increased parenting confidence receiving care from their home. Some fathers also reported that the program enabled them to spend more time with their infant (Holm et al., 2019).

6 Maternal sensitivity refers to 'the quality with which mothers respond to their infants' cues in a timely and appropriate manner' (Leerkes et al., 2009, p. 761)

Programs can also help parents build social connections with other parents and reduce barriers to service engagement. An Australian study of fathers who participated in an Antenatal Dads and First Year Families program found that the program helped them feel less isolated because they were able to connect with other fathers (Parry et al., 2019). It also served as a 'soft entry' to other support services because attendance at one service helped fathers identify other services through word of mouth or direct promotion by program staff.

For parent–child relationship outcomes, studies found improvements in mother–child interactions (Eriksen et al., 2018; Irvine et al., 2021; Treyvaud et al., 2022). For example, an Australian study that evaluated a therapeutic playgroup for mothers with PND found significant improvements in observer-rated assessments of the quality of mother–infant interactions post-intervention (Eriksen et al., 2018).

Qualitative data from parents also highlighted the benefits on parents' relationships with their infants; participants commonly reported how the interventions helped them identify and respond to their baby's behavioural cues and helped them bond and connect with their baby (Armstrong & Ross, 2023; Barnicot et al., 2024; Cleary et al., 2022; Gill et al., 2019).

Parenting programs

Twenty studies focused on parenting programs, with 8 based in Australia (Table 7). Most of these programs involved families with children aged 2–5 years. These programs covered a wide range of programs and interventions aimed at improving parenting skills and knowledge, child development and behaviours and parent–child relationships.

Some programs were targeted at particular parent or child cohorts; for example, socially disadvantaged families (Graham et al., 2025), children with autism spectrum disorder or ADHD (e.g. Larsen et al., 2021; Lauren et al., 2025) and children with challenging behaviours (e.g. Kohlhoff et al., 2020; Saunders et al., 2020). Others were universal support programs (e.g. Bridge et al., 2019; Norman et al., 2024).

Table 7: Australian studies of parenting programs

Program name	Population characteristics	Overview of program	Key findings
Circle of Security Parenting (COS-P) (Maxwell et al., 2021)	256 parents (201 treatment group and 55 waitlist control group) with self-identified early parenting challenges from 2 Australian cities. Participants' mean age 34.27 years; most were born in Australia or another English-speaking country and university educated.	Eight-week group program that included attachment theory principles, video examples of parent–child interactions, guided reflection and group discussion.	Significant improvements in parental mentalising and self-efficacy, reduced caregiving helplessness and hostility towards the child and reduced depression symptoms among participants No difference between intervention and waitlist control groups in perceived child difficultness
Coaching and Parent Emotion Support (CaPES) (Risi et al., 2024)	2 families recruited from the Australian Defence Force. Both families had civilian mothers and serving fathers and the children were aged 2 and 4.	Parenting program designed to strengthen parent–child relationships and support family's deployment in military families with young children. It involves emotion and behavioural regulation principles within an intensive, dyadic, coaching-based delivery format.	Preliminary evidence that CaPES results in improved parent–child relationship quality, parental mental health and wellbeing and child behavioural and emotional outcomes.
Cool Little Kids (Bayer et al., 2018)	545 (265 intervention, 280 control) children identified as 'inhibited' and their parents from socio-economically diverse areas in Melbourne. Children's mean age at baseline was 4.5 years (intervention) and 4.6 years (control). Majority were couple families, born in Australia and spoke English at home.	Parenting group sessions involving 6 sessions, 90-minutes each, that focused on reducing anxiety disorders among children	Little difference in anxiety disorders between intervention and control groups at 1-year follow-up.

Program name	Population characteristics	Overview of program	Key findings
Home Interaction Program for Parents and Youngsters Age 3 (HIPPY) (Graham et al., 2025)	102 socially disadvantaged families and 10 coordinators located across 5 Australian states. Parents' age range 31–45 years, 95% were female, just over half were born outside of Australia, half had a tertiary qualification. Over half were very confident in speaking English and 63% were not in paid employment.	Thirty-week play-based curriculum delivered to families aiming to promote a positive and supportive home learning environment to promote school readiness and increase the quality of parent–child relationships.	Participants reported improvements in their awareness of their children's strengths and interests and how to create positive and stimulating learning opportunities. Most parents reported that the quality of their parenting improved since the program.
Home Parenting Education and Support (HoPES) Program (Giallo et al., 2021)	30 families at risk of child maltreatment and recurrence in Australia. 29 mothers (mean age 28.9 years) and 11 fathers (mean age 34.1 years) located in Victoria. Majority of parents were Australian born and English-speaking, had completed some high school and were partnered.	Intensive 8-week home-visiting intervention for families of infants and preschool-aged children (0–4 years) receiving child protection services or welfare services for concerns about child maltreatment. It consists of parenting education and skill development sessions.	Moderate to large decreases in maternal stress and increases in parental self-efficacy among participants. Interviews with mothers identified perceived benefits for parent mental health and wellbeing, parenting and relationships with children.
Internet-Delivered Parent Training for Young Children (Fleming et al., 2021)	27 mothers of children with conduct problems, living in rural and regional areas of NSW. All but one mother was born in Australia and all were English speaking or English bilingual. Majority were married or in de facto relationships and reported paid employment or home duties as their occupation.	Online-delivered parent management training for parents with children with conduct problems. Aimed at families based in rural and regional areas	Significant improvements in parent-reported and observed child conduct problems and observed parenting behaviours among participants, with 'small' to 'very large' effect sizes
Parent–Child Interaction Therapy (PCIT) (Kohlhoff et al., 2020)	10 parents (9 mothers and 1 father) from south-western Sydney; mean age 34.1 years (range 27–40 years) and mean child age 3 years (range 2–4 years). 8 participants were married or in a de facto relationship and 2 were single.	A short-term, evidence-based parent training program for parents of children aged 2–7 years with disruptive behaviour disorders	Participants reported that they had experienced a reduction in their child's challenging behaviours as a result of attending the program. Some participants reported increased parental confidence and insight, and increased understanding of their child's needs.
Sing&Grow (Savage et al., 2022)	10 mothers from across Australia	Music therapy program utilising group parent–child music therapy sessions, aimed at reducing the impact of adversity and improving child future trajectories	Participants perceived that the program had developed their confidence as parents by increasing their knowledge in child development and parenting skills.

Overall, parenting programs have benefits for the general population as well as specific cohorts including families experiencing challenges (e.g. parental mental health difficulties, social disadvantage) and families with children experiencing developmental and behavioural challenges (e.g. conduct problems).

The majority of parenting programs demonstrated positive impacts on a range of parent outcomes, including:

- decreased parental stress, anxiety, depressive symptoms in families experiencing challenges (Giallo et al., 2021; Maxwell et al., 2021).
- decreased emotional regulation difficulties and increased emotional awareness among military families (Risi et al., 2024).
- increased parental self-efficacy and parenting confidence in families experiencing challenges (Giallo et al., 2021; Maxwell et al., 2021).
- improved parenting skills/behaviours in families with children with conduct problems (Fleming et al., 2021) and ADHD-type behaviours (Leckey et al., 2019).

- improved parental emotion coaching/socialisation behaviours among parents with children in kindergarten (Bølstad et al., 2021).

Participation in parenting programs was also associated with better child outcomes, including:

- reduced child conduct problems among children with conduct problems (Fleming et al., 2021).
- reduced child behavioural problems and increased prosocial behaviours (Westwood et al., 2021).
- reduced child internalising behaviours among inhibited/shy children (Bayer et al., 2018).
- improvements to child dietary behaviours (i.e. increased intake of healthy foods) (Bridge et al., 2019; Norman et al., 2024).

Furthermore, programs contributed to improvements in parent–child relationships (Lauren et al., 2025; Leckey et al., 2019). For example, an Australian qualitative study evaluating the Home Interaction Program for Parents and Youngsters (HIPPY) for socially disadvantaged families found that the intervention resulted in improvements in parenting quality and parents' communication with their child (Graham et al., 2025).

A pilot study based in England examined the impact of a program designed to support early child–caregiver relationships and found that participation in the program resulted in improved parent–child interactions post-intervention, including improvements in parents' responses to their child's emotions (Potter et al., 2024).

Qualitative data collected from parents aligned with the findings outlined above. Moreover, participants generally viewed parenting programs positively. Parenting programs that involved group sessions and discussions also facilitated social connectedness and belonging among participants (Bridge et al., 2019; Savage et al., 2022). Some participants also reported improvements in their relationship with their partners (Kohlhoff et al., 2020; Lauren et al., 2025).

Parent wellbeing programs

There were 8 studies that examined the impact of programs designed to support parental health and wellbeing after the birth of a child. The majority of these programs focused on mothers. Three of the 8 studies were from Australia (Table 8).

Three studies reported on the impact of group singing programs on maternal wellbeing (Fancourt & Perkins, 2018; Mani et al., 2023; Perkins et al., 2018). Two studies examined nurse home-visiting programs (Goldfeld et al., 2021; Høgmo et al., 2023), one study evaluated a perinatal support service (Mugweni et al., 2019), one study focused on fathers (Giallo et al., 2018a) and one study piloted an Acceptance and Commitment Therapy intervention for women with moderate-to-severe mood and/or anxiety disorders (Waters et al., 2020).

Table 8: Australian studies of parent wellbeing programs

Program name	Population characteristics	Overview of program	Key findings
Working Out Dads (Giallo et al., 2018a)	57 fathers; mean age 35 years; located in Melbourne. Most were Australian-born and first-time fathers.	Manualised 6-week group program of psychoeducation about health, coping and parenting challenges, held in a gym/fitness environment. It aimed to promote mental health and self-efficacy.	Significant reduction in fathers' depressive and stress symptoms and no significant change in anxiety symptoms. Parenting self-efficacy significantly increased. Participants indicated that they were satisfied with the program and gained confidence in their parenting skills.
right@home nurse home visiting (Goldfeld et al., 2021)	495 mothers (255 intervention and 240 control) from Victoria and Tasmania. Mean ages were 27.6 years (intervention) and 28.3 years (control). Most participants had completed high school or vocational training, were married/de facto and unemployed.	Nurse home-visiting program offered to pregnant women experiencing adversity, delivered via universal child and family health services	Participants reported better mental health and wellbeing outcomes 1-year post-intervention completion.

Program name	Population characteristics	Overview of program	Key findings
Group singing program (Mani, 2023)	8 new or expectant mothers from a refugee background, located in Logan, Queensland; 3 were from Myanmar and the others from different regions of Africa. They had lived in Australia for a range of 1–10 years and most required interpreters.	12 weekly singing workshops alongside perinatal support classes offered by hospital midwives. Designed for new or expectant mothers from a refugee background.	Workshops afforded respite for mothers and allowed safe spaces for reflection, spiritual connection, social connection and emotional release.

Parent wellbeing programs reported benefits for parents, including reductions in anxiety and depression (Giallo et al., 2018a; Mugweni et al., 2019; Goldfeld et al., 2021; Waters et al., 2020) and increased parenting confidence and self-efficacy (Giallo et al., 2018a, Mugweni et al., 2019).

Three studies evaluated group singing and/or play interventions conducted with 2 different populations: mothers from a refugee background (Mani et al., 2023) and mothers with postnatal depression (PND) (Fancourt & Perkins, 2018; Perkins et al., 2018).

Fancourt and colleagues (2018) examined UK-based, 10-week group singing or group play workshops for mothers with symptoms of PND and their babies using a randomised controlled trial study design. The study found that mothers who participated in the singing workshops had a significantly faster decrease in their symptoms of PND over time compared with mothers who did not participate in the singing workshops. Qualitative insights from workshop participants suggest that the singing workshops helped mothers soothe and calm their babies and provided an opportunity for relaxation, which also contributed to mother–baby bonding (Perkins et al., 2018).

Parent-mediated interventions to address child outcomes

Twenty studies examined parent-mediated interventions focused on improving child outcomes. Parent-mediated interventions (practitioner-to-parent-to-child) involve parents being trained or coached to deliver an intervention to their child or build parent capabilities and skills with the main aim of supporting their child (Strawa et al., 2024). Four of these interventions were Australian-based (Table 9).

Table 9: Australian studies of parent-mediated interventions

Program name	Population characteristics	Overview of program	Key findings
Behavioral sleep intervention (Donovan et al., 2023)	128 parents of preschool children with sleep problems (62 intervention and 66 control), located in southeast Queensland. Parents' age range was 19–49 years (mean age 37.2); majority were female, born in Australia and were married. Almost half worked part-time, had a household income $100K–$200K and held a bachelor's degree.	Parent-focused, group-based behavioural intervention targeting sleep problems in preschool-aged children. It included psychoeducation and training in sleep hygiene and strategies for bedtime fears and behavioural problems at bedtime. Involved in-person, weekly sessions over 6 weeks.	Significant improvements in child sleep, anxiety, behaviour problems and internalising and externalising symptoms from pre- to post-intervention. At 2-year follow-up, improvements in child sleep, anxiety and internalising symptoms were maintained.
Cool Little Kids – Coping with Uncertainty in Everyday Situations (CLK-CUES) (Adams et al., 2024; Simpson et al., 2023)	57 children (29 intervention and 28 control) aged 4–5 years with a diagnosis of autism. Most participants were male and most were reported as Australian ethnicity.	An autism-specific, parent-mediated intervention designed to prevent and reduce anxiety in young autistic children. It includes psychoeducation to help parents identify and manage their child's anxiety symptoms.	Significant decline for the intervention group in anxiety (specifically, anxiety around uncertainty) from pre- to post intervention, maintained at one year follow-up (Adams et al., 2024). Participants received the program positively and reported a reduction in their child's anxiety levels (Simpson et al., 2023)

Program name	Population characteristics	Overview of program	Key findings
Fun with feeling (Cook et al., 2019)	31 children aged 4 to 6 years with autism spectrum disorder and anxiety were randomly assigned to treatment (14) or waitlist control (17) conditions. Majority of children were male, born in Australia, and lived in 2-parent households of middle-to-high income.	Parent-mediated cognitive behavioural therapy program for young children with high-functioning autism spectrum disorder and anxiety.	At post-treatment no treatment effects were found for child or parent outcomes. At 3-month follow-up, children in the treatment group demonstrated significant reductions in internalising behaviours and there was a trend for a reduction in anxiety compared to pretreatment.
Early stuttering treatment program (Druker et al., 2020)	76 preschool children aged 2 to 5 years who stutter and their parent(s). Located in Western Australia (mostly Perth) and most were male.	Early stuttering treatment program integrated with evidence-based parenting support (i.e. Triple P Positive parenting program).	Greater reduction in stuttering compared with group that received the stuttering treatment program only. Families reported large and significant improvements in child behaviour and parenting practices.

Four studies reported on a New Zealand program called Tender Shoots, a parent-mediated preventive intervention for children's language skills (Clifford et al., 2024; Reese et al., 2023; Schaughency et al., 2023; Timperley et al., 2022). This program is designed for children aged 3.5–4.5 years and their parents.

Four studies examined parent-mediated interventions related to supporting children with or at risk of autism spectrum disorder. Three of the four studies involved children aged 3–7 years (Adams et al., 2024; Cook et al., 2019; Leadbitter et al., 2020) and one study focused on infants (Tanner & Dounavi, 2020).

Other studies focused on addressing child sleep problems (Donovan et al., 2023), risk of obesity (Alexandrou et al., 2023; Ek et al., 2020), visual impairment (Dale et al., 2019), child stuttering disorders (Druker et al., 2020) and school readiness (Lee et al., 2019).

Overall, studies reported various benefits from parent-mediated interventions on child outcomes, including:

- improved healthy eating habits (Alexandrou et al. 2023; Ek et al., 2020).
- reduced anxiety in children with autism (Adams et al., 2024).
- reduced internalising behaviours in children with autism (Cook et al., 2019).
- reduced stuttered speech severity for children who stutter (Druker et al., 2023).
- improved cognition and language for children with visual impairment (Dale et al., 2018).

Studies that measured parent outcomes also reported some benefits for parents from the parent-mediated interventions. For example, a Swedish study about a skills-based treatment intervention for childhood obesity found that parents gained knowledge on techniques and tools for managing their child's eating habits and emotional wellbeing and helped parents create a calmer home environment, which reduced conflicts about food (Ek et al., 2020).

Additionally, a UK study of a parent-mediated paediatric autism therapy intervention for young children with autism reported that parents felt the intervention helped them improve their ability to empathise with their child and see things from their perspective and that their relationship with their child strengthened as a result (Leadbitter et al., 2020).

Protective factors for parent and child wellbeing

Fifty-five of the included studies (40% of the total) reported findings from studies that examined the relationship between protective factors and parent and child outcomes. These studies did not involve an intervention or program. Twenty-three of the 55 studies were from Australia.

Key findings:

- Research reflected the importance of positive parental wellbeing and supportive parental environments in early childhood, which contribute to positive outcomes for children.

- Studies identified that parent relationship factors are important in safeguarding parental mental health and enhancing resilience. They also affirmed the role that supportive relationships play in reducing stress and improving overall wellbeing among parents, which may also positively contribute to child outcomes.
- Protective family and social factors include access to healthcare services, family support, community belonging, neighbourhood cohesion and structured social groups.
- Other factors that can be linked to positive parental wellbeing are self-care strategies and use of formal support services.

Parent-related factors

The studies highlighted various parent-related protective factors that were associated with positive parent and child outcomes. Overall, studies identified the following protective parenting practices as consistently linked to positive child outcomes and parental wellbeing: maternal warmth, praise of children, reading, storytelling, structured routines and self-efficacy (e.g. Burnett et al., 2021; Kirby et al., 2020; Rosslund et al., 2025; Russell et al., 2021). Table 10 lists the Australian studies.

Some studies examined factors that positively impacted breastfeeding behaviours and attitudes among mothers. Higher parental self-efficacy, self-esteem and perceived social support were shown to predict lower internalised stigma around breastfeeding choices (Russell et al., 2021). Additionally, longer breastfeeding duration was associated with higher levels of maternal supportive parenting (at 24 months), which then led to higher levels of paternal supportive parenting (at 36 months) (Feldman, Natale et al., 2023).

Other studies examined parental factors that positively influenced child outcomes. For example, an Australian study by Le Bas and colleagues (2022) reported that maternal bonding[7] predicted better social-emotional and behavioural outcomes in infants and small effects on cognitive and language development. Another Australian study found that parental education and involvement in home learning activities were predictors of emotional-behavioural resilience in children (Giallo, 2018b).

A few studies explored the home environment and its impact on child outcomes. One Norwegian study found that shared book reading between parents and children can improve children's vocabulary (Rosslund et al., 2025). Similarly, a Swedish study by Sundqvist and colleagues (2024) found that influences and activities in the home literacy environment, such as teaching colour and letters or talking about daily activities, could have a positive impact on children's vocabulary size.

In relation to children's health outcomes, an Australian study showed that structured meal practices, such as meal timing, monitoring, covert restriction and modelling healthy eating, were positively associated with child dietary quality (Burnett et al., 2021). Another Australian study found that fathers' confidence in promoting healthy dietary behaviours was linked to children's dietary behaviours (Walsh et al., 2019)

Qualitative data collected from parents indicate that they valued support and information on infant care, routines and behaviour management, and postnatal parents subsequently reported higher confidence after receiving the support and information (Morawaska et al., 2018).

Table 10: Australian studies of parent-related protective factors

Author & Year	Population characteristics	Parent-related protective factors
Burnett et al., 2021	1,349 Australian mothers of children aged 2–5 years; over 93% lived in 2-parent households.	Structured meal timing, monitoring, covert restriction, modelling healthy eating and structured meal settings were positively associated with child dietary quality.
Dadi et al., 2023	A birth cohort of 2,380 Northern Territory children (including 1,222 Aboriginal children) who were in their first year of school in 2015. Indigenous children lived mostly in remote/very remote areas (79%), non-Indigenous children were mostly in outer regional areas (74%). On various measures the Indigenous children lived in more disadvantaged circumstances than the non-Indigenous children.	For Aboriginal children, a significant pre-pregnancy predictor of better outcomes was higher socio-economic status (measured using the Index of Relative Socio-Economic Disadvantage).
Giallo et al., 2018b	1,085 mother–child dyads located in Melbourne. Majority of women were aged between 30 and 34 years, born in Australia and in a relationship.	Maternal education and involvement were predictors of emotional-behavioural resilience in children.

7 Measured using the Maternal Antenatal Attachment Scale (MAAS) and the Maternal Postnatal Attachment Scale (MPAS).

Author & Year	Population characteristics	Parent-related protective factors
Hinz et al., 2024	11 young Australian women who gave birth to their first child between the ages of 15 and 23 years. Participants' age at the time of interview ranged from 20 to 25 years (mean 22.36).	Participants described several factors that supported their journey through pregnancy, birth and motherhood. This included self-care (e.g. hobbies and connecting with friends or nature), engaging in education or employment and drawing support from friends, families and services.
Le Bas et al., 2022	1,347 pregnant women located in New South Wales and Western Australia (from Triple B Pregnancy Cohort Study). Majority were born in Australia, high socio-economic status background, had completed university/college studies and lived with a partner.	Strong maternal bonding predicted better social-emotional and behavioural outcomes in infants, with small effects on cognitive and language development
Morawaska et al., 2018	77 prenatal (76 mothers) and 123 postnatal parents (116 mothers) located in capital cities around Australia. Majority of the prenatal cohort were in their second trimester with a mean age of 29.47 years, for the postnatal group the mean parent age 32.98 and mean child age was 12.3 months. Participants were generally well-educated, working and financially secure.	Parents valued support and information on infant care, routines and behaviour management; postnatal parents reported higher confidence.
O'Connor et al., 2025	350 pre-conception men, mean age 32.5 years, and 427 post-natal men; drawn from the *Ten to Men* longitudinal study of men's health. Mean age 33.3 years. Majority of men had completed high school, were employed, in a relationship and lived in metropolitan areas.	Higher wellbeing before fatherhood predicted lower postnatal depressive symptoms.
Walsh et al., 2019	195 fathers from Geelong, Victoria. Mean age was 34.7 years, majority born in Australia. Similar proportions of fathers were university (42.4%) or trade/certificate (39.8%) qualified with the remainder (17.8%) being high school only. Their children were approximately 36 months old.	Parental self-efficacy and child diet: Fathers' confidence in promoting healthy diets was linked to better child dietary outcomes.

Parent relationship factors

Some studies highlighted several relationship factors that contribute to positive outcomes for children and parents. The findings highlight that strong family bonds, supportive partnerships and cooperative parenting play a vital role in buffering stress and fostering emotional resilience (Anke et al, 2019, 2025; Bulford et al., 2022; Case et al., 2018; Garthus-Niegel et al., 2020). Table 11 lists the Australian studies.

Qualitative data from parents highlighted the significance of relational dynamics for both mothers and fathers navigating the challenges of early parenthood. Fathers, in particular, derived strength and emotional stability from the encouragement received from their partners, families and communities (Bulford et al, 2022). Similarly, studies found that a partner's emotional support and postnatal partner behaviours (e.g. respect, shared responsibilities) were highly valued and described as an immense support by most female participants (Anke et al, 2019, 2025; Kirova & Snell, 2019).

Partner support was also shown to be a key buffer against depressive symptoms in first-time pregnant women in a cross-sectional study based in Norway (Øygarden et al, 2023) and relationship satisfaction and social support served as protective factors against paternal perinatal depression in a cohort study based in Germany (Garthus-Niegel et al., 2020). Furthermore, partner support reduced parenting stress, especially in low-trauma contexts (Galbally et al., 2019).

Table 11: Australian studies showing positive relationship factors

Author & Year	Population characteristics	Relationship related protective factors
Bulford et al., 2022	21 men of refugee background, mean age 40 years (range 28–56), with children aged 0–5 years old, living in Melbourne. Participants were from Syria, Afghanistan, Burma, Sierra Leone and Sri Lanka. Mean time in Australia was 5.5 years (range 1–15 years).	Fathers found a sense of joy from fatherhood and support from partners, families and communities.
Galbally et al., 2019	246 women who were 12 months postpartum, from Melbourne. 3 groups: women taking antidepressants, non-medicated women diagnosed with depression, and control women. Mean age 31.37 years (range 19 to 48).	Partner support reduced parenting stress, especially in low-trauma contexts.
Kirova & Snell, 2019	6 mothers located in an affluent area of Melbourne. Age range 26 to 36 years, their children were aged 12 to 17 months, and they had been in their relationship 4–15 years. 5 of the 6 had returned to work.	Helpful postnatal partner behaviours were valued by mothers. These included respect, shared responsibilities and personal time.

Family and social factors

Another theme that emerged from the research was the link between family and social factors and positive parent and child outcomes. Access to healthcare services, family support, community belonging, neighbourhood cohesion and structured social groups were frequently cited as protective family and social resources (Aiyar et al., 2025; Case et al., 2018; Carlin et al., 2021; Farewell et al., 2022; Schuijers et al., 2024). Table 12 lists the Australian studies.

For example, an Australian study identified that, for Aboriginal women, strong family ties were the most prominent protective factor, with participants reporting that these relationships provided essential emotional and practical support (Carlin et al., 2021).

Similarly, a study of parents raising children with a cleft palate found that strong family bonds and an external support network were significant sources of strength (Cronin et al., 2021). Support from family was also the most mentioned source of support among mothers in a New Zealand study by Farewell and colleagues (2022). Familial support from grandparents was also noted as a source of strength for its capacity to mend previously strained familial relationships in a Norwegian study (Anke et al., 2025).

Beyond familial support, some studies demonstrated how wider social support from the community can play a protective role. In an Australian study of mothers of children with craniofacial anomalies, social support was found to buffer their psychological distress and enhance quality of life (Case et al., 2018).

Similarly, the community provided parents from ethnic minority backgrounds in the UK with reassurance, support, understanding and confidence, which subsequently reduced their sense of loneliness (Chowbey & Barley, 2022). In another study, South and Southeast Asian migrant mothers in Australia reported relying on community support to navigate a new health system and saw this support as a key resource (Aiyar et al., 2025).

Furthermore, support from community organisations and schools was revealed in another study to be a prominent source of support for mothers (Farewell, 2022). This can also have positive benefits for children. For example, an Australian study reported that higher levels of social support for mothers were associated with fewer social-emotional problems and greater social-emotional competencies in one-year-old children (Schuijers et al., 2024).

Social support received through community-run programs was also shown to have benefits for fathers. In an Australian study of First Nations fathers, the creation of gathering places for men to connect with and learn from other dads was a protective factor, as were services that were inclusive of men and their role as fathers (Clifford-Motopi et al., 2022).

Interestingly, one qualitative study explored the positive social support that parents can experience from social media platforms. Chee and colleagues' (2024) Australian study found that social media offered inspiration, shared experiences and a sense of togetherness and, subsequently, contributed positively by providing a sense of collective identity among participants. The higher levels of perceived social support from social media were linked with higher quality of life and reduced distress symptoms among parents which, in turn, may have buffered the relationship between quality of life and depression and anxiety symptoms.

Table 12: Australian studies of protective family and social factors

Author & Year	Population characteristics	Family and social related protective factors
Aiyar et al., 2025	9 migrant mothers from S/SE Asia and 22 service providers. Mothers were from Pakistan (4) and 1 from each of Afghanistan, Bangladesh, Bhutan, India and Indonesia. Time in Australia ranged from 3 to 10 years. Mean age 33.8 years (range 26–42).	Community organisations and schools were cited as prominent sources of support. Support from friends, family and community as a key resource in the first 2,000 days.
Carlin et al., 2021	91 Aboriginal women from the Kimberley region of Western Australia. Participants were aged 16–41 years (median 24 years) and all were either pregnant (more than 6 weeks gestation) or had a child aged between 7 days and 12 months. 25% were clinically diagnosed with depression and/or anxiety.	Most Aboriginal women reported strong family ties as protective.
Case et al., 2018	55 mothers of children (newborn to 6 years) with craniofacial anomalies. All participants were in a relationship and were aged 22–44 years (mean 32.31). 56% live in a household with income of $75k per annum or less and 55% had a diploma or degree qualification.	Social support mediated psychological distress and improved child outcomes.
Chee et al., 2024	85 pregnant people and parents of a child aged 5. 97% were women, most were married, had at least a bachelor's degree and earning well above the median Australian income.	Social media offered inspiration, shared experiences and a sense of togetherness.
Cronin et al., 2021	7 mothers, 6 fathers, 4 grandmothers, 2 grandfathers, 1 sibling, 1 aunt and 3 educators of 7 children aged 2 to 3 with cleft palate. Families lived in moderate to high socio-economic status areas of metro and regional Australia.	Strong family bonds and an external support network were significant sources of strength.
Farewell et al., 2022	5,664 postpartum female participants from the Growing Up in New Zealand cohort study. Most (60%) are New Zealand/European with 13% Maori, 13% Pacific Islander and 14% Asian. 40% have a bachelor's degree or higher and a further 30% have a diploma or certificate.	Family support was the most mentioned source of support among mothers in the sample. Support outside of the family unit was also frequently mentioned – social community groups were a large source of support for them.
Green et al., 2024	53 parents of autistic preschoolers in Australia. Majority were mothers, had a non-Australian cultural background, were tertiary educated and did not have a low income.	Results from regression analyses suggested that a combination of parent, child and family/socio-economic factors may predict change in parental wellbeing and mental health.
Clifford-Motopi et al., 2022	8 First Nations men; mean age 24 years (range 18–33) located in Brisbane or communities outside of Brisbane. 6 were first-time fathers.	Study identified social strategies to support new First Nations fathers: creating gathering places for men to connect with and learn from other dads and maternity and early childhood services that are inclusive of men and their role as fathers.
Makama et al., 2023	13 mothers with young children (5 years and under) from Victoria. Mean age 37.1 years; more than two-thirds of participants (69%) were born overseas. Most participants were university graduates, 5 participants were in paid employment.	Mothers valued community peer support, practical help and culturally sensitive leadership.
Schuijers et al., 2024	Mother–infant dyads from 2 longitudinal cohort studies: the Australian Temperament Project (*n* = 1,052) and the Triple B Pregnancy Cohort Study (*n* = 1,537 dyads). Mean maternal age (ATP = 32.03; Triple B = 32.53) and child sex (ATP = 52% female; Triple B = 49% female). In ATP, 88% of participants reported being Australian-born (12% were 'born outside of Australia'), compared to 56% in Triple-B (44% 'born outside of Australia'). In both cohorts, approximately two-thirds of participants had a university or higher education level (ATP = 66%; Triple B = 68%).	Higher maternal social support was associated with fewer social-emotional problems, and more social-emotional competencies, in one-year-old children.

Other protective factors

The review also revealed other factors, not associated with the above key themes, that were found to be associated with positive parent outcomes. Of the other factors, they can largely be grouped together into 2 small sub-themes: 'self-care strategies' and 'formal services' that support parent and child wellbeing. Table 13 lists the Australian studies.

Self-care strategies

Several studies discussed the protective factors of self-care strategies among parents. In Bulford and colleagues (2022), fathers identified personal strategies for managing stress and looking after their own wellbeing; these included reading, listening to music, watching television, meditation and gardening.

Similarly, in Hinz and colleagues (2024), young mothers spoke of the importance of taking steps to protect their psychological wellbeing and promote positive psychological wellbeing. They emphasised the significance of allocating time for themselves and reconnecting with aspects of their identity that exist beyond motherhood (Hinz et al., 2024).

In another study, spending time with children and family, going fishing, listening to music, playing sport, gardening and reading the bible were emphasised by women as ways of enacting self-care and enhancing their sense of wellbeing (Case et al., 2018).

Finally, in 2 studies, participant parents spoke of the value of receiving information and assistance to enable self-care, which had a protective factor on their wellbeing (Makama et al., 2023; Morawaska et al., 2018).

Formal services

Several studies highlighted the role of formal services in supporting parental and child wellbeing. In one study of fathers from a refugee background, the men described healthcare services as being an important source of help and advice, particularly around the health of their children (Bulford et al., 2022).

Similarly, in Lever Taylor and colleagues (2021), women who experienced perinatal mental health difficulties placed a high value on services that offered them continuity of care and tailored supports. Likewise, in Perkins and colleagues (2023), mothers reported the benefits of having therapists who were warm, non-judgemental and accepting.

Finally, in Morawaska and colleagues' (2018) study of prenatal and postnatal parents, family doctors were the most cited source of support.

Table 13: Other factors associated with positive outcomes from Australian studies

Author & Year	Population characteristics	Other protective factors
Bulford et al., 2022	21 men of refugee background, mean age 40 years (range 28–56), with children aged 0–5 years, living in Melbourne. Participants were from Syria, Afghanistan, Burma, Sierra Leone and Sri Lanka). Mean time in Australia was 5.5 years (range 1–15 years).	Fathers identified personal strategies for managing stress and looking after their own wellbeing. These included reading, listening to music, watching TV or a movie, meditation and gardening.
Case et al., 2018	55 mothers of children (newborn to 6 years) with craniofacial anomalies. All participants were in a relationship and aged 22–44 years (mean 32.31). 56% live in a household with income of $75k per annum or less and 55% had a diploma or degree qualification.	Spending time with children and family, going fishing, listening to music, playing sport, gardening and reading the bible were emphasised by women as ways of enacting self-care and enhancing their sense of wellbeing.
Hinz et al., 2024	11 young Australian women who gave birth to their first child between the ages of 15 and 23. Participants' age at the time of interview ranged from 20 to 25 years (mean 22.36).	Participants spoke of the importance of taking steps to protect their psychological wellbeing and promote positive psychological states. They emphasised the significance of allocating time for themselves and reconnecting with aspects of their identity that exist beyond motherhood. They also mentioned: being in nature, hobbies, connecting with friends, employment and education.

Author & Year	Population characteristics	Other protective factors
Makama et al., 2023	13 mothers with young children (5 years and under) located in Victoria. The mean age of participants was 37.1 years and more than two-thirds of participants (69%) were born overseas. Most participants were university graduates, 5 were in paid employment.	Findings demonstrated the need for practical assistance to enable self-care.
Morawaska et al., 2018	77 prenatal (76 mothers) and 123 postnatal (116 mothers) parents located in capital cities around Australia. Majority of the prenatal cohort were in their second trimester with a mean age of 29.47 years, for the postnatal group the mean parent age was 32.98 and mean child age was 12.3 months. Participants were generally well-educated, working and financially secure.	Postnatal parents were interested in parental self-care such as stress and conflict management.

Moderators and mediators

The research on factors that buffer the impacts of negative experiences/factors related to parents on child outcomes is emerging. Few included studies examined the influence of moderators and mediators[8] in buffering the impacts of negative experiences/factors (e.g. adverse childhood events) on child outcomes and parental wellbeing. Key findings from quantitative research are outlined below.

- Among children aged 3–4 years, positive home literacy activities can offset the negative impacts of watching screen media on developing vocabulary (Sundqvist et al., 2024).
- Parenting behaviours (e.g. breastfeeding, reading to children) and maternal health (e.g. general health status, smoking status, depressive symptoms) can mediate mothers' out-of-home residential care (OHC)[9] experience and their child's level of school readiness (Fitzsimons et al., 2025).
- Receipt of psychological treatment buffered the negative effect of maternal psychological distress on harsh parenting practices (Midouhas & Oliver, 2023).
- Positive maternal mental health (self-efficacy, self-esteem and enjoyment) moderated the influence of prenatal stress on children's internalising symptoms, with gender-specific protective factors emerging in the analysis (Claybourne et al., 2023). Specifically, maternal enjoyment buffered the association between prenatal maternal stress and boys' internalising symptoms, whereas maternal self-efficacy buffered the association between prenatal maternal stress and girls' internalising symptoms (Claybourne et al., 2023).
- Parental responsivity and supportive presence (parenting behaviour involving emotional warmth, sensitive reactions to their child's needs and child-centred interaction in emotion and play regulation) were key mediators in the relationship between level of family risk[10] and children's attachment security (Gerlach et al., 2022).

Discussion

This scoping review has identified and summarised a highly diverse body of literature that has explored protective factors for parent and child wellbeing in the early years of childhood. The review focused on research exploring the factors that support parents to meet the needs of their children. Therefore, child outcomes were only reported when studies examined both parent and child outcomes.

Collectively, the studies in this review highlight the various protective factors within the family environment that benefit parents and children, especially those associated with parent–child attachment, positive parenting (e.g. parental warmth, responsiveness and support) and family health.

Most studies were focused on general populations or families with parents (often mothers) experiencing mental health challenges or children with behavioural or developmental challenges. A small number of studies examined

8 A moderator is a variable or factor that affects the strength and direction of the relationship between 2 other variables. A mediator is a variable that explains the process through which 2 variables are related.

9 In this study, OHC refers to mothers who had spent time in a children's home or with foster parents, managed by either a local authority or voluntary society (Fitzsimon et al., 2025)

10 Family risk in this study is measured using a parent-report questionnaire that includes questions on distal (e.g. poverty, crowding, migration) and proximal (e.g. parental conflict, current depression, child's general health) risk factors. Participants are categorised as low, medium or high risk (Gerlach et al., 2022).

protective factors specifically for fathers and cohorts such as families from refugee backgrounds, Aboriginal and Torres Strait Islander families, families with children with disability and families experiencing disadvantage.

The period of infancy and early childhood is a critical time for programs and interventions and an opportunity for parents and families to access and engage with a range of supports. The research indicates that programs and interventions typically focus on promoting positive and nurturing parenting practices and supporting children's development and behaviours. They are generally of short duration, delivered in groups and mostly targeted at mothers.

Overall, research evidence indicates that programs and interventions for pregnant women, early intervention programs, parenting programs, parent wellbeing programs and parent-mediated interventions in the early years can be effective in improving a range of child, parent and family outcomes for both general and specific populations. The findings from this review confirm existing research in this area (Dahlberg et al., 2023; Izett et al., 2021; Jeong et al., 2021).

The volume and breadth of programs and interventions across the early years period recognises the importance of continuity of parenting support, tailored to specific developmental periods, to support parents and families from the antenatal period right through to preschool, prior to children starting school. It also suggests there is a wide variety of needs among families.

Research confirms that both targeted and universal programs have multiple benefits including increasing parenting knowledge, skills and confidence, developing positive and secure parent–child attachment and enhancing the parent–child relationship (Strawa, 2025). Studies also highlight that a single program or intervention can positively impact multiple outcomes for a single population (e.g. parenting knowledge, skills and mental health) as well as provide benefits for different populations (e.g. children and parents) (Bølstad et al., 2021; Eriksen et al., 2018; Irvine et el., 2021; Leckey et al., 2019).

The findings from the subset of studies that examined the relationships between protective factors and parent and child wellbeing underscore a multifaceted group of protective factors that contribute to positive outcomes for both parents and children. The included studies consistently highlight the potential protective nature of positive parenting practices in promoting positive parent and child outcomes.

Practices such as maternal warmth, structured routines, praise to the child and parental self-efficacy were linked to improved emotional, behavioural and cognitive development in children. Similarly, parental involvement in literacy activities and supportive behaviours such as shared book reading contributed to school readiness for children. It was also shown that providing guidance to parents can increase their parenting confidence and wellbeing that may then positively influence their interactions with their children.

Supportive relationships emerged as another critical theme. The findings demonstrated that strong familial bonds, cooperative parenting and partner support could buffer stress and reduce symptoms of depression and anxiety in parents. Fathers benefited from encouragement within their communities, while mothers valued respectful postnatal partner behaviours and shared responsibilities. These relational dynamics were shown to be essential in fostering emotional resilience and safeguarding mental health during early parenthood.

Family and social networks, formal services and self-care strategies further reinforced parental wellbeing. Access to health care, community belonging and culturally inclusive programs (especially for First Nations peoples and migrant families) were shown to have a protective effect on families. Continuity of care from services and care from empathetic professionals were both highly valued, while self-care practices such as music, sport and spiritual activities helped parents maintain psychological wellbeing and reconnect with their identities beyond parenthood.

Research on factors that buffer the impacts of negative experiences on child and parent outcomes is emerging. Nevertheless, the studies that focused on moderators and mediators collectively highlight the complex interplay of potential factors influencing child and parent outcomes. These factors may be at the individual child or parent level or at a broader level, such as with the home environment and social supports.

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