CORE CARE CONDITIONS FOR CHILDREN AND FAMILIES:

Implications for policy and practice

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The Centre for Community Child Health acknowledges the Traditional Owners of the land on which we work and pay our respect to Elders past, present and emerging.

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Executive summary

This Working Paper describes the core care conditions that young children, their parents / caregivers and their families need to flourish. Core care conditions are the key features of the social and physical environments in which young children and their families live that are important for optimal development and functioning.

The paper is intended for policymakers and practitioners who are designing and delivering services and supports to young children and their families. It seeks to broaden the scope of what such efforts involve, to go beyond the provision of services to include all the environmental features known to shape development and functioning. The paper seeks to identify these developmental circumstances or conditions so we can use them as a template for reconfiguring the early years environment to ensure that all young children and their families are provided with these conditions.

The paper begins by outlining the rationale for the approach adopted. Specifically, it addresses the following questions: Why focus on the core care conditions? Why focus on flourishing? Why focus on the early years? Why focus on parents / caregivers and families as well as children?

The main body of the paper lists the core care conditions for young children and families, and summarises the evidence that shows their significance for child and family development and functioning. The core care conditions are presented in three sections, focusing on the core care conditions needed by children, by their parents/caregivers, and those that are shared by both children and their parents/caregivers.

The final section of the paper begins by discussing several questions raised by the overview of core care conditions: How universal are these core care conditions? Are some core care conditions more important than others? Are the core care conditions discussed in the paper are just as important for children with developmental disabilities?

Next, five key takeaway points from the overview of child and family core care conditions are presented.

- The first is that the very earliest stages of development – from conception to the end of the second year – are critical. What happens during this period can have lifelong consequences for children's health and wellbeing.

- Second, child and family functioning are shaped by the conditions in which the families are living – their social and physical environments and their access to material basics. These conditions have a major influence on the capacity of the family to provide their children with appropriate nurturing care as well as safe and stimulating home learning environments.

- Third, the core care conditions have a cumulative synergistic impact – the more we can put in place, the greater the likelihood of positive outcomes. While the cumulative effects of experiencing multiple adverse conditions in early childhood have been well documented, the present paper focuses on the cumulative benefits of positive experiences and conditions.

- Fourth, an important part of the core care conditions for children and families is having access to a range of universal and tiered child and family services – universal services such as maternal and child health and child care services, and tiered services to address additional needs.

- Fifth, *all* young children and families should have their core care conditions met, not just those living in disadvantaged circumstances. As a society we should be focused on ensuring that all children are flourishing. This means focusing on the conditions they need in order to flourish. Poor developmental outcomes are as much a result of our failure to provide children and families with the positive conditions they need to flourish as they are of our failure to protect them from adverse experiences and conditions.

Finally, the paper explores a number of implications for action.

- First, all parents and caregivers need strong social support networks, and there should be a much greater emphasis on helping parents build connections with other parents and families.

- Second, an important part of the core care conditions for children and families is having access to a range of universal and tiered child and family services – universal services such as maternal and child health and child care services, and tiered services to address additional needs.

- Third, one way of ensuring that all families are well-supported socially and have access to the services they need is by establishing *integrated child and family centres or hubs*. Integrated child and family centres can act as a service hub for a range of

universal and specialist services, and can also function as a social hub, providing a safe space for parents and their children to meet other parents and children, and build social support networks.

- Finally, to ensure that all children and their families are flourishing, we need to ensure that they are provided with the core care conditions they need. This could take the form of a *universal early years guarantee* whereby every family of a newborn child would be guaranteed certain basic conditions and services A universal early years guarantee based on the core care conditions identified in this paper would be a major contribution to ensuring that all young children and their families have the opportunity to experience optimal health and wellbeing.

1. BACKGROUND

This Working Paper describes the core care conditions that young children, their parents / caregivers and their families need to flourish. ***Core care conditions are the key features of the social and physical environments in which young children and their families live that are known to be important for optimal development and functioning.***

The paper is intended for policymakers and practitioners who are designing and delivering services and supports to young children and their families. It seeks to broaden the scope of what such efforts involve, to go beyond the provision of services to include all the environmental features known to shape development and functioning. The paper seeks to identify these developmental circumstances or conditions so we can use them as a template for reconfiguring the early years environment to ensure that all young children and their families are provided with these conditions. *All* young children and families should have their core care conditions met. Ideally, these should form part of a *universal early years guarantee* whereby every family of a newborn child is guaranteed that the core care conditions they need to support optimal health and wellbeing are met.

The paper draws on a literature review conducted as part of the Better Start Project, a collaboration between Better Health Network and the Centre for Community Child Health (CCCH), with funding from the City of Port Phillip. The Project aimed to improve the health and development outcomes of children living in public housing in the City of Port Phillip, with a particular focus on the first 1000 days – the period from conception to the end of the child's second year.

To inform these efforts, CCCH conducted a review of the evidence regarding three questions: what is known about the core needs of parents and children during the first 1000 days; what is known about effective ways of engaging with and working with families experiencing vulnerability; and what services are known to be effective in meeting the needs of children and families experiencing vulnerability during the first 1000 days.

The present paper is an expanded extract from the full evidence review, and focuses on the core care conditions that young children, their caregivers and their families need to flourish. The paper also draws and updates previous evidence summaries conducted by the Centre for Community Child Health, including the following:

- Centre for Community Child Health (2010). *Engaging marginalised and vulnerable families* (CCCH Policy Brief No. 18).

- Centre for Community Child Health (2021). *From consumer to partner: Rethinking the parent/ practitioner relationship* (CCCH Policy Brief No. 32).

- Moore, T.G., Arefadib, N., Deery, A. and West, S. (2017*). The First Thousand Days: An Evidence Paper.*

- Moore, T.G. (2021a). *Core care conditions for children and families: Implications for integrated child and family services.*

- Moore, T.G. (2021b). *Developing holistic integrated early learning services for young children and families experiencing socio-economic vulnerability.*

- Moore, T.G. and Arefadib, N. (2022). *Tasmanian Play2learn+ Trial: Evidence Review.*

Outline

The paper begins by outlining the rationale for the approach adopted. Specifically, it addresses the following questions: Why focus on the core care conditions? Why focus on flourishing? Why focus on the early years? Why focus on parents / caregivers and families as well as children?

The paper then lists the core care conditions for young children and families, and summarises the evidence that shows their significance for child and family development and functioning. The core care conditions are presented in three sections, focusing on the core care conditions needed by children, by their parents/caregivers, and those that are shared by both children and their parents/caregivers.

The final section of the paper discusses several issues raised by the overview of core care conditions, highlights the key takeaway points, and concludes with implications for action. An Appendix shows how the core care conditions relate to ARACY's *The Nest* outcomes.

2. RATIONALE

This section outlines the rationale for the approach adopted in this paper. Specifically, it addresses the following questions: Why focus on the core care conditions? Why focus on flourishing? Why focus on the early years? Why focus on parents / caregivers and families as well as children?

2.1   Why focus on the core care conditions?

All human development is contextual (Bronfenbrenner, 1979, 1986, 1992,1993; Barrett et al., 2010; National Scientific Council on the Developing Child, 2023; Mayes & Lewis, 2012). Children's development is shaped by ongoing, reciprocal interactions between children's biology, their developing brains, and their physical and social contexts, with relationships as the key drivers (Cantor et al., 2019; Grace et al., 2016: Osher, 2020). These physical and social contexts constitute the social determinants that play a major role in shaping developmental and wellbeing outcomes. These social determinants have a greater impact on children's health and wellbeing outcomes than do the services they and their families receive.

Default approaches to addressing the challenges that some children and families experience have been treatment-oriented and service-driven rather than prevention-oriented and context-driven (Greenway & Loosemore, 2024; Littleton & Reader, 2022). When children develop mental health or behavioural or learning problems, we develop programs to address these problems. The programs are only ever moderately effective, are difficult to scale up, and never reach all the children who need them. Moreover, the problems continue to grow and many of the services designed to address are overwhelmed by the demand. Not nearly enough effort is put into addressing the conditions that have led to the problems in the first place. Early childhood and family support services can reduce some of the social disadvantages experienced by some families, but will never be enough to reduce early years inequities at a population level. Wholesale improvements in child and family outcomes will only come when the core care conditions that children and families need to flourish are met. This includes addressing inequalities in income and in home and other environments from the earliest possible age (Cattan et al., 2022; Marmot Review, 2010).

Existing child development frameworks (e.g. ARACY, 2014; WHO, UNICEF & World Bank Group, 2018) tend to confound *child outcomes* – children need to be healthy etc. – and the *conditions that children need* in order to achieve these desirable states. Focusing on outcomes leads to the development of strategies that directly address the outcomes. These can be useful – e.g.,

teaching children good dental health habits as a way of preventing tooth decay and promoting dental health. But these approaches are likely to be much less effective if the conditions under which the child and family are living do not provide healthy food – if the family experiences food insecurity, or if they live in areas experiencing disadvantage where there are few fresh food outlets and have to rely on cheap fast foods that contain high amounts of sugar. Focusing on these underlying conditions can be considered a *pre-prevention* approach; building healthy habits is a *prevention* approach; and providing remedial programs is a *treatment* approach. All these approaches are needed, but the current balance is wrong. All our efforts to improve outcomes by focusing on treatment approaches, even when these are supplemented by prevention programs, have not succeeded, and will not do so while the underlying causes of health and other inequities are not also addressed (Berkowitz, 2024; Lynch, 2017, 2020). We need to focus much more upon pre-prevention, ensuring that all children and families have the conditions they need to flourish. This paper seeks to identify those conditions.

2.2   Why focus on flourishing?

Much research has focused on the detrimental effects of adverse early experiences and the cumulative negative impact they have on children's long-term development and wellbeing (Anda et al., 2006; Asmussen et al., 2020; Bellis et al., 2019; Nelson & Gabard-Durnam, 2020). This paper focuses instead on the positive experiences and conditions, and seeks to identify the core care conditions that children and families need in order to flourish. The concept of flourishing (or thriving) is both ancient and modern. Aristotle distinguished between two classes of happiness, that derived from pleasure, *hedonia*, and that derived from a life of virtue and meaning, *eudaimonia*. The term eudaimonia describes the condition of human flourishing or of living well. In more recent times, flourishing has been a focus of the positive psychology movement and has applied to a wide range of topics, including physical health and health care (Lee & Mayor, 2023; Levin, 2021; VanderWeele et al., 2019, 2020), mental health (Keyes, 2002, 2024), education (Chaves, 2021; DeRuyter & Wolbert, 2020; Kern & Wehmeyer, 2021; Wolbert et al., 2017), disability (Eberl, 2022), and even as an overall goal of government and society (Bednar, 2023; Layard, 2022; Narvaez et al., 2016b). Ensuring that all children thrive is the vision underpinning Australia's *Early Years Strategy* (Australian Government, 2024) and the Australian Research Alliance for Children and Youth's *The Nest* (ARACY, 2014).

Flourishing is a broad concept, involving all aspects of wellbeing – emotional, psychological, physical and social wellbeing (Narvaez et al., 2016a; VanderWeele, 2017). As used in this

paper, flourishing is an objective wellbeing theory that seeks to describe objectively the conditions that people need to live well, rather than people's subjective evaluation what it means to live one's life well (DeRuyter & Wolbert, 2020). As applied to children, flourishing is both an end in itself (in that having a good childhood is valuable in its own right) as well as a means to an end (in that flourishing is a necessary precursor for positive functioning in adulthood) (Gheaus, 2014; Wolbert et al., 2021).

Flourishing is a state of being that results from optimal developmental circumstances that enable children and their caregivers to maximise their potential (Narvaez et al., 2016a). Modern societies often fail to provide these conditions and therefore undermine flourishing (Narvaez et al., 2013, 2016a, 2016b). This paper seeks to identify these developmental circumstances or conditions so we can use them as a template for reconfiguring the environment to ensure that all young children and their families are provided with these conditions.

2.3   Why focus on the early years?

The first 1000 days – the period from conception to the end of the second year – are critical for child development (Berry, 2017; CCCH, 2018; Darling et al., 2020; Karakochuk et al., 2017; Miguel et al., 2019; Moore et al., 2017). This is the period when we are most 'developmentally plastic', that is, most responsive to external influences (Ismail et al., 2017). These early exposures and experiences become 'biologically embedded' (Hertzman, 1999; Hertzman & Boyce, 2010), that is they change the infant's anatomical, biological and neurological processes in ways that have an impact on long-term adult health outcomes (Fox et al., 2010; Nelson, 2013; Nist, 2017). As a result, experiences and exposures during this period have a disproportionate influence on later health and development (Gluckman et al., 2015; Heindel & Vandenberg, 2015; Prescott, 2015). When considering the entire life course, it is early experiences, pre- and postnatally, together with individual genetic makeup, that have the greatest influence on the physical, mental, and cognitive development of the child (Halfon et al., 2018; NASEM, 2019a; National Scientific Council on the Developing Child, 2020).

Mother and child wellbeing are intimately connected during pregnancy and the first 12 months of the infant's life. The fetus and child directly experience the mother's life and are shaped by it. A mother's environmental experiences, physical health, and psychological distress affect her interactions with her infant, which in turn have physiological, neurological, and psychological consequences that extend far into the future (Conaboy, 2022; Jones, 2023; McKay, 2023; Orchard et al., 2023). Fathers and other caregivers are also changed in these

same ways in response to the experience of caring for infants and young children (Conaboy, 2022; Hrdy, 2024; Jones, 2023). There is also evidence of the positive influence of father engagement on their children's social, behavioural and psychological outcomes (Lamb, 2010; Sakardi et al., 2008; Yogman & Garfield, 2016).

Plasticity does not end after the first 1000 days. Important as the early years are, development is probabilistic rather than deterministic (Belsky et al., 2020; Curley & Champagne, 2016; Guyer et al., 2018; NASEM, 2019a; Sroufe, 2021; Sroufe et al., 2020): early exposures and experiences set children on developmental trajectories, but these can be altered if there are significant and sustained changes in the environments that have shaped their early development. Any improvements in these environments will increase the likelihood of positive developmental outcomes for children, but the more comprehensive these improvements are the greater the chances that children will flourish. Subsequent experiences and exposures during the second 1000 days (from 3 to 5 years), the third 1000 days (from 5 to 8 years) and beyond continue to shape development and wellbeing – but it becomes progressively harder to shift developmental trajectories with age. Part of the reason why early development is predictive of later development is that the environments that have shaped early development tend not to change (Moore, 2007). This highlights the need to provide children who have stressed or deprived early experiences with more caring and responsive environments as they grow.

2.4   Why focus on parents / caregivers and families as well as children?

Existing developmental frameworks focus on child outcomes and the conditions they need to develop well. There is less attention paid to parent and family outcomes, and the conditions that they need in order to thrive. But the capacity of parents / caregivers and families to provide children with the conditions they need to flourish depends upon whether their own needs are being met. As we shall see, this includes having strong social support networks as well as access to material basics.

The current support system for families is inadequate. It fails to ensure that all families have the support they need from others and access the services they need (Bibby & Deacon, 2020). To rectify this state of affairs, it is just as important that we identify the conditions that parents and families need to flourish, as it is to identify the conditions that children need in order to flourish.

3. CORE NEEDS OF CHILDREN AND FAMILIES

The evidence regarding the core care conditions is presented in three sections, focusing on the core care conditions needed by children, by their parents/caregivers, and by their families. As noted earlier, core care conditions are the key features of the social and physical environments in which young children and their families live that are known to be important for optimal development and functioning.

3.1 Core care conditions for children

There is a wealth of evidence now available regarding child development and the factors that shape development and learning and the core conditions that the children need to flourish. Several frameworks have been developed to capture these key factors. These include the *Nurturing Care Framework* (WHO, UNICEF & World Bank Group, 2018) and *The Nest* (ARACY, 2014). The *Nurturing Care Framework* identifies five core components that young children need to develop well: *good health*; *adequate nutrition; responsive caregiving; opportunities for early learning*; and *security and safety*. The Australian Research Alliance for Children and Youth's *The Nest* framework (ARACY, 2014) focuses on six wellbeing domains: *being loved and safe; having material basics; being healthy; learning; participating;* and *positive sense of culture and identity.*

Drawing on these frameworks and other research and analyses (e.g. Luby, 2024; Moore, 2021a), here is a list of **the core care conditions that children need to flourish.**

Children's core care conditions

- Secure relationships with primary caregivers able to provide the responsive caregiving needed to build secure attachments
- Support for developing emotional and self-regulation skills
- Positive early learning environments, in the home as well as in early childhood education and care (ECEC) and community settings
- Opportunities to mix with other children of different ages, and to build social skills
- Adequate and appropriate nutrition from conception onwards
- Support to establish regular sleep and health care patterns
- Physical opportunities to play and explore

- Protection from relationship and other stresses – abuse and neglect by caregivers, exposure to family or community violence

- **Secure relationships with primary caregivers able to provide the responsive caregiving needed to build secure attachments**. All the core care conditions are important for child development, but perhaps the most important is the development of secure relationships with caregivers (Axford et al., 2018; Britto et al., 2017; Curley & Champagne, 2016; Dykas & Cassidy, 2013; Garner et al., 2021; Gee & Cohodes, 2021; Luby, 2024; NASEM, 2019a, 2019b; NSCDC, 2004; Siegel, 2020). Attuned and responsive caregiving builds attachments and trains the infant's social brain (Atzil et al., 2018; Feldman, 2012a, 2012b). Positive relationships with caregivers are the building blocks for subsequent relationships and child outcomes (Atzil et al., 2018; Black et al., 2021; DePasquale & Gunnar, 2020; NASEM, 2019a, 2019b; Raby et al., 2015). The experience of physiological and behavioural synchrony experienced within early attachments during the critical period of gestation-to-weaning plays an important role in the individual's capacity to form friendships and engage in meaningful relationships throughout life (Feldman, 2012a, 2012b). Sensitive, nurturing care also buffers children from the negative effects of growing up in difficult circumstances such as poverty (DePasquale & Gunnar, 2020).

  There are several factors that may interfere with the development of secure attachments between infants and caregivers. The parent may find it difficult to be fully responsive to the child, either because of mental health issues (e.g., post-natal depression, a history of traumatic experiences) or a compromised attachment history of their own. The parents may also be preoccupied by stressful family circumstances (e.g., housing or financial insecurity, family violence). The child may also be difficult to engage, for example, being slow to respond because of developmental issues.

- **Support for developing emotional and self-regulation skills.** The development of emotional self-regulation and executive regulation are the key developmental foundations upon which much later development and learning depends (NASEM, 2019a, 2019b). These skills are learned by infants and toddlers, and are co-regulated by trusted caregivers (Centre on the Developing Child, 2016b; DePasquale & Gunnar, 2020; Gee & Cohodes, 2021; Zeifman, 2013). *Self-regulation* helps us to draw on the right skills at the right time, respond effectively to the world around us, and resist inappropriate responses.

Executive function includes the ability to focus and sustain attention, set goals, follow rules, solve problems, and delay gratification.

Acquiring self-regulatory skills, including self-control and planning, is made more difficult for children experiencing unstable and chaotic environments, especially in children from birth to three years (Doan & Evans, 2020). Many children, especially those from lower-income families, face considerable instability early in their lives. This may include changes in family structure, irregular family routines, frequent moves, fluctuating daycare arrangements, and noisy, crowded, or generally chaotic environments. Parents facing unpredictable events and unreliable circumstances may find it hard to adapt and be less able to provide the sensitive, nurturing care that their children need (Doan & Evans, 2020).

- **Positive early learning environments, in the home as well as in ECEC and community settings.** Home learning environments play a profoundly important role in the development of young children (Axford et al., 2018; Melhuish, 2010, 2015; Phillips & Lowenstein, 2011; Shuey & Kankaraš, 2018; Yu & Daraganova, 2015). A positive home learning environment has benefits for children's cognitive, social and physical development over and above the effect of socio-demographic factors such as parent education and family income (Axford et al., 2018). When children are provided with a range of learning opportunities in the home, their cognitive, language and social development all improve (Fox et al., 2015; Heckman & Mosso, 2014; Melhuish, 2015; Shuey & Kankaraš, 2018). The home learning environment can have up to twice the effect of early childhood programs, which limits the extent to which even high quality early childhood services can compensate for inadequacies in the child's home learning environment (Melhuish, 2015). Children from advantaged homes typically receive more enriched home learning, are read to more, hear more words, have more books and are taken on more out-of-home activities, whereas children in chaotic households or experiencing high levels of risk have poorer outcomes and receive poorer quality home learning (Axford et al., 2018; Shuey & Kankaraš, 2018; Yu & Daraganova, 2015)

- **Opportunities to mix with other children of different ages, and to build social skills.** As children grow, they need exposure to a range of other caregivers, families and children. While attachments to their parents are primary, young children can also benefit significantly from relationships with other responsive caregivers both within and outside the family (Centre on the Developing Child, 2016b). Close relationships with other nurturing and reliably available adults do not interfere with the strength of a young child's

primary relationship with his or her parents. In fact, multiple caregivers can promote young children's social and emotional development.

ECEC services are an important source of opportunities to mix with other children of different ages, and to build social skills. However, the quality of these services matter: frequent disruptions in care and high staff turnover and poor-quality interactions in early childhood program settings can undermine children's ability to establish secure expectations about whether and how their needs will be met.

The cost of ECEC services is a barrier for some families, stopping them from using them at all or limiting them to fewer hours than they would like (KPMG, 2020; Thorpe & Staton, 2019). In 2018, low-income families were spending nearly twice the proportion of their weekly income on ECEC as high-income families (Productivity Commission, 2019). A lack of access to affordable child care that meets their family's needs is cited by mothers as a key reason for not being employed in the capacity they wish to be (ABS, 2017b).

- **Adequate and appropriate nutrition from conception onwards.** Early life nutrition in the fetus, infant and young child can have profound effects on long-term health (Davies et al., 2016; Schanzenbach & Thorn, 2020; Scott, 2020), as well as being related to behavioural and emotional problems in later childhood (Jacka et al., 2013). Recommended postnatal nutrition takes the form of exclusive breastfeeding (from immediately after birth to the age of 6 months), followed by the introduction of complementary foods that are frequent and diverse enough, and which contain the micronutrients they need for the rapid growth of their body and brain (Luby, 2024; NASEM, 2020a; WHO, UNICEF & World Bank, 2018). Babies who are not breastfed, and women who do not breastfeed, are at an increased chance of many health risks in both the short and long term (Smith et al., 2018). However, socio-economically marginalised populations are less likely to initiate and sustain breastfeeding than their peers and face significant barriers to doing so (Axford et al., 2018). Children from poorer backgrounds are less likely to have been breastfed and also less likely to eat fruit or have breakfast every day, which is important given evidence that breakfast contributes to better behaviour and cognitive performance in school. Only a small proportion of young Australian children have diets that meet national guidelines for eating vegetables and avoiding junk food (Spence et al., 2018). Food safety and family food security are also important issues (NASEM, 2020a; WHO, UNICEF & World Bank, 2018). Low-income families are more likely to buy cheaper and less nutritious food owing to a lack of money and limited access to shops selling healthy food (Axford et al., 2018). Food insecurity can have serious

developmental consequences for children, including compromised mental and physical health and poor academic performance (Fiese et al., 2011).

The first 1000 days is critical for the development of a healthy microbiome, especially the gut microbiome (Giles & Couper, 2020; Moore et al., 2017; Wopereis et al., 2014). Just as the human epigenome is developmentally programmed by the early environment, so too is the human microbiome (Logan et al., 2016). Children reach a mature microbiome by the second or third year of life, and the unique composition established tends to persist for life. Because of the intricate two-way connections between the gut microbiota, the brain and the immune system, the gut microbiome has an effect on both physical and mental health throughout our lives (Blaser, 2014; Collen, 2015; Dietert, 2016; Mayer, 2016).

- **Support to establish regular sleep and health care patterns.** Sleep is a major factor in a child's overall development. Sleep, of good quality and of sufficient duration, is a cornerstone of normal physical, cognitive, language and emotional development (Petit & Montplaisir, 2012). While short-term sleeping problems in young children are common (Hiscock et al., 2007; Hiscock & Davey, 2012; Petit & Montplaisir, 2012), unresolved problems are associated with poorer child health-related quality of life, more behaviour problems, and higher rates of attention-deficit/hyperactivity disorder (Hiscock et al., 2007; Quach et al., 2018) and can have adverse effects on socioemotional development and language development (Petit & Montplaisir, 2012). Resolving sleep problems early (Hiscock & Fisher, 2014; Petit & Montplaisir, 2012) and establishing regular sleep patterns (Luby et al., 2024) are key elements of the core care conditions in the early years.

  Establishing good health care practices is also important. Young children's good health is the result of caregivers who monitor their children's physical and emotional condition, have hygiene practices which minimise infections, make use of promotive and preventive health services, and seek care and appropriate treatment for children's illnesses (ARACY, 2014; WHO, UNICEF & World Bank, 2018). Establishing good oral and oral care practices early is critical. Poor oral health is health is essential to overall health and wellbeing (Goldfeld et al., 2024) and is associated with increased risk of chronic disease later in life, including stroke and cardiovascular disease (AIHW 2019). Children with poor oral health are also more likely to miss school and perform poorly in school (Jackson et al., 2011).

- **Physical opportunities to play and explore.** Young children need opportunities to play and be physically active. Increased physical activity is associated with better physical health (including reduced obesity) and motor and cognitive development (Axford et al.,

2018; Bradley, 2015; Carson et al., 2017; Lieberman, D., 2013), while the decline in opportunities to play has been associated with a rise in mental health problems in children and young people (Gray, 2011). Play functions as a major means by which children develop their interests and competencies, learn how to solve problems and exert self-control, and make friends and learn to get along with others (Gray, 2011). Play in which children take the lead and make personal choices is essential for supporting children's cognitive, social, emotional and physical development and learning in their early years and beyond (Axford et al., 2018; Gopnick, 2016). Having safe environments for children is a high priority for parents, particularly those living in disadvantaged circumstances (including public housing environments) (Winkworth et al., 2009).

- **Protection from relationship and other stresses.** Early developmental plasticity is a double-edged sword: the fetus and infant are more susceptible to both positive and negative experiences. If the conditions are positive, children will thrive, but exposure to adverse experiences in utero and early in life can lead to accelerated ageing (Rentscher et al., 2020) and can be damaging for long-term development and learning (Allen & Donkin, 2015; Asmussen et al., 2020; Bellis et al., 2019; Friedman et al., 2015; Guinosso et al., 2016; Hughes et al., 2017; Quach et al., 2017; Nelson, 2018; O'Hare et al, 2023; Shonkoff et al., 2012, 2021;Teicher & Samson, 2016). Child maltreatment, particularly emotional abuse and neglect, is associated with a wide range of long-term adverse health and developmental outcomes (Nemeroff, 2016; Strathearn et al, 2020; Teicher & Samson, 2016) that can affect adult functioning, including parenting. While such experiences are present across all levels of society, children growing up in disadvantaged areas and in poverty are more likely to be exposed to adverse experiences compared to their more advantaged peers (Allen & Donkin, 2015).

Exposure to domestic and family violence is another major source of stress which affects children's physical and mental wellbeing, development and schooling, and is the leading cause of children's homelessness in Australia. Significant numbers of Australian children are exposed to domestic and family violence. Children who grow up in families where domestic and family violence occur are also more likely to experience other forms of child abuse, such as sexual, physical and emotional abuse/maltreatment (Campo, 2015). A framework for the primary prevention of violence against women and their children has been developed by Our Watch, ANROWS and VicHealth (2015), while advice on how to work with families affected by domestic and family violence has been provided by the Child and Youth Protection Services (2020).

Exposure to multiple adverse experiences in childhood has a cumulative effect that increases the likelihood of adult physical and mental health problems (Allen & Donkin, 2015; Gondek et al., 2021; Guinosso et al, 2016; Nelson, 2018; O'Hare et al., 2023; Oral et al., 2016). Children growing up in disadvantaged areas and in poverty are more likely to experience co-occurring adverse experiences (Allen & Donkin, 2015).

3.2 Core care conditions for parents and caregivers

Families are on a developmental journey, just as much as children are. The arrival of a child alters the environment in which they are living and the demands made upon them. New parents undergo major neurobiological changes, driven by hormones and the deluge of stimuli a baby provides (Conaboy, 2023; Feldman, 2012a, 2012b; Jones, 2023; McKay, 2023; Orchard et al., 2023). These neurobiological changes affect all parents, not just the mother, to adapt in those intense first days and prepare for a long period of learning how to meet their child's needs. Pregnancy itself leads to long-lasting changes in the mother's brain structure (Hoekzema et al., 2017). All highly involved parents, no matter their path to parenthood, show similar changes in brain circuitry and are capable of providing the kind of responsive caregiving that very young children need (Conaboy, 2022).

There are many factors that shape parental and family functioning during the first 1000 days. The child is an active player in this environment, and shapes the parents at the same time as being shaped by the parents. The parents' own histories of being cared for provide them with a model of how to care for their infant. Those whose own childhoods were compromised by neglect, abuse or caregiving disruptions may find it challenging to provide their infants with the responsive caregiving the children need. But the main factors shaping parental and family functioning during this period are the conditions in which they are living and the resources they have to draw on.

The conditions under which families are raising their children shape the parents' capacity to provide children with the conditions that they (the children) need to flourish. These conditions have altered significantly over the past half century (Friedman, 2016; Hertz, 2020; Keeley, 2015; Leigh, 2010; Li et al., 2008; Putnam, 2015; Silbereisen & Che, 2010; Trask, 2010; Wells, 2021). These changes have altered the structure and diversity of families (Golombok, 2015; Trask, 2010; Parke, 2013; Walsh, 2012), and the nature of the communities in which they live (Leigh, 2010). These changes have occurred at such unprecedented speed that our social support and service systems have struggled to adapt. As

a result, families with young children can find themselves without the social supports, material basics and access to services that they need to be able to fulfil their parenting role as effectively as they could.

Children's wellbeing is closely linked to and dependent upon the wellbeing of their parents. Mother and child wellbeing are intimately connected during pregnancy and the first 12 months of the infant's life (O'Sullivan & Monk, 2020). In the womb, the fetus and child directly experience the mother's life and are shaped by it (Gluckman & Hanson, 2004; Moore et al., 2017; Paul, 2010). After birth, a mother's environmental experiences, physical health, and level of psychological distress affect her interactions with her infant, which in turn have physiological, neurological, and psychological consequences that extend far into the future. The physical and psychological toll of environmental experiences such as poverty, trauma, pollution, lack of access to good nutrition, and systemic disadvantage is transmitted from mother to child, thus impairing fetal and infant neurobiological and emotional development (O'Sullivan & Monk, 2020).

The ability of families to provide the nurturing care their children needs depends upon the nurturing care they themselves receive. As we have seen, children have needs in their own right, but so do their parents / caregivers. Some of these needs are common to both but are met in different ways. For example, parents need responsive caregiving just as much as children, but the child usually gets this, initially at least, from their core caregivers, while parents usually get it from their own extended family and from social support networks (Bronfenbrenner, 1979; Dunst, 2022). To guide our efforts to support families of young children more effectively, we need to identify the core care conditions that families need as well as those their children need.

So what conditions do parents and families need in order to meet their children's needs? Various roadmaps and frameworks for supporting families have been developed, including those by Centre on the Developing Child (2017), Braveman et al., (2018), NASEM (2019a), and Ulferts (2020). The following list draws on these frameworks and other research (Moore, 2021a).

Parental / caregiver needs

- Positive social support networks (including support from family, friends, fellow parents and neighbours)

- Safe and easily accessible places to meet other families

- Secure time to build relationship with the newborn (paid maternity/paternity leave)

- Access to relationally-based family-centred services

- Access to universal services during antenatal / perinatal / postnatal periods

- Access to specialist support services to address additional personal needs (e.g. mental health issues, relational violence)

- Information about child care and development , and support for managing the challenges of parenting

- Availability of learning opportunities to build personal capabilities

- Inclusiveness of the immediate social environment – absence of racism or discrimination

- Employment opportunities and family-friendly employment conditions

- **Positive social support networks (including support from family, friends, fellow parents and neighbours).** Positive personal relationships and social networks are a critical aspect of the social conditions in which we live. We are biologically wired to connect with others (Christakis, 2019; Lieberman, 2013). The need to belong and to connect deeply with other people is a fundamental human need that all people seek to satisfy (Allen et al., 2021). Our health and wellbeing are shaped by the quality and extent of our close personal relationships, our wider social networks, and even the general level of civility in the wider society (Barnes et al., 2006; Dunbar, 2021; Edwards & Bromfield, 2009; Farmer et al., 2018; Hawkley & Cacioppo, 2013; Hertz, 2020; Holt-Lunstad, 2018, 2022: Pinker, 2015; Popkin et al., 2010). Loneliness, social isolation and threats to social safety are major contributors to mental health, physical health, and social problems (Cacioppo & Patrick, 2008; Hawkley & Cacioppo, 2013; Hertz, 2020; Slavich, 2020), and even contribute to accelerated biological ageing (Rentscher et al., 2020).

The radical changes in social environments that have occurred over the last half century or so have made loneliness and social isolation more likely (Leigh, 201; Hertz, 2020). There is strong evidence that loneliness affects some groups in society more than others and is particularly acute for those who face multiple forms of disadvantage (Baretto et al., 2023). The more isolated and lonely people are, the less likely they are to be tolerant or accepting of others whom they perceive as different, which makes them less accepting of inclusion policies and practices (Hertz, 2020). Positive social support, on the other hand, promotes more tolerant and inclusive community environments.

Positive social support also has many beneficial effects on parenting. Support during pregnancy reduces the likelihood of maternal stress, depression and risk-taking behaviours during and after pregnancy (Kawachi & Berkman, 2001; Rini et al., 2006). Social connection and social support have a positive effect on parental care-giving capacity by promoting positive mental health and resilience during challenging periods (Green et al., 2007; Palamaro Munsell et al., 2012) and by providing peer advice, support, and connections to other resources (Plesko et al., 2021). Importantly, positive social support reduces the likelihood of child maltreatment, especially for those families experiencing multiple challenges (such as poverty, depression, unemployment) (Bishop & Leadbeater, 1999; MacLeod & Nelson, 2000). The more adverse a person's circumstance and the fewer resources they have, the more important it is for them to have secure supportive relationships with one or more people in their lives (Plesko et al., 2021; Ungar, 2013; Ungar et al., 2013). Single parents can be particularly vulnerable and place a high value on having 'someone to check in on me' (Winkworth et al., 2010).

For parents living in communities affected by poverty, low levels of social connection may be an unintended consequence of parents' efforts to protect their children by distancing themselves from others (Plesko et al., 2021). Efforts to meet the needs of these families facing multiple challenges have usually taken the form of providing support services rather than providing them with opportunities to meet and build positive social networks with other families. However, the evidence strongly suggests that building such networks should be a high priority (NASEM, 2019a; Ulferts, 2020) and would be highly valued by parents (Phillips et al., 2021; Winkworth et al., 2009). Just as children depend upon the nurturing care they receive from parents, so the parents' capacity to provide their children with nurturing care is in turn shaped by the nurturing care they receive from others.

Positive social support involves both emotional support and practical support. In many cultures, practical support takes the form of shared parenting. It is clear from

anthropological evidence that shared parenting (known as alloparenting) is the norm worldwide, and that the Western model of child rearing in nuclear families is an anomaly (Hrdy, 2009; Konner 2011; Lancy, 2022; Nelson, 2020). To broaden the parenting support for families, Bibby and Deacon (2020) advocate what they call parent-powered approaches – models of family support that harness the skills, experiences, and knowledge of parents, carers, and the wider community – to better support families and ultimately improve the life chances of children.

- **Safe and easily accessible places to meet other families.** The early childhood environment for families of infants and preschool children often lacks certain key features that are essential for the effective family functioning – especially places within the community where parents can go where they can meet other families and get access to relevant services (Goldfeld et al., 2018). Instead services are delivered from different sites, and often do not provide places or activities for families and children to meet and socialise. Families of young children can be left with few or no suitable places which they can easily reach, and therefore are at greater risk of social isolation and of not accessing child and family support services.

Having safe and family-friendly places to connect with other families is important for building social support networks for families. The peer group learning that occurs between parents who meet regularly can help parents develop their knowledge and parenting skills (Melhuish, 2015). These networks can also help families to access family and/or early intervention services (Kang, 2012). Without adequate social networks, the opportunity to be 'introduced' to services may be limited (McArthur & Winkworth, 2017; Winkworth et al., 2010a, 2010b).

Various Australian initiatives are underway to explore ways of establishing safe community-based places for families. *Child and family hubs* are one option for meeting family needs for safe places to access services in one place (Honisett et al., 2022a, 2022b, 2023). Another way of providing families with places to meet other families and connect with services are *integrated child and family centres* (Graham & Sydenham, 2023; Moore, 2021b; Social Ventures Australia, 2023). An established model that has demonstrated the value of having child and family services in one location is the Our Place model (https://ourplace.org.au). Based on the original Doveton College model, the Our Place initiative uses the universal platform of schools as a single location where children and families could access high-quality education, including early childhood education, as well as services which could support the entire community to overcome barriers to positive

educational and wellbeing outcomes. Early learning, as well as health and wellbeing services for children and families, and adult participation in education and employment services, are all integrated through a single-entry point and a co-designed service model ((Glover, 2020; McKenzie, 2019; McLoughlin et al., 2020; Newman et al., 2022).

- **Secure time to build relationship with the newborn (paid maternity/paternity leave).** The evidence suggests that paid parental leave can contribute to infants' healthy development and survival by facilitating breastfeeding, by enhancing parents' ability to obtain immunisations and other medical care in the postnatal period. (Earle & Heymann, 2019). Longer periods of maternal leave reduce infant mortality rates. Studies also find that paid parental leave benefits families' economic wellbeing (Earle & Heymann, 2019).

  Paid parental leave represents an underutilised tool to improve societal wellbeing and prosperity (Malamitsi-Puchner et al., 2023). The adequacy of Australia's parental leave policies has been questioned (KPMG, 2021; Ramoso & Hill, 2021). Ramoso and Hill (2023) have compared parental leave in Australia, Canada, Germany and Sweden, and call for urgent improvement in parental leave policies in Australia to address issues of gender inequality, workforce participation, and child and parental health.

- **Access to relationally-based family-centred services.** All parents and caregivers need access to dedicated child and family facilities (Goldfeld et al., 2018). These services need to be relationally-based, that is, have the ability to engage and establish positive, non-judgmental relationships with parents, regardless of their backgrounds, characteristics or circumstances (Carbone et al., 2004; Centre for Community Child Health, 2010, 2021). Families want to feel seen, heard and appreciated (Phillips et al., 2021), and formal services can be important sources of social support if they are respectful, flexible and honest (Winkworth et al., 2009). Although formal services cannot and should not replace family or informal support, there is potential for services to work with and build the capacity of these informal networks (Katz, 2007).

- **Access to universal services during antenatal / perinatal / postnatal periods.** Having ready access to core health services – antenatal services, maternal and child health services, paediatric services, dental services – is essential for all families (ARACY, 2014; Dalziel et al., 2018; Goldfeld et al., 2018; WHO, UNICEF & World Bank, 2018). Australian evidence indicates that suggest that children from low-income or single-parent families may require additional support services during the first two years of life and that maintaining or increasing access to free or very low-cost primary health-care services for

disadvantaged families will promote equity in health (Hayes et al., 2018). However, an inverse care law applies, so that those in most need of these services are the least likely to access them (Eapen et al., 2017). Young children who are developmentally vulnerable and socioeconomically disadvantaged are less likely to access health services than their non-disadvantaged peers (Woolfenden et al., 2020).

Barriers to families accessing universal child and family services include service (or structural) barriers (e.g. not knowing about the services available, not being able to get to the services easily, rigid eligibility criteria), family barriers (e.g. limited income, lack of social support, unstable housing or homelessness), and interpersonal or relational barriers (e.g. insensitive or judgmental attitudes and behaviours of service providers, parents' lack of trust in services, fear of child protection services, or lack of the social skills and confidence to negotiate with professionals) (Centre for Community Child Health, 2010).

The lack of continuity in the services provided can reduce their effectiveness. In Australia, antenatal, perinatal and postnatal supports for parents are usually provided by separate services, rather than a single integrated service. Home visiting programs that begin during pregnancy and continue during the first 1000 days can overcome this problem and have shown to improve parenting and the home learning environment for families experiencing adversity (Goldfeld et al, 2019, 2022).

- **Access to specialist support services to address additional personal needs (e.g. mental health issues, relational violence).** In addition to the universal child and family services that all families should be receiving, there is a need for second and third tier services to meet families' additional needs. These include: parenting challenges and relationship problems; mental health and physical health issues; housing, financial and legal problems; parental or child disabilities; language and citizenship issues. To ensure that those with unique and/or additional needs are not neglected, universal services must be able to offer differential support according to increasing levels of need (Carey et al., 2015; Child Family Community Australia, 2014; Division for Early Childhood, 2021; Dodge, 2020; Higgins & Dean, 2020; NASEM, 2019; Oberklaid et al., 2013). This is known as *progressive* or *proportionate universalism* (Barlow et al., 2010; Feinstein et al., 2008; Goldfeld, 2020; Human Early Learning Partnership, 2011; Marmot Review, 2010; NHS Health Scotland, 2014; Statham & Smith, 2010). In this approach, services are universally available, not only for the most disadvantaged, but additional services are available for those in greater need. Australian evidence suggests that income-related inequalities exist

in government Medicare, spending particularly in the first few years of life, with children from lower income families receiving less specialist care spending (Dalziel et al., 2018).

- **Information about child care and development, and support for managing the challenges of parenting.** The most commonly reported needs of parents and carers are for advice and emotional support, which may be met without referral to specialist services or the need for parenting programs (O'Mara et al., 2011). However, parenting programs are another way of providing support for families managing the challenges of parenting. Recent reviews of parenting programs have been reported by Axford et al., (2018), Barlow and Coren (2017), Gadsen et al., (2016), Jeong et al., (2018, 2021), NHMRC (2017), O'Mara et al., (2011), Peacock-Chambers et al., (2017) and Newham et al., (2020). The focus of programs can vary, with some focusing on promoting responsive caregiving, and others on supporting early learning. Overall, the effects of parenting programs are relatively modest and the quality of much of the research is low (Jeong et al., 2018; Peacock-Chambers et al., 2018). Those that have been shown to be effective include programs to promote responsive caregiving interventions during the first three years of life (Axford et al., 2018; Barlow & Coren, 2017; Jeong et al., 2018, 2021; Peacock-Chambers et al., 2017). Group parenting programs can also play a role in promoting positive parenting (Axford et al., 2018; Donelan-McCall, 2017; Mihelic et al., 2017; Moran et al., 2004; Trivette & Dunst, 2014).

  No parenting program is equally effective with all groups within the community. Parents' beliefs, needs, and resources are so diverse that a menu of approaches needs to be available (Gadsen et al., 2016). Parents who are highly disadvantaged or from CALD backgrounds are not comfortable with many of the available programs. Interventions are more likely to be effective when they are informed by the views of parents, especially for families having difficulties accessing or engaging with services (O'Mara et al., 2011). For these parents, programs such as the *Empowering Parents Empowering Communities* (EPEC) (Day et al., 2012a, 2012b; Prichard, 2018; Winter, 2013) are more engaging and effective. EPEC differs from most other programs in that it is peer-led rather than being facilitated by practitioners.

- **Availability of learning opportunities to build personal capabilities.** Wellbeing is shaped by having the opportunity to participate meaningfully and make valuable contributions to social life (Nussbaum, 2011; Sen, 1985, 2005). Feeling disempowered by lack of opportunities and inequalities can have profound negative effects on physical and mental health (Wilkinson & Pickett, 2018). Just as children need opportunities to learn

and participate, so do parents. This can take the form of opportunities for parents to develop employment and other skills. It can also take the form of opportunities to participate in decisions about the services they receive.

Some family hub models offer parents opportunities to develop skills and gain qualifications. The Doveton College / Our Place model described earlier offers free access to a variety of programs designed to support adults as parents and learners, including parenting programs, as well as activities that promote personal growth. Adults can also take advantage of work and learning opportunities, and connect with organisations and job network providers to assist them in returning to work or study (McKenzie, 2019).

- **Inclusiveness of the immediate social environment – absence of racism or discrimination.** Supportive and inclusive communities play a vital role in creating positive conditions for families of young children. Key qualities that make communities supportive include social capital, level of community trust and sense of safety; acceptance of those from different backgrounds, with no exclusion or rejection on the basis of race or religion or sexual orientation or disability (Goldfeld et al., 2018).

  Racism and racial discrimination are fundamental causes and determinants of health and health inequalities globally (Priest et al., 2020). Racism can take different forms - institutional/structural racism, cultural racism, and interpersonal discrimination (Shonkoff et al., 2021). Institutional / structural racism that is built into institutions, policies, and practices constrain parents' ability to provide healthy living conditions for their children, and affect children's health (Braveman et al., 2018; Michaels et al., 2023; Priest et al., 2020; Shonkoff et al., 2021). The health consequences of toxic living conditions, including exposure to the various forms of racism, can accumulate across lifetimes and generations (Gee et al., 2012; Shonkoff et al., 2021). Children and young people are particularly vulnerable to racism's harms, and can suffer the effects of racism experienced by their parents years or even decades previously.

- **Employment opportunities and family-friendly employment conditions.** Parental employment opportunities are beneficial in a number of ways, bringing in a regular income that allows them to provide for the children better, and giving the parent a sense of contributing. Children in jobless families were more likely to suffer stress and deprivation than children in families where an adult works. They are more than four times more likely to be homeless, nearly twice as likely to be bullied or face social exclusion,

and almost two and a half times more likely to be missing out on learning at home (Sollis, 2019).

Family-friendly work conditions are also important. The benefits of parental employment can be undermined by employment conditions that do not allow for family commitments and involve unpredictable work times, long hours or evening and night shifts. The stress that parents bring home from their jobs can detract from their parenting skills, undermine the atmosphere in the home, and thereby introduce stress into children's lives (Heinrich, 2014). Low-income parents who are most likely to work in stressful, low-quality jobs that feature low pay, little autonomy, inflexible hours, and few or no benefits.

3.3   Shared core care conditions for children and families

Children and families also have shared needs. These relate to material basics and the world around the family. Before we explore these in detail, there are some important points to note.

The health and wellbeing of children, parents and families are strongly shaped by the social, economic and environmental conditions into which they are born and grow (Allen et al., 2014; Braveman et al., 2011; Etzel, 2020; Lovell & Bibby, 2018; Marmot & Wilkinson, 2006; Moore et al., 2015, 2017; Pillas et al., 2014; Ratcliff, 2017; Shuey & Kankaraš, 2018; Spencer, 2018; Tarazi et al., 2016; WHO Commission on the Social Determinants of Health, 2008). These conditions, known as the *social determinants of health*, ultimately work through biological pathways to shape our health and wellbeing (Geronimus, 2023; Kelly-Irving, 2019). A range of social determinants – neighbourhood deprivation, lower parental income/wealth, lower educational attainment, lower occupational social class, parental unemployment, higher parental job strain/heavy physical occupational demands, lack of housing tenure, and material deprivation in the household – are all independently associated with a wide range of adverse health and developmental outcomes in early childhood (Pillas et al., 2014).

These conditions have a greater impact on their health and development than the health and other services they receive (Braveman & Gottlieb, 2014; CCCH, 2018; Moore, 2021a; Moore et al., 2017; Prevention Institute, 2019). This is especially true for those living in the most challenging circumstances, including families with young children. Finding ways of improving the conditions under which such families are raising their children must become a major goal for communities and service systems (Moore, 2021a; Ratliff, 2017).

The conditions under which families are raising young children vary greatly, resulting in many economic, social and health inequities. Inequities are preventable differences in health and wellbeing outcomes between those who are economically or socially disadvantaged and those who are better off (Braveman, 2006, 2014). In Australia, there is a wide gulf between the incomes of those with the lowest and those with the highest incomes, and this gap has grown wider over the last 20 years or so (Davidson et al., 2020b). This means that Australia's continued prosperity has not been shared equally among families. While most families have benefited from economic and social change, those with fewer resources have not, and are struggling to cope with the demands of parenting in a rapidly changing world. A report on the state of Australia's mothers (Save the Children, 2016) found that where mothers lived, their cultural background and their economic resources helped determine their health and wellbeing. Mothers living in rural areas, mothers who are Aboriginal or Torres Strait Islander, and mothers in lower socio-economic households are generally worse off across all indicators examined, including health (maternal mortality, child mortality, antenatal care), education (child development, women's education), income (average household income) and relative socio-economic disadvantage.

As a result, there are significant inequities in children's health, development and wellbeing (Goldfeld et al., 2018a, 2019, 2021; Keeley, 2015; Marmot, 2015, 2016; Sollis, 2019). Maternal and child health inequities emerge even before birth (Keating et al., 2020). These inequities follow social gradients: the more disadvantaged one's circumstances, the worse one's long-term health and wellbeing outcomes are likely to be (Adler & Stewart, 2010). Social gradients represent more than just disparities between the poor and the wealthy, but are continuous: at any given point along the socioeconomic continuum, one is likely to experience inferior health outcomes to those above them (Marmot & Wilkinson, 2006). For children, it is the circumstances in which they live, learn and develop that drive differential health and developmental outcomes: the more disadvantaged their circumstances, the poorer their health and developmental outcomes (Cattan et al., 2022; Goldfeld et al., 2018a).

These inequities in health, development and wellbeing are evident from birth, and, despite overall improvements in health outcomes, continue to grow as children grow (Berry, 2017). Gaps in both cognitive and noncognitive skills between children from advantaged and disadvantaged backgrounds open up in infancy, and widen progressively in the preschool years (Cattan et al., 2022; Heckman & Mosso, 2014; Prior et al., 2011). There are strong differences by family income in the cognitive and socio-emotional development of children at age 3. This 'income gradient' in early development is almost entirely explained by differences in early environments (Cattan et al., 2022). These disparities compromise future education,

employment and opportunities (Brinkman et al., 2012; Goldfeld et al., 2018a, 2021; Heckman & Mosso, 2014; Woolfenden et al., 2013).

Analyses of Australian Early Development Census (AEDC) results clearly reveal social gradient effects. Brinkman and colleagues (2020) summarise research that has explored developmental vulnerability in relation to community and family level socio-economic measures in Australia. Using the Australian Bureau of Statistics (ABS) Socio-Economic Indices for Areas (SEIFA) measures, often used as indicators of the social disadvantage in Australian communities, they found that, across each of the five AEDC collections (2009, 2012, 2015, 2018, 2021), a clear gradient of socioeconomic inequality is evident in child development outcomes for communities. That is, in communities with fewer socio-economic resources (categorised by lower SEIFA quintiles), the percentage of children with developmental vulnerabilities tends to be higher than in more affluent communities (categorised by higher SEIFA quintiles).

With these general points in mind, we will now consider *the core care conditions that children and families share* and that need to be met if they are to flourish.

Shared child and family core care conditions

- Secure and affordable housing

- Financial / employment security

- Healthy physical environment (clean air and water, freedom from environmental toxins, green spaces)

- Safe and easily navigable built environments

- Ready access to family-friendly recreational and other facilities (libraries, swimming pools, sporting facilities, playgrounds)

- Healthy food environments that provide access to fresh food outlets

- Access to support services to address exceptional family needs (e.g. financial counselling, housing services)

- Inclusiveness of the wider society – absence of racism or discrimination

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Each of these core care conditions is explored below.

- **Secure and affordable housing**. Access to safe, stable and adequate shelter is a basic human need, and is important for physical and mental health (AIHW, 2020b; O'Donnell & Kingsley, 2020). The quality and security of housing can have a significant impact on family functioning and children's health, development and wellbeing (Axford, et al., 2018; Dockery et al., 2010; Moore et al., 2017; Sandstrom & Huerta, 2013; Villanueva et al., 2019). Some of these effects are long-lasting and continue into adulthood (Dockery et al., 2010).

  Residential mobility and insecurity can compromise family functioning and child development in multiple ways (Clair, 2019; Coley et al., 2013; Dockery et al., 2013; Jelleyman & Spencer, 2008; Leventhal & Newman, 2010; O'Donnell & Kingsley, 2020). Homelessness is particularly damaging, especially for young children (Clair, 2019; Gibson & Johnstone, 2010; Jelleyman & Spencer, 2008; McCoy-Roth et al., 2012). Children experiencing housing instability or homelessness have lower school readiness skills and academic achievement compared to the general population of children (Manfra, 2019; Ziol-Guest & McKenna, 2014). Children constitute a third of people attending homelessness services (Kirkman et al., 2009). Housing security is another issue that can be an additional stress for families. Not having secure, adequate and affordable accommodation was a central contributor to poor mental and physical health. Children are also vulnerable whilst the family is waiting for social housing. Parents in this situation report that their children have high levels of anxiety, do not sleep well and are chronically unsettled (Morris et al., 2023).

  Housing affordability is another challenge. For socioeconomically vulnerable families, housing options have been contracting, fewer families with lower incomes are able to afford home purchase, and there has been a decline in social housing accessibility for many (Stone & Reynolds, 2016). Stress resulting from housing affordability has direct and indirect effects on families and children (Clair, 2019; Dockery et al., 2013); it affects children most during early childhood via its adverse impact on the family's ability to access basic necessities (Dockery et al., 2010). Housing affordability stress is much more common in families who are in private rental accommodation, compared to those who are paying off a mortgage (Warren, 2018). It is also more common in one-parent families, families with young children, families where the parent was born overseas, and families from the lowest income level (Stone & Reynolds, 2016). Increased housing stress may compromise parental mental health and reduce the money available to spend on children's food, healthcare and education (Robinson & Adams, 2008; Taylor & Edwards, 2012). In contrast, better housing affordability is often associated with better health, academic achievement and school engagement for children (Clair, 2018).

The *type and quality of housing* matters for the health and wellbeing. There is a substantial body of research literature on the impact of housing on adults (Clair, 2019; Rolfe et al., 2020). One recent review (Riva et al., 2022) identified five housing conditions that had a significant impact on the mental health of adults: house type, age, and floor level; housing qualities; household composition; neighbourhood qualities; and access to green spaces. The type and quality of housing also matters for children and families. A growing number of families are raising children in private, inner-city apartments, and find that these are not well suited to children's needs, having been designed for childless couples (Andrews et al., 2019). In general, children in Australia live in homes that are in good physical condition: less than 5%of children live in homes that are in bad external condition or overcrowded (Sartbayeva, 2016). However, 17% of Indigenous children live in overcrowded housing, and 38% live in houses that need repairs (Sartbayeva, 2016).

The quality of housing can affect child development in direct or indirect ways (Coley et al., 2013). Low quality housing may increase stress and mental health problems in parents, therefore compromising their ability to regulate family activities and provide responsive caregiving to the children. Thus, rather than being a source of security and escape from life's pressures, a home with quality deficiencies may add to other stresses experienced by poor families, leading to a cumulative negative impact on wellbeing (Coley et al., 2013).

Factors that have been shown to have an impact on parental wellbeing as well as children's development and wellbeing include multi-family and crowded households, housing quality, and environmental toxins and air quality.

– *Multi-family and crowded households* (Clair, 2019; Dockery et al., 2013; Leventhal & Newman, 2010; O'Donnell & Kingsley, 2020; Solari & Mare, 2012). Children living in overcrowded housing have an increased risk of emotional and behavioural problems and reduced school performance.

– *Housing quality*. Substandard housing, rented or otherwise, can have direct effects on children's health, especially when children are very young (Coley et al., 2013; Clair, 2019; Dunn, 2020; Tischer et al., 2011). Living in housing that lacks heating or cooling, or is vermin-infested or mouldy, or where there are frequent difficulties in getting essential repairs done all increase the risk of children experiencing health problems. Housing can directly affect child health through biological, physical, and chemical mechanisms. These include exposure to biological (e.g. mould, infestations, vermin),

physical (e.g. disrepair, hazards, temperature extremes), and chemical (e.g. radon, chemical exposures) hazards (Dunn, 2020).

- *Environmental toxins and air quality*. Ventilation in home environments is important, as environmental toxins can accumulate and affect air quality and hence the health of residents, especially children (Dunn, 2020; Leventhal & Newman, 2010; Lewis et al., 2023; Ormandy, 2014; Weitzman et al., 2013). Lewis et al. (2023) describe the hidden harms of indoor air pollution, and identify five steps to expose them.

In general, housing characteristics have a significant but modest impact on children's socio-emotional wellbeing, although not nearly as strong an impact as parenting styles (Dockery et al., 2013). The effects of housing characteristics are more pronounced among children from low-income households (Dockery et al., 2013; Dunn, 2020; O'Donnell & Kingsley, 2020; Weitzman et al., 2013). Housing factors have also been shown to be associated with greater safety risks including greater risk of child or sexual abuse (Cant et al., 2019).

- **Financial / employment security.** The lack of secure and sufficient income increases the likelihood of families experiencing poverty. Poverty compromises family functioning and limits parents' capacity to provide the conditions children need for healthy development and learning (Axford et al., 2018; Braveman et al., 2018; Cooper & Stewart, 2017; Monks et al., 2022; Moore et al., 2017; Noble et al., 2015; Wimer & Wol, 2020; Yoshikawa et al., 2012). Family income affects a wide range of children's outcomes, including their cognitive development and school achievement, social and behavioural development, and health (including birthweight) (Cooper & Stewart, 2017). Poverty adds to parental stress and increases the likelihood of maternal mental health problems, hence compromising caregiving. It can also reduce the quality and regular availability of nutrition provided, limit the capacity of families to provide their children with adequate learning opportunities, and expose children to sustained levels of stress (Axford et al., 2018; Braveman et al., 2018; Cooper & Stewart, 2017; Moore et al., 2017; Yoshikawa et al., 2012). Poverty and scarcity undermine people's capacity to plan and take action to address the multiple challenges they face (Mullainathan & Shafir, 2013; Karelis, 2007). Being at the bottom of the socioeconomic gradient has corrosive effects upon our health and wellbeing (Wilkinson & Pickett, 2018). The poorer families are, the more likely it is that mothers will experience depression (Reeves & Krause, 2019) and their children will experience child abuse and neglect (Bywaters et al., 2016). Although poverty does not always lead to abuse and neglect, and is not the only contributing factor, the greater the

economic hardship experienced by the family, the greater the likelihood and severity of child abuse and neglect (Bywaters et al., 2016).

Poverty affects a wide range of people in every Victorian community, even the richest (Stanely et al., 2007; Tanton et al., 2018). Being poor in a well-off community may be even more damaging than being poor in a disadvantaged community; the chances of social isolation are greater because well-off communities provide fewer services for poor people and poor families cannot afford to access services or reciprocate socially. Poverty is greatest in single parent families, the unemployed, and those who do not own their own homes (Tanton et al., 2018). Children in families living below the poverty line suffer effects far wider than just their material basics, being more likely to face food insecurity, to lack good relationships with friends, and to be missing out on learning at home (Sollis, 2019). There is also the potential stigma attached to living in housing estate.

Australian data shows that 13.6% of the population was living in poverty in 2018 (Davidson et al., 2020a). This included 774,000 children aged under 15. This is considerably higher than in many other developed countries, and has remained high for over 30 years (Productivity Commission, 2018). This is a concern because children from households that experience several years of income poverty are more likely to have substantially worse health and impaired psychological wellbeing, and impaired cognitive and emotional development throughout their lifespan (Duncan et al., 2013; Hackman et al., 2010; Luby, 2015; Monks et al., 2022; Noble et al., 2015; Vera-Toscano & Wilkins, 2020; Yoshikawa et al., 2012). Children from a disadvantaged background often struggle to move up the economic ladder. Experiencing just a single year of income poverty during childhood is associated with lower earnings in early adulthood, compared with never having experienced poverty as a child, and experiencing multiple years of income poverty during childhood worsens the socio-economic outcomes of children in adulthood (Vera-Toscano & Wilkins, 2020).

An insight into the needs of such families comes from the families *100 Families WA* project (Phillips et al., 2021) which sought to gain a deep understanding of the lived experience of entrenched disadvantage in Perth, Western Australia. Key findings are summarised in below:

Findings from the 1000 Families WA Report
(Phillips et al., 2021)

- *People experiencing entrenched disadvantage need support.* The experience of disadvantage is difficult at best and unrelentingly brutal at worst. Support can come from various sources, including from government and non-government services, from informal supports such as friends, from their families, and from within. The types of support needed also vary, and include basics for survival, social and emotional needs, and support for health and mental wellbeing.

- *Families want to feel seen, heard and appreciated.* However, for various reasons, they often are not. This is due to various factors, including negative rhetoric about people experiencing hardship, strict eligibility criteria for services, often overburdened workers, difficult social and familial relationships, and the experience of trauma.

- *Families need relationships to be authentic.* There are many ways to involve people with lived experience in policy development and service design, such as consultation, co-design, and collaboration where all voices are given equal weighting. However, in order for families to feel seen, heard, and appreciated, it is important that their involvement is authentic, such that the parties who are developing the policy or program/service listen and change course in response to what they hear.

- *Positive social relationships were extremely valued by family members*, but were often hard to come by, whether due to trust issues, social isolation, or a lack of understanding of family members 'circumstances. In these relationships, the qualities that were highly valued were acceptance, empathy, and encouragement to be the best that one can be.

- *Services play an important role but informal social supports are more valued.* Services featured in people's lives as means to get what they needed to survive. Family members appreciated the services they did receive and many reported positive relationships with service providers. However, services were largely seen as the means to an end, rather than a feature of the ideal end ('the best' for their families). Social systems, on the other hand, were important to family members seeking the best for their families. Some of the time, these informal supports served a similar function to formal services, such that they were crucial to just getting through the day. Most of the time, however, having and embracing

good social relationships (and avoiding negative relationships) were key features of the 'best' life that people were seeking for their families.

- ***People want the best for their families and, crucially, they want to be involved in achieving it.*** Lack of employment opportunities and secure incomes were the major barriers to being able to achieve this.

- **Healthy physical environment (clean air and water, freedom from environmental toxins, green spaces).** Where we live affects our health and wellbeing (Giles-Corti et al., 2016; Minh et al., 2017; National Scientific Council on the Developing Child, 2023; Villanueva et al., 2015). Built and natural environments interact with one another and shape development and lifelong health (National Scientific Council on the Developing Child, 2023). Living in higher quality neighbourhood environments can act as a buffer against the negative consequences of low family socioeconomic status on children's stress physiology and physical health (Roubinov et al., 2018).

  The health of the local environment matters. Environmental health – exposure to chemicals and pollutants – can have a major impact on patterns of health and disease in children (Etzel, 2020; Landrigan, 2016; Landrigan et al., 2017, 2018, 2021). Children have patterns of exposure and susceptibilities to environmental hazards that are quite different from those of adults (Etzel, 2020; Landrigan, 2016), and prenatal and early postnatal life is highly vulnerable to environmental health hazards with lifelong consequences (Bourguignon et al., 2018; Heyer & Meredith, 2017; Wang et al., 2016). Exposure to air pollution has detrimental effects on children's neuropsychological development, and increases their likelihood of developing cardiovascular and pulmonary diseases (Payne-Sturges et al., 2019; Suades-González et al., 2015). As noted already, this includes exposure to common environmental toxicants in poorly ventilated housing.

  Having access to green spaces contributes significantly to children's long-term physical and mental health (Engemann et al., 2019; Freeman & van Heezik, 2018; Louv, 2005, 2011; Miri et al., 2020; Myers, 2020) as well as contributing significantly to parental health and wellbeing (Bagnall et al., 2018; Myers, 2020; Jones, 2020). Contact with nature contributes to the health and wellbeing of children in many ways, beginning at birth – physical health cognitive function and self-control, psychological wellbeing, affiliation and imaginative play and affiliation with other species and the natural world (Freeman & van Heesik, 2018).

- **Safe and easily navigable built environments.** The quality of built environment, the availability of local transport and access to safe recreational facilities all contribute to parental and family wellbeing (Bagnall et al., 2018; Bradley, 2015; Goldfeld et al., 2018; Goldhagen, 2017; Minh et al., 2017; O'Donnell & Kingsley, 2020; Villanueva et al., 2022; What Works Wellbeing, 2018). While the family environment has the greatest impact on the development of very young children, the people, resources and opportunities within their neighbourhood environments affect families' capacity to provide the children with the conditions they need to flourish (Minh et al., 2017). Neighbourhood-built environment characteristics, such as housing, walkability, traffic exposure, availability of services, facilities, and parks, are associated with a range of health and wellbeing outcomes across the life course (Villanueva et al., 2022a, 2022b). Even parents' perceptions of neighbourhood safety have been found to be positively associated with children's social–emotional development and general health (Christian et al., 2015).

- **Ready access to family-friendly recreational and other facilities (libraries, swimming pools, sporting facilities, playgrounds).** Families of young children need access to a range of family-friendly facilities and safe places for children to play (Leventhal, Dupéré & Shuey, 2015; WHO, UNICEF & World Bank Group, 2018). This is particularly important for families living in high-rise apartments with limited space for play and exercise. Having child-relevant neighbourhood destinations, facilities and services within easy reach of families is positively associated with young children's physical health and wellbeing and social competence (Christian et al., 2015), whereas children who live in neighbourhoods with few amenities and more problems are less likely to be healthy and ready to learn than other preschoolers (Moore et al., 2015).

- **Healthy food environments that provide access to fresh food outlets.** The importance of early nutrition has already been noted. The ability of families to provide their children with healthy diets can be compromised by a number of factors, including food insecurity (Fiese et al., 2011), poor quality cheap foods (Carolan, 2018), and lack of access to fresh food outlets. Low-income families are more likely to buy cheaper and less nutritious food owing to a lack of money and limited access to shops selling healthy food (Axford et al., 2018). The poorest areas have the highest concentration of fast food outlets and the fewest fresh food suppliers (Ulmer et al., 2014; Villanueva et al., 2016).

- **Access to support services to address exceptional family needs (e.g. financial counselling, housing services).** To ensure that those with unique and/or additional needs are not neglected, universal services must be able to offer differential support

according to increasing levels of need (Carey et al., 2015; Child Family Community Australia, 2014; Higgins & Dean, 2020; NASEM, 2019; Oberklaid et al., 2013). This is known as *progressive* or *proportionate universalism* (Barlow et al., 2010; Feinstein et al., 2008; Goldfeld, 2020; Human Early Learning Partnership, 2011; Marmot Review, 2010; NHS Health Scotland, 2014; Statham & Smith, 2010). In this approach, services are universally available, not only for the most disadvantaged, but additional services are available for those in greater need.

Another approach to meeting individual needs within a universal service framework is *targeted universalism* (Powell et al., 2019). This is an outcome-focused approach, in which universal goals are established for all children and families, and strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal. In this approach, the services provided for children and families are based on common goals but are personalised to meet their particular circumstances and preferences.

The current system of services is not well-designed to identify child and family additional needs or to provide holistic integrated services and supports to meet these needs. Services are compartmentalised – focused on separate needs and delivered by different departments – and hence unable to respond to the needs of children and families in a holistic and integrated fashion (Barnes et al., 2018). Overcoming this 'silo' effect is challenging (Barnes et al., 2018; Moore & Skinner, 2011). Integrating services and supports across different sectors is an essential step to ensuring that families facing multiple adversities have positive social networks and have access to key services during their children's early years (Black & Dewey, 2014; Black et al., 2016; Charles et al., 2021; NASEM, 2019; WHO, UNICEF & World Bank, 2016, 2018).

One way of addressing this problem is by establishing *integrated child and family centres (ICFCs)* or *hubs* (Honisett et al., 2022a, 2022b, 2023; Moore, 2021b). As described earlier, ICFCs can act as both social hubs and service hubs – natural places in the local community for families with young children to go to connect with other families and get access to a range of services. ICFCs can provide mainstream early childhood and family support services as well as tiered systems of support to address additional child and family needs.

- **Inclusiveness of the wider society – absence of racism or discrimination.** Children and families can be adversely affected by various forms of racism, discrimination and marginalisation. Racism can take several forms – structural racism, cultural racism and

interpersonal discrimination (Shonkoff et al., 2021). Structural racism involves unfair race-based treatments that are built into institutions, policies, and practices (Bailey et al., 2017; Shonkoff et al., 2021; Slopen & Heard-Garris, 2022). These can constrain parents' ability to provide healthy living conditions for their children, and can affect children's physical and mental health in the short-term as well as the long-term (Braveman et al., 2018; Priest et al., 2020). The adverse health consequences of exposure to ongoing racism can accumulate across lifetimes and generations (Braveman et al., 2018; Gee et al., 2012). Young children can suffer the effects of racism experienced by their parents years or even decades ago.

Social exclusion is also a significant problem. Miranti and colleagues (2018) found that, in 2016, one in six Australian children aged 0-14 years were living in poverty but many children were also socially excluded, lacking the opportunities and family resources to be socially connected and to be able to participate fully in their local communities. Among other adverse effects, child social exclusion affects educational attainment – the prevalence of low AEDC scores was twice as high in areas of highest social exclusion rates compared to those with the lowest rates. A local community's risk of child social exclusion is highly persistent over time. In those areas where social inclusion rates improved, the key drivers of improvement in child social exclusion were above-average improvement in the socio-economic wellbeing of families in these areas and in their educational attainment, and reduced housing stress.

4 DISCUSSION, SUMMARY AND IMPLICATIONS

4.1 Discussion

This overview of core care conditions raises several questions that need to be addressed before we summarise the key issues and explore the implications.

How universal are these core care conditions? How much of our development is biological – part of our evolved human biology and therefore universal – and how much is cultural – shaped by the different cultures in which children are raised? We need to ask this question because so much of the research on child development and family functioning has been carried out on developed nations on populations that are not representative of the overall human population, but have relied on predominantly Western, educated, industrialized, rich, democratic (WEIRD) samples (Henrich, 2020; Nielson et al., 2017; Rogoff, 2003, 2016; Rogoff et al., 2017). Anthropological studies suggest that there are many different ways in which children can be nurtured and raised (Lancy, 2022, 2024). For instance, in cultures where child rearing is the prime responsibility of nuclear families, the development of a secure attachment to at least one key caregiver is important. However, in cultures where alloparenting (children being cared for by multiple caregivers) is the norm, the development of a more generalised form of core trust in others may be what is important, as proposed by Erickson (1963) and supported by others (e.g. Fonagy et al., 2024). In both nuclear family and alloparenting contexts, sensitive responsiveness is critical (Mesman et al., 2018), and the core need to connect is common. Core trust later manifests itself as epistemic trust – trusting others for information (Fonagy et al., 2017) – and the lack of epistemic trust is now seen hypothesised to underpin common psychopathologies in later life. More research on infants is needed to understand the origins of core trust in others (Markson & Luo, 2020).

According to McCoy (2022), there is plenty of evidence to support the presence of universal features of development, and there is also consistent and convincing evidence that the form and timing of developmental skills varies across cultures. To reconcile these two sets of evidence, the notion of *developmental universality without uniformity* has been proposed (McCoy, 2022; Mesman et al., 2018). This involves high-level agreement about the existence of basic developmental constructs while accepting that these can manifest themselves differently across cultures and recognising that all developmental skills are culture-specific to some extent (McCoy, 2022). This implies that the core care conditions identified in this paper

may be universally applicable, but met is a variety of ways in different cultural contexts. The validity of this interpretation needs to be tested empirically.

Are some core care conditions more important than others? In seeking to understand early development, there has been a tendency to focus on neurological development at the expense of other aspects of development. However, as Moore (2014a) has noted, framing brain development in terms of building neuronal connections and brain architecture fails to capture the fact that brain is not a stand-alone bodily system, but is intricately connected to other major bodily systems, including the immune, endocrinal, metabolic, gastrointestinal, cardiovascular, enteric and musculoskeletal systems (Barrett, 2011; Beilock, 2015; Claxton, 2015; Damasio & Damasio, 2006; Lyman, 2024; McFarlane, 2017; Mayer, 2016; National Scientific Council on the Developing Child, 2020). These systems shape and are shaped by each other, and function as an integrated mind-brain-body system. This means that what is 'learned' in the prenatal and first two to three years of life affects not only the neurological system but also the other bodily systems to which the brain is connected, with potentially profound consequences over the life course (Moore, 2014a; Moore et al., 2017). It also means that whatever we do to promote the positive development of any bodily system (including the microbiome) will have flow-on positive benefits for other bodily systems (Lyman, 2024).

What this implies is that improvements in any of the core care conditions will have some flow-on effects for multiple aspects of child development and family functioning. However, this does not mean that all the core care conditions are of equal importance. The most fundamental needs for children and parents / caregivers alike are those relating to relationships, nutrition and safety. For children, the development of secure relationships with caregivers is the core building block for subsequent development and wellbeing, while for parents, having positive social support networks is the key to personal wellbeing and to effective parenting. Nutrition is also critical; having adequate and appropriate nutrition from conception onwards is essential for children's long-term health and development. Finally, safety is vital for both children and parents. This involves protection from physical and relational stressors and dangers. While improvements in any of the core care conditions will be beneficial, addressing these three conditions should be a priority.

Are the core care conditions discussed in the paper are just as important for children with developmental disabilities? The evidence indicates that children with developmental disabilities have the same core needs as all children – needs for attachment, nurturance, emotional responsiveness, care, safety and security and so on (Biringen et al., 2005; Moore,

2009; World Health Organisation & UNICEF, 2012). Moreover, these crucial conditions have the same impact on their development as they do on other children.

However, children with developmental disabilities may have difficulty having these needs realised because of the nature of their disabilities. They may initiate interactions less frequently and give cues that are more subtle and difficult to read (Biringen et al., 2005; Howe, 2006; Kelly & Barnard, 2000). As a result, children with a developmental delay or disability may be at greater risk of insecure or disorganized attachment than children without disabilities (Alexander et al., 2023; Moore, 2009). They may also have reduced access to the range of environments and experiences that other children have, and fewer opportunities to participate (World Health Organisation & UNICEF, 2012, 2023). Their families may also have reduced opportunities to work and to participate in community life. Thus, it is important in seeking to meet the needs of children with developmental disabilities and their families, particular attention should be paid to ensuring that their core care conditions are met, and that additional support and adaptations are provided.

4.2   Key takeaways

There are five key points to note from this overview of child and family core care conditions.

The first is that ***the very earliest stages of development – from conception to the end of the second year – are critical.*** What happens during this period can have lifelong consequences for their health and wellbeing. Therefore it is important to intervene as early as possible in the developmental sequence in order to have maximum preventive effect (Boyce et al., 2021; Fox et al., 2015; Luby et al., 2024; Moore & McDonald, 2013; NASEM, 2019a; Prevention Institute, 2019; Yousafzai, 2020). The most effective form of prevention is to improve the early lives of disadvantaged children (Heckman, 2012). This means focusing much more on improving the conditions under which families are raising young children (Moore & McDonald, 2013).

The second point is that ***child and family functioning are shaped by the conditions in which the families are living*** – their social and physical environments and their access to material basics. These conditions have a major influence on the capacity of the family to provide their children with appropriate nurturing care as well as safe and stimulating home learning environments. These conditions can have a greater impact on child and family outcomes than do the services they receive. There are large socioeconomic variations in the conditions under which families are living, contributing to the socioeconomically-graded outcomes observable in children and families. Services will always struggle to overcome these variable

outcomes as long as the underlying factors that produce them are not addressed as well. There is an urgent need for more effective strategies to support young children by addressing poverty, racism, violence, housing instability, food insecurity, and other sources of chronic adversity that impose significant stresses on their families (Centre for Community Child Health, 2018). Services and supports must move beyond a sole focus on children and parents to an intentional, 'upstream' focus on macro-level policies that systematically threaten the health and wellbeing of families affected by structural inequities and systemic racism (Berkowitz, 2024; Curtis et al., 2023: Higgins et al., 2019; Daro & Karter, 2019; Heath, 2020; Lynch, 2017, 2020; National Collaborating Centre for Determinants of Health, 2014; Ratcliff, 2017). This should include poverty alleviation as one of the major goals (Braveman et al., 2018; NASEM, 2019c; National Scientific Council on the Developing Child, 2020; Ulferts, 2020). Marmot and the Commission on the Social Determinants of Health (2007) called these the 'causes of the causes', the fundamental structures of social hierarchy and the socially determined conditions these create in which people grow, live, work, and age. Focusing on these upstream causes may be considered a form of pre-prevention, preceding the more usual universal or primary prevention approaches. There is a growing consensus across many human services that the predominantly service-focused approach to meeting the needs of those experiencing health, mental health and social problems is no longer working and that we need a much greater focus on the social determinants of health and wellbeing that are fostering these problems (Patel et al., 2023; Suetani et al., 2024).

Third, ***the core care conditions have a cumulative synergistic impact – the more we can put in place, the greater the likelihood of positive outcomes*** (Rusk et al., 2017). The cumulative effects of experiencing multiple adverse conditions have been well documented. Adverse childhood experiences (ACEs), defined as various forms of child abuse and neglect and family exposure to toxic stress, become biologically embedded, that is, they change the child's neural and biological infrastructure in ways that have a negative impact of developmental trajectories and outcomes (Nelson, 2013). The more adverse experiences in early life, the greater the likely incidence of later health, mental health and developmental problems (Anda et al, 2006; Bellis et al., 2019). When these adverse home experiences are combined with adverse community environments, the negative impacts are even greater, and can be felt at the individual, family and population levels (Ellis et al., 2022).

The present paper seeks to shift this focus on adverse early experiences to positive ones. The core care conditions in this paper also have a cumulative effect, but the effect is positive: the

more core care conditions of children and families are met, the greater the likelihood of positive outcomes.

Fourth, **all young children and families should have their core care conditions met.** Most of the efforts to reduce inequities and improve child and family outcomes have been directed to families who experience disadvantage or areas experiencing high disadvantage. This *targeted* service approach is in contrast to a *universal* service approach in which services are universally available (that is, available to all members of a population, regardless of location or socioeconomic status). This is sometimes referred to as population or public health approach (Child Family Community Australia, 2014; Higgins & Dean, 2020). Targeted services on the other hand are only provided to those families deemed to be at risk or socioeconomically vulnerable or living in socioeconomically disadvantaged areas. Although many early childhood initiatives are targeted at those living in the areas experiencing the most disadvantage, there are good grounds for making services universally available (CCCH, 2006; Mantoura & Morrison, 2016; Moore, 2008a, 2008b; Moore et al., 2016). While the greatest concentrations of poor outcomes are among the lowest socioeconomic populations, such outcomes are evident across the whole population (albeit in progressively decreasing concentrations), and the majority of cases overall are found at levels other than the lowest socioeconomic one. To reach all families experiencing disadvantage, wherever they are on the social gradient, a universal approach is needed, providing 'soft entry' points into more intensive services (Barnett et al., 2017; CCCH, 2006; Fox et al., 2015; Moore, 2008). There is evidence that such universal or population approaches to early intervention and prevention can help reduce the prevalence of child abuse and neglect at a population level (Higgins & Dean, 2020).

Fifth, **as a society we should be focused on ensuring that all children are flourishing.** This paper has focused on the positive conditions that children and families need in order to flourish. This is in contrast to identifying the negative conditions that are known to place children at risk, and then seeking to reduce or eliminate them or ameliorate the effects of these adverse conditions and experiences. We will never be able to protect all children and families from such conditions, so there will always be a need for prevention and remedial services. However, this should not be the sole or main focus of our efforts. The rates of children experiencing suboptimal care conditions (and therefore experiencing poor outcomes) will continue to be unacceptably high unless we improve the conditions under which they are living. Hence the need to identify those conditions (as in this paper) and focus on promoting them. Poor developmental outcomes are as much a result of our failure to

provide children and families with the positive conditions they need to flourish as they are of our failure to protect them from adverse experiences and conditions.

Focusing on conditions is different from focusing on outcomes. While we need to be clear what outcomes we are seeking for children, it is a mistake to put all our efforts into services that seek to promote the outcomes directly. Instead, we should put more effort into ensuring that children and families enjoy the conditions that are known to lead to positive outcomes. If we provide the right conditions, the outcomes will look after themselves, or at least will be greatly enhanced. (See Appendix for a diagram showing how the core conditions relate to ARACY's *The Nest* outcomes.)

4.3   Implications for action

With these conclusions in mind, the following implications for action are outlined.

First, ***all parents and caregivers need strong social support networks***, people who they can rely on to support them in emotional and practical ways. Effective parenting is dependent upon the caregivers' own wellbeing. It is critical to ensure that children's parents and caregivers have the necessary supports for maintaining good physical health, and good mental health and psychological wellbeing (NASEM, 2019b). There should be a much greater emphasis on helping parents build connections with other parents and families. One way of doing this is to provide safe places for families to meet and build supportive networks.

Second, an important part of the core care conditions for children and families is ***having access to a range of universal and tiered child and family services*** – universal services such as maternal and child health and child care services, and tiered services to address additional needs. To ensure that those with unique and/or additional needs are not neglected, universal services must be able to offer differential support according to increasing levels of need (Carey et al., 2015; Child Family Community Australia, 2014; Higgins & Dean, 2020; NASEM, 2019; Oberklaid et al., 2013). This is known as *progressive* or *proportionate universalism* (Barlow et al., 2010; Feinstein et al., 2008; Human Early Learning Partnership, 2011; Marmot Review, 2010; NHS Health Scotland, 2014; Statham & Smith, 2010). In this approach, services are universally available, not only for the most disadvantaged, and additional services are available for those in greater need.

One way of ensuring that all families are well-supported socially and have access to the services they need is by establishing ***integrated child and family centres (ICFCs) or hubs*** (Honisett et al., 2022a, 2022b, 2023; Newcomb et al., 2023; Moore, 2021b). Finding ways of ensuring that families have access to all the services they need and that these are delivered in an integrated fashion has always been a challenge. The conditions under which families are raising young children have changed so rapidly over the past half century that our services and institutions have struggled to keep up with them. The service system is still planned, funded and administered in ways that were originally designed decades ago when society was less diverse and social conditions were simpler. Services continue to be compartmentalised – focused on separate needs and delivered by different departments – and hence unable to respond to the needs of children and families in a holistic and integrated fashion. There is a growing consensus that the current system of services is no longer fit for purpose and needs to be radically reshaped (Centre for Policy Development, 2023; Runions et al., 2022). Integrated child and family centres offer one way of addressing this challenge, acting as a service hub for a range of universal and specialist services. In addition, they can also function as a social hub, providing a safe space for parents and their children to meet other parents and children, and build social support networks (Moore, 2021b).

Finally, to ensure that all children and their families are flourishing, we need to ensure that they are provided with the core care conditions they need. This could take the form of a ***universal early years guarantee*** whereby every family of a newborn child would be guaranteed certain basic conditions and services (Centre for Policy Development, 2021; European Commission, 2021). Existing child guarantee initiatives, such as the European Commission's *European Child Guarantee*, have a limited scope, e.g. guaranteeing free early childhood education and care, free education, free healthcare, healthy nutrition, and adequate housing. The idea of an early guarantee is an appealing one, but, to be effective, it would need to be based on the complete list of core conditions identified in this paper. A universal early years guarantee based on the core care conditions identified in this paper would be a major contribution to ensuring that all young children and their families have the opportunity to experience optimal health and wellbeing.

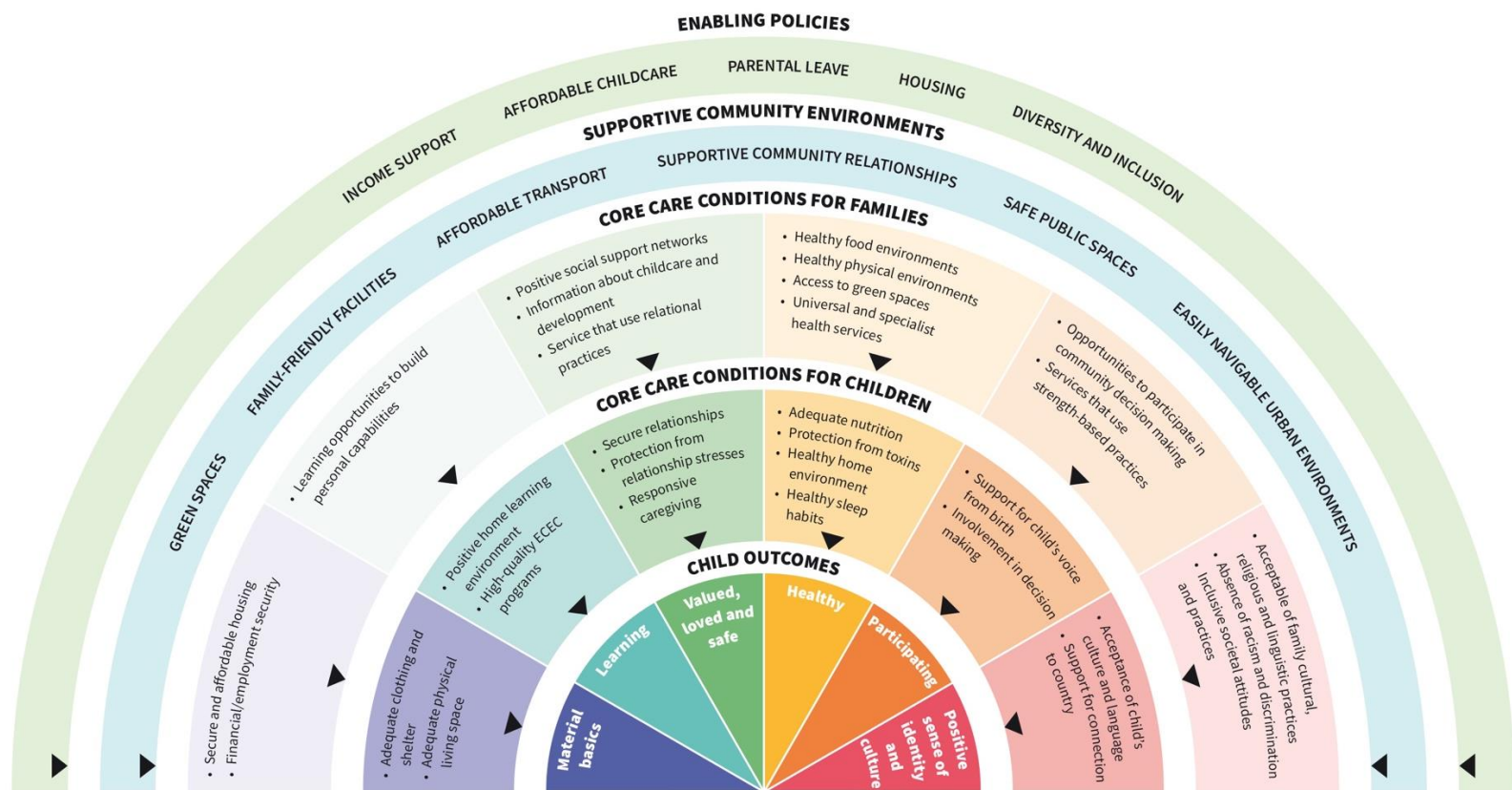# APPENDIX: CORE CARE CONDITIONS AND CHILD OUTCOMES

This paper makes a distinction between core care conditions and outcomes. Outcomes are the product of the conditions under which children and families have experienced and are experiencing. Other major factors contribute to outcomes – most notably genetic inheritance and chance exposures – but usually there is little that can be done to change these directly, leaving environmental conditions as the one major contributor to outcomes that we can shape.

The most commonly used outcomes framework in Australia is ARACY's *The Nest* (ARACY, 2014). This identifies six child outcomes:

- *Valued, loved and safe* - feels loved and secure, and aware environment is protected
- *Material basics* – feels provided for
- *Healthy* - emotionally and mentally well and supported, and physically healthy and active
- *Learning* - goes to school or early education and enjoys learning
- *Participating* - feels heard, plays, and has opportunities to have a say
- *Positive sense of identity and culture* - belonging, positive sense of self, and positive cultural and spiritual identity.

The figure below shows how the core care conditions identified in this paper lead to the six outcomes in *The Nest*. This is an approximate matching; *The Nest* outcomes cover children and youth (aged 0-24), whereas the core care conditions discussed in this paper apply particularly to the first 1000 days.

The figure also shows that the core care conditions needed by families and children extend beyond what families can provide on their own and include supportive community environments as well as enabling policies that are the responsibility of state and federal governments.

The relationship between core care conditions for children and families[1] and child outcomes[2]

1: Moore, T.G. (2004). *Core Care Conditions for Children and Families: Implications for policy and practice.* CCCH Working Paper No. 6. Parkville, Victoria: Centre for Community Child Health, Murdoch Children's Research Institute. https://doi.org/10.25374/MCRI.26065597

2: ARACY (2014). *The Nest Action Agenda: Improving the wellbeing of Australia's children and youth while growing our GDP by over 7% (2nd Ed.).* Canberra, ACT: Australian Research Alliance for Children and Youth. http://www.aracy.org.au/documents/item/182

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