# Preparation for Parenting: Developing a Conceptual Framework and Strategies

by

Candace Bergeson

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfilment of the requirements of the degree of

DOCTOR OF PHILOSOPHY

Department of Educational Administration, Foundations & Psychology

University of Manitoba

Winnipeg

**Abstract**

Being unprepared for parenting is an almost universal experience that can affect parental competence, confidence, and result in lost opportunities to maximize early child development. Previous studies have identified parent characteristics, contextual factors, and child factors as determinants of parenting and parenting outcomes. Despite its direct applicability, the function of preparation as a determinant of parenting has been relatively unexplored, and similarly, there is a lack of understanding of how preparation may be improved. The purpose of this study was to explore, conceptualize, and prioritize what was needed to help people prepare for parenting.

Purposive sampling was used to recruit 18 parents, 19 service providers, and 10 administrators living in Manitoba. Concept mapping, a participatory mixed methods approach, was used to engage participants in the co-construction of a conceptual framework identifying what would help people prepare for parenting. Using an online venue, participants generated ideas, sorted and rated the ideas, and provided reflections on the results. Three primary areas for helping people prepare for parenting emerged: Education, Support, and Parents Matter. Twenty-one strategies were identified and were used to develop four recommendations.

The results of this study challenged the current view that prenatal and postnatal programs are sufficient for developing effective parenting skills. This study contributed to current knowledge about preparation for parenting by creating a conceptual framework. A key understanding that encapsulates these research findings is found in the strategy that participants rated as being the most important and the most feasible: Promote the message that parenting is learned, and we all need to learn how to parent. I believe this work will be of interest to those who work in the areas of primary prevention, parenting education, transition to parenthood, and positive human development. It is intended to have utility and application for those making policy and program decisions in Manitoba.

**Acknowledgements**

I would like to acknowledge my advisor, Dr. Charlotte Enns, my committee members, Dr. David Mandzuk and Dr. Steven Feldgaier, and my guest committee member, Dr. Joan Durrant for their support and guidance. I also want to acknowledge Dr. Jessica Griffin Burke, my External Examiner, for her feedback on my dissertation in the final stages of this process.

Research depends on an act of generosity: the willingness of people to share their ideas, their stories, and their experiences. Thank you to each parent, service provider, and administrator who took time to share their vision of what people need to prepare for parenting. A special thank you to my research assistant for her invaluable assistance. You kept me out of the rabbit holes and helped me see the forest when I was lost in the trees.

There were many people from whom I drew strength. I am grateful for my family and friends – for the people who have encouraged and supported me, and more importantly were there to help me reset as needed. I am especially grateful for my husband who has always believed in me and accepted the many changes this process has brought to our lives, and for my daughters who walked beside me every step of this long and hard journey. You each gave me exactly what I needed when I needed it - and you have always made me want to be a better parent.

I would like to gratefully acknowledge the financial support I received from the University of Manitoba Graduate Fellowship, the Manitoba Graduate Scholarship, and the Education Graduate Student Research Award. I would like to thank Concept Systems Inc. for awarding me the graduate student license.

**Dedication**

I dedicate this work to my father.

You showed me the importance of parenting.

## Table of Contents

## List of Tables

## List of Figures

## Chapter One: Introduction

> Throughout our lives, we undertake few more important responsibilities than those which accompany parenthood. However, in few areas of life are we so poorly prepared. No test must be passed or license acquired to become a parent. Yet, the responsibility carries with it requirements that are of monumental significance in our lives and the lives of our children. (Pehrson & Robinson, 1990, p. 232)

The capacity of people to effectively fulfill the parenting[1] role impacts the development, health, and well-being of children (National Academics of Sciences Engineering and Medicine, 2016; Reeves, Sawhill, & Howard, 2013; Volmert, Kendall-Taylor, Cosh, & Lindland, 2016). While parental capacity is essential throughout a child's life, it is especially important in the early years when a child's development is at its peak and dependent on environmental experiences for optimal growth (McCain & Mustard, 1999; National Research Council and Institute of Medicine, 2000). Child outcomes in all developmental domains are enhanced by early positive and supportive interactions with parents and other caregivers (National Academics of Sciences Engineering and Medicine, 2016).

Parenting capacity ranges from optimal to good enough to harmful (Belsky, 1984) and it is clear that some children are advantaged and others disadvantaged by the quality of parenting they receive in the early years (Heckman, 2011; Reeves et al., 2013). The determinants of parenting literature tells us that the nature and outcome of parenting is influenced by the personal characteristics the parent brings to the parenting role, including planning for parenting, parental self-perceptions, and actual knowledge of child development and parenting strategies (Belsky, 1984; Bornstein, 2016; Winter, Morawska, & Sanders, 2012). However, little attention has been

[1] Parents will refer to those who provide care for children, including biological parents, grandparents, other relatives or adults.

paid to how people develop or acquire these key determinants. In fact, we know far less about parent development than we know about the impact of parenting (Volmert et al., 2016), what constitutes effective parenting (Johnson, Berdahl, Horne, Richter, & Walters, 2014), and what determinants influence parenting after people become parents (Bornstein, 2016). Few theories exist that help us understand parent development and none incorporate preparation for parenting (Galinsky, 1987; Mowder, 2005).

Despite the importance of early parenting to lifelong health and well-being, very little research has been done on preparation for parenting (Glade, Bean, & Vira, 2005; Hogg, 2017). This lack of research is concerning given parenting is an almost universal life experience with between 80% and 90% of all people becoming parents (Bornstein, 2015; Glade et al., 2005). Parenting should not be an unanticipated life event and being prepared for parenting should not be left to chance (Sher, 2017).

However, it appears it is. The majority of Canadian parents of young children are not prepared for parenting, do not feel competent as parents, lack knowledge about child development, do not engage in enough positive parenting, and do not feel supported in their parenting role (Crill Russell, Birnbaum, Avison, & Ioannone, 2011; Oldershaw, 2002). Being unprepared for parenting is associated with increased anxiety, isolation, feelings of inadequacy, and stress in parents (Sanders, Lehmann, & Gardner, 2014). When parents feel equipped to parent their confidence is increased, anxiety reduced, and they demonstrate more effective parenting (Parens et al., 2006).

Because of the familiar role that parenting occupies in society, it is often assumed that parenting is not a life role that requires active preparation (Glade et al., 2005). The pervading belief is that we are *hardwired* for parenting (Papoušek & Papoušek, 2002), that we innately

possess the skills we need to provide quality parenting for our children, and that "good parenting comes naturally" (Volmert et al., 2016, p. 23). It is expected that we will arrive at parenthood in a prepared state. However, we know effective parenting is not about intuition (Bornstein, 2016), luck (Sher, 2017), is not accidental (Bortolotti & Cutas, 2009; Pehrson & Robinson, 1990), and we do not arrive at parenthood in a prepared state (Oldershaw, 2002). Effective parenting requires a set of skills that need to be learned (Johnson et al., 2014; Michaux, 2017). Therefore, the underlying assumption of this research is that parent development involves intentional preparation over multiple life stages. This will be critical in addressing feelings of unpreparedness in parents and in realizing optimal early environmental experiences for children.

I was drawn to this research both for personal and professional reasons. As a parent, I experienced self-doubt and anxiety regarding parenting decisions. I wanted to do my best for my children but often did not know what that was. Later, when working as a school psychologist, I began to realize that my experience with parenting was not personal, but rather quite widespread: more political. Many of the parents I worked with faced challenges because they lacked an understanding of typical developmental stages, basic parenting strategies, and lacked support in the parenting role. I found that parents wanted the best for their children, but often unknowingly created relational roadblocks. These challenges were seen in the early school years, where parental expectations for behaviour exceeded children's developmental capacity, through to adolescence where the need for independence was interpreted and reacted to negatively. I began to wonder why we did not teach people how to parent. When I started looking at this issue, I found that there had been many attempts over the years to implement parenting education in

schools, but most were never long-term or well-integrated into the school curriculum. I also found there was a lack of research on preparing people for parenting[2].

**Definition of Terms**

*Preparation For Parenting:* Preparation for parenting, while a widely used concept, lacks clarity and consistency (Spiteri, Borg Xuereb, Carrick-Sen, Kaner, & Martin, 2014). Some of this confusion is a matter of semantics. The words preparation and prepared have been used interchangeably in research, regardless of their different meanings. Preparation is an action while prepared is a state of being (Salmela-Aro, Mutanen, & Vuori, 2012; Sweeny, Carroll, & Shepperd, 2006). The words parenting and parenthood have also been used interchangeably and again they are different concepts. Parenting involves the practices related to raising children while parenthood is the state of being a parent (Spiteri et al., 2014). Within this research, preparation will be defined as the activity or process of becoming ready for something (Merriam-Webster, 2005). Parenting will be defined as the ongoing process of providing consistent and appropriate caregiving that promotes the physical, cognitive, and social/emotional development of children from infancy to adulthood (Alvarado & Kumpfer, 2000; Conger & Simons, 1997; National Research Council and Institute of Medicine, 2000). Preparation for parenting is therefore understood as the actions taken to become ready to provide consistent and appropriate caregiving for children and is undertaken so that a person may arrive at parenthood in a prepared state.

[2] The literature review and current research are both situated primarily within a western, developed, and democratic world context due to the geographic location in which I am positioned and do not imply preference or importance over any other context.

**Concept Mapping Terms**: The definitions that follow are taken from the book, Concept Mapping for Planning and Evaluation (Kane & Trochim, 2007) and from material acquired during my participation in the Concept Systems® Facilitator Training workshop.

*Concept Mapping*: Concept mapping is a general term used to describe a process for representing ideas visually. In this research, concept mapping refers to a structured methodology involving specific analyses and data interpretation steps to produce maps that can be used for planning.

*Brainstorming* – Participants generate ideas in response to a focus prompt.

*Bridging Value* – A bridging value is calculated for each statement and is unique to the concept mapping software. The bridging value provides information about the relationship of each statement to other statements on the map.

*Cluster Analysis* – Hierarchical cluster analysis is used to group individual statements on the point map into clusters of statements that reflect similar concepts.

*Cluster Map* – A map that shows how statements were grouped by the cluster analysis along with the labels given to each cluster. This map shows the overview of the domain of ideas.

*Cluster Rating Map* **–** The cluster map with the average cluster ratings (i.e., importance and feasibility) overlaid.

*Focus Prompt* – The focus prompt reflects the focus of the research and is worded in such a way as to elicit responses from participants.

*Go-zones* – A bivariate scatterplot divided into four quadrants using the mean of each rating variable as the bisecting line. Statements that are above the mean on both rating variables are identified as being in the go-zone and are used to identify potential courses of action.

*Multidimensional Scaling* – Non-metric multidimensional scaling is used to analyze the degree of similarity or distance between statements based on how many times they were sorted together. Each statement is located as a separate point on a two-dimensional point map.

*Pattern Matches* – Pattern matches are used to show pairwise comparisons of cluster ratings across groups using a ladder graph representation.

*Point Map* - A map that shows where each statement was placed in two-dimensional space by multidimensional scaling. The point map is the foundation for all other analyses and maps and shows the interrelationships between the statements.

*Point rating maps* - The point map with the rating data overlaid that provides a graphical representation of the rating priorities for each statement.

*Sort Data* – Participants complete an unstructured sort activity where they group statements based on the conceptual similarity between the statements.

**Problem Statement**

Limited research has been directed toward preparation for parenting and what role it could play as a determinant of parenting (Glade et al., 2005; Spiteri et al., 2014). The lack of research is surprising for two main reasons. First, the link between early effective parenting and desired child outcomes is well-established (Cypel & Vidigal, 2013; Hertzman & Boyce, 2010; National Research Council and Institute of Medicine, 2000; Scott, 2012) with parenting accounting for between 30% and 40% of child outcomes (Reeves et al., 2013; Waldfogel & Washbrook, 2011). When parents can meet the physical, cognitive, and social/emotional needs of their children in the earliest years, in a manner that is both stimulating and nurturing, children do better throughout life (Michaux, 2017). Second, the key determinants of effective parenting are also well established. Belsky (1984) and Bornstein (2016) have identified the personal resources

of the parent as being a significant factor in determining both the nature and outcome of parenting. While there is abundant research on what determines a person's ability to parent after they become parents, very little attention has been paid to how people develop these personal resources: the knowledge, skills, and supports needed for parenting (Glade et al., 2005).

To date, research on preparation for parenting has suffered from a lack of conceptual clarity (Spiteri et al., 2014), has primarily been completed with parents as they transition to parenthood (Deave, Johnson, & Ingram, 2008), and has not resulted in the identification of preparation for parenting strategies relevant to the local context (Billingham, 2011). The current study addresses these gaps by co-constructing a conceptual model that identifies areas that would help people prepare for parenting and by determining what strategies are seen as important and feasible in Manitoba. Manitoba is a Canadian province where the majority of the population is concentrated in a few major centres while the rest of the population is spread out over a large geographical area. While Manitoba has a variety of parent programs and services delivered through a number of agencies, access and awareness of the existing services continues to be a challenge.

Preparation for parenting is being proposed as a way to increase parental competence by having people begin parenting with the knowledge, skills, and supports they need to parent effectively. It is believed that increasing parental competence through preparation for parenting will improve developmental outcomes and reduce harmful outcomes for children.

**Statement of Purpose and Research Questions**

The purpose of this study was to explore, conceptualize, and prioritize what could help people prepare for parenting in Manitoba utilizing concept mapping to elicit the perceptions of parents, service providers, and administrators. Concept mapping is a methodology that is

particularly well suited to collaborative exploratory research (Burke et al., 2005). It involves a number of phases including brainstorming, conceptual sorting, value rating, and participant reflection. It was anticipated that multiple perspectives would provide a better understanding of the range and priority of strategies and lead to more informed decision making regarding needed services and supports to increase readiness for parenting and parent development. The following research questions were addressed: (1) What do parents, service providers, and administrators identify as services, supports, or actions that could help people prepare for parenting in Manitoba? (2) What strategies do participants identify as being the most important and the most feasible? Are there differences in what is seen as most important and or feasible by participant subgroups? (3) Based on the value ratings of strategies by participants, what are the most actionable recommendations for helping people prepare for parenting in Manitoba?

## Chapter Two: Literature Review

In this literature review, a rationale will be developed for exploring preparation for parenting. I begin by introducing the impact of early and effective parenting on children's development to establish the importance of preparation for parenting. I then review research that looks at how prepared people are for parenting and examine lack of preparation within the context of the determinants of parenting research. Theoretical and practical approaches to parent development are reviewed. Finally, the literature review concludes by examining current research on preparation for parenting, identifying the way forward, and outlining the purpose of the study.

### Background

Parenting is understood as the ongoing process of providing for and promoting the physical, cognitive, and social/emotional development of children. Our awareness of the impact of parenting on desired child outcomes has increased considerably in the last two decades (McCain & Mustard, 1999; National Academics of Sciences Engineering and Medicine, 2016; National Research Council and Institute of Medicine, 2000). Growth in the fields of developmental science, biology, and neuroscience, have led to substantial changes in our understanding of how children develop and the role the early environment plays in that development. This has allowed researchers to move beyond the nature versus nurture debate and direct attention to better understanding "nature through nurture" (National Research Council and Institute of Medicine, 2000, p. 41). Child development is a continuous two-way interchange between genetic heredity and environmental experience (Gottlieb, 1991), primarily the environmental experiences that occur between an infant and their caretakers (Shonkoff & Levitt, 2010; Ward, Brown, & Westlake, 2012). It is during these early years that the foundation for

health and well-being is established (Felitti et al., 1998; National Research Council and Institute of Medicine, 2000; Shonkoff & Levitt, 2010).

There is no one right way to parent (O'Connor & Scott, 2007), but there are core components of effective parenting that have been linked to improved physical, cognitive, and social/emotional outcomes for all children (National Academics of Science, 2016). These include nurturance, warmth, sensitivity, and responsiveness; predictability and consistency; parental monitoring and protection; and the absence of harsh and punitive forms of discipline (Barber, Stolz, Olsen, Collins, & Burchinal, 2005; Bornstein & Lansford, 2010; Claes et al., 2011; Elmore & Gaylord-Harden, 2013; Joussemet, Mageau, & Koestner, 2013; Khaleque, 2014; O'Connor & Scott, 2007; Underdown & Barlow, 2012).

Advances in expert understanding of parenting do not align with public understanding. Experts believe there are core components of effective parenting that require specific knowledge, skills, and practices "whereas this know-how is excluded from public thinking by the assumptions that good parenting flows naturally and automatically from simply having concern for one's children" (Volmert et al., 2016, p. 41). Experts identify the desired outcomes for children as being related to building children's capacity in important developmental domains, while "the public, by contrast, equate parenting success with raising a happy, socially integrated child" (Volmert et al., 2016, p. 41). Finally, experts see early parenting as critical while "the public consistently age up when thinking about parenting, focusing instead on older children" (Volmert et al., 2016, p. 41). This divergence between expert and public knowledge in understanding what is needed to engage in effective parenting, the goals of parenting, and when parenting skills are critical, may in part help explain the lack of intentional preparation for parenting.

Super's (1980) theory of life-role readiness tells us that preparation (i.e., the attainment of the knowledge, skills, and awareness of what is required for an activity beforehand) increases the likelihood of success. Preparation is done to minimize the possibility of harm or adverse outcomes (Johnson et al., 2014) and people are more likely to engage in preparation when the activity and outcomes are valued (Niles, 2012). Given that over 90% of parents think parenting is one of the most important things they will do in their lifetime (Oldershaw, 2002), it is startling that, globally and locally, so many begin parenting feeling unprepared.

**Lack of preparation.**

Feeling unprepared for parenting is something parents all over the world report experiencing. In Malta, Borg Xuereb, Abela, and Spiteri (2012) looked at the challenges parents faced during the transition to parenthood. They found that a lack of preparation influenced the transition to parenting, that parents were concerned about being able to care for their child as many had never held a baby before becoming a parent, and that "preparation could have made a big difference to them" (Borg Xuereb et al., 2012, p. 480). Tugut, Tirkes, and Demirel (2015) found that a lack of preparation for childbirth and the postpartum period was associated with decreased coping abilities in a study with new parents in Turkey. In Ireland, Cronin (2003) found that first-time mothers were unprepared for birth and motherhood. In the United States, it was reported new mothers felt prepared "for pregnancy, labor, and delivery, (but) a clear 'lack of preparedness' for the early postpartum period was evident . . . and included the following themes: a change in priorities, overwhelming responsibility, unclear role expectations, and knowledge deficit" (George, 2005, p. 253). And in Canada, a major national study highlighted the extent of unpreparedness locally (Oldershaw, 2002).

Invest in Kids[3] commissioned the Canadian National Survey of Parents of Young Children (NSPYC) to explore the behaviour, knowledge, and confidence of parents with children below the age of six years (Oldershaw, 2002). Although preparation for parenting was not the focus of this survey, the reported lack of feeling prepared to parent was an important finding. With over 1,600 parent participants, it was found that "before their first baby was born only 44% of parents felt prepared for parenthood; after their first baby was born the percent of parents who felt confident plummeted to 18%" (Oldershaw, 2002, p. IV). This indicates there is a "substantial gap in what parents believe they know and what they need to know to support their child's development" (Benzies, Clarke, Barker, & Mychasiuk, 2013, p. 1452; Rikhy et al., 2010).

In only one study in the United States were the majority of parents found to be prepared for parenting. Gager, McLanahan, and Glei (2002) explored levels of readiness of new parents and found most were prepared for parenting. They determined level of readiness using four factors: pregnancy intention (95%), attendance at either prenatal or parenting education (75%), the presence of support in case of an emergency (70%), and confidence in the ability to parent (40%). Gager et al. (2002) based their conclusions regarding preparedness on four factors that may or may not reflect readiness to parent. For example, accessing formal education does not mean people are prepared for parenting, particularly if it was a prenatal program as these have been found to do little to prepare people for actual parenting (Entsieh & Hallström, 2016). Confidence in the ability to parent (40%) may be a better indicator and appears to be more aligned with Oldershaw's (2002) use of the concept of preparedness. The discrepancy between these two national studies highlights the lack of clarity and consistency in how the concept of preparation for parenting is understood and used.

[3] Invest in Kids, a non-profit national organization engaged in research on parenting and the development of training and resource materials for parents, closed September 2010 due to a lack of funding.

**Components of preparation.**

Although the concept of being unprepared for parenting was not clearly defined by Oldershaw (2002), given our understanding of what preparation involves (i.e., acquiring the knowledge, skills, and awareness of supports required for an activity beforehand) (Super, 1980), we can infer being unprepared would mean people did not have the knowledge, skills, or awareness of what was needed to parent beforehand. This appears to be an accurate inference.

***Knowledge.***

Canadian parents of young children demonstrated a low level of knowledge about child development with correct responses averaging only 23% (Oldershaw, 2002). Parents felt they knew the most about physical development (55%), but only 6% felt this was an area of development they could influence. They knew less about intellectual (15%), emotional (18%), and social development (12%), but felt these were the areas where they had the greatest influence (intellectual -18%, emotional - 44%, and social - 32% respectively). Paradoxically, parents felt most knowledgeable about an area of development they did not believe they could influence and less knowledgeable about the areas they believed they could influence.

Similar findings were reported by Rikhy et al. (2010) in a sample of over 1400 parents and nonparents in Alberta, Canada, where knowledge about physical development (63%) was much higher than knowledge about cognitive (15%), social (7%), and emotional (2%) development. There were few differences in the level of knowledge between parents and non-parents. Rikhy's study was repeated in the same province six years later, and it was found that overall knowledge levels had dropped from 23% in 2007 to 21% in 2013 (Pujadas Botey et al., 2017).

***Skills.***

In the NSPYC it was also found that parents lacked skills to manage children's behaviour. The majority of parents of young children in Canada (62%) regularly used angry and punitive parenting behaviours when managing their child's misbehaviour, and 34% lacked effective child management skills (Oldershaw, 2002). Half of all parents used physical punishment when their child misbehaved and perhaps even more disturbing was the finding that 40% of parents of infants under the age of one, reported using physical punishment at least occasionally with their babies.

In another Canada-wide study, the National Longitudinal Survey of Children and Youth (NLSCY), Chao and Willms (2002) report that only about one third of Canadian parents engaged in an authoritative parenting style[4], while two-thirds used harsh/controlling or permissive parenting practices. Both harsh/controlling and permissive parenting styles have been linked to poorer outcomes for children (Baumrind, 1978; Steinberg & Morris, 2001).

Crill Russell et al. (2011) surveyed 2,554 Canadian parents and found there is not enough positive parenting and too much negative parenting. Fifteen percent of mothers and nearly 30 percent of fathers report insufficient levels of positive parenting and 25 percent of mothers and 30 percent of fathers indicated excessive levels of negative parenting. This occurred across demographic groups, and it was not confined to parents with low income or less education.

In Manitoba, between the years 2002-2003 and 2010-2011, the number of children aged two to five years who were living in families with high ineffective parenting style scores remained constant at about 10% (Healthy Child Manitoba, 2012). However, the percentage of

[4] Authoritative parenting style refers to "the sense this term is used in the literature" (Chao & Willms, 2002, p. 164). Authoritative parenting is characterized as warm, responsive, and involved parenting without being intrusive (Baumrind, 1966).

children living in families with a low, consistent parenting style score increased from 8% in 2002-2003 to 14% in 2010-2011.

***Supports.***

The majority of Canadian parents of young children do not feel supported by government in their role as parents (Oldershaw, 2002), are unable to the get the validation they need in their community (Birnbaum, Crill Russell, & Clyne, 2007), and are unable to get the support they need from family and friends (Crill Russell et al., 2011). Healthy Child Manitoba (HCM) reported that the percentage of children (aged two to five years) living in families that reported low social support rose from 12% in 2002-2003 to 15% in 2010-2011 (Healthy Child Manitoba, 2012), indicating that the number of parents in Manitoba who feel unsupported is increasing.

**Summary: Background**

Parenting is an important and valued life role. However, there is a discrepancy between what experts and the general public (Volmert et al., 2016) believe is needed for effective parenting. This discrepancy may help explain why people feel unprepared when they begin parenting. Being unprepared for parenting was identified as lacking knowledge of child development, lacking effective parenting strategies, and not having adequate support in the parenting role. The significance of this lack of preparation for parenting becomes clear when we look at what is known to determine the nature and outcome of parenting and the role preparation for parenting might play within each of these determinants.

**Determinants of Parenting**

The determinants of parenting research can largely be traced back to Belsky's seminal work where, to better understand the variability in parenting, he developed a model to conceptually frame the "determinants of individual differences in parenting" (Belsky, 1984, p.

83). Belsky identified three groups of determinants of parenting: personal resources of the parent, contextual sources of stress and support, and individual child characteristics. These three determinant groupings have been consistently identified and used by others interested in understanding individual differences in parenting (Abidin, 1992; Bornstein, 2016).

While a number of child characteristics have been found to have an influence on parenting including child temperament (Belsky, 1984), child health/disability (Ciciolla, Crnic, & West, 2013), goodness of fit between the parent and child (Belsky, 1984), and the differential susceptibility of children to the impact of both positive and negative parenting (Belsky & Pluess, 2009), they will not be further examined in this review. Child characteristics are significant and not to be negated as determinants of parenting, but they are less amenable to influence through preparation for parenting. The two groups of determinants that are of particular relevance to this research are the determinants associated with the parent and the context.

***Personal resources of the parent.***

Who a person is and what they bring with them to the parenting role significantly influences their ability to parent effectively. This includes life experiences and personal characteristics.

***Life experiences.***

One of the most well-known life experiences that influences parenting is the lived experience of having been parented (Bornstein, 2016). The parenting we experience during our formative years provides the "template – default setting – for our later attitudes and behaviour" (Sher, 2017, p. 4). Lay people and academics agree that, for the most part, our parenting skills reflect those of our parents (Santrock, 2007; Serbin et al., 1998; Serbin & Stack, 1998).

This intergenerational transmission of parenting hypothesis has been primarily researched looking at continuities in the transmission of abusive and harmful parenting practices. Harsh parenting in one generation is associated with harsh parenting in the next generation (Dixon, Browne, & Hamilton-Giachritsis, 2008; Hops, Davis, Leve, & Sheeber, 2003; Simons, Whitbeck, Conger, & Wu, 1991). Individuals abused as children are at heightened risk for less effective parenting as adults (Jefferis & Oliver, 2006), for using more harsh and physical punishment with their children (Simons et al., 1991), and for maltreating their children (Belsky, 1980).

Preparation for parenting could be used to help a person resolve their own negative experience of being parented (Thomas & Bhugra, 2014) and provide education on appropriate parenting behaviour to prevent or alleviate negative outcomes before people become parents (Lee, Wilsie, & Brestan-Knight, 2011). Without preparation, many people will parent as they were parented, in spite of a desire to parent differently (Gray & Sims, 2007).

***Personal characteristics.***

There are few personal characteristics that we bring with us to the parenting role that do not influence how we parent. For example, things like gender, intelligence, personality (e.g., conscientiousness, neuroticism), executive functioning (e.g., impulse control and self-regulation), and biological endowment all influence our capacity to parent (Bornstein, 2016). Some personal characteristics are less amenable to change, such as those related to intelligence or biological endowment. The personal characteristics that have received the most attention in the research, and are more amenable to change through preparation, are parental cognitions. Parental cognitions reflect our knowledge and understanding of parenting, they structure our thinking about parenting and guide our parenting practices (Bornstein, 2016). Parental cognitions

include things like planning for parenting, parental self-perception, and actual knowledge of child development and parenting strategies.

*Planning for parenting.*

Although the vast majority of people will become parents, becoming a parent is a choice. The increased availability of contraception, advances in assisted reproduction, and greater acceptance of childlessness as a life choice are some factors that have increased individual autonomy in deciding to become a parent (Bornstein, 2016; Bortolotti & Cutas, 2009; Verbiest, Kiko Malin, Drummonds, & Kotelchuck, 2016). With this increased autonomy, it is startling that 40% of all pregnancies in Canada are unintended or unplanned (Black et al., 2015). An unplanned pregnancy does not always mean an unwanted pregnancy, but it has been found that unplanned pregnancies have been associated with less consideration of preconception health behaviour, delayed prenatal care, and less readiness to become a parent (Leathers & Kelley, 2000; Pierce Keeton, Perry-Jenkins, & Sayer, 2008; Sher, 2017; Spiteri et al., 2014; Stranger Hunter, 2017).

Planning for parenting affects both preconception and prenatal health behaviour (Bornstein, 2016; Sher, 2017). Preconception health behaviours related to nutrition, lifestyle choices (e.g., use of alcohol and drugs, levels of physical activity), and the use of supplements like folic acid and Vitamin D are all significant health contributors before conception (Genuis & Genuis, 2016; Sher, 2016, 2017; Stephenson et al., 2018). Prenatal health behaviours also significantly impact the health and well-being of children, with one of the most well-known being that of prenatal alcohol exposure. Fetal alcohol exposure can affect the development of the central nervous system in multiple ways, including physical health, physical abnormalities, and organic brain deficits (Riley, Alejandra Infante, & Warren, 2011; Streissguth et al., 2004). While

the majority of research and focus on preconception and prenatal health behaviour has been directed toward women, it is interesting to note that we are now finding that men's preconception health and behavioural choices can also have a significant impact on fetal and infant health. For example, preconception paternal alcohol use can impact fetal health outcomes (e.g., increased spontaneous abortion) and infant health (e.g., low birth weights) (McBride & Johnson, 2016). Before most people begin planning or thinking about being parents, the choices they make are influencing the health of their child.

The importance of prenatal care has been well accepted and widely used as a preventive health strategy (Alexander & Kotelchuck, 2001). It has been associated with fewer fetal and neonatal deaths, the reduction of low birthweight and preterm births, the reduction of maternal mortality, and improved outcomes for infant and maternal health in general (Alexander & Kotelchuck, 2001; Kirkham, Harris, & Grzybowski, 2005; Nicolaides, 2011). While there are considerable variations in prenatal care, it generally consists of regular visits with a primary health provider, screening for the detection of pregnancy complications, and the provision of information and support for the expectant mother (Kirkham et al., 2005; Nicolaides, 2011). Even with the widespread uptake of prenatal care, not everyone is convinced of its utility. Alexander and Kotelchuck (2001) point out that prenatal care is the most frequently used preventive health care service in the United States, regardless of the fact that there is little scientific evidence demonstrating its efficacy or impact on health outcomes. While they suggest strategies to improve research related to prenatal care, Sher suggests that the focus on prenatal care is misguided. He argues that prenatal care is often too late and that it is preconception care we need to focus on. "The best predictor of birth outcomes – good and bad – is the health and well-being of prospective mothers at conception" (Sher, 2016, p. 5). A sentiment seconded by Stranger

Hunter, who states “prenatal care usually cannot undo already present adverse impacts on the developing fetus” (Stranger Hunter, 2017, p. 22).

Planning for parenting versus “parenthood-by-surprise” (Stranger Hunter, 2017, p. 20) also has implications related to readiness to parent. The transition to parenthood is a major life transition that requires numerous lifestyle changes (Deave et al., 2008). This life transition has been found to be less stressful when people are psychologically and financially prepared (Mansfield, 1982; Spiteri et al., 2014). Being psychologically prepared to parent includes cognitive and emotional readiness. Cognitive readiness to parent has been identified as having knowledge of child development, a parenting attitude that is nurturing and supportive, and a parenting style that is authoritative and includes positive discipline rather than physical punishment (Bornstein, 2016; Sommer et al., 1993). Cognitive readiness to parent has been found to predict child attachment at one year of age (Lounds, Borkowski, Whitman, Maxwell, & Weed, 2005; Whitman, Borkowski, Keogh, & Weed, 2001), quality of parenting at three years of age (Whitman et al., 2001), and cognitive development of children at 2 years of age (Deave, 2005). Cognitive readiness to parent has been found to have longer-term impacts as well. In a longitudinal study with adolescent mothers, where cognitive readiness to parent was measured prenatally, and children’s adjustment (i.e., internalizing and externalizing behaviour) and school achievement was measured 10 years later, children, whose mothers had lower levels of prenatal cognitive readiness to parent, had more behavioural challenges and lower school achievement scores (Farris, Burke Lefever, Borkowski, & Whitman, 2013).

Emotional readiness to parent includes being ready to put your child’s needs ahead of your own; being ready to accept changes to your social life, your lifestyle, and the demands on your time; and being ready to accept the changes parenting brings to the marital/partner

relationship (Mansfield, 1982; Spiteri et al., 2014). Relationship-based interventions (i.e., planning and preparation for the transition to parenting) with expectant parents have been found to decrease the decline in marital/partnership relationships following the birth of a child (Deave et al., 2008; Glade et al., 2005; Schulz, Cowan, & Cowan, 2006).

Financial readiness to parent includes establishing financial security, stable/desired employment, adequate housing, and the capacity to acquire things needed for a child (Mansfield, 1982; Shirani, Henwood, & Coltart, 2011; Spiteri et al., 2014). Unplanned pregnancies have been found to impact the educational and economic prospects of women (Sawhill, Karpilow, & Venator, 2014), to contribute to cycles of intergenerational inequality and poverty (Venator & Reeves, 2015), and to increase depression and anxiety in expectant parents as a result of financial strain (Pierce Keeton et al., 2008). When people engage in financial planning for parenting and are prepared for the extra costs and the decreased income in a dual income family, there is less stress on both parents (Borg Xuereb et al., 2012; Gager et al., 2002).

*Parental self-perception.*

Parental self-perception is the idea a person has regarding the kind of parent they are or will be (Bornstein, 2016). It reflects how a parent evaluates their parenting ability and has been studied using concepts such as perceived parental self-efficacy, parental confidence, and parental competence (de Montigny & Lacharité, 2005). Increased parental self-efficacy has been associated with the use of more positive discipline practices, increased parenting competencies, improved outcomes for children, and increased parent well-being (Coleman & Hildebrandt Karraker, 2003; Coleman & Karraker, 1997; Jones & Prinz, 2005; Sanders & Woolley, 2005). Parents who report higher levels of parenting confidence experience less parenting stress (Sepa,

Frodi, & Ludvigsson, 2004), and parents who perceive themselves as more competent use more effective parenting strategies (Teti & Gelfand, 1991).

These three concepts used to examine parental self-perception have been used interchangeably (Löfgren, Petersen, Nilsson, Ghazinour, & Hägglöf, 2017) but they contain overlapping and distinct characteristics. de Montigny and Lacharité (2005) completed a concept analysis of perceived parental efficacy to distinguish it from parental confidence and parental competence. From this analysis they defined the three concepts: perceived parental self-efficacy was the belief a parent had about their capability to perform the needed tasks to parent a child; confidence was about the overall strength of belief regarding success or failure; and competence was the actual ability that could be observed, measured, and judged by others (de Montigny & Lacharité, 2005, p. 387). The importance in delineating these concepts is twofold. The first has to do with the relationship between perceived self-efficacy and naïve confidence. The second has to do with the mediating variable of parental knowledge.

Perceived parental self-efficacy has been widely examined because it can influence motivation when parenting and it plays a role in sustaining effort in the face of challenges and setbacks (Bandura, 1982, 2001). However, our perceived parental self-efficacy may also play a role in decreasing preparation for parenting. Each person has had some experience with parenting before becoming a parent, whether through relationships with children or through the act of having been parented and therefore has a personal theory of what parenting is and what it requires (Bornstein, 2015). Unfortunately, there is often a discrepancy between what we *believe* is required for parenting and what is *actually* required (Benzies et al., 2013; Volmert et al., 2016) as demonstrated in the NSPYC study where confidence in parenting ability dropped significantly following the birth of a child (Oldershaw, 2002).

Hess, Teti, and Hussey-Gardner (2004) identified this phenomenon as *naïve confidence* in a study looking at parental self-efficacy, parent knowledge, and parental competence with mothers of infants in a neonatal intensive care unit. They found that high levels of parental knowledge were associated with high levels of both parental self-efficacy and parenting competence. But when parent knowledge was low, there was an inverse relationship between parental self-efficacy and parenting competence. Mothers with low levels of knowledge and high self-efficacy were the least sensitive when interacting with their infants. Similar findings were reported by Coleman and Hildebrandt Karraker (2003) where maternal self-efficacy beliefs were not associated with actual parenting competence. Although parental perceived self-efficacy, confidence, and competence have all been associated with improved parental effectiveness, it is parenting knowledge that appears to mediate the relationship between perceived parental self-efficacy and parenting competence.

*Parenting knowledge.*

Parenting knowledge includes having information regarding the normative development of children and knowledge of effective parenting practices and strategies (Bornstein, 2016; Winter et al., 2012). Parenting knowledge affects the quality of parent-child interactions, parental behaviour, and has been associated with better outcomes for children (Huang, Caughy O'Brien, Genevro, & Miller, 2005; Rowe, 2008). While not intended to be an extensive review, the impact of parent knowledge on three developmental domains (physical, cognitive, and social/emotional) will briefly be examined.

Parents are responsible for the physical health and safety of their children. This includes meeting basic needs for nutrition, physical well-being, and monitoring for safety. Parental choices impact the physical development of children. For example, decisions made around

breastfeeding (Knaak, 2010) and whether or not to vaccinate/immunize your child (Wilson, Barakat, Vohra, Ritvo, & Boon, 2008) have physical implications for children and are both in part influenced by parental knowledge. Parents also play a role in the food and physical activity choices of their children and thus play a central role in childhood obesity (Loveman et al., 2015).

Parental knowledge of child development and parenting strategies also impacts the physical health and safety of children. When parents have a better understanding of age-appropriate developmental capabilities, they have a better capacity to predict a child's ability to do things (e.g., climbing on furniture) which has been associated with a reduction in the risk of unintentional injury (Kendrick et al., 2013). They also have more accurate expectations regarding the ability of children to comply with parental requests. This has implications as inaccurate expectations for compliance have been associated with increased use of harsh and punitive discipline practices and with an increased potential for child abuse (Azar & Rohrbeck, 1986; Durrant, Ensom, & Coalition on Physical Punishment of Children and Youth, 2004; Oldershaw, 2002; Reich, 2005; Twentyman & Plotkin, 1982). When parents interpret their child's non-compliance as defiance (i.e., a challenge to parental authority), rather than being related to developmental abilities or needs, it can lead to increased anger and more punitive discipline practices which increase the risk of injury to the child (Durrant et al., 2004). Results from the first cycle of the Canadian Incidence Study of Reported Child Abuse and Neglect (Trocmé, Tourigny, MacLaurin, & Fallon, 2003) tell us that 75% of the over 10,000 cases of substantiated physical abuse, were the result of using physical punishment as discipline. Given that we know 50% percent of Canadian parents of young children and 40% of Canadian parents of infants less than one-year-old use physical punishment, it is important in this review to highlight the impact this has on children.

In addition to an increased risk of child injury, Durrant et al. (2004), in the Joint Statement on Physical Punishment of Children and Youth, outline further risks associated with the use of physical punishment: it can interfere with trust in the parent-child relationship; it is a risk factor for increased childhood mental health problems such as depression and anxiety; it decreases opportunities to develop internal motivation to engage in appropriate behaviour; and it is a model of behaviour and not an inhibitor of aggression and as such leads to increased levels of aggression throughout life, including with one's own children and spouse. Parents who have an understanding of developmental needs and have effective parenting strategies to respond to those needs using positive discipline (i.e., discipline intended as way to guide learning rather than discipline used as punishment), are better able to parent in a way that promotes and enhances the development of children (Committee of Ministers of the Council of Europe, 2006; Durrant, 2013; Oldershaw, 2002; Parens et al., 2006; Rodrigo, Almeida, Spiel, & Koops, 2012).

Cognitive development includes the development of mental processes like thinking, understanding, reasoning and remembering (Bjorklund, 2004; PFL Evaluation Team at the UCD Geary Institute for Public Policy, 2016). These mental processes contribute to children's school readiness and academic success, both of which have been associated with improved living conditions in adulthood (Byford, Kuh, & Richards, 2012; Cowan & Cowan, 2014). Parenting behaviours that are associated with improved school readiness and academic success include sensitive and responsive parenting (National Research Council and Institute of Medicine, 2000; Reeves & Howard, 2013; Wang & Sheikh-Khalil, 2014), the provision of a cognitively stimulating environment (Barlow et al., 2010; Cunha & Heckman, 2008; Rao et al., 2010; Shonkoff & Levitt, 2010; Ward et al., 2012), and the guiding of child development by

scaffolding activities and adjusting expectations for behaviour according to developmental readiness (Asmussen, Feinstein, Martin, & Chowdry, 2016; Volmert et al., 2016).

Social development refers to developing the skills needed to interact with others (Denham, 2006). Emotional development is related to the ability to understand, manage, and regulate feelings and to control how they are expressed through behaviour (PFL Evaluation Team at the UCD Geary Institute for Public Policy, 2016). Social/emotional competence plays a role in how we think about ourselves, interact with others, experience our emotions, adhere to behavioural norms and is fundamental to our mental health and psychological well-being (Shulman, 2016; Tani, Pascuzzi, & Raffagnino, 2017).

Sensitive and responsive parenting plays a significant role in social/emotional development because of the influence it has on an infant's ability to establish attachment and trust, to develop a normal range of emotional arousal, and to control the stress response (Ainsworth & Bowlby, 1991; Bowlby, 1988; Rispoli, McGoey, Koziol, & Schreiber, 2013; Underdown & Barlow, 2012). Infants depend on parents to respond to their signals of distress in order to regulate their emotional states (Ward et al., 2012). In adolescence, higher levels of maternal psychological control (i.e., identified as less effective parenting behaviour) were associated with lower levels of emotional regulation (Manzeske & Dopkins Stright, 2009) and negative parenting practices were associated with increased anxiety, depressive symptoms, and aggression (Whittle et al., 2014). Conversely, when parents were able to understand and encourage typical adolescent need for autonomy, there were decreases in both internalizing and externalizing mental health problems (Joussemet et al., 2013) and these effects have been found to extend to adulthood (Price-Robertson, Smart, & Bromfield, 2011; Tani et al., 2017).

Understanding the needs of children based on their developmental stage informs the decisions parents make and guides parenting behaviour (National Academics of Sciences Engineering and Medicine, 2016). Parental knowledge of effective parenting practices and strategies is beneficial for all parents (Winter et al., 2012). Knowledge of child development and effective parenting strategies are acquired, not innate, and both could be enhanced through preparation (Parens et al., 2006).

The personal characteristics a person brings with them to the parenting role are essential determinants of parenting. Planning for parenting is, in effect, preparation for parenting. Even with the increased choices around becoming a parent almost half of all pregnancies in Canada are still unplanned. This impacts preconception and prenatal health behaviour and impacts readiness to parent. Parental self-perception is influenced by perceived self-efficacy, confidence, and competence. Parenting knowledge of child development and parenting strategies increases actual competence.

***Contextual determinants.***

The contextual determinants of parenting are aspects of the social and physical environment that impact a person's ability to parent (Belsky, 1984; Bornstein, 2016; Bradley, 2002). Environmental factors have the potential to increase stress (Cowan & Cowan, 2002; Zahn-Waxler, Duggal, & Gruber, 2002) and can decrease the ability of a person to engage in effective parenting (Shaw, Owens, Giovannelli, & Winslow, 2001). Parenting can be impacted by the demands of the situation, family structure, neighbourhood conditions, religion, culture, ethnicity, political views, historical conditions, and even evolution (Bornstein, 2016). The contextual determinants of parenting that have been widely examined are socio-economic status and social support systems.

*Socioeconomic factors.*

Socioeconomic factors that impact parenting include things like economic hardship (Parke et al., 2004), parent education (Bornstein, Cote, Haynes, Hahn, & Park, 2010), and employment opportunities/stress/demands (Hsueh & Yoshikawa, 2007). Understanding the impact of socioeconomic factors is challenging given the high degree of co-occurrence among these influences (Bradley & Corwyn, 2002). For example, parents who have less education often have fewer employment opportunities resulting in decreased income levels. Regardless of the challenge in untangling these factors, the detrimental effects of poverty on parenting have been commonly researched (Ghate & Hazel, 2002; Katz, Corlyon, La Placa, & Hunter, 2007; Parke et al., 2004) and will be further examined.

Stress theory is the most prevalent theory used to explain the impact poverty has on parenting (Katz, Corlyon, et al., 2007). Economic stress can negatively impact the parent (i.e., less time, fewer resources, fewer social and community supports, increased depression, and increased irritability) and therefore, parenting (Banovcinova, Levicka, & Veres, 2014; Hoghughi, 1998; Parke et al., 2004). Parental financial strain has been associated with less nurturing parenting behaviour, increased use of harsh discipline, and less parental monitoring of children (Conger, Elder, Lorenz, & Simons, 1994; Katz, Corlyon, et al., 2007).

Waylen and Stewart-Brown (2010) found that while increased economic pressure predicted a decline in parenting scores, decreased economic pressure did not predict an increase in parenting scores. Ghate and Hazel (2002) suggest that it is less about the actual income level and more about the ability of the parent to cope with stressors and utilize available opportunities. This theory is supported by the parent competency model developed by Johnson et al. (2014), where they found increased parental competence was associated with better management of

environmental stressors. Nonetheless, it is clear that economic stress impacts the capacity of people to parent and while planning and preparation might offset some of this stress (i.e., financial readiness as discussed earlier), Taylor, Spencer, and Baldwin (2000) point out this is related to the bigger issue of social inequity.

*Social support.*

Social support exists within social relationships and includes the sharing of resources, knowledge, and reciprocal care (Bäckström et al., 2017; Williams, Barclay, & Schmied, 2004). It can facilitate a sense of connection, mitigate stress, and has been positively related to parental functioning (Belsky, 1984; Bradley & Corwyn, 2002; Gray & Sims, 2007; McConnell, Breitkreuz, & Savage, 2012). Support networks can include family, friends, neighbours, people at work, or other community groups (Billingham, 2011; Birnbaum et al., 2007; Darlington & Miller, 2000). Family appears to be the most relied upon social support system for parents and includes support in the form of helping with child care, financial support, informational support, and emotional support (Billingham, 2011; Miller & Darlington, 2002).

Waylen and Stewart-Brown (2010) found that increased social support was associated with improved parenting scores, but that deterioration in social support did not predict a decline in parenting scores. Much like socioeconomic status, social support while significant appears to be a moderating rather than a mediating[5] variable related to parenting.

Preparation involves establishing an awareness of what is needed for an activity (Niles, 2012). Acquiring needed resources and building social support networks before parenting could be important determinants associated with preparation for parenting.

[5] Moderator variables influence the strength of a relationship between two variables while mediator variables explain the how or why of the relationship between two variables (Baron & Kenny, 1986)

### Summary: Determinants of Parenting

There are a wide range of personal characteristics and contextual factors known to impact parenting. The personal resources a person brings to the parenting role, including their lived experience of having been parented and parental cognitions (i.e., planning for parenting, parental self-perception, and parenting knowledge), influence parenting. Contextual factors like poverty and social support also influence parenting. Preparation for parenting could influence preconception and prenatal health behaviour, lead to increased knowledge of child development and effective parenting strategies, and influence efforts made to attain resources and supports. In essence, preparation for parenting appears to be one determinant where the potential has not been fully realized.

Bornstein (2016) states that parent determinants are factors that equip people to respond to the requirements and responsibilities of parenting. Equip typically means "to make ready or to prepare" (Merriam-Webster, 2005). While Bornstein uses the word equip, the determinants of parenting research appears to be less about equipping or preparing, and more about what influences a person once they are parenting. As noted earlier, there is a difference between preparation and prepared. The determinants of parenting have focused mainly on the end state with little attention paid to how people arrive at this end state. We know far less about parent development and how people acquire the needed knowledge, skills, and supports that contribute to effective parenting.

### Parent Development

People are not born knowing how to parent; parenting is a learned skill (Arcus et al., 2003). And while parenthood begins when we become responsible for raising and caring for a child, the psychosocial transition to parenting is a much longer process (Glade et al., 2005). Our

parenting reflects learning and experiences accumulated across multiple life stages (Bornstein, 2015). Parent development will be examined using both a theoretical (i.e., the explanation of how we develop as parents) and a practical (i.e., established practices related to parent development) lens.

### *Theoretical lens.*

Despite the almost universal experience of becoming a parent, there is a lack of theory looking at parent development (Glade et al., 2005). Some broad developmental theories have incorporated parenthood as a life stage (Erikson, 1982) but there are few theories dedicated to parent development (Demick, 2002). Two of these will be reviewed.

#### *Parent development theory.*

Mowder's parent development theory (PDT) suggests that the parent role is a cognitive concept or schema that we develop throughout life (Mowder, 2005). In childhood, we observe those around us and begin to develop an understanding of the parenting role. As we mature and are exposed to different experiences, we refine our understanding. If we become parents, this schema will inform our parenting views and behaviours. This schema is not static but is continually adjusted to accommodate for and meet the needs of, our children as they develop. Mowder has identified six parent role characteristics that occur in the parenting role and in essence describe parent development: (1) bonding (love, affection, warmth), (2) discipline (setting limits, managing children's behaviour), (3) education (teaching and guidance), (4) general welfare and protection (meeting basic survival needs), (5) responsivity to the child, and (6) sensitivity (appropriateness of responses to the child's needs). Mowder's PDT suggests that all people have a cognitive conception of what the parent role entails informed by these six components and moderated by individual perceptions and life experiences, parent and child

characteristics, the parent-child relationship, family dynamics, and the social-cultural milieu (Mowder, 2005).

*Six stages of parenthood theory.*

Galinsky (1987) introduced the six stages of parenthood theory which describes stages of parent development as being driven by the experiences one has while parenting. She identifies the following stages in her theory: (1) parental image stage, which occurs after the birth of a child and involves the mother and father forming an image of themselves as parents; (2) nurturing stage, which occurs during infancy and involves developing an attachment to the child; (3) authority stage, which occurs when the child is between the ages of two and four years and parents question their effectiveness as parents; (4) integrative stage, which occurs from preschool to the middle school years, when parents need to set boundaries, communicate effectively and establish authority; (5) independent teenage stage, which occurs when the child becomes an adolescent dealing with increasing maturity and identity concerns and parents are striking a balance between fostering their teens' autonomy and exerting their authority; and (6) departure stage, which occurs when adolescents leave home and parents adapt to a different relationship with their child.

In the six stages of parenthood theory, Galinsky suggests that parent development happens as a function of parental self-reflection and self-evaluation. Parents compare expectations of how they will parent with the reality of how they do parent in relation to children's developmental stages (Galinsky, 1987).

*Challenges with parent development theories*.

While Mowder and Galinsky's theories on parent development are helpful, each presents challenges. Mowder's PDT (2005) relies heavily on observational learning as a way to develop

parenting skills. Observational learning creates inherent inequity in parent development. Not everyone has the same, or even remotely similar, opportunities to develop these skills. Some people will have positive parenting role models from which to learn, but the majority will be far less fortunate (Reeves et al., 2013). Galinsky's (1987) six stages of parent development rely primarily on experiential learning (i.e., learning that results from reflecting on experience). While experiential learning can be useful in many activities, and will always be important in informing parenting behaviour, it does not seem that all parents can learn from experience alone. In the NSPYC, it was found that parents with more parenting experience (i.e., multiple children) did not have more knowledge about child development nor did they feel more confident in their parenting role (Oldershaw, 2002). Additionally, experiential learning does not prepare people to support their child in the next developmental stage. Crill Russell (2003) concluded that although mothers become more comfortable in their parenting role during the first year of parenting, they never reach a point where they feel competent because their child's needs change with age.

Relying on observational and experiential learning does not seem sufficient in preparing people for parenting (i.e., acquiring the needed knowledge, skills, and supports) given the large number of people who feel unprepared for parenting (Oldershaw, 2002). Neither of these theories on parent development incorporates intentional preparation activities.

**Practical lens.**

There have been numerous curricula, programs, and services developed with the intent of preparing people for parenting and enhancing parent development. This review of parent development practices is not exhaustive but will provide a general overview of parent education

and support using the following framework: purpose/rationale, a specific Manitoba example[6], evidence of effectiveness, and known challenges.

***Parent education.***

Parent education programs and curricula have been developed for people across multiple life stages. The focus and intent of the education programs are different for people before pregnancy (i.e., preconception), during pregnancy (i.e., prenatal), and following pregnancy (i.e., postnatal).

*Preconception.*

Parenting education for students enables them to acquire the skills, knowledge, and values needed to understand parenting before they become parents and includes topics such as family relationships, the roles and responsibilities of parents, childhood development, and positive parenting practices (Hope & Sharland, 1997; McDermott, 2003, 2014; Parens et al., 2006; Scattergood, 1986). Parenting education can be used to increase empathy, improve social and emotional skill development, and facilitate human development literacy (McDermott, 2014). As McDermott points out, the benefits are not restricted to improved relational and academic success at school, but extend into adulthood and impact parenting, partnerships, and community involvement. Some contend that enhancing the traits of empathy and caring is a way to break through patterns of child abuse, neglect, and violence (Cooper, Garfinkle Chevrier, Schiffer, & Schuver, 2002).

Parenting education can also be used to help young people make informed choices about reproduction and parenting (Bortolotti & Cutas, 2009). Bortolotti and Cutas are strong advocates

[6] Given the variety of opportunities for preparation for parenting and enhanced parent development (both formal and informal) that exist within individuals, private organizations, community groups, and government-funded programs not all can be included in this review and therefore only examples will be provided.

for mandatory parental education for students and argue if young people were provided with reliable information regarding parenting and were given the opportunity to reflect on their reasons for choosing to parent, they would become more aware of the responsibility of their choice and have the tools to make an autonomous choice. This argument is supported by Sher (2017), who points out that a lack of preconception education related to preparing for pregnancy and parenthood weakens the ability to decide about if, when, and why one becomes a parent. Additionally, Sher (2017) and Genuis and Genuis (2016) believe that using education during the preconception life stages could decrease unplanned pregnancies and increase understanding of the importance of preconception health behaviours.

Students in Manitoba can take Family Studies as an optional course in Grades 9-12. As shown in Table 1, on average, fewer than 10% of students in Manitoba took Family Studies in any given year between 2006 and 2013 (C. Bilyk[7], personal communication, March, 2015). In addition to Family Studies courses, many schools in Manitoba incorporate opportunities to learn about parenting in other ways. Some examples would be Roots of Empathy (Gordon, 2005) where parent-infant visitors come to the classroom. Another program used in Manitoba schools is Baby Think It Over (Qi Wang, 2011). This program includes classroom learning and experiential learning where students are given a vest to wear that simulates pregnancy in the last trimester. It is unknown how many teachers use additional opportunities to teach about parenting in their classrooms.

[7] Carole Bilyk. Coordinator of the Development Unit, Manitoba Education and Advanced Learning

Table 1. Students enrolled in Family Studies per year in Manitoba

| | Year | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Grade** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** |
| **9** | 807 | 748 | 928 | 924 | 996 | 1339 | 1138 | 1171 |
| **10** | 1716 | 1579 | 1655 | 1772 | 1943 | 2282 | 2105 | 2044 |
| **11** | 965 | 1018 | 904 | 863 | 1068 | 1350 | 1239 | 323 |
| **12** | 1368 | 1340 | 1332 | 1743 | 1771 | 1732 | 1717 | 1577 |
| **Total Enrolled** | 4856 | 4685 | 4819 | 5302 | 5778 | 6703 | 6209 | 5115 |
| **Eligible to be Enrolled** | 65668 | 66130 | 66492 | 66992 | 67463 | 66947 | 66591 | 65802 |
| **Percentage** | 7.3 | 7.1 | 7.2 | 7.9 | 8.5 | 10 | 9.3 | 7.8 |

Parenting education in schools has been found to have psychosocial benefits for students. Programs, such as the Roots of Empathy (Gordon, 2005) have been shown to decrease physical aggression, indirect aggression, and increase pro-social behaviour (Santos, Chartier, Whalen, Chateau, & Boyd, 2010). Other studies looking at parenting education in schools have found it was associated with increased problem-solving skills, communication skills, and conflict resolution skills (Jacobson, 2001; McDermott, 2002; Weller Meyer, Jain, & Canfield-Davis, 2011). Preconception parent education has been found to decrease naïve confidence in high school students by increasing realistic expectations of parenthood (Sasso & Williams, 2002). It has also been found to increase knowledge of child development in high school students (Shorr, 1981; Zoline & Jason, 1985) and to increase understanding of effective parental discipline with undergraduate students (Lee et al., 2011).

There is a lack of research looking at the long-term impact of preconception parenting education on parenting. The only published material[8] I found was done by Griffith (2002) with a group of people who had participated in the Adolescent Development Program (ADP). The ADP was a 3-month program intended to help prepare adolescents for adulthood and included skill

[8] This is the only published work I was able to find after an extensive search. If there are other published works available, I am unaware of them.

development related to employment, civic engagement, and parenting. Forty ADP participants were contacted 10 years after completing the program to see what influence the program had on their lives. Griffith reported that ADP participants felt the course had enhanced their parenting skills, female ADP participants postponed childbearing (although this was not found for male participants), and ADP participants reported improved communication with their parents. Griffith (2002) recommended that ADP programs be included in high school education based on the positive feedback from participants.

A significant challenge faced by those wanting to implement parenting education in schools relates to the low importance it is given compared to academic subjects (Hope & Sharland, 1997; McDermott, 2014). Teachers have to be accountable for student achievement, and the focus is on subjects measured by standardized assessments (Hope & Sharland, 1997; Jacobson, 2001).

*Prenatal.*

Prenatal education has traditionally been used to prepare expectant parents for changes during pregnancy and to decrease anxiety and pain during labour and childbirth (Crill Russell, 2003; Public Health Agency of Canada, 2009). It is most often done in a group setting led by a health professional and targeted toward the latter part of pregnancy (Svensson, Barclay, & Cooke, 2008). More recently there has been increased interest in prenatal education that supports the transition to parenting with added emphasis on emotional changes, the couple relationship, bonding and attachment, and parenting skills (Barlow et al., 2008; Renkert & Nutbeam, 2001; Schrader McMillan, Barlow, & Redshaw, 2009; Svensson et al., 2008). In addition to prenatal classes, it has been found that expectant parents engage in self-directed learning by talking with

their primary medical provider, with family and friends, reading books, and accessing information on the internet (Ateah, 2003; Crill Russell, 2003; Oldershaw, 2002).

Prenatal classes are offered in Manitoba through government agencies, volunteer groups, community groups, and private organizations. It is unknown how many expectant parents attend prenatal classes in Manitoba, but we do know that in Canada, about one-third of all women attend prenatal classes (Public Health Agency of Canada, 2009).

A systematic review of studies looking at the effectiveness of prenatal education found some evidence for increased knowledge and preparation for parenthood, increased maternal satisfaction with the birth experience, fewer pre-term and low birth weight babies, and a higher rate of breastfeeding (Schrader McMillan et al., 2009). However, these authors cautioned that the evidence was limited. Prenatal programs vary in quality and intensity (Clavero, 2001; Crill Russell, 2003; Schrader McMillan et al., 2009) and this diversity in content and duration makes it difficult to assess their benefits (Public Health Agency of Canada, 2009) leaving the effect of prenatal education on parenthood unknown (Crill Russell, 2003; Gagnon & Sandall, 2007).

There are two main challenges related to parenting education for expectant parents. First, most prenatal education programs are offered over a short time frame. Prenatal classes are offered for about an hour a week and typically range between four and ten weeks (Crill Russell, 2003; Matusicky & Crill Russell, 2009). According to Crill Russell,

> No program exists that could be identified as comprehensive, structured parent education. There are points along the way during pregnancy and babyhood when information is directed toward parents in quasi-educational efforts, but there's nothing that constitutes a real education program that fully shows parents how to prepare for parenting and how to

> enhance their child's social and emotional development during the first two years of life. (Crill Russell, 2003, p. 79).

Second, it has been found that prenatal classes focus on pregnancy and childbirth (Renkert & Nutbeam, 2001), on the medical aspects of childbirth and early child care (Entsieh & Hallström, 2016), and allocate little or no time to preparing people for parenting (Billingham, 2011; Crill Russell, 2003; Deave et al., 2008; Entsieh & Hallström, 2016; Schrader McMillan et al., 2009).

*Postnatal.*

Once people become parents, parenting education involves the teaching of specific knowledge and skills to develop parenting capacity in order to enhance children's well-being, improve family functioning, and decrease child maltreatment (Barlow & Stewart-Brown, 2001; Baruch, Vrouva, & Wells, 2011; Kumpfer & Alvarado, 2003; Ponzetti Jr., 2016; Reichle, Backes, & Dette-Hagenmeyer, 2012; Scholer, Hudnut-Beumler, & Dietrich, 2012; Scott et al., 2012; Webster-Stratton & Taylor, 2001). While most parenting education programs have the same goal (i.e., improve parent-child interactions) the content can vary based on the intent of the program. For example, some programs are designed to help parents with specific child concerns like autism spectrum disorder (Steiner, Koegel, Koegel, & Ence, 2012), self-regulation and anger control issues (Baruch et al., 2011), attention deficit hyperactivity disorder (Fabiano et al., 2012), or antisocial behaviour (Stolz, Vargas, Clifford, Gaedt, & Garcia, 2010). Others are used by courts when parents are divorcing (Salem, Sandler, & Wolchik, 2013), by government agencies when children have been or are at risk for being neglected or abused (Barth, 2009), or by community groups to increase positive parenting and decrease the use of physical punishment (Durrant et al., 2014).

It is unknown how many parents in Manitoba participate in parent education, but in a survey of over 2,300 Canadian parents of children between 2 and 12 years old, it was found that 15% had attended a program focused on child behaviour, child development, or parenting in the previous year (Lee et al., 2014). One of the more available parent education programs in Manitoba is the Triple P Positive Parenting Program (Triple P) (Sanders, Cann, & Markie-Dadds, 2003). Triple P was implemented in Manitoba in 2005 by Healthy Child Manitoba (HCM) as a "prevention strategy to strengthen parents' confidence, skills, and knowledge of caring and effective parenting" (Healthy Child Manitoba, 2010, p. 7). HCM covers the cost of the training for service providers and the resources needed to deliver the program to parents (Smith, Brown, Feldgaier, & Lee, 2015). There are more than 2,600 people from over 325 community agencies in Manitoba who have completed their accreditation as Triple P practitioners (Healthy Child Manitoba Office, 2016). In addition, in 2011 HCM introduced the Triple P parent line (now called the Manitoba Parent Line) that offers counselling over the phone, an online newsletter, podcasts, and a series of online videos to increase access to parent education and support for Manitoba families who live in remote communities (Smith et al., 2015). HCM also has the ManitobaParentzone website which provides an Ask the Expert portal, tip sheets, information about becoming a parent or caregiver, resource lists, and emergency contact numbers (Healthy Child Manitoba, n.d.).

Parenting education for parents has been widely used for parent development (DeBord, Heath, McDermott, & Wolfe, 2000; Liggett-Creel, Barth, Mayden, & Pitts, 2017; Popkin, 2014). It has been found to lead to increased confidence in parenting skills (Skrypnek, 2008), more positive parenting (Joussemet et al., 2013; Reichle et al., 2012), and better outcomes for children (Kumpfer & Alvarado, 2003; O'Connor & Scott, 2007). Parenting education has also been found

to be effective with parents across cultures (Fabrizio, Lam, Hirschmann, & Stewart, 2013; Sumargi, Sofronoff, & Morawska, 2014) and at a population-level (Barlow et al., 2010; Barlow, Smailagic, Huband, Roloff, & Bennett, 2012; Löfgren et al., 2017; Sanders et al., 2003).

Two main challenges have been identified with parenting education for those already parenting. The first is related to the quality of parent education programs. Gilmer et al. (2016) found that the many parent education programs in existence are not based on adult learning theories or parent-child interaction theories, that there is often no link between the program objectives and child development outcomes, and that program administrators are inconsistent in their use of evaluation criteria.

The second challenge is related to attendance. Parents say they want more information about parenting (Oldershaw, 2002; Zepeda, Varela, & Morales, 2004) but most people are not motivated to learn about parenting until they run into problems (Crill Russell, 2003; Drummond, 2005). While about one-third of Canadian mothers attend prenatal classes, (Public Health Agency of Canada, 2009), only about 15 percent of Canadian parents participate in a parenting program after their child is born (Lee et al., 2014). This may be the result of people believing that parenting is natural, innate, and does not require intentional learning (Rodrigo et al., 2012; Volmert et al., 2016) and that only those who are unsuccessful at parenting need to participate in a parenting program.

Barth et al. (2005) report that in the United States approximately 400,000 parents involved with child welfare services are annually referred to parenting programs. Because parenting programs have been used as an intervention strategy for parents who maltreat or are at-risk for maltreating their children (Berkovits, O'Brien, Carter, & Eyberg, 2010; Reppucci, Britner, & Woolard, 1997) the programs have become associated with failing as a parent. This

stigma associated with parenting education has influenced parents' willingness to participate (DeBord & Matta, 2002; Gray & Sims, 2007; Heinrichs, Bertrram, Kuschel, & Hahlweg, 2005; Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Lindsay et al., 2014; Zepeda et al., 2004), particularly parents who are disadvantaged or vulnerable as they fear this will increase their risk of social exclusion (Allen et al., 2012; Molinuevo, 2012; Sanders, Cann, & Markie-Dadds, 2003; Utting, 2007). Thus, participation in parenting education programs tends to be less likely among parents in lower income brackets, those with less post-secondary education (Schrader McMillan et al., 2009; Zepeda et al., 2004), and those from different cultural backgrounds (Bornstein, Putnick, & Lansford, 2011).

***Parent support.***

In recent years there has been a rapid increase worldwide in government initiatives to improve outcomes for children by increasing support to parents (Shulruf, O'Loughlin, & Tolley, 2009). Britto et al. (2017) point out that in the year 2000, seven countries had early childhood development policies and by 2014, this number had risen to 68 countries. Locally, an illustration of this can be seen in the creation of Healthy Child Manitoba (HCM) in the year 2000, which is a cross-departmental prevention strategy focused on developing a network of programs and supports for children, youth, and families (Healthy Child Manitoba, 2015). Parent support programs increase access to resources and information to strengthen parent capacity and include financial support, home visiting, and community support programs (Dillon Goodson, 2014; Parenting Research Centre, 2014; Trivette & Dunst, 2014).

*Financial support.*

Financial strain is a significant stressor that can be associated with other adverse life circumstances such as lack of employment, substandard housing, and poor nutrition (Ghate,

2002). It can impact parenting behaviour, the emotional climate within the home, and parental mental health (National Research Council and Institute of Medicine, 2000). Financial support has been used to help parents meet their own and their children's nutritional needs, their housing needs, and to provide access to other basic living necessities to improve outcomes for children and families (National Academics of Sciences Engineering and Medicine, 2016).

In Manitoba, there are universal financial support programs for all parents such as family allowance, parental leave, and tax benefits related to raising children (Birnbaum, 2007). There are also targeted[9] financial support programs. One example is the Healthy Baby Prenatal Benefit (HBPB) program initiated in 2001 for low-income pregnant women (i.e., women with a net family income of less than $32,000 a year[10]). The HBPB is intended to improve health and birth outcomes, is paid on a monthly basis, and every cheque is accompanied by inserts providing information on prenatal care, the importance of early child development, and information about the Healthy Baby Community Support program (Brownell et al., 2010). The HBPB in Manitoba is unique in that it is unconditional financial support (i.e., pregnant women are not told how to spend the money) (Brownell et al., 2016; Racine, 2016). Conditional cash transfers are far more common and refer to money being given based on compliance with a pre-determined requirement such as attending health education or completing immunizations (Lagarde, Haines, & Palmer, 2009; Racine, 2016).

In an evaluation of The HBPB program, it was found that out of the 56,560 births in Manitoba (between 2004/2005 and 2007/2008) 29% of mothers accessed the prenatal benefit

[9] Targeted interventions are intended for individuals using a specific demographic risk indicator such as economic disadvantage (Asmussen et al., 2016).

[10] The HBPB available to expectant women is based on their family net income and ranges from the maximum of $81.41 per month for those with a net income below $21,744 to $10.00 per month for those with a net income between $30,000 and $31,999 (Brownell, Chartier, Au, & Schultz, 2010). It is available to eligible women in the second and third trimester of pregnancy.

(Brownell et al., 2010). This unconditional financial support was associated with a reduction in both low birth weight and preterm births and with an increase in breastfeeding initiation (Brownell et al., 2016). Conditional cash transfers have also been found to have positive impacts on the increased use of preventive services by pregnant women and to improve health and nutritional outcomes of children as reported in a Cochrane Review of conditional cash transfer programs (Lagarde, Haines 2009).

Challenges with both unconditional and conditional financial support include determining why or how the financial support made a difference (Brownell et al., 2016; Lagarde et al., 2009), their sustained feasibility, and knowing the impact level or threshold of the financial support (Lagarde et al., 2009). A challenge associated with unconditional financial support is that the financial support is not linked to changing behaviours associated with improved well-being (Lagarde et al., 2009).

*Home visiting.*

Home visiting programs are used to enhance parent development by supporting parents in their capacity to provide more sensitive and competent care (Brooks-Gunn, Fuligni, & Berlin, 2003; Garner, 2013; National Collaborating Centre for Determinants of Health, 2010). The home visiting model of support is widely used (Adirim & Supplee, 2013; Cowley et al., 2015; Godin et al., 2015; Olds, Henderson, Tatelbaum, & Chamberlain, 1986) and primarily targeted to socially disadvantaged mothers with some well-known programs being the Maternal, Infant and Early Childhood Home Visiting in the United States (Adirim & Supplee, 2013) and the Family Nurse Partnership program in the United Kingdom (Asmussen & Weizel, 2010).

Two examples of home visiting programs in Manitoba include the Families First Program and postnatal home visiting done through public health. The first is a targeted program and the

second a universal program. Access to the Families First program is based on a determination of family risk factors. A screening tool is used with families following the birth of a child, and if three or more risk factors are identified, an additional Parent Survey is completed (Healthy Child Manitoba, 2010). Based on responses to the Parent Survey, parents are offered either the home-visiting program (i.e., parents identified as being more at-risk) or they are asked to participate in the comparison group where they are offered a few home health visits or referrals to other supports in the community as needed (Healthy Child Manitoba, 2010). Parental participation is voluntary. Public Health Nurses (PHN) in Manitoba provide home visiting services for parents of newborns as a universal health promotion strategy (Cusack, Cohen, Mignone, Chartier, & Lutfiyya, 2017; National Collaborating Centre for Determinants of Health, 2013). Typically, this involves one visit that occurs shortly after the mother and infant return home from the hospital. The purpose of the visit is to make a connection with the parent, to identify how things are going, to confirm physical recovery, to informally assess the emotional transition to parenthood, to discuss support systems, and to inform parents about the services and supports in their community (C. Cusack[11], personal communication, April 18, 2018). PHN home visits are not mandatory.

In a recent study, Chartier et al. (2018) found that children whose parents participated in Manitoba's Families First program were less likely to be taken into care of child welfare and more likely to have received complete immunization at age one as compared to children whose parents were eligible but did not participate. In a review of the evaluations of nine home-visiting programs, Howard and Brooks-Gunn (2009) found that while there was little evidence that

[11] Dr. Cheryl Cusack, RN, PhD. Senior Public Health Nursing Practice Advisor & Professional Practice Lead Manitoba Health, Seniors, and Active Living – Population & Public Health Branch

programs prevented child abuse and neglect, they did have a positive influence on parenting skills, the home environment, and child development. The National Collaborating Centre for Determinants of Health (2010) completed an extensive review of home visiting models to determine what type would be most appropriate for Canada. They could not draw conclusions given the variability in the studies evaluating the effectiveness of various home visiting programs.

Some challenges have been identified related to home visiting programs. To begin, they are resource intensive (i.e., cost and skilled personnel required) and may not be a sustainable model of parent support (Gilmer et al., 2016). As well, nurse visitors report there can be challenges engaging mothers in the learning process given the frequent crises happening in mothers' lives (Kitzman, Cole, Yoos, & Olds, 1997). It can also be hard to meet the unique needs of the mothers while maintaining program fidelity (Barak, Spielberger, & Gitlow, 2014).

*Family support programs.*

Family support programs in Canada operate primarily as community-based organizations that promote healthy child development and improved family functioning by building parental capacity, enhancing existing parenting strengths, and providing information about and access to resources (Gardiner, 2012; Smythe, 2004). While there are some commonalities across support programs (e.g., use of a strengths-based approach), each is formed by the needs of the families and the communities in which it exists (Gardiner, 2012). Family Resource Programs (FRPs) Canada is a national not-for-profit organization that supports family resource organizations in Canada by ensuring they have the tools, training, and resources needed to operate (Canadian Association of Family Resource Programs, 2000, 2011).

In the national directory of family resource programs, there were 561 family resource programs listed in Canada and 49 in Manitoba on April 4, 2018 (FRP Canada, n.d.). Each year over 500,000 Canadian families access resources through family resource centres (Canadian Association of Family Resource Programs, 2011). It is unknown how many families in Manitoba access family resource centres.

The Canadian Association of Family Resource Programs (2011) reports that family resource programs support parents by decreasing their isolation and by providing access to information and resources. In a national evaluation of family support programs in the United States, it was reported that programs were most effective when they used professional staff to deliver parent education, when they were focused on specific types of families, and when they offered services directly to children (Layzer, Goodson, Bernstein, & Price, 2001).

Adequate and stable funding for family resource programs in Canada has been identified as a significant challenge to effective service delivery (Kyle & Kellerman, 1997). Family resource programs receive their funding from a number of different sources including federal, provincial, and municipal governments. Changing priorities and political agendas can influence resource allocations (Gabor, 2003). Additionally, funding (often linked to program evaluation) is a challenge given the individual nature of the programs and the variety of services provided (Berman, 2004; Gabor, 2003).

**Summary: Parent Development**

Parent development was examined using both a theoretical and a practical lens. Parent development theories tell us that people develop as parents through observational and experiential learning. Neither of these theories incorporates intentional preparation for parenting. Practical approaches to parent development include education across multiple life stages and

parent support strategies designed to enhance parenting. Prenatal parent education is the most accessed type of parent education. Unfortunately, prenatal classes do little to prepare people for parenting. The practice of using postnatal parent education as a targeted intervention has led to an associated stigma. Significant efforts and resources have been directed toward supporting parent development once people begin parenting, but there are issues of sustainability. There are far fewer resources directed toward people before conception.

**Current Research Preparation for Parenting**

While preparation for parenting is a concept that has been widely referenced (Spiteri et al., 2014) very few studies have looked specifically at preparation for parenting. The studies most closely linked to preparation for parenting, as defined in the context of this study, will now be reviewed.

Spiteri et al. (2014) completed a concept analysis of preparation for parenthood given "parents all over the world still feel unprepared for the reality of parenthood" (p. 148). They set out to understand what was meant by preparation for parenting, to identify how it was different from other similar concepts, and to explore how it might be relevant in informing health care and support practices through the development of a preparation for parenthood measurement tool. They found that despite the general use of the term in fields such as psychology, sociology, and the health professions, the concept had never been fully explored and was used inconsistently in the research. Spiteri et al. (2014) concluded that while their analysis provided groundwork for the development of a measurement tool, further research was needed to understand what was meant by the term.

One of the only studies looking at preparation for parenting before conception was done by Thomas and Bhugra (2014). They completed a needs assessment on preparation for

parenthood with a group of 70 young adults who were participating in a mandatory marriage preparation course in India. These authors felt that something similar was needed to help prepare young people for the responsibilities of parenthood. While specific strategies were not identified, four broad categories were proposed to address preparation within programs: self-management (e.g., managing personal feelings of anger/frustration in dealing with a child), parenting skills (e.g., knowledge of child development, parenting styles, and developmentally appropriate behaviour management strategies), dealing with past issues (e.g., dealing with negative experiences from childhood including use of physical punishment by their father), and developing confidence as parents (e.g., how to be a good role model). They report that all participants agreed there was a need for such a program and concluded that young people had a wide range of concerns related to preparing for parenthood (Thomas & Bhugra, 2014).

Eastlick Kushner, Pitre, Williamson, Breitkreuz, and Rempel (2014) looked at how expectations of parenting shaped expectant parents' preparation for parenting. Expectant parents anticipated they would prepare for parenting by using their experience of having been parented, their observations of other parents, information gathered by talking with others, and through reading. The expectations for preparation for parenting identified in this Canadian study were consistent with preparation strategies identified in other Canadian studies (e.g., relying on the experience of having been parented, reading books) (Crill Russell et al., 2011; Oldershaw, 2002). The focus of the study by Eastlick Kushner et al. (2014) was not as much about preparation for parenting as it was about preparation for parenthood (i.e., the role/stage) and how cultural and gendered norms (e.g., good mother as nurturing and good father as providing) impact the role expectant parents assume.

In a study looking at the needs of expectant and new parents during the transition to parenthood, it was found there was a lack of awareness and preparation for this major life transition (Deave et al., 2008). Participants would have liked more information on elements of parenting, caring for a baby, and relationship changes prior to parenting. The mothers interviewed felt supported by their female relatives while the fathers felt somewhat excluded by antenatal preparation and the available literature. This study highlighted "how ill-equipped new parents are for parenthood: both the practical aspects of caring for a baby and the change in themselves on becoming parents" (Deave et al., 2008, p. 8 of 11) leading the authors to conclude there was a need to improve parents' preparation for parenthood.

Pålsson, Persson, Ekelin, Kristensson Hallström, and Kvist (2017) also looked at the need for early parenting preparation but with first-time fathers in Sweden. They found that fathers wanted guidance in preparation and wanted accurate information about life with a new baby so they could build realistic expectations and develop strategies on how to manage. Pålsson et al. (2017) also found that fathers had gaps in practical knowledge about how to care for an infant.

The study on preparation for parenting most similar to the one being proposed here was done in England where The Department of Health brought together a group of experts to identify different ways to support expectant and new parents (Billingham, 2011). This study was initiated in response to a review of antenatal education where limited evidence was found for the effectiveness of the programs (Schrader McMillan et al., 2009) and led to the development of a Preparation for Pregnancy, Birth and Beyond (PPBB) framework. Within that framework the following six themes were identified as being important for all preparation programs or antenatal classes: the development of the unborn baby, changes for parents during pregnancy, health and well-being during pregnancy, birth and bonding, caring for the baby, and identification of

services and supports for parents. While similar to this current study, the PPBB framework was intended to be used for planning local programs and services in England (Billingham, 2011) and as such may not be applicable in the Canadian context. As well, this framework was developed for expectant and new parents, did not consider a lifespan approach to preparation for parenting, and was constructed by a group of experts.

The studies on preparation for parenting have identified a need for increased knowledge on child development, parenting strategies, baby care, relationship changes, personal growth as a parent, realistic expectations, and increased awareness of existing services and supports. While each of these studies adds to the knowledge base on preparation for parenting, only one study reported strategies for preparation for parenting, none looked at preparation across multiple life stages, none created a conceptual framework for preparation for parenting using multiple perspectives (e.g., parents and those who work with parents), and none were specific to the Manitoba context.

**The Way Forward**

Parenting is an important and valued life role. Research suggests that the capacity of people to parent effectively can be increased when they have knowledge of child development, parenting strategies, and access to supports (Zepeda et al., 2004).

The majority of parent development and parent support strategies have been targeted at people who have been identified as being at-risk for poor parenting. This approach is based on a deficit model where remediation and risk reduction are the primary goals (Lam & Kwong, 2012). Focusing on deficits is disempowering, results in increased stigma and shame, and decreases the willingness of parents to seek support (Zepeda et al., 2004): and it does not seem to be working (Olds, Sadler, & Kitzman, 2007). Targeting only the most at-risk parents for parent education

and support is not a sufficient strategy for improving early child development outcomes at a population level (Cowley et al., 2015). It also inadvertently suggests that everyone else knows how to parent effectively, but we know this is not the case. No parent subgroup (i.e., sex, marital status, socioeconomic status, or level of education) in Oldershaw's Canadian sample knew more or felt more confident than any other parent subgroup (Oldershaw, 2002). Lack of adequate knowledge about child development and low confidence in parenting skills exists on a broad continuum, is spread across social classes, and is not made better by improved financial circumstances (Oldershaw, 2002; Waylen & Stewart-Brown, 2010). Effective parenting is about more than the absence of adverse parenting (Price-Robertson et al., 2011), and as a society, we must not only respond to adverse parenting but lay the foundation for the development of effective parenting (Mullin, 2012).

Universal approaches to parent development are gaining momentum. They are being used to increase parenting competence, confidence, and decrease harmful parenting (Barlow et al., 2010; Glavin & Schaffer, 2014; Joussemet et al., 2013; Lindsay et al., 2014; Löfgren et al., 2017; Sanders & Kirby, 2014; Seay, Freysteinson, & McFarlane, 2014; Wang, Wang, & Wang, 2017). This signifies a shift: a movement from a deficit-based approach to a strengths-based approach, where parent development becomes essential for all people and empowerment becomes the goal (Lam & Kwong, 2014; Rodrigo et al., 2012; Wang et al., 2017). As Molinuevo suggests, "Parenting is a set of skills that every parent can and should improve" (Molinuevo, 2012, p. 3).

It is not clear exactly why this shift toward universal parent development is happening. I would suggest a number of factors may be involved: the growing body of evidence linking early life experiences to long term health outcomes (Felitti et al., 1998; Fleming et al., 2018; McCain & Mustard, 1999; National Research Council and Institute of Medicine, 2000), the increased

understanding that parenting requires a set of skills and competencies that can be learned and improved (Johnson et al., 2014; Michaux, 2017; Volmert et al., 2016), the increased understanding that positive and negative parenting are not on the same continuum and constitute qualitatively different aspects of parenting (Whittle et al., 2014), or it may reflect a more general paradigm shift where we now recognize that flourishing and positive human development are as vital as problem reduction (Keyes, 2007; Kurtines et al., 2008; Lerner, 2015; Stewart-Brown, 2008). Most likely it is some combination of all these factors, but the central underlying catalyst is about enhancing the opportunity for children and parents to maximize their potential.

Supporting parent development for people who are currently parenting is essential, but it does not address the lack of preparation reported when people begin parenting. The impact of parenting behaviours, particularly in the first three years of a child's life, has been so repeatedly proven that "the trial and error common sense approaches to parenting so familiar to most of us can be made to appear hopelessly naïve and amateurish, even irresponsible" (Miller & Sambell, 2003, p. 32). A lack of parental competence is frequently the result of not knowing what to do, not being prepared to raise children, and not having had the opportunity to learn (Lloyd, 1999; Molina, Pastor, & Violant, 2011; Oldershaw, 2002; Smith, Cudaback, Goddard, & Myers-Walls, 1994). Creating the conditions for positive parenting (Committee of Ministers of the Council of Europe, 2006) and equipping people for effective parenting (Seay et al., 2014) is really about preparation for parenting across life stages and increasing the skills and resources people bring with them to the parenting role (Rodrigo, Byrne, & Álvarez, 2011).

**Purpose of Current Study**

Many Canadian parents do not feel prepared for parenting. They lack knowledge of child development, effective parenting strategies, and feel unsupported in the parenting role

(Oldershaw, 2002). This lack of preparation to parent could play a role in determining the nature and outcome of parenting (Bornstein, 2016). As seen in the review of theories on parent development, there is a reliance on observational learning and experiential learning to explain how people develop the knowledge and skills needed to parent effectively. This does not appear to be meeting the needs of parents (Oldershaw, 2002). A review of the current practices for parent development found that few people engage in preparation for parenting before conception and few resources are directed toward preparation before conception. Preparation for parenting increases after conception but the time frame is short, and prenatal educational primarily focuses on pregnancy concerns and preparation for childbirth (Entsieh & Hallström, 2016; Renkert & Nutbeam, 2001). Parent development efforts with people already parenting have been challenged by the quality of parent education programs (Gilmer et al., 2016), by issues related to a lack of attendance because of naïve confidence (Volmert et al., 2016), and by barriers such as stigma (Lindsay et al., 2014; Molinuevo, 2012). Current research on preparation for parenting suggests people want knowledge about child development, parenting strategies, and supports (Pålsson et al., 2017; Thomas & Bhugra, 2014). However, much of this research was focused on expectant and new parents (Deave et al., 2008) and failed to consider preparation for parenting over multiple life stages. Moreover, these studies did not result in a co-constructed conceptual framework (Billingham, 2011). Finally, the lack of clarity around preparation for parenting has made the advancement of theoretical understanding and real-world action more difficult (Spiteri et al., 2014).

The widespread feeling of being unprepared to parent and the impact this has on determining the nature and outcome of parenting, along with a lack of conceptualization around preparation for parenting, has led to this research. Additionally, because this research was

conducted using a participatory approach, it was essential to identify actionable recommendations for Manitoba.

In this study, I explored and conceptualized preparation for parenting and prioritized strategies to help people prepare for parenting in Manitoba. The findings of this study have theoretical as well as practical implications through contribution to the conceptual knowledge base related to preparation for parenting, and through the provision of recommendations to inform public policy on the education, service, and support needs of people in Manitoba related to preparation for parenting. I am not aware of any study that has asked parents and those who work with parents, for their perspectives on what would help people prepare for parenting.

## Chapter Three: Methodology

This research was conducted using a constructivist/interpretive paradigm. Preparation for parenting is a multidimensional issue that we know little about. It is socially constructed and situated within a context. To better understand what would help people prepare for parenting it was necessary to explore in a collaborative and participatory manner, the multiple realities of people based on their understanding and lived experience. An exploratory mixed methods study design was used where priority was given to the qualitative perspective and supplemented by complementary quantitative research methods (Creswell, 2003; Creswell & Plano Clark, 2011). As an applied research study, the goal was also to generate useful and practical knowledge that could be used in the local context (Brodsky & Welsh, 2012) and as such, is consistent with the aims of community-based participatory research (Burke et al., 2005; Minkler et al., 2008).

The purpose of the study was to explore, conceptualize, and prioritize the perceptions of parents, service providers, and administrators regarding what could be done to help people prepare for parenting. Three research questions were addressed: (1) What do parents, service providers, and administrators identify as services, supports, or actions that could help people prepare for parenting in Manitoba? (2) What strategies do participants identify as being the most important and the most feasible? Are there differences in what is seen as most important and or feasible by participant subgroups? (3) Based on the value ratings of strategies by participants, what are the most actionable recommendations for helping people prepare for parenting in Manitoba?

Addressing these research questions required a methodology that was both flexible and structured: one that would allow me to explore the topic area, consolidate a large amount of individual experiential knowledge, and permit participants to place value ratings on identified strategies. Concept mapping, a process used to co-construct knowledge, is consistent with the

philosophical assumptions of this study which contend that humans actively construct knowledge and meaning from their lived experience (Novak & Canas, 2004; Trochim, 1989). It is a collaborative and participatory approach that helps democratize knowledge creation and reflects the valuing of a subjectivist and socially-constructed reality (Rosas, 2012). Concept mapping combines qualitative data collection (brainstorming, unstructured individual sorting, and participant reflection), quantitative data collection (value rating inputs), qualitative data analyses (idea synthesis, cluster solution analysis, and labeling of cluster themes), and quantitative data analyses (multidimensional scaling and hierarchical cluster analysis) to produce a visual representation of the ideas of participants and to identify the most important and most feasible strategies (Kane & Trochim, 2007; Rosas & Kane, 2012; Trochim, 1989; Valdes-Vasquez & Klotz, 2014; Wheeldon & Faubert, 2009).

Concept mapping has been used successfully when exploring a wide range of community health issues with diverse stakeholder groups. For example, it has been used with community members and experts to plan a statewide health improvement initiative (Trochim, Milstein, Wood, Jackson, & Pressler, 2004); with parents, service providers and administrators to identify the critical components of a mentoring and support service for parents of children with severe mental health challenges (Byers, Johnson, Davis-Groves, Byrnes, & McDonald, 2014); and with sexual minority youth to identify needed psychosocial supports (Davis, Saltzburg, & Locke, 2010). Concept mapping has also been used successfully to identify next steps in service and program planning. For example, Ridings et al. (2011) used concept mapping to identify community-based strategies when developing a program for Latino youth at risk for school dropout, early parenthood, and limited employment opportunities. Lobb, Pinto, and Lofters (2013) used differences in stakeholders' perspectives identified during concept mapping to

inform next steps in overcoming barriers to the use of cancer control programs by South Asian residents in Ontario.

Concept mapping has a number of benefits that make it particularly relevant to my research. First, it has been found to be useful in clarifying areas where little research has been done and where theory is underdeveloped (Trochim, 1989). Burke et al. (2005) suggest that concept mapping is particularly useful in community public health research because it allows for the exploration of relationships among multiple themes and can capture the complex nature of social phenomena. With concept mapping, I was able to develop a conceptual framework of what people need to help them prepare for parenting. A conceptual understanding of an issue is the first step in developing a framework oriented toward change (Rosas & Kane, 2012).

Second, concept mapping is participatory, and as such is suited to community public health research (Burke et al., 2005; Cambraia Windsor, 2013). It uses the experiential knowledge of participants which fits with my participatory worldview (Coghlan & Brydon-Miller, 2014), and it "allows community health researchers and stakeholders to tackle complicated problems alongside each other in a way that is equitable and able to inform future interventions" (Walker, Jones, & Burke, 2014, p. 171). Concept mapping is not about consensus building but accommodates multiple perspectives (Vaughn, Jacquez, & McLinden, 2013). By gathering a multitude of ideas from a variety of participants and having participants identify what was relatively more important and more feasible among those ideas, I was able to identify solutions with contextual relevance that would help people prepare for parenting (Vaughn et al., 2013).

Third, concept mapping is very flexible in implementation, which increases accessibility and convenience for participants. Concept mapping can be completed in person, online, or some combination of the two; it can be synchronous or asynchronous; and people can participate in

one or more phases of the study (Kane & Trochim, 2007; Walker et al., 2014). I used an asynchronous online forum as it increased accessibility by decreasing logistical barriers such as geographical location, availability of transportation, and availability of child care (Vaughn et al., 2013). Asynchronous online concept mapping allowed people to add data from their computers at a time and place that was convenient for them.

Lastly, concept mapping provided a visual representation of the collective ideas of the group, making the results easier to understand (Kane & Trochim, 2009). This provided increased access to the results by participants and facilitated knowledge transition (Kane & Trochim, 2007).

Regardless of the benefits and appropriate application of concept mapping for my research, the potential drawbacks must be discussed. Walker et al. (2014) identify some of the common concerns associated with concept mapping. One is related to participant burden and fatigue during in-person concept mapping. I reduced this concern by choosing an online approach. Rather than having to complete the tasks in a short time frame, participants had over two months to complete the tasks.

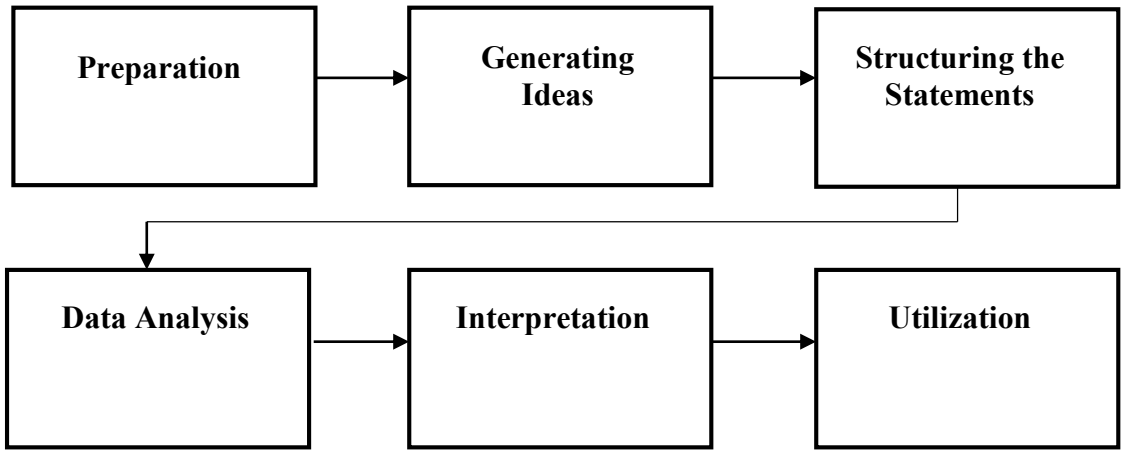
A second concern identified with concept mapping is related to the literacy level of participants (Walker et al., 2014). The majority of participants in this study (n=40 or 83%) had either a college diploma or a university degree, and all had graduated from high school, suggesting concerns related to literacy levels will have been less of a limitation. As well, participants were encouraged to ask questions about the statements, the instructions, or to contact me with any concern they might have during their participation. No participant requested support related to reading or comprehending the statements. A lack of confidence with technology was not identified as a limitation by Walker et al. (2014), who point out that the software is easy to

understand and people can access support if they have questions as the researcher contact information is available.

A final concern, one specifically related to using an online concept mapping forum, is the loss of a group dynamic during the brainstorming activity (Walker et al., 2014). The concept mapping software has been designed to allow participants to see all other ideas generated (in real time) when they contribute their ideas. This could facilitate the generation of additional ideas by participants (Kane & Trochim, 2007).

The description of the methodology has been organized using the six-phase concept mapping process: preparation, generating ideas, structuring the statements, data analysis, interpretation, and utilization of the results (Figure 1) (Kane & Trochim, 2007).

Figure 1. Concept mapping phases




**Phase One: Preparation**

The preparation phase involved identifying appropriate participant groups and participant recruitment strategies, creating a focus prompt that would elicit responses relevant to my research questions, and developing two sets of rating criteria to determine the importance and feasibility of the ideas generated. Additionally, the preparation phase involved CS Global

MAX™ software training and gaining ethical approval from the Education Nursing Research Ethics Board (ENREB) at the University of Manitoba (Appendix A).

**Participants.**

Purposive sampling was used to ensure participants embodied characteristics identified as relevant to the research question (Creswell, 2007). It is understood that in utilizing nonprobability sampling, the information gathered cannot be used to make inferences from this group of people to the general population. Given this is a community health issue, I explored the experience and knowledge of three groups of participants, where each group had a different relationship to helping people prepare for parenthood: parents, service providers, and administrators. The inclusion of these three stakeholder groups has been used before when creating a concept model of services for parents (Byers et al., 2014).

- Parents were defined as any person over 18 years of age currently parenting or acting as a caregiver for one or more children. Parents were chosen because they have experiential knowledge related to what is needed to be prepared for parenting.
- Service providers were defined as any person doing direct service work with parents. Service providers were chosen because they work with parents on a regular basis and have acquired knowledge about what would help people prepare for parenting.
- Administrators were defined as any person who works in an administrative position (e.g., the Agency CEO, Director, or Manager) in an organization that provides services and supports to parents. Administrators were chosen because they are familiar with the needs of parents, have knowledge about the services and supports available for parents, and have some understanding of the policy and funding mechanisms regulating programs.

I used three recruitment stages to engage participants. In the first stage, I identified the CEO, Director, Coordinator, or Manager (i.e., the administrator group) of 62 organizations in Manitoba that provide services and supports to parents through an online search (Appendix B). I sent a letter in the form of an email to each administrator where I introduced myself, explained my study, and invited them to participate (Appendix C). Additionally, I asked for their assistance in recruitment which involved forwarding an invitation to participate to service providers who worked in their organization (second stage of recruitment) (Appendix D) and forwarding an invitation to participate to parents in the form of a flyer, to be distributed in the facilities within their organization (third stage of recruitment) (Appendix E). The second stage of recruitment was dependent upon administrators forwarding the invitation to participate to service providers, and the third stage was dependent upon service providers posting the invitation to participate to parents. I began recruitment with the administrator group because further recruitment within their organization was dependent on their willingness to have service providers and parents affiliated with their organization be contacted. People were asked to respond to me by email if interested in participating. I recognize the limitations of my sampling strategy. First, my participant identification and recruitment processes were not exhaustive and some organizations will have been inadvertently missed. Second, my recruitment strategy may have led to the underrepresentation of some sectors of participants, specifically those with no internet access or familiarity with technology and those who were not affiliated with one of the identified parent service or support organizations.

People who responded to my request for participation were sent a consent form that outlined what the study was about, what would be asked of them, and how they would be compensated for their time and effort (Appendix F). People who signed consent forms were

assigned an online username and password by my research assistant. This ensured participant identity could not be linked to participant data. Participant activity online was tracked by username. At the end of the data collection, participant remuneration was identified by a username and sent by my research assistant.

I received a 50% response rate from Administrators with 31 responding to my initial email. Out of the 31 Administrators who responded, 28[12] agreed to participate and forward my request for participation to service providers and parents in their organizations (one administrator requested additional information, one administrator was unable to commit the time but requested a copy of the results, and one administrator was unable to participate because of their organization's external research project policy[13]).

In Table 2, I have outlined the number of parents, service providers, and administrators who contributed data in each of the concept mapping activities. There were more participants in the sorting (n=41) and rating (n= 44 Importance rating and n=43 Feasibility rating) activities than in the brainstorming activity (n=25). This was most likely the result of my three stages of recruitment where the invitation to participate did not reach all people simultaneously. In concept mapping participants can participate in one or more phases of the study (Kane & Trochim, 2007). Three sets of participant sort data had to be discarded[14] because the statements seemed to be randomly assigned to groups, the items were sorted based on priority and value (e.g., bad idea, already doing that, good but not possible), and the items were sorted based on whose responsibility it was to implement the strategies (e.g., health's role, not up to the workplace). It is

[12] While 28 administrators agreed to participate only 10 administrators actually participated. It may be that their agreement to participate only included forwarding the invitation to service providers. It may also be attributed to how administrators self-identified when answering the demographic questions. Some of the administrators may actually be both administrator and service provider (and so may have self-identified as a service provider).
[13] The organization this administrator worked for has an external research policy that does not allow staff to participate in external research projects during the months of May, June, and September.
[14] Forty-four participants completed the sort activity and forty-one participant sorts were used in the analysis.

crucial to ensure participants sort the statements based on their interrelationships as this is the foundation of the point map (Kane & Trochim, 2007). Seven participants reviewed results through the online webinar and returned the reflection workbooks (participants were not asked to self-identify by group in the reflection activity). The lower number of participants in the reflection activity could be the result of a number of factors. First, there was no remuneration for participation in the reflection activity. Second, there was a three-month delay between the sorting and rating activities and the reflection activity. Third, the reflection activity was sent out at the beginning of September, a busy time for parents and those who are associated with parent organizations as it coincided with the start of the school year. Four participants were assigned usernames but never contributed any data.

Table 2. Number of participants by group in concept mapping activities

| Group | Brainstorming | Sorting | Rating 1 | Rating 2 | Interpretation |
|---|---|---|---|---|---|
| **Parents** | 8 | 17 | 17 | 17 | |
| **Service Providers** | 12 | 15 | 17 | 16 | |
| **Administrators** | 4 | 9 | 10 | 10 | |
| **Did Not Identify** | 1 | | | | |
| **Total** | 25 | 41 | 44 | 43 | 7 |

Participants were asked five demographic questions (self-identify by group, locale, age, education, and income) (Appendix G) when they entered the online concept mapping site. Demographic data were collected to facilitate additional analysis of the rating responses. The demographic questions could be answered during any activity and were not required for participation. Two people did not complete one or more of the demographic questions. Participant responses to the demographic questions can be found in Table 3. Eighteen participants self-identified as parents, 19 as service providers, and 10 as administrators[15]. Just

[15] Participants were given the choice if they wanted to participate in this study as a parent, a service provider, or an administrator.

over half of the participants lived in rural Manitoba, four lived in northern Manitoba, and 17 were from urban areas in Manitoba, providing good representation across the province as shown in Figure 2. No participants were under 25 years of age. The majority of participants were between the ages of 25 and 54 years, had either a college diploma or university degree, and a combined household income over $75,000. Participants in this study were predominantly rural, well-educated, and had a household income that was above the Manitoba average (Statistics Canada, 2013).

Figure 2. Province-wide representation of participants (Google Maps, 2017)


.

Table 3. Participant demographic information

| Self-identified Participant Group | Frequency | Percentage |
|---|---|---|
| Parent | 18 | 37.50 |
| Service Provider | 19 | 39.58 |
| Administrator | 10 | 20.83 |
| Did Not Respond | 1 | 2.08 |
| | 48 | 100% |
| **Locale** | | |
| Rural Manitoba | 26 | 54.17 |
| Northern Manitoba | 4 | 8.33 |
| Urban Manitoba | 17 | 35.42 |
| Did Not Respond | 1 | 2.08 |
| | 48 | 100% |
| **Age** | | |
| 18 – 24 years | 0 | 0.00 |
| 25 – 34 years | 11 | 22.92 |
| 35 – 44 years | 14 | 29.17 |
| 45 – 54 years | 15 | 31.25 |
| 55 years or older | 7 | 14.58 |
| Did Not Respond | 1 | 2.08 |
| | 48 | 100% |
| **Education** | | |
| Some High School (no diploma) | 0 | 0.00 |
| High School Graduate or equivalent (e.g., GED) | 1 | 2.08 |
| Some College or University (no degree) | 6 | 12.50 |
| College diploma | 6 | 12.50 |
| University degree | 34 | 70.83 |
| Did Not Respond | 1 | 2.08 |
| | 48 | 100% |
| **Household Income** | | |
| Less than $25,000 | 1 | 2.08 |
| $25,000 - $49,999 | 4 | 8.33 |
| $50,000 - $74,999 | 7 | 14.58 |
| $75,000 - $99,999 | 12 | 25.00 |
| Greater than $100,000 | 22 | 45.83 |
| Did Not Respond | 2 | 4.17 |
| | 48 | 100% |

Focus prompt and rating criteria. The focus prompt was developed to produce ideas relevant to my research questions. It was reviewed for content by my doctoral advisory committee and then checked for effectiveness in eliciting responses with Jennifer Royer, a Client Services Consultant with Concept Systems Incorporated (CSI). The focus prompt for this study was, *To help people prepare for parenting, a specific service, support, or action would be . . .*

The two rating criteria developed for this study were *How important do you think this statement is related to preparing people for parenting in Manitoba?* (i.e., 1-not at all important, 2-somewhat important, 3-important, 4-very important, and 5-extremely important) and *How possible or feasible do you think this statement is related to preparing people for parenting in Manitoba?* (i.e., 1-not at all possible, 2-somewhat possible, 3-possible, 4-very possible, and 5-extremely possible). Participants were asked to keep in mind that this was about relative importance/feasibility (so how important or feasible compared to the other statements). These rating criteria were used to explore consensus for action among participants and to identify actionable recommendations.

**Software training.**

I used the Concept System® Global Max™ software (Build 2017.181.20 ) [Web-based Platform] (2017) proprietary cloud-based software to manage the data entry and analysis and to create a display of the results of my research. It is specialized software available through Concept Systems Incorporated (CSI) that is designed specifically for the concept mapping approach used here (Trochim, 1989). It has been used successfully in previous social science research (Burke et al., 2005; Handley, Pappas, & Kander, 2004; Rosas & Camphausen, 2007; Walker et al., 2014). CSI offers online webinars and in-person training on both the concept mapping process and use of the software. I participated in an online webinar in 2015 and

completed a certified Concept Systems facilitator course in Ithaca, New York in June 2016. The course was held over two-and-a-half days, and I received certification as a Concept Systems facilitator.

### Ethical approval.

Following the development of the focus prompt, the rating questions, participant recruitment strategies, and participant instruction materials, a request for ethics approval was submitted to the Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba. The application also included information on steps taken to ensure participant data could not be connected to personally identifying information and on the compensation offered participants for their time and effort. Approval was granted with a request to submit an amendment after the idea generation phase to identify the statements that would be used in the sorting and rating activities. The amendment was also approved (Appendix H).

## Phase Two: Generating Ideas

### Idea generation.

The goal of idea generation was to create a list of what would help people prepare for parenting in Manitoba. Idea generation consisted of asking participants to individually generate ideas (i.e., brainstorm) in response to the focus prompt in an online forum where they were able to see the statements contributed by others (Kane & Trochim, 2007). While there are no guidelines regarding the number of people who contribute ideas or the number of ideas contributed, it is important that the set of statements generated represent the complete conceptual domain related to the topic and that saturation is reached. One way to gauge saturation is to look at the number of repeated or similar ideas being generated (Kane & Trochim, 2007).

Participants were sent an email by my research assistant providing them with a username and a password to be used for the duration of the research. The email also contained an explanation of the brainstorming activity, a link to the online site, and an invitation to begin the activity (Appendix I). Participants had two weeks to generate ideas in response to the focus prompt, *To help people prepare for parenting a specific service, support, or action would be . . .* Brainstorming usually takes between 10 and 15 minutes (Kane & Trochim, 2007) and participants were able to log back in as many times as they wanted during the two-week period. At the end of the brainstorming activity, participants had generated 106 statements (Appendix J).

**Idea synthesis.**

To structure the qualitative data for use in the next phases of the study, I reviewed and coded the content. In concept mapping, the purpose of the content review and coding is to reach saturation of the topic and arrive at a final statement set that preserves the overall integrity of the data. It is understood as "a means to an end" and is not intended to be a thematic coding process or a grounded theory approach (S. Rosas[16], personal communication, June 21, 2016). It involves an emergent approach where observation and identification implicit in the terms used by participants are formed from the unique content provided by participants (Rosas, 2017). Saturation of the topic is based on participants' input (S. Rosas, personal communication, June 21, 2016).

The 106 ideas generated by participants during brainstorming were exported from the online site to a Microsoft Excel® file. Idea synthesis involved three stages (Kane & Trochim, 2007). First, all statements were read to gain familiarity with the complete data set and any compound statements that held two or more ideas were split to ensure each statement contained

[16] Scott Rosas, PhD. Senior Consultant Concept Systems Inc.

only one idea. An example can be seen in Table 4. There were 31 statements with more than one idea. Splitting compound statements into single idea statements increased the statement set to 150 statements (Appendix K).

Table 4. Example of splitting compound statements during idea synthesis

| Original Statement Set | Split Edited Statement Set |
|---|---|
| 6. Parenting mentors need to have knowledge about child development, parenting strategies, and how to talk to parents. | 6. Parenting mentors need to have knowledge about child development. |
| | 6a. Parenting mentors need to have knowledge about parenting strategies. |
| | 6b. Parenting mentors need to know how to talk to parents. |

Next, each statement was reviewed, and keywords from that statement were placed in a column beside the statement (Appendix K). To develop a sense of the larger conceptual areas being identified, all statements and keywords were reread. Code words were identified and defined based on recurring similarity of ideas in the statements and keywords (Appendix K). These were placed in a second column beside each statement. Statements were grouped by code word, reviewed for appropriateness of placement, and code word definitions revised as required. Once all statements were placed in a group by code word, statements within groups were reviewed, and duplicate or redundant statements were removed or combined (Appendix L). An example of this statement reduction process can be seen in Table 5. Finally, while important to maintain the language used by participants in the statements, it is recommended that statements be edited for syntax to align with the focus prompt to ensure they are appropriate for the sorting and rating activities (Kane & Trochim, 2007).

Table 5. Example of statement reduction

| Final Statement Set | Original Statement Set |
|---|---|
| 3. Make parenting courses mandatory for families with higher risk factors. | 59. Mandatory parenting courses for identified at risk families. |
| | 90. Mandatory parenting programs and other supports for families who are at risk including those who have open files with CFS, RCMP, etc. |

I completed the idea synthesis and presented it to my doctoral advisory committee for review. Some adjustments were made leaving 72 unique single idea statements. This final statement set was imported into the CS Global Max™ software program and the order randomized to minimize the proximity of statements generated by the same participant (Kane & Trochim, 2007). The suggested ideal number of statements for sorting and rating is between 70 and 85 (S. Rosas, personal communication, June 21, 2016), with a maximum of 100 because of participant fatigue during the sorting and rating tasks (Kane & Trochim, 2007). The final statement set in this study fell within those guidelines and is presented in the Results section (see Table 7).

**Phase Three: Structuring the Statements**

Structuring the statements involved asking participants to first sort the statements into groups based on perceived conceptual similarity and then rate the statements on relative importance and feasibility related to the focus prompt. Participants were emailed instructions for the sorting and rating tasks along with a link to the online concept mapping site where they had four weeks to complete the two tasks (Appendix M).

The sorting activity is completed first, and participants were instructed to place all 72 statements into groups in a way that made sense to them and to give each group a name that described its theme or contents. Participants were instructed not to create groups according to priority or value, and not to create groups labelled miscellaneous or other. The sorting task on

average takes about 45 to 60 minutes. This was an unstructured sort task as there were no pre-determined number of groups or group labels identified. Sorting revealed how participants judged the interrelationships of the 72 statements. The combined sorts from all participants provided the data for the clustering of statements and conceptual groupings (Kane & Trochim, 2007).

Next, participants were asked to rate each statement twice, first according to how important they felt the statement was to preparing people for parenting, and second how feasible they felt the statement was to preparing people for parenting. Participants were instructed to rate each statement relative to all the other statements. They were also encouraged to use the full range of the 5-point Likert rating scale to make distinctions. The rating task on average takes about 20 to 30 minutes. Importance and feasibility ratings of all participants were averaged for each of the statements and for each of the clusters to produce the point rating maps, cluster rating maps, pattern matches, and go-zones (Kane & Trochim, 2007). Data from the rating activity indicated the importance and feasibility participants placed on the ideas and was used to inform actionable recommendations.

**Phase Four: Data Analysis**

In phase four, the sorting and rating data were analyzed using the CS Global Max™ software. The sorting data from each participant was converted into an *n* by *n* binary square symmetric similarity matrix where the rows and columns represent the statements (Kane & Trochim, 2007). An example can be seen in Figure 3. If statements were sorted together, then both statements received 1's in those particular statement rows and columns. There are all 1's along the diagonal because each statement is considered to be sorted in a pile with itself.

Figure 3. Example of a binary square symmetric similarity matrix

Hypothetical Sort of Ten Statements into Four Groups by One Participant

| | | | |
|---|---|---|---|
| **4** | **1** | **5** | **2** |
| **9** | **3** | **7** | **6** |
| | | **8** | **10** |

Binary Square Symmetric Similarity Matrix

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| 3 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| 5 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 |
| 6 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| 7 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 |
| 8 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 |
| 9 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| 10 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |

The individual binary square symmetric similarity matrices of all participants were summed to produce a total similarity matrix where the cell values indicated the number of times two statements were sorted together by all participants (N x N) (Kane and Trochim, 2007). The cell values can range from zero (no one put the two statements together) up to the number of participants in the activity (everyone put the two statements together).

The sort data from the total similarity matrix was transformed from a matrix to a point map by applying non-metric multidimensional scaling (MDS). MDS is a method used to analyze the degree of similarity or distance between statements (based on how many times they were sorted together) and to locate each statement as a separate point on a two-dimensional point map created from that information (Borg, Groenen, & Mair, 2013).

Point maps used in concept mapping rely on relative rather than absolute position and provide a visual representation of the inter-relationships of the statements. The relative distance

between points is meaningful, but the orientation of the map is not. Rotating the map does not change the distance between points. The point map is the foundation from which all other maps are constructed (Kane & Trochim, 2007).

Placement of statements on the point map provides an initial understanding of how the themes or concepts will develop. Statements that were sorted together more often appear closer together on the map and statements that were sorted together less often appear farther apart. Statements on the edge of the map tend to be sorted with fewer other statements and often revolve around one or two cohesive themes, while statements closer to the middle of the map are often sorted with many statements and reflect broader ideas that relate to different areas of the map (Kane & Trochim, 2007).

When the statements were placed as points on the point map, each statement was assigned a bridging value calculated by CS Global MAX™ software. The bridging value provides information about the relationship of each statement to other statements on the map, and values range from 0 to 1.0, with 0 being the lowest bridging value and 1.0 being the highest bridging value (Kane & Trochim, 2007). A statement with a high bridging value may have strong relationships to statements located further away on the map. In this way, it tends to bridge or connect to all areas of the map. This can happen when the statement reflects a broader idea or is more philosophical (J. Royer[17], personal communication, June 26, 2017). A statement with a low bridging value was sorted more often with other statements close to it and can be thought of as an anchor statement as it reflects the core meaning in that area of the map (Kane & Trochim, 2007). The bridging values of the statements within a cluster are averaged to get a cluster

[17] Jennifer Royer. Client Services Consultant Concept Systems Inc.

bridging value. Cluster bridging values provide important information about the cohesiveness of ideas in a cluster and can help inform the decision on the final cluster solution.

In MDS, the overall degree of correspondence between the total similarity matrix and the distances between points on the point map is estimated by the stress value (Trochim, 1989). Higher stress values are the result of an increased need for estimation or interpolation. A lower stress value indicates a better fit between the point map and the participant's compiled sorting data.

Although the point map shows how participants sorted statements, it can be challenging to identify themes occurring across areas of the map. Cluster analysis is an explorative analysis that is used to identify structures within data and to create groups based on similarity. This provides a way to examine the data at a higher conceptual level. Ward's method of agglomerative (bottom-up) hierarchical cluster analysis used the X, Y coordinate data from the MDS analysis to combine statements into groups or clusters with the least amount of variance. This procedure configured all the dots in the point map into non-overlapping clusters in a two-dimensional space format and created boundaries around items with relative similarity (Kane & Trochim, 2007).

The CS Global MAX™ software allows you to examine different cluster solutions for the concept map. Choosing the number of clusters for the best solution within the cluster map can be challenging as the point map does not change and statements do not move from cluster to cluster, only the number of clusters change based on the algorithm. There are usually some statements in a cluster, typically those with higher bridging values, which appear better suited for a different cluster. Kane and Trochim (2007) recommend beginning with a large cluster solution and as each cluster merge occurs (fewer clusters), examining each new solution to determine if the

merge improved conceptual clarity. I reviewed the conceptual fit for cluster solutions that ranged from 15 to 2 (Appendix N) and based my final cluster solution decision on my understanding of the topic area, my reflective judgement on the content (i.e., did the merging help or hinder an understanding of the map), a review of the cluster bridging values, and in consultation with my doctoral advisory committee.

The final cluster labels were arrived at by reviewing the CS Global MAX™ software generated suggestions (which were based on the labels participants gave to groups they created), by reviewing the statements in each cluster, by examining the bridging values of each statement within each cluster (anchor statements more closely representing the core meaning within that cluster), by reflecting on the intent of statements within the cluster, and by considering my overall understanding of the contents of the whole map. Additionally, I took into consideration how participants named the clusters in the reflection activity, and I consulted with my doctoral advisory committee on the final cluster labels.

The data gathered and analyzed during this phase of the concept mapping process was used to identify what participants perceived would help people prepare for parenting in Manitoba. This information was used to answer the first research question.

**Rating maps.**

The data generated from participants' rating of the statements on importance and feasibility were averaged across participants to identify the overall importance and the overall feasibility attributed to each statement (Kane & Trochim, 2007). This was displayed on the point rating maps. The cluster rating maps showed the average importance and the average feasibility ratings for all statements in each cluster, and so represented an average of the averages (Trochim, 1989). The information from the point rating maps and the cluster rating maps identified the

strategies participants felt were the most important and the most feasible and was used to answer the second research question.

***Pattern matches.***

Pattern matches graphically compare the average ratings for each cluster on a ladder graph where the clusters are displayed in descending order (Kane & Trochim, 2007). For each pattern match a Pearson product-moment correlation coefficient was computed with a scale of -1 to 0 to +1, with -1 being a negative correlation, +1 a positive correlation, and 0 representing no correlation, to assess the relationship between the variables. Pattern matches were used to compare the average ratings of importance and feasibility of the clusters by all participants. They were also used to see if differences existed between participant subgroups.

Participant subgroups based on demographic information were examined for differences in ratings of importance and feasibility of the clusters. The differences between participants based on groups (i.e., parent, service provider, administrator) were examined because of the different relationship people within each group had to the research topic. Administrators and service providers both work in providing programs and supports for parents and therefore have a perspective that involves identifying and planning for support and service needs. Parents have experiential knowledge of what would help people prepare for parenting.

Participant subgroups based on locale were also examined. Manitoba is a large and relatively sparsely populated province, where a few urban centres house the majority of the population. In consideration of this, I wanted to look at the ratings between participants from rural, northern, and urban areas. I combined Rural and Northern participants into one group. This was done for a number of reasons. First, there were only three participants from northern Manitoba who completed the rating activity, and while I wanted to ensure their voice was heard,

I also wanted to protect their anonymity. Second, in Manitoba, there has been a tendency to group rural and northern citizens when reviewing need and access related to services and supports (A. Hawkins[18], personal communication, August 23, 2017). Finally, when I examined the rating responses of the groups based on locale, I found a high correlation between Rural and Northern participants, as shown in Table 6, which also provided a mathematical rationale for the grouping.

Table 6. Locale subgroup correlations on cluster value ratings

| | **Importance Ratings** | **Feasibility Rating** |
|---|---|---|
| **Locale Subgroup Comparisons** | | |
| **Rural and Northern** | r = 0.86 | r = 0.74 |
| **Rural and Urban** | r = 0.40 | r = 0.40 |
| **Northern and Urban** | r = 0.29 | r = 0.24 |

Differences in importance and feasibility ratings between subgroups based on other demographic indicators, such as age, education, and income were not examined given the homogeneity of participant characteristics in these areas.

***Go-zones.***

The go-zone display was used to examine the relative ratings of importance and feasibility by participants for each statement. These two dimensions were compared using a bivariate scatterplot, with the average importance ratings on the horizontal dimension (x-axis) and the average feasibility ratings on the vertical dimension (y-axis). Each axis showed the low and high ratings for that variable and was divided into four quadrants using the mean value of each variable (Kane and Trochim, 2007 p.126). The upper right-hand quadrant, referred to as the go-zone, contained statements that had above average importance *and* feasibility ratings and thus

[18] Allan Hawkins. Director Programs and Student Services Manitoba Education and Training

were considered the most actionable statements. Statements in the bottom left-hand quadrant were rated as the least relatively important and feasible ideas. Statements in the upper left-hand quadrant were rated as more feasible and less important, and statements in the bottom right-hand quadrant were rated as more important and less feasible. The statements in the go-zone that were rated as above average on both importance and feasibility were used in the development of actionable recommendations.

**Phase Five: Interpretation**

In phase five, post-hoc member checking was conducted by sharing the final concept maps and results with participants via an online narrated PowerPoint® presentation that was accompanied by a reflection workbook (available for viewing over a three-week period). The purpose of this study was to develop a conceptual framework and actionable recommendations based on the perceptions of parents, service providers, and administrators, so it was important to receive feedback and assess credibility through the reflections of participants (Bryman, 2011).

I presented the results highlighting the overall themes and their importance and feasibility for action. Following the recommendations of Kane and Trochim (2007), the point map was introduced first, so participants saw the frequency of how statements were sorted together. The cluster map was then presented showing how the statements were grouped conceptually. Cluster rating maps were shared showing the average ratings of importance and feasibility for the clusters, and results of the pattern matching analysis were given to provide participants with a visual representation of the differences in ratings of importance and feasibility between clusters. The go-zone scatterplot was shared to identify the statements with the highest ratings of both importance and feasibility. A final list of tentative actionable statements was also presented. Using the reflection workbook as a guide, participants were asked to complete four reflection

activities: (1) reflect on the cluster groupings and identify cluster themes/labels, (2) reflect on the cluster ratings of importance and feasibility, (3) comment on the tentative actionable recommendations and their priority, and (4) share their experience as a participant (Appendix O).

**Phase Six: Utilization**

In the final phase, I developed general recommendations for action. These were based on the statements that had the highest importance and feasibility ratings. Determining the final general recommendations also included reviewing participants' reflections, synthesizing similar ideas within the statements, and my interpretation based on a familiarity with the research in this area. These general recommendations answered the final research question.

## Chapter Four: Results

In this chapter, the results are organized by research question. First, I present the conceptual framework identifying what is needed to help people in Manitoba prepare for parenting. Next, the strategies that were seen as most important and most feasible by participants are reviewed, along with subgroup differences. Finally, the recommendations are presented.

### Research Question One

*What do parents, service providers, and administrators identify as services, supports, or actions that could help people prepare for parenting in Manitoba?*

Over a two-week period, 25 participants generated 106 statements. In reviewing the statements before closing the activity online, it was clear that many ideas were repeated and saturation had been achieved. These 106 statements were edited and synthesized. This resulted in a final set of 72 statements that were imported into the online site, randomized, and then used for the sorting and rating activities. This final statement set is shown in Table 7.

Table 7. Final statement set

| | Statement |
|---|---|
| 1. | Make family studies classes mandatory in high school. |
| 2. | Add parenting classes to college and university programs. |
| 3. | Ensure prenatal classes are available in every community. |
| 4. | Develop programs for new fathers with male mentors. |
| 5. | Offer child development courses in high school where parents and babies are brought into the school to interact with students. |
| 6. | Include mandatory gender-neutral life skills classes in high school. |
| 7. | Increase availability of high-quality child care. |
| 8. | Provide all expectant parents with consultation on services they may need including mental health, alcohol/drug issues, housing, etc. |
| 9. | Facilitate peer support groups for parents to meet with other parents. |
| 10. | Expand Family's First programs for all parents and not just parents identified as being at risk or who have a low income. |
| 11. | Concentrate on resource centres rather than time-limited programs so that parents have a consistent place to seek advice and support. |
| 12. | Find ways to increase the value placed on parenting. |
| 13. | Ensure Public Health services include information about parenting classes. |

| | |
|---|---|
| 14. | Have trained parent support people to visit new parents in the hospital to supply information about community resources in their area. |
| 15. | Promote the message that parenting is learned and we all need to learn how to parent. |
| 16. | Promote positive parenting and discipline. |
| 17. | Implement provincially mandated parenting classes into existing or new high school curriculum. |
| 18. | Develop online parenting classes and child development videos for expecting parents using a variety of learning styles. |
| 19. | Have doctors or the Public Health Nurse refer parents to specific programs (e.g., Parent-Child Coalitions, Family Resource Centres) like a prescription. |
| 20. | Offer monthly parenting classes to teach parents about all stages of child development and parental expectations for child behaviour. |
| 21. | Assign a parent mentor for every new parent who can offer support throughout all stages of child-rearing. |
| 22. | Reduce the stigma parents feel when they ask for help with parenting. |
| 23. | Lobby the government to increase support for parents and children. |
| 24. | Educate parents on the benefits of helping your children be as screen-free as possible. |
| 25. | Make parenting courses mandatory for families with higher risk factors. |
| 26. | Provide appropriate pay for those working with parents (e.g., Family Resource Centres). |
| 27. | Provide more information to parents on bonding and attachment. |
| 28. | Provide all expecting parents with baby boxes like those given to parents in Finland. |
| 29. | Ensure workplaces provide parenting classes as part of their employee assistance programs or benefits package. |
| 30. | Support parents in times of crisis. |
| 31. | Increase society's understanding of the significance and impact of parenting. |
| 32. | Create mandatory child development courses with a focus on mental health. |
| 33. | Increase access and support to Healthy Baby programs throughout the province. |
| 34. | Increase support services to remote/rural/northern communities - including mental health, counselling, recreational programming, medical, educational, etc. |
| 35. | Ensure people who support parents are educated and competent. |
| 36. | Include information about parenting strategies during Public Health home visits. |
| 37. | Develop a system of accountability for Public Health Nurses, home visitors, and direct service staff who work with parents. |
| 38. | Provide financial support, so the most basic of needs are met for all parenting families. |
| 39. | Develop prenatal courses that teach about child mental health and emotional well-being. |
| 40. | Ongoing support for existing Better Beginnings programs. |
| 41. | Ensure parenting classes are sensitive to varied cultural parenting styles. |
| 42. | Teach students about relationships as a life skill. |
| 43. | Share parenting strategies at parent support groups. |
| 44. | Build relationships with parenting service providers and families. |
| 45. | Increase funding for parenting programs. |
| 46. | Implement mandatory Public Health visits at regular intervals until 2-3 months of age to monitor baby's health and mother's well-being. |
| 47. | Secure maternity leave with 100% of income paid during leave for lowest income earners. |

| | |
|---|---|
| 48. | Create central family resource centres where all parenting services can be easily accessed. |
| 49. | Make parenting classes mandatory for first-time parents during baby's first year. |
| 50. | Extend the Families First program by two or three years. |
| 51. | Share parenting tips on the TV, radio, and social media. |
| 52. | Provide detailed feeding and sleeping guides to parents when a baby is discharged from the hospital. |
| 53. | Build a framework to gain quality feedback from clients on parenting services (e.g., Public Health, home visitors, direct service staff). |
| 54. | Increase awareness of existing services and supports for parents. |
| 55. | Offer financial support for parents who chose to stay home to raise their children. |
| 56. | Additional funding for Healthy Child Parent Child Coalitions. |
| 57. | Increase employment income assistance payments for pregnant mothers to improve nutrition and quality of life during pregnancy and as a new mother. |
| 58. | Offer support for families living in First Nations communities through health care professionals or elders. |
| 59. | Expand breastfeeding resources. |
| 60. | Provide free prenatal classes on child development. |
| 61. | Develop an easy access computer app with general information on child development and links to credible websites. |
| 62. | Ensure parenting mentors know how to talk with new parents. |
| 63. | Set up a parenting website that includes an online forum and newsletter. |
| 64. | Expand parental leave for fathers. |
| 65. | Teach people how to balance a new baby with the other demands of home and life. |
| 66. | Ensure proper services and support (financial and emotional) are available when mothers have to leave their community to have their baby. |
| 67. | Offer free parenting classes with child care provided. |
| 68. | Set up a parenting helpline that is accessible 24 hours a day like health links. |
| 69. | Include information about baby's physical health during Public Health visits. |
| 70. | Connect every person with Public Health upon finding out they are pregnant to support them with the planning and preparation for the new baby. |
| 71. | Have permanent family spaces that offer play activities to support development for infants and children. |
| 72. | Offer father-focused parent programs. |

A wide range of ideas were generated (e.g., parent mentors, online access to parent education, parents and babies visiting schools, addressing the mental health needs of parents) and included strategies for different life stages (e.g., high school students, secondary students, soon to be parents, and people already parenting). A small number of ideas were targeted to specific

groups of people (e.g., high risk), while the majority of ideas were broader and referred to universal strategies for parent development.

Forty-one participants completed an unstructured sort activity using the 72 statements developed during the brainstorming (17 parents, 15 service providers, and nine administrators). Rosas and Kane (2012) recommend that 20 to 30 completed participant sorts are needed to produce a reliable map. This standard for a reliable map was met. The number of groups created by participants ranged from four to eighteen and the average number of sorted piles was 8.88. This is consistent with what Rosas and Kane (2012) found where the average number of sorted piles was 10.93. When reviewing the initial sort data, I saw themes emerging related to education, government support, access to programs and services, and the valuing of parents and parenting.

Each participant's sort data was converted into an *n* by *n* binary square similarity matrix, and then the individual matrices were aggregated into a total square similarity matrix for all participant sort data. Nonmetric multidimensional scaling (MDS) was used to transform the total square similarity matrix into a point map shown in Figure 4. Each numbered point is a statement, and the grouping or clustering of the points reflects statements that were sorted together more often. For example, in Figure 4 statements 31, 22, and 12, which reflect a need to increase the value of parenting, are clustered together on the left side, while statements 36, 19, and 69, which refer to Public Health services, are clustered together on the right side of the map. The point map showed the underlying grouping of conceptual themes.

Figure 4. Point map showing the relation between statements


MDS analysis produces a stress value to assess the goodness of fit between the aggregated similarity matrix and the point map produced and is used to gauge internal validity (Borg et al., 2013; Kane & Trochim, 2007). In a pooled analysis of 69 concept mapping studies, Rosas and Kane (2012) found the average stress value for concept mapping studies to be 0.28. The stress value for this study was 0.27 indicating an acceptable degree of correspondence between the similarity matrix (input) and the point map (output).

Bridging values were calculated for each statement and are denoted in Figure 5 by the number of dots by the statement. Statements with a higher bridging value have more dots, and statements with a lower bridging value have fewer dots. For example, as illustrated in Figure 5 below, statement 15 *Promote the message that parenting is learned and we all need to learn to parent*, has a bridging value of 0.81 and reflects a broader and more philosophical concept than statement 9 *Facilitate peer support groups for parents to meet with other parents,* which has a

bridging value of 0.20 and reflects a more specific idea. The statements with higher bridging values had more connections to other areas of the map. The bridging values provide a way to gain a deeper understanding of the underlying connections in the concept map.

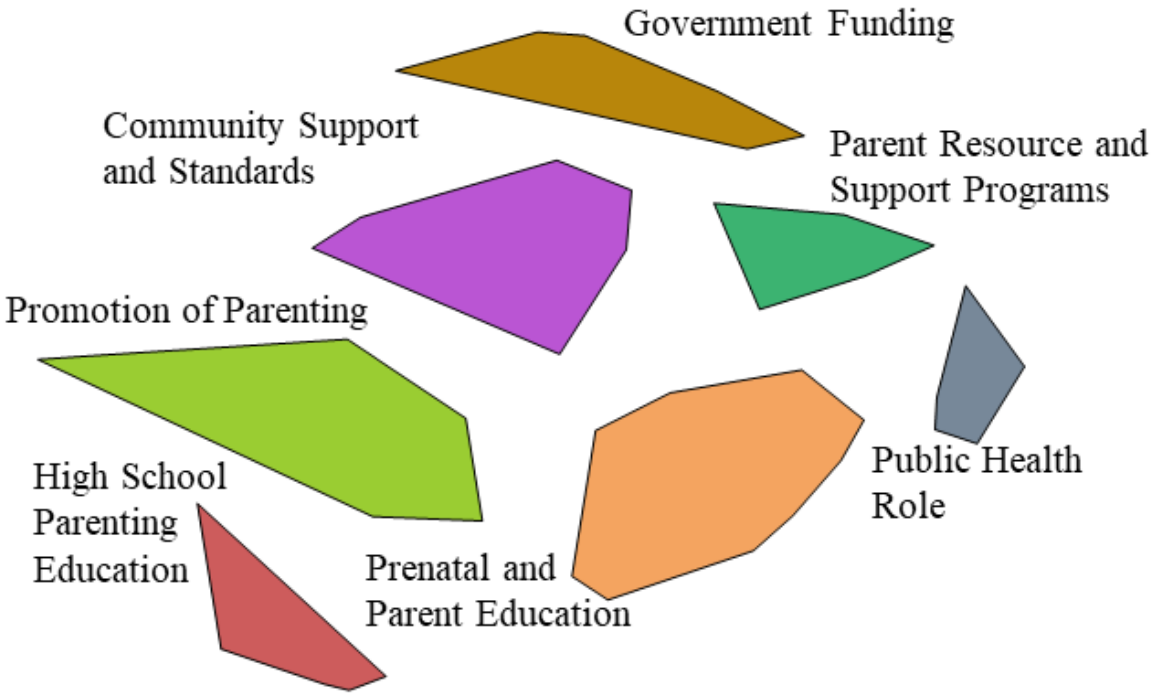
Figure 5. Point bridging map


A cluster map was created using hierarchical cluster analysis (HCA) within the CS Global MAX™ software. A similarity cut off of one was used to help with the development of the cluster map. This means that statements that were sorted together only once were not factored into the similarity index. This was done to improve the interpretability of the map (S. Rosas, personal communication, June 21, 2016).

I determined that a 7-cluster solution, as shown in Figure 6, provided the best intra-cluster coherence and clarity. Cluster solutions above seven divided items which conceptually appeared to fit together (e.g., in an 8-cluster solution Promotion of Parenting was broken into two clusters but the clusters seemed conceptually similar in that both spoke to promoting the value of parenting in order to increase societal value) and cluster solutions below seven led to the

grouping of dissimilar ideas obliterating unique concepts (e.g., in a 6-cluster solution the role of public health was put in the same cluster as the need to increase resource centres and other programs). Rosas and Kane (2012) found the average number of clusters in 69 concept mapping studies was 8.93. Cluster labels were chosen to reflect the general intent of the cluster.

Figure 6. Cluster map




The seven clusters in this map identify the conceptual framework outlining strategic areas that would help people prepare for parenting. The clusters were named High School Parenting Education, Prenatal and Parent Education, Public Health Role, Parent Resource and Support Programs, Government Funding, Community Support and Standards, and Promotion of Parenting. The code words established during idea synthesis (Appendix K) were similar to the final cluster solution. Larger sized clusters, like Promotion of Parenting, represent broader

concepts and smaller sized clusters, like Public Health Role, indicate more specific concepts. The statements in each of the clusters, along with their bridging values, are presented in Table 8.

Table 8. Statements in clusters with bridging values

| Statement | | Bridging Value |
|---|---|---|
| **High School Parenting Education** | | **0.24** |
| 1. | Make family studies classes mandatory in high school. | 0.03 |
| 2. | Add parenting classes to college and university programs. | 0.29 |
| 5. | Offer child development courses in high school where parents and babies are brought into the school to interact with students. | 0.00 |
| 6. | Include mandatory gender-neutral life skills classes in high school. | 0.01 |
| 15. | Promote the message that parenting is learned and we all need to learn how to parent. | 0.81 |
| 17. | Implement provincially mandated parenting classes into existing or new high school curriculum. | 0.16 |
| 42. | Teach students about relationships as a life skill. | 0.35 |
| **Prenatal and Parent Education** | | **0.35** |
| 3. | Ensure prenatal classes are available in every community. | 0.35 |
| 8. | Provide all expectant parents with consultation on services they may need including mental health, alcohol/drug issues, housing, etc. | 0.36 |
| 9. | Facilitate peer support groups for parents to meet with other parents. | 0.20 |
| 18. | Develop online parenting classes and child development videos for expecting parents using a variety of learning styles. | 0.56 |
| 20. | Offer monthly parenting classes to teach parents about all stages of child development and parental expectations for child behaviour. | 0.28 |
| 24. | Educate parents on the benefits of helping your children be as screen-free as possible. | 0.39 |
| 25. | Make parenting courses mandatory for families with higher risk factors. | 0.32 |
| 32. | Create mandatory child development courses with a focus on mental health. | 0.61 |
| 39. | Develop prenatal courses that teach about child mental health and emotional well-being. | 0.42 |
| 41. | Ensure parenting classes are sensitive to varied cultural parenting styles. | 0.27 |
| 43. | Share parenting strategies at parent support groups. | 0.27 |
| 49. | Make parenting classes mandatory for first-time parents during baby's first year. | 0.32 |
| 60. | Provide free prenatal classes on child development. | 0.32 |
| 65. | Teach people how to balance a new baby with the other demands of home and life. | 0.44 |
| 67. | Offer free parenting classes with child care provided. | 0.26 |
| 72. | Offer father-focused parent programs. | 0.30 |

| | | |
|---|---|---|
| **Public Health Role** | | **0.45** |
| 13. | Ensure Public Health services include information about parenting classes. | 0.41 |
| 14. | Have trained parent support people to visit new parents in the hospital to supply information about community resources in their area. | 0.42 |
| 19. | Have doctors or the Public Health Nurse refer parents to specific programs (e.g., Parent-Child Coalitions, Family Resource Centres) like a prescription. | 0.50 |
| 21. | Assign a parent mentor for every new parent who can offer support throughout all stages of child-rearing. | 0.37 |
| 36. | Include information about parenting strategies during Public Health home visits. | 0.46 |
| 46. | Implement mandatory Public Health visits at regular intervals until 2-3 months of age to monitor baby's health and mother's well-being. | 0.43 |
| 52. | Provide detailed feeding and sleeping guides to parents when a baby is discharged from the hospital. | 0.51 |
| 69. | Include information about baby's physical health during Public Health visits. | 0.47 |
| 70. | Connect every person with Public Health upon finding out they are pregnant to support them with the planning and preparation for the new baby. | 0.46 |
| **Parent Resource and Support Programs** | | **0.25** |
| 10. | Expand Family's First programs for all parents and not just parents identified as being at risk or who have a low income. | 0.26 |
| 11. | Concentrate on resource centres rather than time-limited programs so that parents have a consistent place to seek advice and support. | 0.18 |
| 33. | Increase access and support to Healthy Baby programs throughout the province. | 0.31 |
| 34. | Increase support services to remote/rural/northern communities - including mental health, counselling, recreational programming, medical, educational, etc. | 0.23 |
| 48. | Create central family resource centres where all parenting services can be easily accessed. | 0.19 |
| 50. | Extend the Families First program by two or three years. | 0.46 |
| 58. | Offer support for families living in First Nations communities through health care professionals or elders. | 0.25 |
| 59. | Expand breastfeeding resources. | 0.23 |
| 71. | Have permanent family spaces that offer play activities to support development for infants and children. | 0.18 |
| **Government Funding** | | **0.22** |
| 7. | Increase availability of high-quality child care. | 0.40 |
| 23. | Lobby the government to increase support for parents and children. | 0.24 |
| 26. | Provide appropriate pay for those working with parents (e.g., Family Resource Centres). | 0.15 |
| 38. | Provide financial support, so the most basic of needs are met for all parenting families. | 0.08 |
| 40. | Ongoing support for existing Better Beginnings programs. | 0.32 |
| 45. | Increase funding for parenting programs. | 0.14 |

| | | |
|---|---|---|
| 47. | Secure maternity leave with 100% of income paid during leave for lowest income earners. | 0.13 |
| 55. | Offer financial support for parents who chose to stay home to raise their children. | 0.04 |
| 56. | Additional funding for Healthy Child Parent Child Coalitions. | 0.19 |
| 57. | Increase employment income assistance payments for pregnant mothers to improve nutrition and quality of life during pregnancy and as a new mother. | 0.05 |
| 64. | Expand parental leave for fathers. | 0.63 |
| 66. | Ensure proper services and support (financial and emotional) are available when mothers have to leave their community to have their baby. | 0.28 |
| **Community Support and Standards** | | **0.55** |
| 28. | Provide all expecting parents with baby boxes like those given to parents in Finland. | 0.38 |
| 29. | Ensure workplaces provide parenting classes as part of their employee assistance programs or benefits package. | 0.33 |
| 30. | Support parents in times of crisis. | 0.43 |
| 35. | Ensure people who support parents are educated and competent. | 0.81 |
| 37. | Develop a system of accountability for Public Health Nurses, home visitors, and direct service staff who work with parents. | 0.57 |
| 44. | Build relationships with parenting service providers and families. | 0.46 |
| 53. | Build a framework to gain quality feedback from clients on parenting services (e.g., Public Health, home visitors, direct service staff). | 0.89 |
| 62. | Ensure parenting mentors know how to talk with new parents. | 0.71 |
| 68. | Set up a parenting helpline that is accessible 24 hours a day like health links. | 0.34 |
| **Promotion of Parenting** | | **0.72** |
| 4. | Develop programs for new fathers with male mentors. | 0.79 |
| 12. | Find ways to increase the value placed on parenting. | 0.87 |
| 16. | Promote positive parenting and discipline. | 0.61 |
| 22. | Reduce the stigma parents feel when they ask for help with parenting. | 0.93 |
| 27. | Provide more information to parents on bonding and attachment. | 0.56 |
| 31. | Increase society's understanding of the significance and impact of parenting. | 1.00 |
| 51. | Share parenting tips on the TV, radio, and social media. | 0.89 |
| 54. | Increase awareness of existing services and supports for parents. | 0.67 |
| 61. | Develop an easy access computer app with general information on child development and links to credible websites. | 0.43 |
| 63. | Set up a parenting website that includes an online forum and newsletter. | 0.49 |

The High School Parenting Education cluster was heavily slanted toward mandatory high school parenting education related to child development (items 1, 6, 15, 17). Item number 42 reflected a broadening of this idea to include relationship education. This was a very cohesive cluster with a bridging value of only 0.24, indicating strong connections between the statements.

The main idea in the Prenatal and Parent Education cluster was parenting education for people either when they were expecting a baby (items 3, 8, 18, 39, 49, 60) or when they had a child (items 20, 24, 65). There was an aspect of accessibility in this cluster speaking to different needs parents might have (items 18, 41, 67, 72) as well as the importance of learning from peers (items 9, 43). Some items in this cluster focused on mandatory parent education (items 25, 32).

Almost every item in the Public Health Role cluster was related to Public Health and Health services for parents. Some of the statements referred to providing information about services and supports (items 13, 14, 19, 70) while others focused on providing direct parenting education (items 36, 52, 69).

The Parent Resource and Support Programs cluster reflected the need for increased services and supports. Some statements indicated the importance of expanding current programs either in length or access (items 10, 33, 34, 50, 58, 59). Some statements specifically identified resource centres as being essential supports (items 11, 48, 71).

In the Government Funding cluster, all statements were related to actual government spending. Half the statements were related to providing more money directly to parents (items 23, 38, 47, 55, 57, 64, 66) while the other half were related to more money for programs and services for parents (items 7, 26, 40, 45, 56).

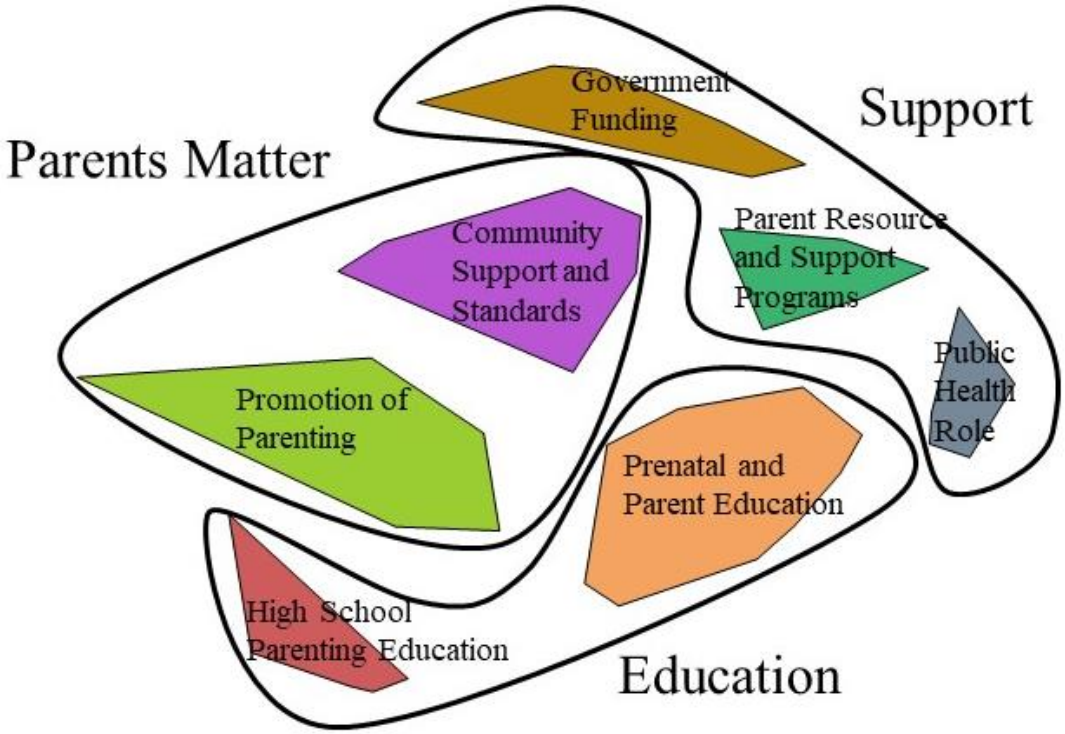
The Community Support and Standards cluster was about building a sustainable community of support. This included welcoming new parents in their role with baby boxes (item 28), being there to support parents when they face challenges (items 30, 68), and having support from employers (item 29). This also included establishing standards for service providers and establishing opportunities for parents to provide feedback on services received (items 35, 37, 44,

53, 62). I understood this cluster as one that spoke to both community involvement and community responsibility toward parents.

Promotion of Parenting was the largest physical cluster on the map, and it contained some statements that reflected broader concepts (i.e., ideas that are hard to define and operationalize such as *reduce the stigma* and *increase society's understanding*). This cluster had the highest bridging value (0.72) indicating that many of the statements were sorted with statements in other areas of the map. In addition to encompassing broader concepts, there was a focus on general communication with the public about parenting and providing information about parenting. An underlying thread that appeared to link these statements was a need to change our thinking about parents and parenting. This included recognizing the value of parents and the critical role they play in society (items 12 and 31), including fathers who have traditionally been left out of the conversation around parenting (item 4), increasing the focus on the positive relationships we can have with our children (items 16, 27), decreasing the judgements made when parents seek support (item 22), and expanding the way information is shared about services and supports for parents (items 51, 54, 61, 63).

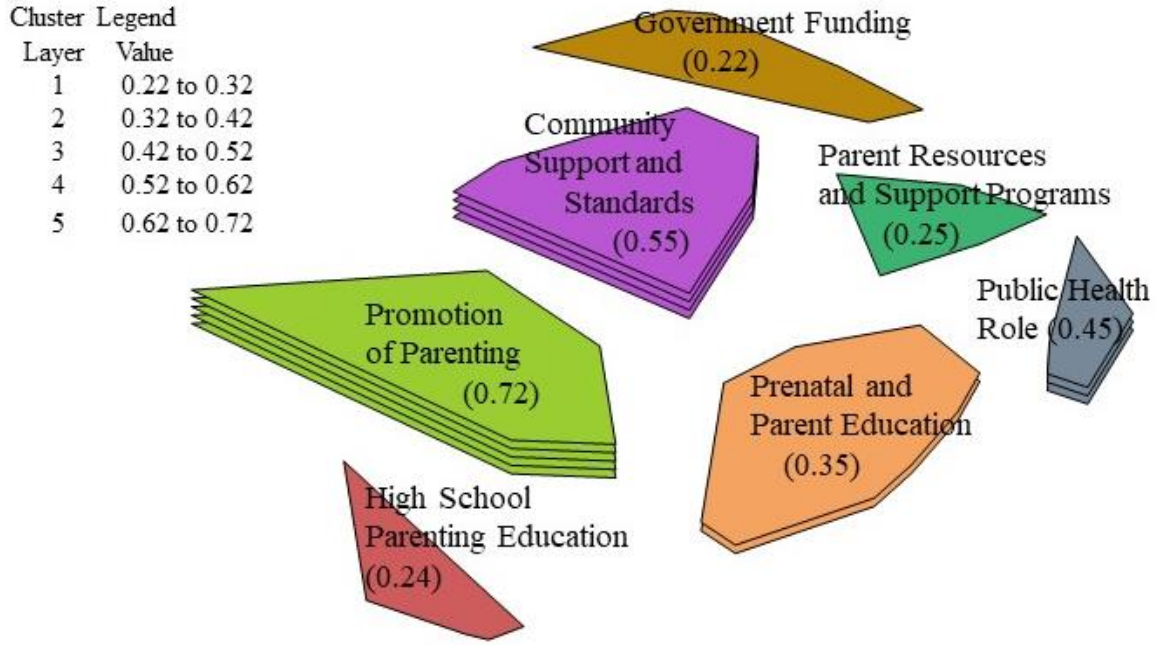
Clusters that are closer together on the map are more conceptually similar. There appear to be three regions for planning that can be identified in this cluster map and they are outlined in Figure 7. The middle left-hand side of the map encompasses a general theme of how we think about and value parents and the parenting role in society (named Parents Matter), the bottom of the map is related to education across life stages (named Education), and the top right-hand side of the map reflects ideas related to government commitment to parents through needed services and supports (named Support).

Figure 7. Regional areas for planning




The cluster bridging analysis results, seen in Figure 8, show that three of the seven clusters fell at or below a 0.25 bridging value and that the overall average bridging value for all seven clusters was below 0.40. Bridging values can range between 0.0 and 1.0. The lower bridging values for the clusters in this study indicate overall cohesive clusters.

Figure 8. Cluster bridging map




**Summary: Research Question One**

Within the online concept mapping forum, participants generated 106 original statements which were then reduced to a final statement set of 72 through idea synthesis. This ensured that all statements contained one unique idea for the sorting and rating activities. Participants sorted the 72 statements into groups based on conceptual similarity. MDS was used to transform this sort data into a point map, where statements that had been sorted together more often appeared in closer proximity. HCA was used to partition these points into clusters. A 7-cluster solution appeared to be the best conceptual fit for the statements. Clusters were given labels reflecting their general intent: High School Parenting Education, Prenatal and Parent Education, Public Health Role, Parent Resource and Support Programs, Government Funding, Community Support and Standards, and Promotion of Parenting. There was conceptual similarity between adjacent clusters, and three regions for planning were identified: Support, Education, and Parents Matter.

Participants identified seven general areas and three larger conceptual regions, that would help people prepare for parenting in Manitoba.

**Research Question Two**

*What strategies do participants identify as being the most important and the most feasible? Are there differences in what is seen as most important and or feasible by participant subgroups?*

The following section describes what participants perceived as important and feasible in achieving the goal of helping people prepare for parenting. Variations in perceptions will be examined by group and locale.

There were 44 participants who completed the importance rating (17 parents, 17 service providers, and 10 administrators) and 43 who completed the feasibility rating (17 parents, 16 service providers, and 10 administrators). No participant rating data was removed from the analysis. One service provider did not complete the second rating activity.

Two point rating maps, showing the collective importance and feasibility ratings for each statement are shown in Figures 9 and 10, respectively. The point rating maps look the same as the point map but have stacked circles beside each statement number. The more important or feasible that statement was rated by the group collectively, the more circles beside the statement number. For each point rating map, a legend is provided which illustrates the range of rating values for that map. In Figure 9 we can see that statement 45 *Increase funding for parenting programs*, has five dots beside it and an average relative importance rating of 4.39, while statement 28 *Provide all expecting parents with baby boxes like those given to parents in and Finland*, has one dot beside it and an average relative importance rating of 3.27. In Figure 10, statement 63 *Set up a parenting website that includes an online forum and newsletter*, has five

dots beside it and an average relative feasibility rating of 4.26, while statement 29 *Ensure workplaces provide parenting classes as part of their employee assistance programs or benefits package*, has one dot beside it and an average relative feasibility rating of 2.77. The point rating maps help identify priorities and possibilities.

Figure 9. Point rating map for importance

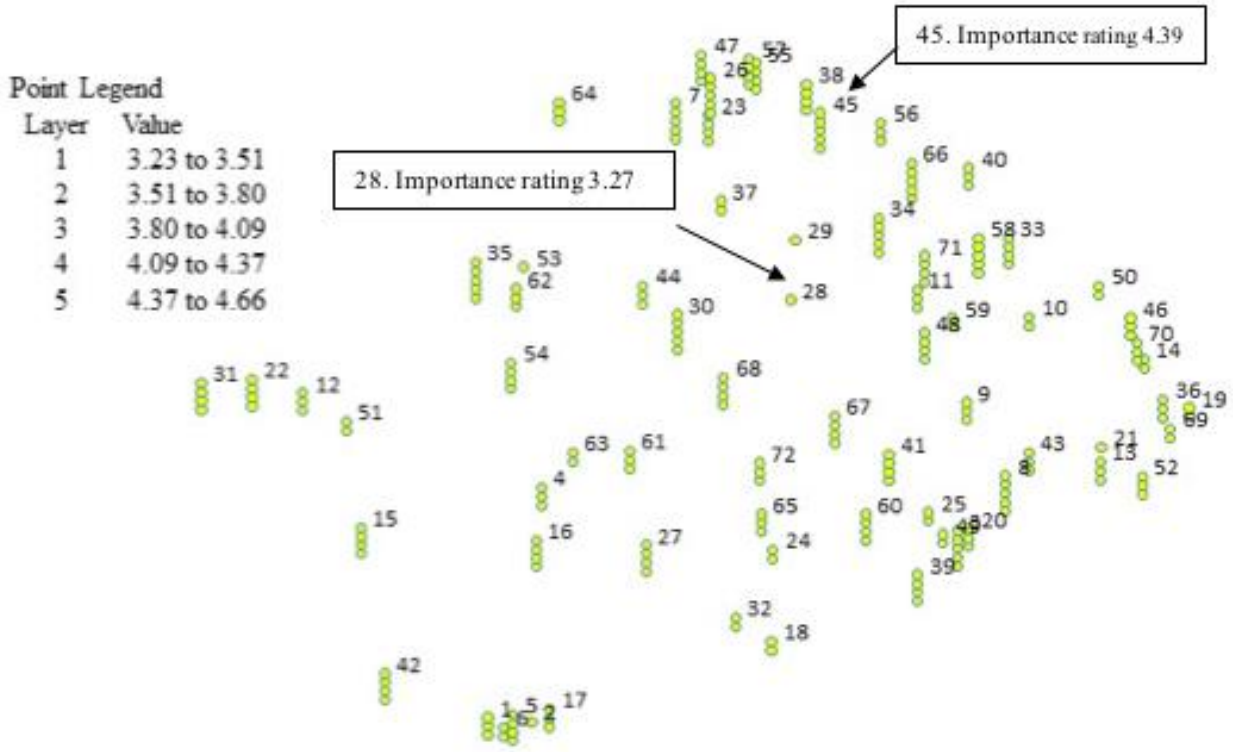


Figure 10. Point rating map for feasibility


Cluster rating maps were generated to assess the relative importance and feasibility for each cluster as they relate to helping people prepare for parenting. The more layers in a given cluster, the higher the average value rating given that cluster by participants. For each cluster rating map, a legend is provided which illustrates the range of rating values for that map. The average rating of all statements within that cluster is noted on the respective figures. In Figure 11 we see that Government Funding (4.23) had the overall highest relative rating of importance while Public Health Role (3.79) had the lowest. Figure 12 displays the same information but for the feasibility rating criteria. Promotion of Parenting (4.07) had the overall highest relative feasibility rating, while Government Funding (3.38) the lowest. There was a discrepancy between what participants saw as important and what they saw as feasible.

Figure 11. Cluster rating map importance

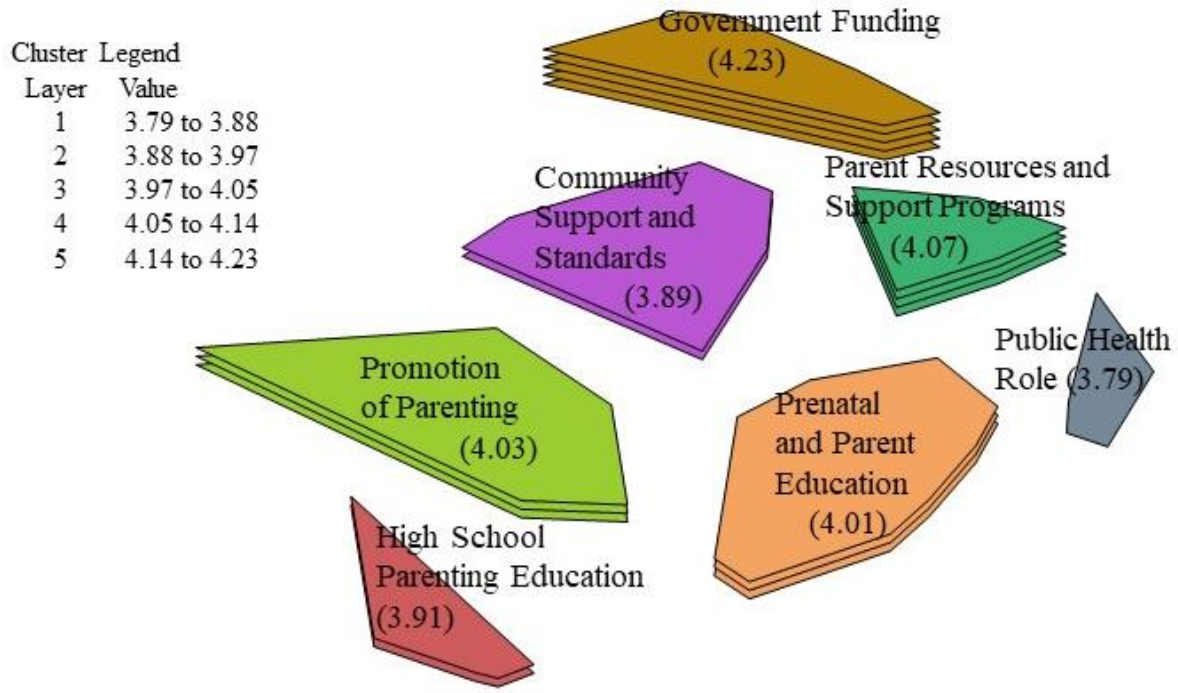
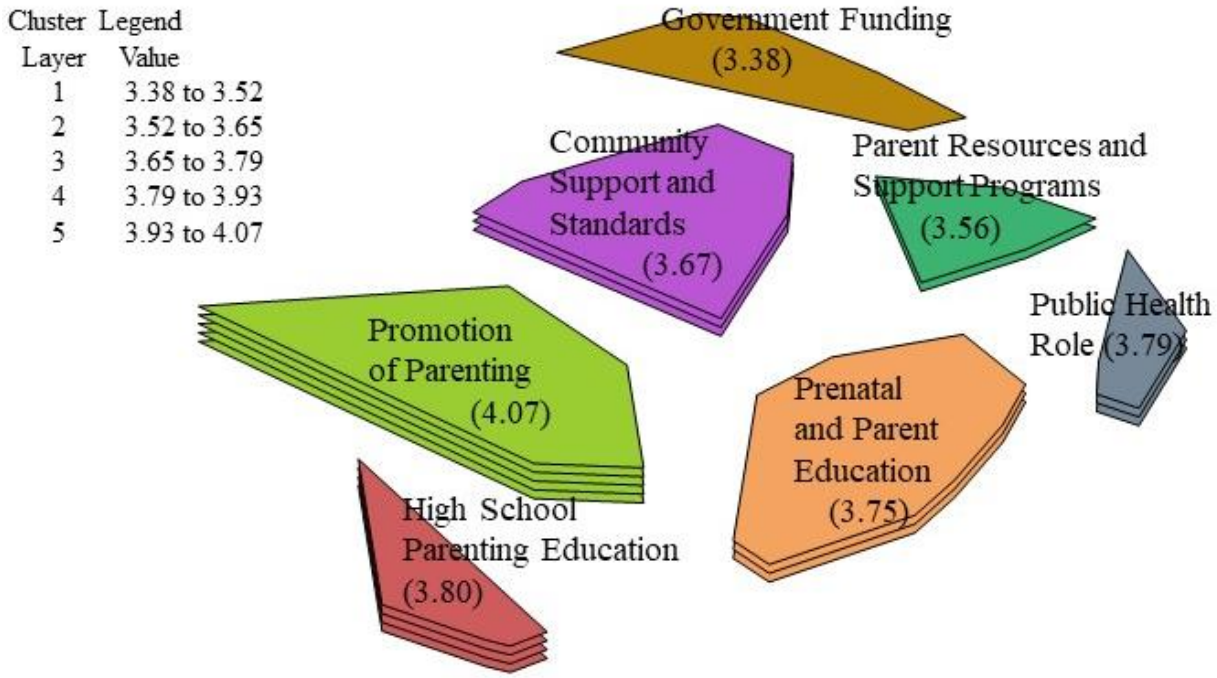



Figure 12. Cluster rating map feasibility



The average cluster ratings were further examined using a pattern match to highlight areas of agreement and disagreement, and a Pearson product-moment correlation coefficient was reported to assess the relationship between the variables. The pattern match in Figure 13 highlighted the difference between participants' ratings of relative importance and relative feasibility of the clusters. Most striking was the sharp downward slope of the Government Funding cluster. Although seen as the most important area related to helping people prepare for parenting, it was also seen as the least likely to happen. The Parent Resource and Support Programs cluster also has a steep downward slope. Again, this was seen as a central area for planning and action, but one that was less likely to happen. Overall, the average importance ratings were higher than the average feasibility ratings. In fact, there was a negative correlation between importance and feasibility, $r = -0.51$, indicating that increases in importance ratings were correlated with decreases in feasibility ratings. The average ratings can be seen in Table 9.

Figure 13. Pattern match for importance and feasibility ratings by cluster

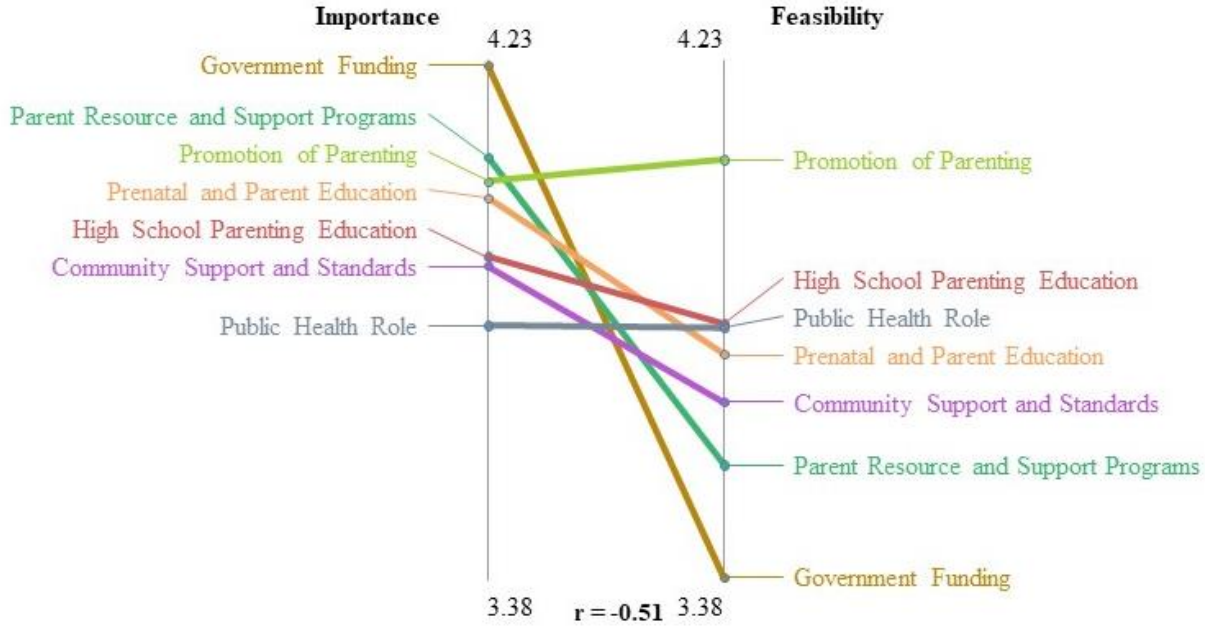


Table 9. Cluster averages for importance (n = 44) and feasibility (n = 43) ratings

| **Cluster** | **Importance Mean** | **Importance *sd*** | **Feasibility Mean** | **Feasibility *sd*** |
|---|---|---|---|---|
| Promotion of Parenting | 4.03 | 0.22 | 4.07 | 0.28 |
| High School Parenting Education | 3.91 | 0.33 | 3.80 | 0.40 |
| Prenatal and Parent Education | 4.01 | 0.31 | 3.75 | 0.53 |
| Public Health Role | 3.79 | 0.24 | 3.79 | 0.61 |
| Parent Resource Support Programs | 4.07 | 0.35 | 3.56 | 0.18 |
| Government Funding | 4.23 | 0.19 | 3.38 | 0.30 |
| Community Support & Standards | 3.89 | 0.43 | 3.67 | 0.45 |

**Subgroup comparisons.**

The purpose of this research was to build a conceptual framework outlining what could be done to help people prepare for parenting and to identify actionable recommendations that could be a foundation for future planning. Therefore, I was interested in seeing if priorities or possibilities were viewed differently within participant subgroups. As indicated in the participant demographic descriptive data, participants in this study were quite similar in age, education and combined family income, and so no further comparisons were made based on those demographic characteristics. I did examine subgroups based on self-identification (i.e., parent, service provider, administrator) and locale (i.e. rural/northern and urban). No tests of significance were conducted because of the small numbers of participants in some of the subgroups.

***Group.***

Administrators and Service Providers identified Government Funding as the area that was most important in helping people prepare for parenting, although Administrators rated it much higher than Service Providers. Administrators may have rated Government Funding higher given they are more likely to be involved in applying for and managing funding provided by the government. Parents rated it as the second most important cluster. Parents rated Parent Resource and Support Programs as the most important area while Service Providers and Administrators

(people currently working in the agencies supporting parents), rated this at about the middle of the scale. Also, it is interesting to see that all three groups rated Public Health Role as the least relatively important area in helping people prepare for parenting. Generally, Service Providers rated all items lower than either Administrators or Parents. Administrators were closer in their importance ratings to Service Providers (r= 0.69) than they were to Parents (r = 0.42). Parents and Service Providers had the least similarity on importance ratings (r = 0.40), suggesting a difference in priority ratings between parents and people doing direct service work in the field. Figures 14 and 15 compare the three groups and Tables 10 and 11 provide summary statistics.

Figure 14. Pattern match on importance ratings by group

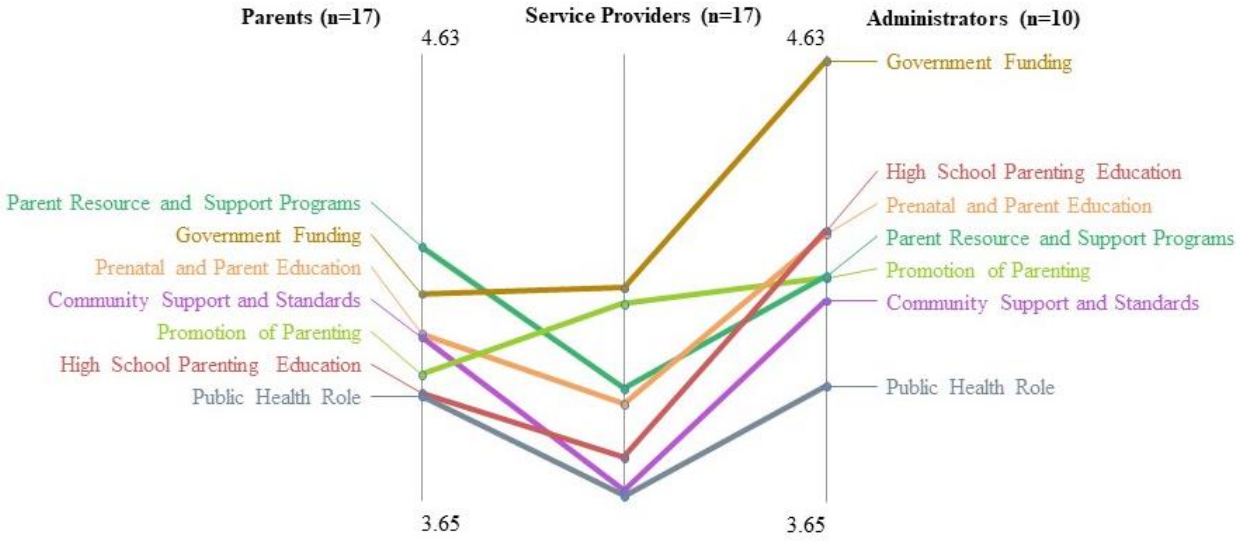


Table 10. Importance (R1) cluster averages for Parents, Service Providers (SP), and Administrators (Admin)

| **Cluster** | **R1 Parents Mean** | **R1 Parents *sd*** | **R1 SP Mean** | **R1 SP *sd*** | **R1 Admin Mean** | **R1 Admin *sd*** |
|---|---|---|---|---|---|---|
| Promotion of Parenting | 3.92 | 0.34 | 4.08 | 0.24 | 4.14 | 0.27 |
| High School Parenting Education | 3.88 | 0.48 | 3.74 | 0.27 | 4.25 | 0.26 |
| Prenatal and Parent Education | 4.01 | 0.45 | 3.86 | 0.37 | 4.24 | 0.28 |
| Public Health Role | 3.88 | 0.28 | 3.65 | 0.27 | 3.90 | 0.35 |
| Parent Resource and Support Programs | 4.21 | 0.32 | 3.89 | 0.41 | 4.14 | 0.34 |
| Government Funding | 4.10 | 0.20 | 4.12 | 0.25 | 4.63 | 0.20 |
| Community Support and Standards | 4.01 | 0.47 | 3.66 | 0.45 | 4.09 | 0.38 |

Despite differences in the importance ratings, Parents, Service Providers, and Administrators were much closer in their assessment of feasibility. Importance ratings are value-based while feasibility ratings are linked to practicality (Kane & Trochim, 2007). While there were some differences in the valuing of what was important, there was greater consensus regarding what might actually be possible. All three groups identified Promotion of Parenting as the most feasible area for action and Government Funding and Parent Resource and Support Programs as the least feasible. In fact, there were very high correlations between groups on the feasibility ratings, Parents and Service Providers ($r = 0.92$), Parents and Administrators ($r = 0.92$), and Service Providers and Administrators ($r = 0.80$). It seems that the feasibility of the clusters was agreed upon by most participants.

Figure 15. Pattern match on feasibility ratings by group

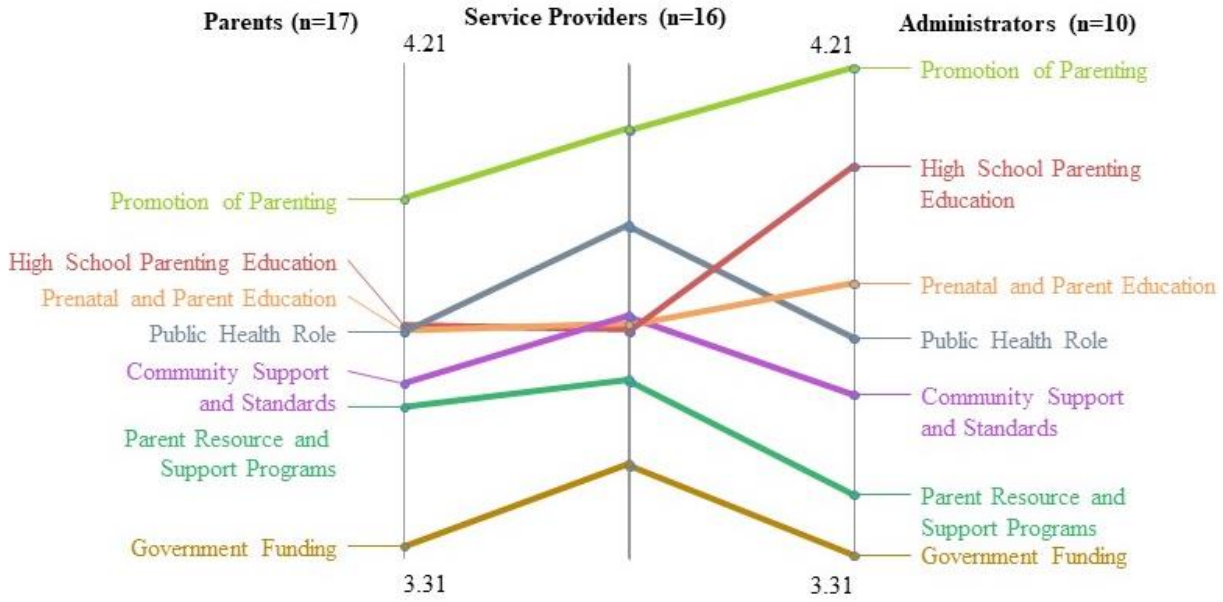



Table 11. Feasibility (R2) cluster averages for Parents, Service Providers (SP), and Administrators (Admin)

| Cluster | R2 Parents Mean | R2 Parents *sd* | R2 SP Mean | R2 SP *sd* | R2 Admin Mean | R2 Admin *sd* |
|---|---|---|---|---|---|---|
| Promotion of Parenting | 3.96 | 0.28 | 4.09 | 0.40 | 4.21 | 0.25 |
| High School Parenting Education | 3.73 | 0.48 | 3.72 | 0.47 | 4.03 | 0.40 |
| Prenatal and Parent Education | 3.72 | 0.49 | 3.73 | 0.80 | 3.81 | 0.32 |
| Public Health Role | 3.72 | 0.57 | 3.92 | 0.67 | 3.71 | 0.70 |
| Parent Resource and Support Programs | 3.58 | 0.20 | 3.63 | 0.21 | 3.42 | 0.35 |
| Government Funding | 3.32 | 0.32 | 3.48 | 0.38 | 3.31 | 0.28 |
| Community Support and Standards | 3.63 | 0.44 | 3.75 | 0.56 | 3.61 | 0.39 |

***Locale.***

Rural/Northern and Urban participants rated Government Funding as being the most important area to address in helping people prepare for parenting while Public Health Role was rated as the least or second least important area. Interestingly, High School Parenting Education

was rated as the second most important area by Rural/Northern participants while Urban participants saw it as the least important area. It may be that Rural/Northern participants are more reliant on the public education system given they typically have fewer services and supports within their communities. Cluster ratings for importance and feasibility by locale subgroups are shown in pattern matches in Figures 16 and 17 and Tables 12 and 13 respectively.

Figure 16. Pattern match on importance ratings by locale

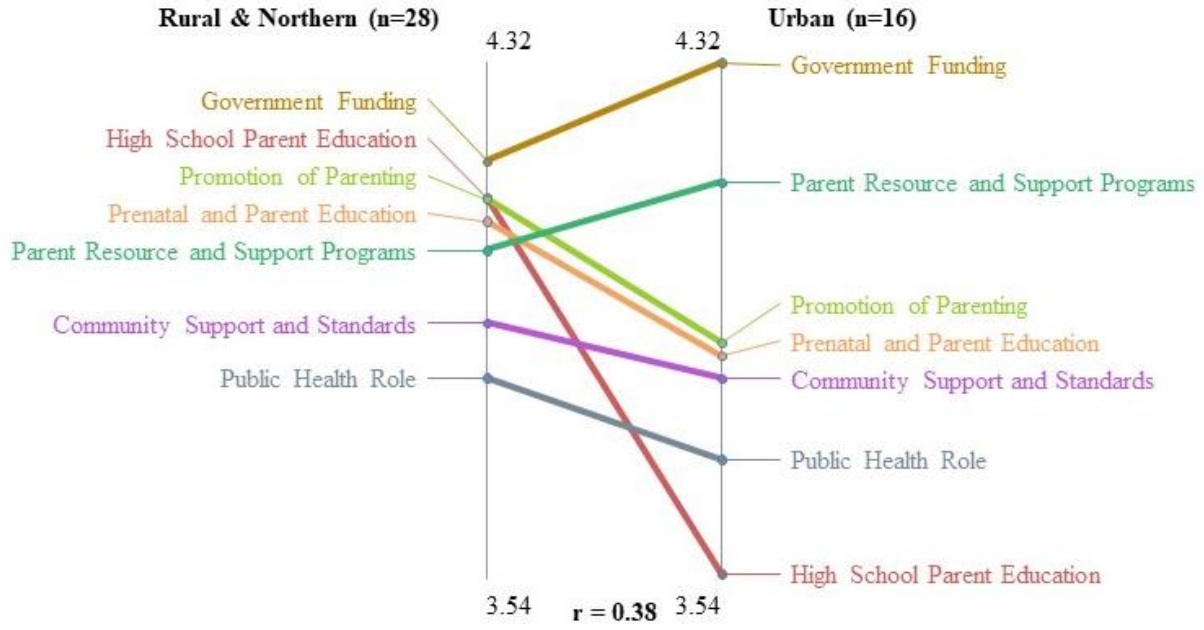



Table 12. Importance (R1) cluster averages for Rural/Northern, and Urban participants

| Cluster | R1 Rural & Northern Mean | R1 Rural & Northern *sd* | R1 Urban Mean | R1 Urban *sd* |
|---|---|---|---|---|
| Promotion of Parenting | 4.11 | 0.27 | 3.89 | 0.26 |
| High School Parenting Education | 4.12 | 0.31 | 3.54 | 0.49 |
| Prenatal and Parent Education | 4.08 | 0.24 | 3.87 | 0.47 |
| Public Health Role | 3.84 | 0.21 | 3.72 | 0.36 |
| Parent Resource and Support Programs | 4.04 | 0.31 | 4.14 | 0.46 |
| Government Funding | 4.17 | 0.23 | 4.32 | 0.25 |
| Community Support and Standards | 3.92 | 0.43 | 3.84 | 0.49 |

A comparison of the feasibility ratings for Rural/Northern and Urban groups revealed consensus on Promotion of Parenting as having the highest probability of occurring, and Government Funding as being the least feasible. What is important to note is the steep slope on the Government Funding line between the Rural/Northern group and the Urban group. Even though Urban participants rated this as the second least likely to happen, they rated it as much more likely than did the Rural/Northern group. Another interesting dynamic to note was found with the High School Parenting Education cluster. The Rural/Northern group felt it was far more feasible to implement High School Parenting Education while the Urban group felt it was far more feasible to implement Prenatal and Parent Education. Urban participants rated High School Parenting Education as both the least important and the least feasible area in helping people prepare for parenting.

Figure 17. Pattern match on feasibility ratings by locale

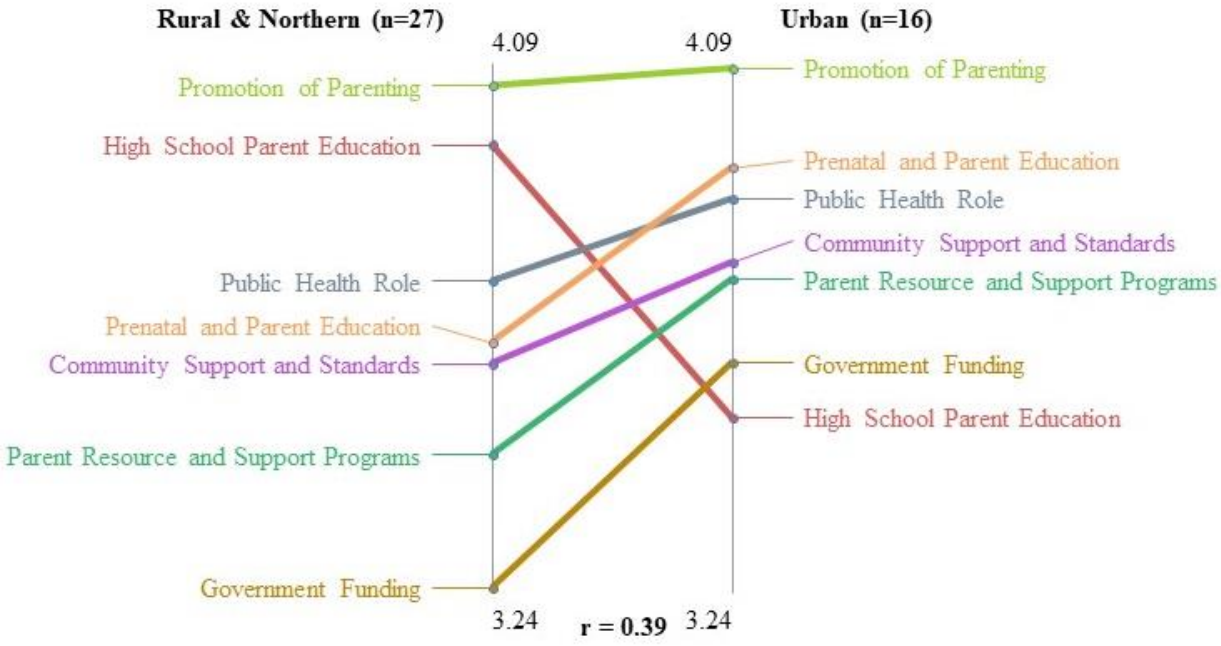


Table 13. Feasibility (R1) cluster averages for Rural/Northern, and Urban participants

| **Cluster** | **R2 Rural & Northern Mean** | **R2 Rural & Northern *sd*** | **R2 Urban Mean** | **R2 Urban *sd*** |
|---|---|---|---|---|
| Promotion of Parenting | 4.06 | 0.31 | 3.89 | 0.26 |
| High School Parenting Education | 3.96 | 0.32 | 3.54 | 0.49 |
| Prenatal and Parent Education | 3.64 | 0.45 | 3.87 | 0.47 |
| Public Health Role | 3.74 | 0.61 | 3.72 | 0.36 |
| Parent Resource and Support Programs | 3.46 | 0.16 | 4.14 | 0.46 |
| Government Funding | 3.24 | 0.29 | 4.32 | 0.25 |
| Community Support and Standards | 3.61 | 0.45 | 3.84 | 0.49 |

**Summary: Research Question Two**

Participants provided relative ratings of importance and feasibility for each statement as it related to the focus prompt. The average combined rating of the statements for importance and feasibility were then calculated for statements within each cluster to arrive at cluster ratings. Government Funding was rated as being the most important cluster by participants followed by (in descending order of importance), Parent Resource and Support Programs, Promotion of Parenting, Prenatal and Parent Education, High School Parenting Education, Community Support and Standards, and finally Public Health Role. Promotion of Parenting was rated as the most feasible cluster by participants followed by (in descending order of feasibility), High School Parenting Education, Public Health Role, Prenatal and Parent Education, Community Support and Standards, Parent Resource and Support Programs, and lastly Government Funding. While Government Funding was seen as the most important area in helping people prepare for parenting, it was also seen as the least feasible.

Subgroup comparisons on importance and feasibility were completed to see if importance or feasibility ratings were different based on group or locale. Both Administrators and Service Providers rated Government Funding as being the most important area related to helping people prepare for parenting, while Parents rated this as the second most important area. Parents rated Parent Resource and Support Programs as being the most important area for planning while people working in the field (i.e., Administrators and Service Providers) rated it at about the relative middle of the importance scale. The Public Health Role cluster was rated as the least relatively important area by all three groups. There was a much higher consistency between the subgroups on the feasibility ratings.

Rural/Northern and Urban participants agreed that Government Funding was the most important area in helping people prepare for parenting and that the Public Health Role was the relatively least important. Interestingly, Rural/Northern participants rated High School Parenting Education as the second most important area while Urban participants rated this as the least important area to help people prepare for parenting.

**Research Question Three**

*Based on the value ratings of strategies by participants, what are the most actionable recommendations for helping people prepare for parenting in Manitoba?*

Statement ratings of importance and feasibility were plotted on a bivariate scatterplot called a go-zone to identify strategies with above average ratings of importance *and* feasibility. As shown in Figure 18, points falling into the go-zone (green upper right-hand quadrant) were statements that were rated as being the most relatively important *and* the most relatively feasible by all participants. The *r* value for this analysis was 0.29, indicating a low correlation between importance ratings and feasibility ratings across all statements.

There were 21 statements identified as being above average in ratings of importance and feasibility. All seven clusters had one or more statements in the go-zone. The 21 statements in the go-zone and the cluster in which they were located are listed in Table 14.

Figure 18. Go-zone importance and feasibility ratings of statements

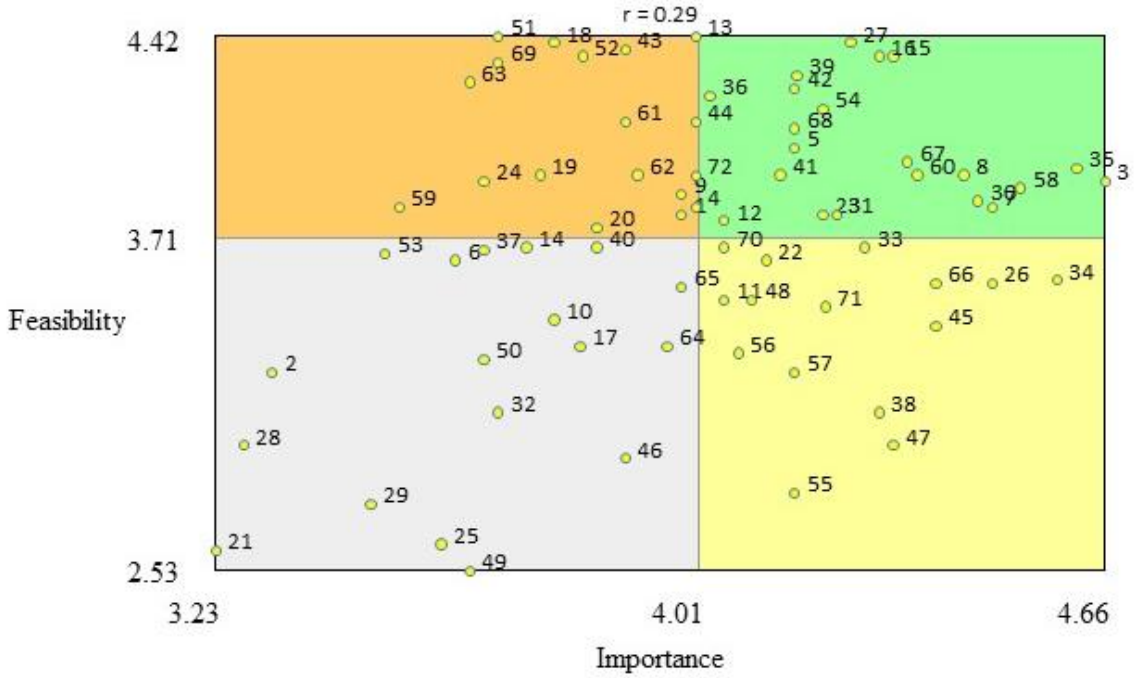


Table 14. Statements by cluster, identified as most important and most feasible from go-zone

| Cluster | Statement |
|---|---|
| Promotion of Parenting | 12. Find ways to increase the value placed on parenting.<br>16. Promote positive parenting and discipline.<br>27. Provide more information to parents on bonding and attachment.<br>31. Increase society's understanding of the significance and impact of parenting.<br>54. Increase awareness of existing services and supports for parents. |
| High School Parenting Education | 5. Offer child development courses in high school where parents and babies are brought into the school to interact with students.<br>15. Promote the message that parenting is learned and we all need to learn how to parent.<br>42. Teach students about relationships as a life skill. |
| Prenatal and Parent Education | 3. Ensure prenatal classes are available in every community.<br>8. Provide all expectant parents with consultation on services they may need including mental health, alcohol/drug issues, housing, etc.<br>39. Develop prenatal courses that teach about child mental health and emotional well-being.<br>41. Ensure parenting classes are sensitive to varied cultural parenting styles.<br>60. Provide free prenatal classes on child development.<br>67. Offer free parenting classes with child care provided. |
| Public Health Role | 36. Include information about parenting strategies during Public Health home visits. |
| Parent Resource and Support Programs | 58. Offer support for families living in First Nations communities through health care professionals or elders. |
| Government Funding | 7. Increase availability of high-quality child care.<br>23. Lobby the government to increase support for parents and children. |
| Community Supports | 30. Support parents in times of crisis.<br>35. Ensure people who support parents are educated and competent.<br>68. Set up a parenting helpline that is accessible 24 hours a day like health links. |

The top areas for action were Prenatal and Parenting Education (six items), Promotion of Parenting (five items), High School Parenting Education and Community Support and Standards (three items each), Government Funding (two items) and finally Public Health Role and Parent Resource and Support Programs (each with one item).

Prenatal and Parenting Education had the highest number of actionable statements. Four of the six statements were related to issues of accessibility: free classes (both prenatal and

parenting), free child care when attending the classes, prenatal classes available in every community, and parenting classes that were sensitive to various cultural parenting styles. Two of the statements in this cluster were related to mental health (i.e., the mental health of the parent and teaching the expectant parent about the mental health and well-being of children).

Promotion of Parenting had the next highest number of actionable statements. Two of the statements were related to increasing the value placed on parenting and increasing understanding of the significance and impact of parenting. Three statements were related to increasing awareness about positive parenting and discipline, bonding and attachment, and available services and supports.

Both High School Parenting Education and Community Support and Standards each had three actionable statements. The statements in the High School Parenting Education cluster can be summarized as learning about parenting, child development, and relationships in schools. The Community Support and Standards cluster can be summarized as parents needing accessible and appropriate support when in crisis.

Government Funding included statements about increasing the number of high-quality child care spaces and increased support for parents and children. In Public Health Role, having Public Health Nurses provide information about parenting strategies during home visits was identified. Within the Parent Resource and Support Programs cluster, offering support to families in First Nations Communities either through health care professionals or Elders was identified as an actionable statement.

Action planning can become ineffective if large numbers of ideas are proposed simultaneously. It is important to identify first steps and next steps. To do this, I determined the

statements with the highest ratings on importance and feasibility from the go-zone by adding together the two ratings (Johnson, 2012) and ranked them from 1-21 as seen in Table 15.

Table 15. Highest ranked statements on both importance and feasibility ratings from go-zone

| Rank | Statement | | R1 | R2 | Total |
|---|---|---|---|---|---|
| 1 | 15 | Promote the message that parenting is learned and we all need to learn how to parent. | 4.32 | 4.35 | 8.67 |
| 2 | 27 | Provide more information to parents on bonding and attachment. | 4.25 | 4.40 | 8.65 |
| 3 | 16 | Promote positive parenting and discipline. | 4.30 | 4.35 | 8.65 |
| 4 | 3 | Ensure prenatal classes are available in every community. | 4.67 | 3.91 | 8.58 |
| 5 | 35 | Ensure people who support parents are educated and competent. | 4.61 | 3.95 | 8.56 |
| 6 | 39 | Develop prenatal courses that teach about child mental health and emotional well-being. | 4.16 | 4.28 | 8.44 |
| 7 | 58 | Offer support for families living in First Nations communities through health care professionals or elders. | 4.52 | 3.88 | 8.40 |
| 8 | 42 | Teach students about relationships as a life skill. | 4.16 | 4.23 | 8.39 |
| 9 | 8 | Provide all expectant parents with consultation on services they may need including mental health, alcohol/drug issues, housing, etc. | 4.44 | 3.93 | 8.37 |
| 10 | 54 | Increase awareness of existing services and supports for parents. | 4.20 | 4.16 | 8.36 |
| 11 | 67 | Offer free parenting classes with child care provided. | 4.34 | 3.98 | 8.32 |
| 12 | 7 | Increase availability of high-quality child care. | 4.49 | 3.81 | 8.30 |
| 13 | 60 | Provide free prenatal classes on child development. | 4.36 | 3.93 | 8.29 |
| 14 | 30 | Support parents in times of crisis. | 4.45 | 3.84 | 8.29 |
| 15 | 68 | Set up a parenting helpline that is accessible 24 hours a day like health links. | 4.16 | 4.09 | 8.25 |
| 16 | 36 | Include information about parenting strategies during Public Health home visits. | 4.02 | 4.21 | 8.23 |
| 17 | 5 | Offer child development courses in high school where parents and babies are brought into the school to interact with students. | 4.18 | 4.02 | 8.20 |
| 18 | 41 | Ensure parenting classes are sensitive to varied cultural parenting styles. | 4.14 | 3.93 | 8.07 |
| 19 | 31 | Increase society's understanding of the significance and impact of parenting. | 4.23 | 3.79 | 8.02 |
| 20 | 23 | Lobby the government to increase support for parents and children. | 4.20 | 3.79 | 7.99 |
| 21 | 12 | Find ways to increase the value placed on parenting. | 4.07 | 3.77 | 7.84 |

When identifying actionable recommendations for planning in concept mapping, both importance and feasibility ratings need to be considered. The balancing of priority and possibility is typically undertaken by the group of stakeholders who initiated the research (Kane & Trochim, 2007). In this study, I found the balance between importance and feasibility by reviewing participants' reflections, by reviewing the go-zone maps and statement ratings on importance and feasibility, and through my interpretation based on a familiarity with the data and the research in this area. As well, consideration was given to having fewer and more focused recommendations to increase the possibility of implementation (Bloomberg & Volpe, 2012). The twenty-one statements in the go-zone were used to develop four general recommendations for action and are shown in Table 16. The strategies under each recommendation are listed in order of their ranking for both importance and feasibility.

Table 16. General recommendations for helping people prepare for parenting in Manitoba

| **Raise Community Awareness of Parenting** | |
|---|---|
| Rank | Strategies |
| 1 | Promote the message that parenting is learned and we all need to learn how to parent. |
| 3 | Promote positive parenting and discipline. |
| 19 | Increase society's understanding of the significance and impact of parenting. |
| 21 | Find ways to increase the value placed on parenting. |
| **Integrate Learning to Parent Across Life Stages** | |
| Rank | Strategies |
| 2 | Provide more information to parents on bonding and attachment. |
| 6 | Develop prenatal courses that teach about child mental health and emotional well-being. |
| 8 | Teach students about relationships as a life skill. |
| 16 | Include information about parenting strategies during Public Health home visits. |
| 17 | Offer child development courses in high school where parents and babies are brought into the school to interact with students. |
| **Ensure Supports and Services Meet Need** | |
| Rank | Strategies |
| 5 | Ensure people who support parents are educated and competent. |
| 9 | Provide all expectant parents with consultation on services they may need including mental health, alcohol/drug issues, housing, etc. |
| 10 | Increase awareness of existing services and supports for parents. |
| 12 | Increase availability of high quality child care. |
| 14 | Support parents in times of crisis. |
| 15 | Set up a parenting helpline that is accessible 24 hours a day like health links. |
| 20 | Lobby the government to increase support for parents and children. |
| **Address Issues of Access** | |
| Rank | Strategies |
| 4 | Ensure prenatal classes are available in every community. |
| 7 | Offer support for families living in First Nations communities through health care professionals or elders. |
| 11 | Offer free parenting classes with child care provided. |
| 13 | Provide free prenatal classes on child development. |
| 18 | Ensure parenting classes are sensitive to varied cultural parenting styles. |

### Summary: Research Question Three

The general recommendations for helping people prepare for parenting in Manitoba were developed from the 21 statements that had above average ratings on both importance and feasibility ratings by participants, from participant reflections, by synthesizing similar ideas, and from my interpretation based on a familiarity with the research in this area. The final four

general recommendations were Raise Community Awareness of Parenting, Integrate Learning to Parent Across Life Stages, Ensure Supports and Services Meet Need, and Address Issues of Access.

**Participant Reflections**

Participants were invited to review the results of this study through an online narrated PowerPoint® presentation. They were also sent a reflection workbook containing reflection activities.

When asked about the cluster ratings of importance and feasibility, three participants thought High School Parenting Education would have been rated as more important (e.g., "need early education for parenting so they can make good parenting decisions", "I feel knowledge makes all the difference in parenting readiness and the approach chosen", and "at least as a mandatory course in our high schools"). One participant thought Prenatal and Parent Education would have been rated as more feasible given that many programs are in place and just need expanding. However, this urban participant recognized this might not be the case in all parts of the province. Two participants were surprised at the Public Health Role ratings. One person thought it would have been rated higher on both feasibility and importance. The second felt it would have been rated lower on feasibility given recent cuts to health funding.

Participants were asked about their thoughts on why Government Funding was rated as the most important but least feasible cluster. Six of the seven participants responded that government was not willing to put money into parents and families. This can be seen in the following comments: "Because it costs money and they haven't yet figured out that prevention is the solution", "I feel like Parents have been lobbying the government for years with little to no changes", and "Feel like family is low on government priorities." There was a particular

emphasis that the current government in Manitoba was especially unlikely "to provide the funding and prioritize positive parenting practices and support."

Participants were also asked their thoughts about why Public Health Role was rated as the relatively least important of the clusters. Some participants said it was because the services already exist, and others wondered if it was an issue of effectiveness and the stigma attached to accessing support services. Two participants found this low rating on importance unexpected given their own positive experiences with public health and the "vital role (it plays) as the first point of contact with parents."

Next, participants were asked what they thought of the actionable recommendations, if there were others they would have liked included, and what they thought about the order of priority. All seven participants felt positive about the recommendations, felt they summed up the study, and reflected the findings accurately. This was evidenced in their comments: "good recommendations and fairly feasible", "Excellent", "Fantastic", "reflect the findings of the study", "doable and accessible", and "they seem to sum up the most important statements."

Regarding other recommendations that they would have liked to include, one participant thought there might have been "some reference to the unique challenges of rural/northern and the need for equitable supports for everyone." It was also suggested that the words mandatory and universal could have been included in the recommendations. Otherwise, there were no other suggestions. Five of the seven respondents thought the order of priority was good. Two people identified item #5 *Increase the value placed on parenting by raising awareness of the significance and impact to society* as needing to be higher in priority. The rationale being that "Without that, it is unlikely that any of the others will happen."

The final reflection question related to recommendations was a wish question. I asked people if they could make one recommendation happen, what would it be? While one person was unsure, the other six people shared their wish:

1. "Include opportunities for students to learn about relationships and parenting."
2. "Probably just that – that we need to be convinced that parenting is important. If we are, time and money will be put into doing it well."
3. "Universal parenting education as part of the high school curriculum."
4. "I would promote the message that parenting is learned and we all need to learn how to parent, and to promote it from a young age. The sooner parents feel able to ask for help, the sooner problems can be caught and dealt with."
5. "I wish we could rid of the stigma in accessing programs already available to mothers as well as the stigma against being a stay at home mom."
6. "Increase the value placed on parenting by raising awareness of the significance and impact to society."

In the last reflection activity, participants were asked how the results fit with their perspective, and about their experience as a participant in this study. Six of the seven participants said the concept map reflected their perspective. One participant said it reflected their view in a general way, but there were some areas where they had differing views. Four of the seven participants did not feel anything had been missed about preparation for parenting. Two participants said recognition and importance of diversity (cultural and geographic) was missed. One participant said we need to stress that this is for everyone (e.g., all parents, grandparents, community members, male and female etc.).

No one had any difficulty with the online concept mapping although one participant stated they would have liked to add comments about why they made particular choices. All participants liked the concept mapping approach and their comments included, “loved the concept map”, “interesting”, “easy to follow”, “accessible”, and “a good way to coordinate a variety of perspectives.” When asked about their overall experience, all participants indicated they enjoyed the experience (e.g., “positive”, “very interesting”, “easy”, “enjoyed reading the statements”). Two participants commented on how it made them think about the work they do and its importance to children and families. Two participants talked about how parenting is the most important job in the world. Four participants expressed appreciation at being invited and felt their opinion counted in trying to help find ways to support parents. One participant said “Enjoyed reading all the statements and made me reflect and wished these were actually implemented. Being a mom of 3 young kids is the most rewarding experience but also a constant guessing game, sense of failure and hard work.” When asked if they had any other comments or thoughts to share, two participants said they were very interested in knowing what would be done with the research.

The purpose of this research was to develop a conceptual framework and actionable recommendations regarding what was needed to help people prepare for parenting in Manitoba. This purpose was achieved by exploring what parents, service providers, and administrators thought were needed strategies, by having participants conceptually group the strategies, and then by asking them to rank the strategies according to relative value ratings of importance and feasibility. Participant reflections indicate that the final concept map and recommendations for action reflect their perspective.

# Chapter Five: Discussion

The purpose of this exploratory study was to gather data to provide a better understanding of what could help people prepare for parenting in Manitoba. As noted in the Introduction, research on preparation for parenting has suffered from a lack of conceptual clarity, has primarily been completed with parents as they transition to parenthood, and has not resulted in strategies that could be applied to the local context. I attempted to address these gaps through the co-construction of a conceptual model with parents, service providers, and administrators to identify areas that are important to preparation for parenting and to determine strategies that were both important and feasible using the importance and value ratings of participants.

At the outset, I proposed three research questions: (1) What do parents, service providers, and administrators identify as services, supports, or actions that could help people prepare for parenting in Manitoba? (2) What strategies do participants identify as being the most important and the most feasible? Are there differences in what is seen as most important and or feasible by participant subgroups? (3) Based on the value ratings of strategies by participants, what are the most actionable recommendations for helping people prepare for parenting in Manitoba? The findings of this research are discussed by research question and examined against the current literature. The limitations and implications of this study are reviewed, and areas for future research discussed.

## Research Question One

*What do parents, service providers, and administrators identify as services, supports, or actions that could help people prepare for parenting in Manitoba?*

This question was answered using the data gathered through the brainstorming and sorting activities in the concept mapping process. Participants generated 72 unique statements in response to the focus prompt *To help people prepare for parenting a specific service, support, or*

*action would be. . .* The 72 statements were conceptually grouped using participants' sort data and multivariate analyses. This resulted in a concept map that identified seven areas that participants perceived would help people prepare for parenting: High School Parenting Education, Prenatal and Parent Education, Public Health Role, Parent Resource and Support Programs, Government Funding, Community Support and Standards, and Promotion of Parenting. These seven conceptual areas presented "a geography of thought" (Kane & Trochim, 2007, p. 141) containing three regions: Education, Support, and Parents Matter.

**Education.**

Participants identified parenting education as important to preparation for parenting for students, expectant parents, and parents. The Education region contained two clusters, High School Parenting Education and Prenatal and Parent Education. The results indicate the need for a continuum of parenting education across multiple life stages.

Brainstormed statements in the High School Parenting Education call for mandatory parenting education in high school that includes child development, relationship skills, and opportunities to interact with parents and infants. However, mandating parenting education in high school is controversial. Advocates for mandatory parenting education in high school argue that parenting education would provide people with the information they need to make an informed decision about becoming (or not becoming) a parent, provide universal access to evidence-based knowledge in a timely manner, challenge the belief that parenting is innate, and challenge the belief that raising children is a solitary effort, thereby increasing the willingness to seek support when parenting (Bortolotti & Cutas, 2009). Others contend it is needed to increase understanding of the importance of preconception health and health behaviour (Sher, 2017), to increase human development literacy and promote caring, empathy development, and

social/emotional learning (McDermott, 2014), and to reduce naïve confidence and provide a realistic perspective of what parenting involves (Sasso & Williams, 2002).

Mandating parenting education would ensure universal and timely access to learning about child development and parenting strategies before parenting begins, and thus would constitute primary prevention. Schools have played a similar role in other areas of primary prevention such as increasing physical activity and decreasing the use of tobacco (Patel, Flisher, Hetrick, & McGorry, 2007; Wei & Kutcher, 2011). As well, it would convey the message that parenting is a learned behaviour. Schools validate what knowledge is important and have the potential to change students' attitudes and beliefs which can spread to homes and communities (Pinheiro, 2006). This would speak to the strategy given the highest rating of importance and feasibility in this study *Promote the message that parenting is learned and we all need to learn to parent.*

Those who oppose mandatory parenting education maintain that the information is already available so it would be an unnecessary drain on already scarce resources (Bortolotti & Cutas, 2009). There are also concerns that parenting cannot be taught in schools because it is too complex (Furedi, 2001) and that the role of government in family life is an infringement on parental autonomy (Lykken, 2001; Redding, 2002). Some even consider it a form of social engineering (McGaw & Lewis, 2002). Mandating parenting education in schools is not a new idea (Spencer, 1861) but few attempts have been successful (Bell, 1975; Hope & Sharland, 1997; Karal, 1984; The University of the State of New York State Education Department, 2000). Although there is no research examining this phenomenon, it may be related to what is valued as important knowledge in society as evidenced by the curricular focus on academic subjects (Apple, 2000).

The second cluster in the Education region was about parenting education for parents[19]. Participants indicate a need to make prenatal and postnatal education available to everyone, to expand the content to include education about child mental health and emotional well-being, and to extend the mode of delivery to include peer learning and online learning.

Making education programs available to everyone speaks to equitable access and was identified a number of times by participants (e.g., *availability in all communities, sensitive to varied cultural parenting styles, for parents with a variety of learning styles, and father-focused*). Different types of access barriers have been identified in the research, each requiring a different reduction strategy. Structural access barriers include things like a lack of child care, money, transportation, or location (Whittaker & Cowley, 2012). Strategies to reduce structural barriers include providing child care on site and providing people with bus tickets to attend sessions (Brownell et al., 2010). Social and cultural access barriers have been identified for parents from culturally or linguistically diverse backgrounds, for parents who are socially disadvantaged, for parents with disabilities, and for fathers (Deave et al., 2008; Katz, La Placa, & Hunter, 2007; La Placa & Corlyon, 2014; Molinuevo, 2012). After reviewing a popular parent education program in Sweden, Widding (2011) found the ideals portrayed in the parenting education facilitators guide and DVDs depicted working class and immigrant parents as problematic and the material reinforced gender stereotypes. Perhaps one way to reduce social and cultural access barriers would be to ensure parenting education materials reflect and value the practices of the people attending and that fathers are given the same importance as mothers in the parenting role.

Participants identify the need for more learning opportunities related to the mental health and emotional well-being of children. This would be important to add to prenatal and parent

[19] Parents in this context is meant to include both expectant parents and people currently parenting.

education programs as evidenced by the finding that over 80% of Canadian parents lack accurate knowledge about social/emotional development (Oldershaw, 2002). Current prenatal education does not address issues like the mental health and emotional well-being of children (Matusicky & Crill Russell, 2009). Prenatal and postnatal parenting education curricula should include knowledge that is important to parents (Bornstein et al., 2010) and be reviewed to ensure the content is relevant and meets the needs of parents (Godin et al., 2015)

Participants suggested that peer support groups be used to help people prepare for parenting. It has been found that parents prefer informal to formal support. In the preparation for parenting framework developed in England, peers (i.e., family, friends, and community) were identified as the preferred source for receiving information (Billingham, 2011).

Online parenting courses were identified as another strategy by participants. Although there is limited evidence for the effectiveness of this as a universal approach, there have been studies documenting its application, and moderate success, with specific groups of parents (Lindsay et al., 2014). This may help address some of the earlier noted structural access barriers.

***Summary.***

Education was identified as a strategic region in helping people prepare for parenting. Mandating parent education for high school students continues to be controversial. Prenatal and parent education could be enhanced by addressing issues of access, content, and mode of delivery. Unlike other studies on preparation for parenting, this study has identified education across multiple life stages as important in helping people prepare for parenting.

**Support.**

The Support region, on the right-hand side of the map, includes three clusters, Public Health Role, Parent Resource and Support Programs, and Government Funding. All the

statements in these three clusters were related to government support in helping people prepare for parenting, and all were directed toward expectant parents and people already parenting.

Almost half the statements within the Public Health Role cluster identified health and public health as essential in facilitating access to information and supports. Additionally, it was suggested that public health nurses become involved with parents early in the pregnancy, that their visits continue past the birth of the baby, and that they act as a source of information about child development and parenting strategies. This is similar to what Ateah (2003) found in another Manitoba study where it was suggested that public health nurses should visit once or twice a month. It is also consistent with a recommendation by the Royal College of Physicians and Surgeons of Canada in their Early Childhood Development Position Statement, where they support early prenatal screening for parent mental health and continued assessment following the birth of the child to monitor attachment and social/emotional development (Royal College of Physicians and Surgeons of Canada, 2014). As one participant commented:

> "Public Health is ideally suited as a first point of contact between new or expectant parents. It is important, I think, that that contact be regular and consistent, and that Public Health personnel be able to connect parents with other resources once the child grows older and the role of PH becomes less major."

Access was the underlying theme in the Parent Resource and Support Programs cluster. Participants want current Manitoba programs (i.e., Healthy Baby[20] and Families First) to be universal rather than targeted and feel the programs should be increased in length. This suggests that the programs are valued. Parents prefer, and are more likely to use, resources and programs

[20] The Healthy Baby program in Manitoba has two components. The first is the Healthy Baby Prenatal Benefit (discussed earlier) which is a targeted program and access is determined by income. The second component is the Healthy Baby Community Support Program which consists of educational support groups available to all parents (universal) beginning prenatally and extending to one year postnatal (Brownell et al., 2010).

if they are "universal (versus targeted or remedial), informal, unstructured, flexible and lacking the potential for any criticism of their parenting" (Crill Russell et al., 2011, p. 53).

Participants identified the need for a central place/facility that would act as a hub: a place to access services and supports and a place to gather. This is consistent with findings in other studies where having a central location to access information decreased fragmentation of services, increased opportunities for peer support and community building, and decreased isolation (Canadian Association of Family Resource Programs, 2011; Johnson, Akister, McKeigue, & Wheater, 2005).

Participants recognize that parenting supports and services may not be available to people living in rural/northern areas and to people living in First Nations communities. This is a concern across Canada (Lee et al., 2014) and in other places where there is a low population living in a vast geographical terrain (Molinuevo, 2012; Radey & Randolph, 2009). Both the federal and provincial governments are working toward increasing internet access for Manitobans living in First Nations communities and for Manitobans living in communities without year-round road access (Government of Canada, 2018). Some of the ideas suggested by participants in this study (e.g., web-based parenting education, online parent forum), could be implemented throughout the province if universal internet access is achieved.

The Government Funding cluster included a range of strategies that were linked by the underlying theme of increased government spending. Some of the strategies involved increasing disposable income for families, either through direct payment for stay-at-home parents or enhanced parental leave benefits. Other strategies were focused on the supports people would need once they had children (e.g., quality daycare, services and supports when mothers leave the community to give birth).

Participants point out the need for increased availability of high-quality child care. The Centre of Excellence for Early Childhood Development (2009) identifies a high-quality child care centre as one that has qualified, well-paid, and stable staff who are able to respond sensitively and appropriately to children's individual needs, and where there is a learning program that covers all aspects of child development (i.e., social/emotional, physical, cognitive, moral, and language). In terms of early childhood public policy, Manitoba has been identified as having "a strong regulatory framework, high-quality Early Childhood Educator (ECE) education programs, a progressive approach to funding for child care, and an exceptionally well-developed system for integrated services" (Flanagan & Beach, 2016, p. 1). The issue identified by participants in this study may be more of a concern with *availability*, rather than *quality*, of child care. In 2015, the Government of Manitoba announced they would invest in the creation of 12,000 new Early Learning and Child care spaces by 2021 and create a universally accessible child care system (Government of Manitoba, 2015). At the time of this announcement, there were approximately 12,000 children on the wait list for a child care space (Flanagan & Beach, 2016). Creating 12,000 new spaces over six years may not meet people's needs. A second more recent announcement of a bilateral agreement between the governments of Canada and Manitoba, indicates that 47 million dollars will be invested over 3 years to create up to 1400 new early learning and child care spaces in Manitoba with an emphasis on improving availability and quality of child care services for rural and northern Manitobans and for people where access has been a concern (e.g., newcomer families, French language families) (Government of Manitoba, 2018). It is unclear if the 1400 new child care spaces announced in 2018 (to be completed by the year 2021) fulfill or replace, the promise of the 12,000 new spaces made in 2015 (also to be completed by the year 2021).

A number of strategies identified in the Support region are already available in Manitoba, such as the ManitobaParentzone website which provides parenting tips and videos; links to websites; and information on positive parenting, bonding, and attachment; as well as the Manitoba Parent Line that is accessible from 8:00 am to 8:00 pm Monday to Friday (Healthy Child Manitoba, n.d.). Participants indicate the need for extended access to a parenting help and support line as reflected in this comment:

> "I have found health links[21] to be extremely valuable for health situations with my children when what I really need to know is whether I should be worried or not. A similar parenting phone line would be helpful for questions not related to health."

Given participants identified the need for services and supports that already exist, it can be inferred that there is a lack of knowledge of said services and supports: a condition that exists elsewhere and has been identified as a barrier to engagement of parents in support programs (Gazmararian et al., 2014; Katz, La Placa, et al., 2007; La Placa & Corlyon, 2014). In the UK, Johnson et al. (2005) surveyed over 400 parents and found that the majority were not aware of any of the agencies offering support to parents. The problem has commonly been attributed to the fragmentation that occurs in the dissemination of services and supports for parents (Shapiro, Prinz, & Sanders, 2010), but in Manitoba, through HCM, we have a centralized government body that provides programs and services for parents and children (Healthy Child Manitoba, 2015). Although it is unclear why there continues to be a lack of awareness of existing services and supports in Manitoba, it may be related to how the information is written, developed, or shared. Gazmararian et al. (2014) found that new mothers reported difficulty both accessing and

[21] The health links telephone health information service is available 24 hours a day in Manitoba.

understanding existing parenting education materials. One solution proposed by La Placa and Corlyon (2014) is to create user-friendly information that is available at appropriate locations.

***Summary.***

Within the Support region participants identified a number of strategies that would help people prepare for parenting. These included increasing services and supports offered through public health and health, ensuring equitable access to services and supports, increasing family income and parental leave benefits, and increasing access to child care. While a number of the supports identified by participants already exist in Manitoba, it is clear that some are not meeting the need and others are unfamiliar to people. I will now discuss the final region of the concept map, Parents Matter, which focuses on the broader societal valuing of parents and parenting.

**Parents Matter.**

There were two clusters in the Parents Matter region, Community Support and Standards and Promotion of Parenting. Both contained larger philosophical ideas related to how parenting is valued and the beliefs we hold about parenting. Items within these two clusters had connections to many other areas of the map (evidenced by their high bridging values) and as such this region contains the underlying threads that draw together the conceptual framework for helping people prepare for parenting. As one participant clearly articulated, "I think Parents Matter should be the first. Without that, it is unlikely that any of the others will happen".

The Community Support and Standards cluster reflected the need for community support for parents[22]. One participant called this cluster the "welcome wagon." Within this cluster, over half the strategies identified were related to having quality standards for people who work with parents. A recent report reviewing five decades of parent program evaluations showed the most

[22] All community support strategies identified were for expectant parents and people currently parenting.

substantial benefits were in programs where staff were trained, where standards were implemented, where staff adhered to the program model, and where staff were compensated appropriately for their work (Center on the Developing Child at Harvard University, 2016). The quality and the competency of service providers were also identified as critical components of the health visiting model (Cowley et al., 2015). There were other items in this cluster that spoke to building relationships between parents and service providers. Relational issues between parents and service providers have consistently been identified as being an influential factor in parent access and use of support services (Cowley et al., 2013; Cowley et al., 2015; Katz, La Placa, et al., 2007). It is vital that service providers be sensitive to imbalances in power (Cowley et al., 2015) and use participatory and experiential learning approaches in parent programs (Entsieh & Hallström, 2016). The critical nature of this issue is embodied in the following participant comment: "People do not want help from agencies. They feel threatened by them".

The second theme in this cluster is about providing support to parents when they are in crisis. As noted earlier, parents tend not to seek increased knowledge, skill development, or support until they are in crisis (Joussemet et al., 2013; Rasmussen, 2014). Depending on the nature of the crisis, parental support can be superseded by concerns for the safety and well-being of children, "There is a need to improve the delivery of effective child protection services to increase the chances of preserving the unity of the family living under at-risk circumstances, thereby avoiding removal of the minor from the family home" (Rodrigo et al., 2011, p. 90). Within Canada, Manitoba has the highest number of children in the care of a provincial government[23]. A recent announcement by the Manitoba Government indicated reforms would be

[23] In the 2016-2017 Manitoba Families Annual Report there were 10,714 children in care (Manitoba Government, 2017). Media coverage following the announcement by the Manitoba Government to reform the Child Welfare System on October 12, 2017, reported there were over 11,000 children in care in Manitoba.

made to the Child Welfare System (Government of Manitoba, 2017). One area of reform identified was the development of a community-based prevention model. The details of how this prevention model will be developed have not been identified but it does speak to the need for a focus on prevention and is consistent with what participants have identified in this study. An example of support for vulnerable parents and parents in crisis is the SafeCare® program. It is currently being piloted in Australia (Michaux, 2017) and consists of 18-20 sessions delivered weekly in the home. Parents are taught parenting skills and offered ongoing support in the mastering of those skills. In a large-scale longitudinal study, SafeCare® was found to reduce the child maltreatment recidivism rate by about 26% (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012).

A final area identified in this cluster was the need for support from employers. Birnbaum et al. (2007) found that even though parental leave is a legislated benefit in Canada, parents (especially fathers), often face pressure from employers and co-workers that prevents them from fully utilizing this leave. Birnbaum et al. (2007) suggest that Canada's "policy on parental leave may be ahead of our societal norms and practices" (p.22). Resentment by other employees (e.g., those without children, older employees) who see family-friendly policies as being unfair and inequitable, have led human resource researchers to consider shifting from work-family balance policies to broader work-life balance policies (Kim & Wiggens, 2011). This may facilitate better use of existing parental leave.

The second cluster in the Parents Matter region is Promotion of Parenting. This cluster contained statements related to shifting societal perspectives about parenting, beginning with increased recognition of the value of parenting and the importance of parenting to society. Birnbaum et al. (2007) found that parents want to be valued and recognized in their role as

parents. Parenting is a challenging and often undervalued task and "we all have a responsibility to advocate for societal recognition of the crucial role parents have in shaping our future as a people and as a nation" (Gray & Sims, 2007, p. 116).

Participants recognize the need to promote positive parenting. This is consistent with current research interests related to parenting (Durrant et al., 2014; Rodrigo et al., 2012) and with family policy agendas globally where efforts are being made to increase positive parenting (Shulruf et al., 2009). It is an important area to address locally, as we know that only one third of Canadian parents engage in an authoritative parenting style, the parenting style identified by Johnson et al. (2014) as being most closely associated with positive parenting, and about two thirds of Canadian parents could decrease their negative parenting behaviour (Chao & Willms, 2002; Oldershaw, 2002).

Participants want to find ways to increase fathers' involvement in preparing for parenting. It has been found that fathers are reluctant to access parenting services and supports (Lindsay et al., 2014; Molinuevo, 2012). Some have attributed this to the media and health promotion messages that focus on the mother-child relationship (Birnbaum et al., 2007). In Sweden, this issue has been addressed by training men as parenting program instructors. They now report that one-third of all participants in parenting programs are male (Molinuevo, 2012). This is far higher than the nine percent participation rate reported in the CANparent universal parenting class trial in the UK (Lindsay et al., 2014). Finding ways to increase fathers' participation is an important area to address as increased involvement by fathers has been found to benefit all family members (Parke et al., 2002).

Shifting societal perspectives also includes finding ways to reduce the stigma people feel when they ask for help with parenting. "Today parents raise children in isolation with very little

support yet face immense criticism when they experience problems" (Gray & Sims, 2007, p. 105). Feeling judged by others is important as "parents care a lot about how others perceive their parenting skills" (Pew Research Center, 2015, p. 7). The stigma associated with asking for help with parenting can be reduced by talking about parenting from a competency framework (Johnson et al., 2014). This would allow parents to identify areas of strength and areas that need skill development. Stigma can also be reduced by *debunking the myth* that effective parenting comes naturally, as we have seen that is not the case (Oldershaw, 2002). "Effective parenting is no accident" (Pehrson & Robinson, 1990, p. 232) but the result of intentional skill development (Bortolotti & Cutas, 2009).

Also, within the Promotion of Parenting cluster, there were strategies related to increasing the awareness of and access to, services and supports using media and technology. Gilmer et al. (2016) found parent education programs designed for internet delivery to be a relevant option for parents given their comfort with technology, the convenience of having information right away, and the increased accessibility. Using the internet as a delivery mode for education and support is promising and one that parents prefer (Devolin et al., 2012). Although as File and Ryan (2014) point out, information delivered through the internet is more difficult to access for people whose first language is not English, for people with less formal education, and for those living in rural or remote areas.

While there are a variety of ideas in the Promotion of Parenting cluster, it was concisely summed up by one participant.

> "I appreciate that this includes ideas to change the ideas of society as a whole on the importance and impact of parenting, and that it includes media platforms, which will also spread that idea. Having a society expect parents to need and ask for help is half the battle."

***Summary.***

The Parents Matters region contains a range of ideas. One participant labelled this as the "hodgepodge" area of the map. While some areas of the map like Education, contained very connected strategies and ideas, it was harder to identify the conceptual links in this area. The broad underlying theme that appears to connect this region is that of being valued and respected as a parent. Having standards and accountability measures for people who work with parents would show that parents, as recipients of the services, are valued. Having people who work with parents attend to the importance of relationship building, speaks to respecting parents as partners. Ensuring services and supports are accessible when parents need them (i.e., when in crisis) acknowledges that parenting can be difficult. Having employers support parents, as they balance work and life priorities, speaks to the value placed on the role of parenting in the workplace.

**Summary: Research Question One**

The concept map created in this study provided the conceptual framework for understanding what would help people prepare for parenting in Manitoba. There were three primary regions identified for helping people prepare for parenting: Education, Support, and Parents Matter. The strategies identified in this study are broadly consistent with what has been referenced in the parenting literature and are also consistent with what appears to be a global movement toward increasing parental competency. It became clear that there are preparatory strategies that can extend beyond our current view of parent education and parent support. We know that parent development occurs over life stages, that most people will become parents, and that there are benefits to ensuring all people have access to the education and support needed to prepare them for parenting.

**Interesting Omissions**

There were some concepts identified in the literature as being important to parenting that were not brought forward by participants. The first was social support. Social support has been found to be a factor that enhances the well-being of people as they transition into parenthood (Billingham, 2011; Miller & Darlington, 2002). This omission may be the result of the way the focus prompt was worded or it may be associated with changes in family connections as people live greater distances from their extended families (Sanders et al., 2014). Additionally, self-reflection and observational learning (two important concepts in parent development theories) were not mentioned by participants. Again, this may be the result of the wording of the focus prompt.

**Research Question Two**

*What strategies do participants identify as being the most important and the most feasible? Are there differences in what is seen as most important and or feasible by participant subgroups?*

Concept mapping produced a group-defined conceptual framework which provided an overview of the domain of ideas. Identifying the strategies that were seen as more important and more feasible within these larger domains was done using the data gathered through the rating activity in the concept mapping process. This provided the answer to the second research question.

There were distinct discrepancies in participant identification of what were the most important and the most feasible clusters. Government Funding and Parent Resource and Support Programs were seen as most important, while Promotion of Parenting and High School Parenting Education were seen as most feasible. The possible implications of each are discussed.

Government Funding and Parent Resource and Support Programs were seen as the most important areas in helping people prepare for parenting, but they were also seen as the least feasible. One possible explanation for this discrepancy may be a perceived lack of available resources needed to address the identified needs (Kane & Trochim, 2007). In Manitoba, there is ongoing media coverage related to reductions in government spending and cuts to programming. Recent examples include closing the Lactation consultation program at Health Sciences Centre, the QuickCare clinics in Winnipeg, half of the emergency rooms in Winnipeg, and the mature women's clinic at one hospital (Dana, 2017). A second possible explanation for this discrepancy may be related to the deeper issue of feeling undervalued by the government. As stated earlier, the majority of parents of young children in Canada do not feel supported by government in their parenting role (Oldershaw, 2002). Undervaluing of parents in social policy can lead to a lack of available quality child care (Pocock, 2005): a condition currently being experienced in Manitoba. It can also lead to the underfunding of research centres (Crill Russell, 2003). An example of this can be found in the closure of Invest in Kids, the non-profit organization who commissioned the National Survey of Parents of Young Children by Oldershaw. Based on participant reflections it appears that the explanation for this finding may be more attributed to the second possibility, as summed up in one participant's comment: "Feel like family is low on government priorities."

Promotion of Parenting and High School Parenting Education were identified as the most feasible strategic areas related to helping people prepare for parenting. Promotion of Parenting contained strategies about shifting cultural beliefs regarding the way parents and parenting are valued by society. One way to address this is by raising community awareness of the importance of parenting. The Parenting Research Centre and Murdoch Childrens Research Institute (2017) reviewed 14 initiatives that had been undertaken to raise awareness about parenting practices and

strategies. From this review, they identify five areas that need to be considered when developing a community awareness-raising initiative: developing messages (e.g., ensuring the messages are accessible, understandable, credible, and empowering), messaging about parenting (e.g., ensuring the messages include information about the importance of parenting and early childhood development, that effective parenting benefits communities and society, that parenting skills can be learned, that support improves parenting skills, and that communities and societies have a collective responsibility toward parenting), messaging channels (e.g., align the communication channel with the target audience, use multiple communication channels, and use existing initiatives as partners in disseminating messages), campaign development (e.g., develop core campaign messages and develop a long-term commitment to ensure the messages are established and reinforced over time), and communications research (e.g., research what the public thinks about parenting to develop suitable messages, pilot test the messages with parents, and conduct research specifically for the development of messages for indigenous communities). It is interesting to note that a number of the areas and examples provided in this research report are reflected in the strategies identified by participants in this study. Shifting cultural beliefs by raising community awareness cannot be a one-time information campaign but requires a committed and mindful approach.

High School Parenting Education received the second highest feasibility rating by participants. Schools are established places of learning that have the necessary infrastructure and personnel to provide parenting education. There would be little in the way of additional cost and resource allocation when implementing parenting education in high schools. Thus, it would be more feasible than a number of the other strategies that are dependent on new resources for implementation.

Public Health Role was rated as the relatively least important cluster overall. Given the prominent role public health plays in prenatal and parent support in Manitoba, this finding was unexpected. As a result, I asked participants to reflect on this during the final activity. Participants had mixed feelings. Some were surprised given their own positive experience; others felt it may have been rated lower because it is already available, and some wondered if it was about effectiveness. The role of Public Health Nurses in Manitoba, related to preparing people for parenting, is not clearly defined, has experienced change as a result of early hospital discharge following birth, and involves the provision of both targeted and universal programs (C. Cusack, personal communication, April 18, 2018). In light of some of these challenges, efforts are being made to provide more clarity on the role of public health nurses as evidenced by the recent release of the Provincial Public Health Nursing Standards: Prenatal, Postpartum, and Early Childhood document (Government of Manitoba, 2015) and the current work being done to define scope of practice (C. Cusack, personal communication, April 18, 2018).

**Subgroup differences.**

An important goal of this study was to identify actionable recommendations for future planning and to ensure differences in priorities were identified if they existed. Comparison of subgroups through self-identification revealed that all participant groups agreed Government Funding and Parent Resource and Support Programs were important in helping people prepare for parenting, but they were not feasible. Administrators rated Government Funding much higher than either Parents or Service Providers. This is an issue that would be of primary importance to Administrators. They, most likely, are in the position of balancing the funding they receive from the government with the needs of parents and service providers in the programs they administer.

Differences in cluster ratings of importance and feasibility between Parents, Service Providers, and Administrators did not indicate the need for specific group recommendations.

Subgroup comparisons based on Rural/Northern and Urban participant groups identified some discrepancies on both the importance and feasibility ratings of the clusters. Rural/Northern participants rated High School Parenting Education as being more important and more feasible than Urban participants, and they identified Government Funding and Parent Resource and Support Programs as being less feasible than Urban participants. This may reflect the fact that rural/northern communities have access to schools but do not always have access to other government programs and services. In Manitoba, inequitable access to programs and services for rural/northern citizens has been an ongoing concern identified within government departments (A. Hawkins, personal communication, August 23, 2017). Differences in cluster ratings by locale did not indicate a need for group-specific recommendations but could be used to inform implementation strategies.

**Summary: Research Question Two**

Government Funding and Parent Resource and Support Programs were identified as the most important but the least feasible in helping people prepare for parenting. Participant reflections tell us this is the result of parents and parenting not being a high priority for government. There was a lack of consensus between participants as to why Public Health Role was rated as the relatively least important of all the clusters. Subgroup discrepancies indicate attention needs to be directed toward equitable access to services and supports across the province.

**Research Question Three**

*Based on the value ratings of strategies by participants, what are the most actionable recommendations for helping people prepare for parenting in Manitoba?*

Identifying actionable recommendations provided the answer to the third research question. Twenty-one strategies, located in each of the seven clusters, had above average importance and feasibility ratings in the go-zone scatterplot and were used as the foundation for developing recommendations. The final four recommendations were also informed by participant feedback, existing literature, and my interpretation of the aforementioned.

**1. Raise Community Awareness of Parenting**

Most people understand the importance of parenting (Oldershaw, 2002) but research indicates there is a lack of planning and preparation for parenting (Sher, 2017), a general disregard for the need to learn to parent (Bortolotti & Cutas, 2009), a lack of understanding regarding what constitutes effective parenting (Volmert et al., 2016), and little recognition of the importance and value of parenting and the broader impact parenting has on society (Michaux, 2017). A community awareness-raising strategy must be developed to inform all Manitobans of the benefits of preparation for parenting for individuals, families, and society. As discussed earlier it is recommended that five areas be addressed when developing a community awareness-raising strategy, with the first being the development of core messages that are accessible, understandable, credible, and empowering (Parenting Research Centre and Murdoch Childrens Research Institute, 2017). The following key messages are offered to raise community awareness:

- Becoming a parent is an important life choice.

- Preparation for parenting increases readiness, decreases stress, and promotes the health and well-being of children and parents.
- Effective parenting requires a set of skills that can be learned.
- Effective parenting and positive discipline enhance child development.
- Parenting is an important and valuable life role that benefits communities.

Raising community awareness regarding the importance of preparation for parenting is complex because it involves changes to people's values and challenges what is seen as normative and accepted behaviour.

**2. Integrate Learning to Parent Across Life Stages**

Parent development theory tells us that we develop as parents across multiple life stages (Mowder, 2005). Yet the majority of parent education and resource allocation to support parent development occurs during the prenatal and early postnatal periods. Universal parenting education must be offered to all people to provide knowledge of child development and effective positive parenting practices and should be undertaken using a continuum of learning approach (i.e., where there is a structured plan for learning that occurs across life stages). Based on the results of this study and existing literature the following suggestions have been developed:

- Appoint key stakeholders to produce a seamless preparation for parenting strategy that will address parenting education over multiple life stages. This could include parents, community members, teachers, people from post-secondary institutions, and people from relevant government departments (e.g., Healthy Child Manitoba Office and K-12 Education Division; Education and Training Curriculum Development & Implementation; Families, Health, Seniors and Active Living; and Indigenous and Northern Relations).

- Expand the intersectoral Manitoba government HCM strategy to include preconception as part of their prevention and early intervention mandate.

Integrating learning to parent across life stages requires a shift from a deficit-based approach where intervention occurs after parents face challenges, to an empowerment approach where all people are given the knowledge and skills they need to flourish as parents.

**3. Ensure Supports and Services Meet Need**

While provincial resources are directed toward supporting parents through HCM, it appears that some resources are underutilized. For example, of the 30% of mothers who accessed the prenatal benefit component of the Healthy Baby Program, only 5% accessed the support component of the same program (Brownell et al., 2010). It also appears there is a lack of awareness of the existing services and supports, that some resources (e.g., child care) are in short supply, and other resources such as those needed during times of crisis (e.g., a parent helpline) are not meeting the need. Additionally, it is important to ensure that people who provide services to parents meet educational and competency-based standards. The following suggestions have been developed:

- Revise the current approach used to inform parents about services and supports.
- Review the plan for meeting the need for child care spaces.
- Utilize existing services more fully (e.g., PHN, parent helpline).
- Involve parents in the development of the community-based prevention model being proposed as part of the reform to the Child Welfare System.
- Develop provincial standards for those who work in services that support parents.
- Actively elicit parent evaluations on the service and supports they access.

**4. Address Issues of Access**

Equity of access is a challenge in Manitoba given the majority of the population is concentrated in a few major centres while the rest of the population is spread out over a large geographical area. Additionally, Manitoba, like other Canadian provinces, faces a challenge in the equity of services between communities as a result of provincial and federal jurisdictional boundaries.

- Prenatal and parenting education, services, and supports need to be fully accessible to all people in Manitoba. This includes addressing barriers related to locale, language, culture, gender, financial constraints, and learning styles.

Commitment to preparing people for parenting will require sustained effort, a long-term view, and can be achieved by supporting and working toward the above recommendations. This list should not be understood to be complete or exhaustive but rather be seen as a point of departure: a place from which we might begin moving toward universal preparation for parenting.

**Limitations of Current Study**

Although concept mapping has been widely used for planning, it is typically initiated by a stakeholder group (Kane & Trochim, 2007). In this study, concept mapping was undertaken to identify what could be done to help people prepare for parenting in the local Manitoba context, but it was not initiated at the request of a stakeholder group. This concept mapping study reflects my agenda, and therefore, I will have brought some bias into this study based on my assumptions, beliefs, values, and the choices made that shaped the inquiry of the research process (Creswell, 2007). Because this research was not initiated by a stakeholder group, the formation of the focus prompt, which defines the boundaries of conceptualization (Kane &

Trochim, 2007), and the rating questions were done by me and may not reflect what a stakeholder group would have identified as important. The online concept mapping process did not allow input from participants during the idea synthesis or the cluster solution decision. Therefore, I was one of the main research instruments in this project. The online approach also limited my ability to seek clarification on meaning and intent of the statements generated. To mitigate my influence and improve the trustworthiness of the study, I completed post-hoc member checking using a narrated PowerPoint® presentation and guided reflection activity with participants and incorporated their reflections in the results and discussion.

The initial identification of agencies contacted was not exhaustive, and some will have been missed. People not affiliated with the agencies contacted did not have the opportunity to participate, thus decreasing the perspective on what is needed to help people prepare for parenting. There was no representation from any of the Child and Family Services (CFS) agencies in Manitoba (although all were invited to participate) and so a valuable voice in the parenting field was absent. Given the high caseload many CFS workers carry and the uncertainty of their workday (i.e., crisis response), it could be they felt unable to commit to participating in this study.

The people who chose to participate in this study were quite homogeneous on some demographic characteristics (e.g., well-educated participants in higher income brackets). More diversity of age, education, and income levels may have provided a broader insight into what people need to prepare for parenting. In other Canadian studies looking at the needs of parents, very similar participant profiles were found (Devolin et al., 2012; Godin et al., 2015). Katz, La Placa, et al. (2007) found that “like service users, the majority of research participants have been

white, able-bodied mothers" (p.2). This suggests different recruitment approaches are needed to ensure all voices are heard when conducting research with parents.

There were fewer participants in the final reflection activity. This may have been the result of timing (there was a three-month delay between the concept mapping activities and the reflection activity, and the reflection activity was sent at the beginning of September which coincided with the start of the new school year) or the lack of remuneration offered for this activity. In a qualitative synthesis of 103 concept mapping articles it was found that in the majority of studies stakeholders/participants were not asked for feedback on the results (Vaughn, Jones, Booth, & Burke, 2017, p. 235). Despite the lower numbers, including this reflection activity was valuable and added to the trustworthiness of my research.

As an exploratory study within a local context, these results cannot be generalized. The intent of this study was for parents, service providers, and administrators to have a voice in shaping our understanding of what is needed to help people prepare for parenting in Manitoba. Replication of this study in other regions would partially address this concern.

**Implications**

Social change begins with a conceptualization of the issue, a needs assessment, theory development, and action. This study represents a first step in understanding what is needed to help people prepare for parenting. The results contribute knowledge on preparation for parenting and as such have added to the research base in this growing field of study. The conceptual framework and individual constructs found in this study may be used as building blocks for a theory that views parent development as a life development task (Luse, Mennecke, & Townsend, 2012).

Additionally, recommendations relevant to the Manitoba context were developed which has implications for how we can support parents and parent development in Manitoba. Government or community utilization of the findings may be appropriate next steps. The categories of need identified here could be used as a starting point in carrying out a needs assessment on this topic in the province.

**Recommendations for Further Research**

To address some of the limitations in this study several points have been identified as possibilities for future research on preparation for parenting using a concept mapping methodology. First, the scope of participants could include people of different ages/stages (e.g., youth, nonparents), people with different education and income levels, and different providers of services and supports for parents (e.g., CFS service providers) to provide additional perspectives regarding needed strategies. It could also include having stakeholders participate in the development of the focus prompt. This might expand the boundaries of conceptualization providing different ways to think about preparation for parenting. Finally, in person concept mapping could be done to see if group interaction would influence the findings. Understanding how to help people prepare for parenting from a broader perspective would provide further insight in addressing this important community issue.

Second, given that parenting is influenced by social and cultural factors (Bornstein, 2012; Spiteri et al., 2014), it may be important to repeat this concept mapping study with people who share specific demographic characteristics (e.g., gender, non-parents, ethnic, and cultural groups). This would allow for an examination of the consensus or difference in perspectives regarding what is needed to help people prepare for parenting. This information would not only

increase our understanding of preparation for parenting but could also be used to guide implementation strategies.

Third, participants in this study identified parenting education across multiple life stages as being important to preparation for parenting. Future research could explore how preparation needs might change related to factors such as the child's age and developmental stage or first-time parents compared to parents with one or more children. This would be similar to the research being done using the International Parenting Survey, where parents are being asked about their preferences and needs and the data is being used to inform the development of parenting programs (Morawska, Heinrichs, & Sanders, 2011).

Last, and in a more general context, an area that has challenged preparation for parenting is the belief that parenting skills come naturally (Volmert et al., 2016). Active preparation for parenting is still primarily seen as unnecessary and is not pursued by a majority of people (Lindsay et al., 2014). Even with over 90% of parents of young children saying they want to know more about parenting (Oldershaw, 2002), it appears they do not actively seek out learning opportunities until in crisis (Rasmussen, 2014). This paradox, of parents wanting to know more but not accessing currently available resources, was not examined in this study but is important to explore in the future, particularly as it relates to identifying opportunities for increased positive parenting.

## Chapter Six: Conclusion

The purpose of this research was to provide insight into what was needed to help people prepare for parenting in Manitoba. This was accomplished by presenting the ideas of parents, service providers, and administrators in a conceptual framework and using participant value ratings to inform recommendations. I consider this research to be a collaborative effort in identifying general areas of intervention that could help people prepare for parenting. Preparation for parenting involves the development of parenting knowledge and skills using a continuum of learning opportunities that occur over multiple life stages. Accessible and appropriate services and supports are essential for parents given the often-challenging task of raising children. Both education and support are available, but often underused. The reason for this may relate to the third region of the map, Parents Matter. There needs to be a concerted effort in changing the way we, as a society, think about parenting if we are to move toward universal preparation for parenting.

**References**

Abidin, R. R. (1992). The determinants of parenting behaviour. *Journal of Clinical Child Psychology, 21*(4), 407-412.

Adirim, T., & Supplee, L. (2013). Overview of the Federal Home Visiting Program. *Pediatrics, 132*(Supplement 2), S59-S64.

Ainsworth, M. D. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist, 46*(4), 333-341.

Alexander, G. R., & Kotelchuck, M. (2001). Assessing the role and effectiveness of prenatal care: History, challenges, and directions for future research. *Public Health Reports, 116*, 306-316. doi: 10.1093/phr/116.4.306

Allen, K., Collier, S., Kelly, C., Pates, A., Sher, J., & Thomson, C. (2012). *Exploration of the information support needs of parents: Executive summary* (Online ed., pp. 13). Scotland: NHS Health Scotland: Retrieved from https://childreninscotland.org.uk/exploration-of-the-information-support-needs-of-parents/.

Alvarado, R., & Kumpfer, K. (2000). Strengthening America's families. *Juvenile Justice, 7*(3), 8-18.

Arcus, M. E., Cassidy, D., Czaplewski, M. J., Makino, K., Ueno, A., & Whitfield, R. (2003). Family life education. In J. J. Ponzetti Jr. (Ed.), *International Encyclopedia of Marriage and Family* (2nd ed.). Farmington, MI: Gale.

Asmussen, K., Feinstein, L., Martin, J., & Chowdry, H. (2016). Foundations for life: What works to support parent child interaction in the early years.: Early Intervention Foundation.

Asmussen, K., & Weizel, K. (2010). Evaluating the evidence: What all practitioner's need to know to deliver evidence-based parenting support (pp. 8): King's College of London.

Ateah, C. (2003). Disciplinary practices with children: Parental sources of information, attitudes, and educational needs. *Issues in Comprehensive Pediatric Nursing, 26*, 89-101. doi: 10.1080/01460860390197853

Azar, S. T., & Rohrbeck, C. A. (1986). Child abuse and unrealistic expectations: Further validation of the parent opinion questionnaire. *Journal of Consult Clin Psychol, 54*(6), 867-868. doi: 0022-006X/86/$00.75

Bäckström, C., Larsson, T., Wahlgren, E., Golsäter, M., Mårtensson, L. B., & Thortensson, S. (2017). 'It makes you feel like you are not alone': Expectant first-time mothers' experiences of social support within the social network, when preparing for childbirth and parenting. *Sexual & Reproductive Healthcare, 12*, 51-57. doi: 10.1016/j.srhc.2017.02.007

Bandura, A. (1982). The assessment and predictive generality of self-percepts of efficacy. *Journal of Behaviour Therapy and Experimental Psychiatry, 13*(3), 195-199.

Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review of Psychology, 52*(1), 1-26. doi: 10.1146/annurev.psych.52.1.1

Banovcinova, A., Levicka, J., & Veres, M. (2014). The impact of poverty on the family system functioning. *Social and Behavioural Sciences, 132*, 148-153. doi: 10.1016/j.sbspro.2014.04.291

Barak, A., Spielberger, J., & Gitlow, E. (2014). The challenge of relationships and fidelity: Home visitors' perspectives. *Child and Youth Services Review, 42*, 50-58. doi: 10.1016/j.childyouth.2014.03.023

Barber, B. K., Stolz, H. E., Olsen, J. A., Collins, W., & Burchinal, M. (2005). Parental support, psychological control and behavioural control: Assessing relevance across time, culture, and method. *Monographs Society for Research in Child Development, 70*(4), 1-147.

Barlow, J., Schrader McMillan, A., Kirkpatrick, S., Ghate, D., Barnes, J., & Smith, M. (2010). Health-led interventions in the early years to enhance infant and maternal mental health: A review of reviews. *Child and Adolescent Mental Health, 15*(4), 178-185. doi: 10.1111/j.1475-3588.2010.00570.x

Barlow, J., Schrader McMillan, A., Kirkpatrick, S., Ghate, D., Smith, M., & Barnes, J. (2008). Health-led parenting interventions in pregnancy and early years. UK: Department for Children, Schools and Families.

Barlow, J., Smailagic, N., Huband, N., Roloff, V., & Bennett, C. (2012). Group-based parent training programmes for improving parental psychosocial health. *Cochrane Database Syst Rev, 6*, CD002020. doi: 10.1002/14651858.CD002020.pub3

Barlow, J., & Stewart-Brown, S. (2001). Understanding parenting programmes: Parents' views. *Primary Health Care Research & Development, 2*, 117-130. doi: 10.1191/146342301678787067

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *J Pers Soc Psychol, 51*(6), 1173-1182.

Barth, R. P. (2009). Preventing child abuse and neglect with parent training: Evidence and opportunities. *The Future of Children, 19*(2), 95-118. doi: 10.1353/foc.0.0031

Barth, R. P., Landsverk, J., Chamberlain, P., Reid, J., Rolls, J., Hurlburt, M., . . . Kohl, P. L. (2005). Parent-training programs in child welfare services: Planning for a more evidence-

based approach to serving biological parents. *Research on Social Work Practice, 15*(5), 353-371. doi: 10.1177/1049731505276321

Baruch, G., Vrouva, I., & Wells, C. (2011). Outcome findings from a parent training programme for young people with conduct problems. *Child and Adolescent Mental Health, 16*(1), 47-54. doi: 10.1111/j.1475-3588.2010.00574.x

Baumrind, D. (1966). Effects of authoritative parental control on child behaviour. *Child Dev, 37*(4), 887-907.

Baumrind, D. (1978). Parental disciplinary patterns and social competence in children. *Youth and Society, 9*, 238-276.

Belsky, J. (1980). Child maltreatment: An ecological integration. *American Psychologist, 35*(4), 320-335.

Belsky, J. (1984). The determinants of parenting: A process model. *Child Dev, 55*(1), 83-96.

Belsky, J., & Pluess, M. (2009). Beyond diathesis stress: Differential susceptibility to environmental influences. *Psychological Bulletin, 135*(6), 885-908. doi: 10.1037/a0017376

Benzies, K., Clarke, D., Barker, L., & Mychasiuk, R. (2013). UpStart Parent Survey: A new psychometrically valid tool for the evaluation of prevention-focused parenting programs. *Maternal & Child Health Journal, 17*(8), 1452-1458. doi: 10.1007/s10995-012-1152-2

Berkovits, M. D., O'Brien, K. A., Carter, C. G., & Eyberg, S. M. (2010). Early identification and intervention for behaviour problems in primary care: A comparison of two abbreviated versions of Parent-Child Interaction Therapy. *Behaviour Therapy, 41*(3), 375-387. doi: https://doi.org/10.1016/j.beth.2009.11.002

Berman, R. (2004). Evaluation outcomes in Family Support: A focus on benefits for children. *Perspectives in Family Support, 1*(1), 33-40.

Billingham, K. (2011). Preparing for parenthood: The role of antenatal education. *Community Practitioner, 84*(5), 36-38.

Birnbaum, N., Crill Russell, C., & Clyne, G. (2007). *Vital communities, vital support: How well do Canada's communities support parents of young children? Phase 1 Report: What is known?* Toronto, ON: Invest in Kids Foundation.

Bjorklund, D. F. (2004). Special issue: Memory development in the new millennium. *Developmental Review, 24*, 343-346. doi: 10.1016/j.dr.2004.08.002

Black, A. Y., Guilbert, E., Hassan, F., Chatziheofilou, I., Lowin, J., Jeddi, M., . . . Trussell, J. (2015). The cost of unintended pregnancies in Canada: Estimating direct cost, role of imperfect adherence, and the potential impact of increased use of long-acting reversible contraceptives. *Journal Obstet Gynaecol, 37*(12), 1086-1097. doi: 10.1016/S1701-2163(16)30074-3

Borg, I., Groenen, P. J. F., & Mair, P. (2013). *Applied multidimensional scaling* doi:10.1007/978-3-642-31848-1

Borg Xuereb, R., Abela, A., & Spiteri, G. (2012). Early parenting - portraits from the lives of first time parents. *Journal of Reproductive and Infant Psychology, 30*(5), 468-482. doi: 10.1080/02646838.2012.744961

Bornstein, M. H. (2012). Cultural approaches to parenting. *Parent Sci Pract, 12*(2-3), 212-221. doi: 10.1080/15295192.2012.683359

Bornstein, M. H. (2015). Children's parents. In M. H. Bornstein & T. Leventhal (Eds.), *Ecological settings and processes in developmental systems. Vol. 4: Handbook of child*

*psychology and developmental science*. In R. M. Lerner (Series Ed.) (7th ed., pp. 1-78). Hoboken, NJ: Wiley doi: 10.1002/9781118963418.childpsy403

Bornstein, M. H. (2016). Determinants of parenting. In D. Cicchetti (Ed.), *Developmental psychopathology. Third Edition.* Online: John Wiley & Sons, Inc. doi: 10.1002/9781119125556.devpsy405

Bornstein, M. H., Cote, L. R., Haynes, O. M., Hahn, C. S., & Park, Y. (2010). Parenting knowledge: Experiential and sociodemographic factors in European American mothers of young children. *Developmental Psychology, 46*(6), 1677-1693. doi: 10.1037/a0020677

Bornstein, M. H., & Lansford, J. E. (2010). Parenting. In M. H. Bornstein (Ed.), *Handbook of cultural developmental science* (pp. 259-277). New York: Psychology Press.

Bornstein, M. H., Putnick, D. L., & Lansford, J. E. (2011). Parenting attributions and attitudes in cross-cultural perspective. *Parent Sci Pract, 11*(2-3), 214-237. doi: 10.1080/15295192.2011.585568

Bortolotti, L., & Cutas, D. (2009). Reproductive and parental autonomy: An argument for compulsory parental education. *Reproductive BioMedicine Online (Reproductive Healthcare Limited), 19*, 5-14.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

Bradley, R. H. (2002). Environment and parenting. In M. H. Bornstein (Ed.), *Handbook of parenting: Vol. 2: Biology and ecology of parenting* (2nd ed., pp. 282-314). Mahwah, NJ: Lawrence Erlbaum Associates.

Bradley, R. H., & Corwyn, R. F. (2002). Socioeconomic status and child development. *Annual Review of Psychology, 53*(1), 371-399. doi: 10.1146/annurev.psych.53.100901.135233

Britto, P. R., Lye, S. J., Proulx, K., Yousafzai, A. K., Matthews, S. G., Vaivada, T., . . . Early Childhood Development Interventions Review Group for the Lancet Early Childhood Development Series Steering Committee. (2017) Nurturing care: Promoting early childhood development. *Vol. 389. Advancing Early Childhood Development: From Science to Scale 2* (pp. 91-102): Lancet. doi 10.1016/S0140-6736(16)31390-3.

Brodsky, A. E., & Welsh, E. A. (2012). Applied research. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods*. Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412963909.

Brooks-Gunn, J., Fuligni, A. S., & Berlin, L. J. (Eds.). (2003). *Early child development in the 21st century: Profiles of current research initiatives*. New York, NY: Teachers College Press.

Brownell, M., Chartier, M. J., Au, W., & Schultz, J. (2010). *Evaluation of the Healthy Baby Program*. Winnipeg, MB: Manitoba Centre for Health Policy.

Brownell, M., Chartier, M. J., Nickel, N., Chateau, D., Martens, P. J., Sarkar, J., . . . Katz, A. (2016). Unconditional prenatal income supplement and birth outcomes. *Pediatrics, 137*(6). doi: 10.1542/peds.2015-2992

Bryman, A. (2011). Member validation and check. In M. S. Lewis-Beck, A. Bryman & T. F. Liao (Eds.), *SAGE Encyclopedia of social science research methods* (pp. 633-634). Thousand Oaks: Sage Publications, Inc.

Burke, J. G., O'Campo, P., Peak, G. L., Gielen, A. C., McDonnell, K. A., & Trochim, W. M. K. (2005). An introduction to concept mapping as a participatory public health research method. *Qual Health Res, 15*(10), 1392-1410. doi: 10.1177/1049732305278876

Byers, K., Johnson, T., Davis-Groves, S., Byrnes, K., & McDonald, T. (2014). Elevating stakeholder voice: Considering parent priorities in model development for community mental health center services. *Children and Youth Services Review, 43*, 124-130. doi: 10:1016/j.childyouth.2014.05.009

Byford, M., Kuh, D., & Richards, M. (2012). Parenting practices and intergenerational associations in cognitive ability. *International Journal of Epidemiology, 41*, 263-272. doi: doi:10.1093/ije/dyr188

Cambraia Windsor, L. (2013). Using concept mapping in community-based participatory research: A mixed methods approach. *Journal of Mixed Methods Research, 7*(3), 274-293. doi: 10:1177/1558689813479175

Canadian Association of Family Resource Programs. (2000). *Family support: A national priority*: Canadian Association of Family Resource Programs. Retrieved from http://www.frp.ca/index.cfm?fuseaction=page.viewpage&pageid=1244.

Canadian Association of Family Resource Programs. (2011). *Family is the foundation: Why family support and early childhood education must be a collaborative effort*. Ontario, Canada: Canadian Association of Family Resource Programs.

Center on the Developing Child at Harvard University (Producer). (2016). *From best practices to breakthrough impacts: A science-based approach to building a more promising future for young children and families*. Retrieved from http://www.developingchild.harvard.edu

Centre of Excellence for Early Childhood Development. (2009). High-quality child care services: A stimulating and caring environment for children. *Early Childhood Development: Eyes on Parents* (pp. 4). Online: Centre of Excellence for Early Childhood

Development. Retrieved from http://www.child-encyclopedia.com/child-care-early-childhood-education-and-care/resources.

Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in child protective services. *Pediatrics, 129*(3), 1-7. doi: 10.1542/peds.2011-1840

Chao, R. K., & Willms, J. D. (2002). The effects of parenting practices on children's outcomes. In J. D. Willms (Ed.), *Vulnerable children: Findings from Canada's national longitudinal survey of children and youth* (pp. 149-105). Edmonton, AB: The University of Alberta Press.

Chartier, M. J., Nickel, N. C., Chateau, D., Enns, J. E., Isaac, M. R., Katz, A., . . . Brownell, M. (2018). Families First home visiting programme reduces population-level child health and social inequities. *Journal of Epidemiol Community Health, 72*, 47-53. doi: 10.1136/jech-2017-209321

Ciciolla, L., Crnic, K. A., & West, S. G. (2013). Determinants of change in maternal sensitivity: Contributions of context, temperament, and developmental risk. *Parent Sci Pract, 13*(3), 178-195. doi: 10.1080/15295192.2013.756354

Claes, M., Perchec, C., Miranda, D., Benoit, A., Bariaud, F., Lanz, M., . . . Eric, L. (2011). Adolescents' perceptions of parental practices: A cross-national comparison of Canada, France, and Italy. *Journal of Adolescence, 34*(2), 225-238. doi: 10.1016/j.adolescence.2010.05.009

Clavero, S. (2001). *Parenting support an international overview*. The Queen's University of Belfast: School of Sociology and Social Policy.

Coghlan, D., & Brydon-Miller, M. (2014). *The SAGE encyclopedia of action research.* London: SAGE Publications Ltd.

Coleman, P. K., & Hildebrandt Karraker, K. (2003). Maternal self-efficacy beliefs, competence in parenting, and toddlers' behaviour and developmental status. *Infant mental health journal, 24*(2), 126-148. doi: 10.1002/imhj.10048

Coleman, P. K., & Karraker, K. (1997). Self-efficacy and parenting quality: Findings and future applications. *Developmental Review, 18*, 47-85.

Committee of Ministers of the Council of Europe. (2006). Recommendation 19. Retrieved from https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d6dda.

Conger, R. D., Elder, G. H., Lorenz, F. O., & Simons, R. (1994). Economic stress, coercive family process, and developmental problems of adolescents. *Child Dev, 65*, 541-561.

Conger, R. D., & Simons, S. L. (1997). Life-course contingencies in the development of adolescent antisocial behaviour: A matching law approach. In T. P. Thornberry (Ed.), *Development theories of crime and delinquency: Advances in criminological theories* (pp. 55-99). New Brunswick, NJ: Transaction.

Cooper, C. L., Garfinkle Chevrier, S., Schiffer, J., & Schuver, A. (2002). Preparing tomorrow's parents today: How to bring parenting education for children and teens to your schools. In J. Schiffer (Ed.). Florida: The Parenting Project.

Cowan, P. A., & Cowan, C. P. (2002). Interventions as tests of family systems theories: Marital and family relationships in children's development and psychopathology. *Development and Psychopathology. Special Issue on Interventions as Tests of Theories, 14*(4), 731-760. doi: 10.1017/S0954579402004054

Cowan, P. A., & Cowan, C. P. (2014). The role of parents in children's school transition *Encyclopedia on Early Childhood Development*. Online.

Cowley, S., Whittaker, K., Grigulis, A., Malone, M., Donetto, S., Wood, H., . . . Maben, J. (2013). Why health visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families. *National Nursing Research Unit* (pp. 180). UK: Department of Health Policy Research Programme.

Cowley, S., Whittaker, K., Malone, M., Donette, S., Grigulis, A., & Maben, J. (2015). Why health visiting? Examining the potential public health benefits from health visiting practice within a universal service: A narrative review of the literature. *International Journal of Nursing Studies, 52*, 465-480. doi: 10.1016/j.ijnurstu.2014.07.013

Creswell, J. (2007). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: SAGE Publications.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). California: SAGE Publications.

Crill Russell, C. (2003). *Parent education: What is required to build the skills parents need to raise healthy children?* Toronto, Ontario: Invest in Kids.

Crill Russell, C. (2003). *Parenting in the beginning years: Priorities for investment*. Toronto, Ontario: Invest in Kids.

Crill Russell, C., Birnbaum, N., Avison, W. R., & Ioannone, P. (2011). *Vital communities, vital support: How well do Canada's communities support parents of young children? Phase 2*

*report: What parents tell us.* Toronto, Ontario: The Phoenix Centre for Children & Families.

Cronin, C. (2003). First-time mothers - identifying their needs, perceptions and experiences. *Journal of Clinical Nursing, 12*, 260-267. doi: 10.1046/j.1365-2702.2003.00684.x

Cunha, F., & Heckman, J. J. (2008). Formulating, identifying and estimating the technology of cognitive and noncognitive skill formation. *Journal of Human Resources, 43*(4), 738-782. doi: https://doi.org/10.1353/jhr.2008.0019

Cusack, C., Cohen, B., Mignone, J., Chartier, M. J., & Lutfiyya, Z. (2017). Reorienting Public Health Nurses' practice with a professional practice model. *Canadian Journal of Nursing Research, 49*(1), 16-27. doi: 10.1177/0844562116686003

Cypel, S., & Vidigal, F. M. C. S. (2013) What happens in the brain as very young children learn. *Vol. June. Early Childhood Matters* (pp. 13-17): Bernard van Leer Foundation.

Dana, F. (2017). Coming cuts to health services for newborns, moms 'staggering' nurse's union says *CBC News* (pp. 1). Online. News release July 13. Retrieved from http://www.cbc.ca/news/canada/manitoba/lactation-hsc-manitoba-nurses-union-1.4204212: CBC.

Darlington, Y., & Miller, J. R. (2000). Support received by families with dependent children: The importance of receiving adequate support. *Journal of Family Studies, 6*(1), 65-77. doi: 10.5172/jfs.6.1.65

Davis, T. S., Saltzburg, S., & Locke, C. R. (2010). Assessing community needs of sexual minority youths: Modeling concept mapping for service planning. *Journal of Gay & Lesbian Social services, 22*(3), 226-249. doi: 10.1080/10538720903426354

de Montigny, F., & Lacharité, C. (2005). Perceived parental efficacy: Concept analysis. *Journal of Advanced Nursing, 49*(4), 387-396. doi: 10.1111/j.1365-2648.2004.03302.x

Deave, T. (2005). Associations between child development and women's attitudes to pregnancy and motherhood. *Journal of Reproductive & Infant Psychology, 23*(1), 63-75. doi: 10.1080/02646830512331330938

Deave, T., Johnson, D., & Ingram, J. (2008). Transition to parenthood: The needs of parents in pregnancy and early parenthood. *BMC Pregnancy and Childbirth, 8*(30). doi: 10.1186/1471-2393-8-30

DeBord, K., Heath, H., McDermott, D., & Wolfe, R. (Producer). (2000). Special focus: Parenting education. Sharing the wisdom on parenting: Turning information overload into a curriculum that works. *America's family support magazine.* Retrieved from http://npen.org/pdfs/2000pe-DeBord.pdf

DeBord, K., & Matta, M. (2002). Designing professional development systems for parenting educators. *Journal of Extension, 40*(2), 1-14.

Demick, J. (2002). Stages of parent development. In M. H. Bornstein (Ed.), *Handbook of parenting: Being and becoming a parent* (2nd ed., Vol. 3, pp. 389-414). New York, NY: Psychology Press Taylor & Francis Group.

Devolin, M., Phelps, D., Duhaney, T., Benzies, K., Hildebrandt, C., Rikhy, S., & Churchill, J. (2012). Information and support needs among parents of young children in a region of Canada: A cross-sectional survey. *Public Health Nursing, 30*, 193-201. doi: 10.1111/phn.12002

Dillon Goodson, B. (2014). Parent support programs and outcomes for children *Parenting Skills*: Encyclopedia on Early Childhood Development.

Dixon, L., Browne, K., & Hamilton-Giachritsis, C. (2008). Patterns of risk and protective factors in the intergenerational cycle of maltreatment. *Journal of Family Violence, 24*(2), 111-122. doi: 10.1007/s10896-008-9215-2

Drummond, J. (2005). Parent support programs and early childhood development: Comments on Goodson, and Trivette and Dunst. In R. E. Tremblay, R. G. Barr & R. Peters, DeV. (Eds.), *Encyclopedia on early childhood development [online]* (pp. 1-6). Montreal, Quebec: Centre of Excellence for Early Childhood Development. Retrieved from http://www.child-encyclopedia.com/parenting-skills/according-experts.

Durrant, J. E. (2013). *Positive discipline in everyday parenting* (Third ed.). Stockholm: Save the Children Sweden.

Durrant, J. E., Ensom, R., & Coalition on Physical Punishment of Children and Youth. (2004). *Joint statement on physical punishment of children and youth*. Ottawa, Ontario: Coalition on Physical Punishment of Children and Youth.

Durrant, J. E., Pierre Plateau, D., Ateah, C., Stewart-Tufescu, A., Jones, A., Ly, G., . . . Tapanya, S. (2014). Preventing punitive violence: Preliminary data on the Positive Discipline in Everyday Parenting (PDEP) program. *Canadian Journal of Community Mental Health*, 109-125. doi: 10.7870/cjcmh-2014-018

Eastlick Kushner, K., Pitre, N., Williamson, D. L., Breitkreuz, R., & Rempel, G. (2014). Anticipating parenthood: Women's and men's meanings, expectations, and idea(L)s in Canada. *Marriage & Family Review, 50*, 1-34. doi: 10.1080/01494929.2013.834026

Elmore, C., & Gaylord-Harden, N. (2013). The influence of supportive parenting and racial socialization messages on African American youth behavioral outcomes. *Journal of Child and Family Studies, 22*(1), 63-75. doi: 10.1007/s10826-012-9653-6

Entsieh, A. A., & Hallström, I. K. (2016). First-time parents' prenatal needs for early parenthood preparation - A systematic review and meta-synthesis of qualitative literature. *Midwifery, 39*, 1-11. doi: 10.1016/j.midw.2016.04.006

Erikson, E. H. (1982). *The life cycle completed*. New York: Norton.

Fabiano, G. A., Pelham, W. E., Cunningham, C. E., Yu, J., Gangloff, B., Buck, M., . . . Gera, S. (2012). A waitlist-controlled trial of behavioral parent training for fathers of children with ADHD. *Journal of Clinical Child & Adolescent Psychology, 41*(3), 337-345. doi: 10.1080/15374416.2012.654464

Fabrizio, C., Lam, T., Hirschmann, M., & Stewart, S. (2013). A brief parenting intervention to enhance the parent–child relationship in Hong Kong: Harmony@Home. *Journal of Child and Family Studies, 22*(5), 603-613. doi: 10.1007/s10826-012-9614-0

Farris, J., Burke Lefever, J. E., Borkowski, J. G., & Whitman, T. L. (2013). Two are better than one: The joint influence of maternal preparedness for parenting and children's self-esteem on academic achievement and adjustment. *Early Education & Development, 24*(3), 346-365. doi: 10.1080/10409289.2012.658551

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *Am J Prev Med, 14*(4), 245-258. doi: 10.1016/S0749-3797(98)00017-8

File, T., & Ryan, C. (2014). *Computer and internet use in the United States: 2013*. United States: U.S. Census Bureau Retrieved from https://www.census.gov/history/pdf/2013computeruse.pdf.

Flanagan, K., & Beach, J. (2016). *Manitoba Early Learning and Child Care Commission final report* (pp. 87). PEI: Kathleen Flanagan and Associates, Inc. Retrieved from http://www.cccf-fcsge.ca/2016/01/12/manitoba-early-learning-and-child-care-commission-final-report/.

Fleming, T. P., Watkins, A. J., Velazquez, M. A., Mathers, J. C., Prentice, A. M., Stephenson, J., . . . Godfrey, K. M. (2018). Origins of lifetime health around the time of conception: Causes and consequences. *Lancet, 391*, 1842-1852. doi: 10.1016/S0140-6736(18)30312-X

Furedi, F. (2001). *Paranoid parenting*. Harmondsworth: Allen Lane: Penguin.

Gabor, P. (2003). *The evaluation of Family Resource Programs: Challenges and promising approaches*. Ottawa, ON: FRP Canada.

Gager, C. T., McLanahan, S. S., & Glei, D. A. (2002). Preparing for parenthood: Who's ready, who's not? In N. Halfon, K. Taaffe McLearn & M. A. Schuster (Eds.), *Child rearing in America: Challenges facing parents with young children*. UK: Cambridge University Press.

Gagnon, A. J., & Sandall, J. (2007). Individual or group antenatal education for childbirth or parenthood, or both (Review). *Cochrane Database of Systematic Reviews*(3). doi: 10.1002/14651858.CD002869.pub2

Galinsky, E. (1987). *The six stages of parenthood*. New York: Addison-Wesley Publishing Company.

Gardiner, E. (2012). Family resource programs: Values, evidence and challenges. *Canadian Journal of Family and Youth, 4*(1), 53-77.

Garner, A. S. (2013). Home visiting and the biology of toxic stress: Opportunities to address early childhood adversity. *Pediatrics, 132*(Supplement 2), S65 - S73. doi: 10.1542/peds.2013-1021D

Gazmararian, J. A., Dalmida, S. G., Merino, Y., Blake, S., Thompson, W., & Gaydos, L. (2014). What new mothers need to know: Perspectives from women and providers in Georgia. *Matern Child Health J, 18*, 839-851. doi: 10.1007/s10995-013-1308-8

Genuis, S. J., & Genuis, R. A. (2016). Preconception care: A new standard of care within maternal health services. *BioMed Research International*, 30. doi: 10.1155/2016/6150976

George, L. (2005). Lack of preparedness: Experiences of first-time mothers. *MCN The American Journal of Maternal/Child Nursing, 30*(4 July/August), 251-255. doi: 10.1097/00005721-200507000-00009

Ghate, D., & Hazel, N. (2002). *Parenting in poor environments: Stress, support and coping*. London: Jessica Kingsley Publishers.

Gilmer, C., Buchan, J. L., Letourneau, N., Bennett, C. T., Shanker, S. G., Fenwick, A., & SMith-Chant, B. (2016). Parent education interventions designed to support the transition to parenthood: A realist review. *International Journal of Nursing Studies, 59*, 118-133. doi: 10.1016/j.ijnurstu.2016.03.015

Glade, A. C., Bean, R. A., & Vira, R. (2005). A prime time for marital/relational intervention: A review of the transition to parenthood literature with treatment recommendations. *The American Journal of Family Therapy, 33*, 319-336. doi: 10.1080/01926180590962138

Glavin, K., & Schaffer, M. A. (2014). A comparison of the Well Child Clinic services in Norway and the Nurse Family Partnership programme in the United States. *Journal of Clinical Nursing, 23*(3-4), 492-503. doi: 10.1111/jocn.12206

Godin, K. M., Alton, G. D., Gangodawilage, H. P., Procter, T. D., Bourdages, N. B., Blue, S. E., . . . Horan, M. J. (2015). Knowledge change associated with participation in prenatal education programs in Ontario: A cohort study. *Canadian Journal of Public Health, 106*(6), e401-e407. doi: 10.17269/CJPH.106.5057

Google Maps. (2017). [Google Maps province of Manitoba]. Retrieved August 30, 2017, from https://www.google.ru/maps/@55.0563339,-99.0755917,5.25z.

Gordon, M. (2005). *Roots of Empathy: Changing the world child by child*. Toronto, Ontario: Thomas Allen.

Gottlieb, G. (1991). Epigenetic systems view of human development. *Developmental Psychology, 27*(1), 33-34.

Government of Canada. (2018). *More than 100 rural communities in Manitoba will benefit from faster Internet*. Online: Government of Canada Retrieved from https://www.canada.ca/en/innovation-science-economic-development/news/2018/01/more_than_100_ruralcommunitiesinmanitobawillbenefitfromfasterint.html

Government of Manitoba. (2015). *Provincial public health nursing standards: Prenatal, postpartum, and early childhood*. Winnipeg, MB: Government of Manitoba. Retrieved from https://www.gov.mb.ca/health/publichealth/phnursingstandards/index.html.

Government of Manitoba. (2015). *Speech from the Throne*. Online: Author Retrieved from www.gov.mb.ca/asset_library/en/thronespeech/throne_speech_2015.pdf.

Government of Manitoba. (2017). *Manitoba Government announces Child Welfare System reform*. Retrieved from http://news.gov.mb.ca/news/index.html?item=42322&posted=2017-10-12.

Government of Manitoba. (2018). *Governments of Canada and Manitoba announce bilateral agreement on early learning and child care*. Online: Government of Manitoba Retrieved from http://news.gov.mb.ca/news/index.html?item=43194&posted=2018-02-23.

Gray, C., & Sims, M. (2007). Parental stress and child rearing decisions. *NZ Research in Early Childhood Education Journal, 10*, 105-118.

Griffith, J. (2002) To handle life's challenges: A tracer study of Servol's Adolescent Development Programme in Trinidad. *Early Childhood Development: Practices and Reflections: Following Footsteps*. The Hague, Netherlands: Bernard van Leer Foundation. Retrieved from https://eric.ed.gov/?id=ED463857.

Handley, M., Pappas, J., & Kander, R. (2004). *Developing a faculty consensus on program learning goals and objectives using collaborative concept mapping software*. Paper presented at the International Conference on Engineering Education. Retrieved from http://www.conceptsystems.com/content/view/publications.html

Healthy Child Manitoba. (2010). *Families First program evaluation: Evaluating the effectiveness of the Families First home visiting program in improving the well-being of at-risk families with preschool children*. Winnipeg, MB: Government of Manitoba. Retrieved from http://www.gov.mb.ca/healthychild/familiesfirst/ff_eval2010.pdf.

Healthy Child Manitoba. (2010). *Triple P - The Positive Parenting Program: A developmental evaluation of Manitoba's provincial implementation. Data from the 2008 comprehensive practitioner and manager interview*. Winnipeg, MB: Government of Manitoba Retrieved from http://www.gov.mb.ca/healthychild/publications/triplep_implementation_fall2010.pdf.

Healthy Child Manitoba. (2012). *Healthy Child Manitoba: 2012 Report on Manitoba's children and youth* (pp. 176). Winnipeg, MB: Government of Manitoba. Retrieved from http://www.gov.mb.ca/healthychild/publications/index.html.

Healthy Child Manitoba. (2015). *About Healthy Child Manitoba*. Retrieved April 27, 2015, from http://www.gov.mb.ca/healthychild/about/#vision

Healthy Child Manitoba. (2015). *Starting early, starting strong: Manitoba's five-year plan for early childhood development Healthy Child Manitoba: Putting Children and Families First* (pp. 15). Winnipeg, MB: Government of Manitoba. Retrieved from http://www.gov.mb.ca/healthychild/ecd/index.html.

Healthy Child Manitoba. (n.d.). *ManitobaParentZone*. Retrieved September 3, 2017, from http://www.manitobaparentzone.ca/

Healthy Child Manitoba Office. (2016). *Healthy Child Manitoba annual report 2015-2016*. Retrieved November 26, 2017 http://www.gov.mb.ca/healthychild/about/annual.html

Heckman, J. J. (2011). The economics of inequality: The value of early childhood education. *American Educator, 35*(1), 31-35.

Heinrichs, N., Bertrram, H., Kuschel, A., & Hahlweg, K. (2005). Parent recruitment and retention in a universal prevention program for child behaviour and emotional problems: Barriers to research and program participation. *Prevention Science, 6*(4), 275-286. doi: 10.1007/s11121-005-0006-1

Hertzman, C., & Boyce, T. (2010). How experience gets under the skin to create gradients in developmental health. *Annu Rev Public Health, 31*, 329-347.

Hess, C. R., Teti, D. M., & Hussey-Gardner, B. (2004). Self-efficacy and parenting of high-risk infants: The moderating role of parent knowledge of infant development. *Applied Developmental Psychology, 25*(4), 423-437. doi: 10.1016/j.appdev.2004.06.002

Hogg, S. (2017). Preconception: Early preparation for pregnancy and parenthood. *International Journal of Birth and Parenting Education, 5*(1), 40-41.

Hoghughi, M. (1998). The importance of parenting in child health. *British Medical Journal, 316*, 1545-1552.

Hope, P., & Sharland, P. (1997). *Tomorrow's parents: Developing parenthood education in schools*. London: Calouste Gulbenkian Foundation.

Hops, H., Davis, B., Leve, C., & Sheeber, L. (2003). Cross-generational transmission of aggressive parent behaviour: A prospective, mediational examination. *Journal of Abnormal Child Psychology, 31*(2), 161-169. doi: 10.1023/A:1022522224295

Howard, K. S., & Brooks-Gunn, J. (2009). The role of home-visiting programs in preventing child abuse and neglect. *The Future of children / Center for the Future of Children, the David and Lucile Packard Foundation, 19*(2), 119-146. doi: 10.1353/foc.0.0032

Hsueh, J., & Yoshikawa, H. (2007). Working nonstandard schedules and variable shifts in low income families: Associations with parental psychological well-being, family functioning, and child well-being. *Developmental Psychobiology, 43*(3). doi: 10.1037/0012–1649.43.3.620

Huang, K. Y., Caughy O'Brien, M., Genevro, J. L., & Miller, T. L. (2005). Maternal knowledge of child development and quality of parenting among White, African-American and Hispanic mothers. *Applied Developmental Psychology, 26*, 149-170. doi: 10.1016/j.appdev.2004.12.001

Jacobson, L. (2001) *Program builds young students' parenting skills*. *Vol. 20*. Online: Education Week. Retrieved from http://www.edweek.org/ew/articles/2001/06/06/39parent.h20.html.

Jefferis, P. G., & Oliver, C. (2006). Associations between maternal childrearing cognitions and conduct problems in young children. *Clinical Child Psychology and Psychiatry, 11*(1), 83-102. doi: 10.1177/1359104506059125

Johnson, B. D., Berdahl, L. D., Horne, M., Richter, E. A., & Walters, M.-g. (2014). A parenting competency model. *Parenting, 14*(2), 92-120. doi: 10.1080/15295192.2014.914361

Johnson, K., Akister, J., McKeigue, B., & Wheater, J. (2005). What does 'Supporting Parents' mean? - Parents' views. *Practice: Social Work in Action, 17*(1), 3-14. doi: 10.1080/09503150500058009

Johnson, M. A. (2012). *United States evaluation policy: A theoretical taxonomy.* (Doctor of Philosophy), Cornell University, Ithaca, NY. (UMI Number: 3586275)

Jones, T. L., & Prinz, R. J. (2005). Potential roles of parental self-efficacy in parent and child adjustment: A review. *Clin Psychol Rev, 25*(3), 341-363. doi: 10.1016/j.cpr.2004.12.004

Joussemet, M., Mageau, G., & Koestner, R. (2013). Promoting optimal parenting and children's mental health: A preliminary evaluation of the How-to Parenting Program. *Journal of Child and Family Studies*, 1-16. doi: 10.1007/s10826-013-9751-0

Kane, C., & Trochim, W. M. K. (2007) Concept mapping for planning and evaluation: Applied social research methods series. *Vol. 50*. Thousand Oaks, CA: SAGE.

Kane, M., & Trochim, W. M. (2009). Concept mapping for applied social research *Social Research Methods*. Online: SAGE Publications, Inc.

Kane, M., & Trochim, W. M. K. (2007). *Concept mapping for planning and evaluation.* Thousand Oaks, CA: Sage Publications.

Katz, I., Corlyon, J., La Placa, V., & Hunter, S. (2007). *The relationship between parenting and poverty*. UK: Joseph Rowntree Foundation.

Katz, I., La Placa, V., & Hunter, S. (2007). *Barriers to inclusion and successful engagement of parents in mainstream services* (pp. 1-36). York, UK: Joseph Rowntree Foundation

Kemp, S. P., Marcenko, M. O., Hoagwood, K., & Vesneski, W. (2009). Engaging parents in child welfare services: Bridging family needs and child welfare mandates. *Child Welfare, 88*(1), 101-126.

Kendrick, D., Mulvaney, C. A., Ye, L., Stevens, T., Mytton, J. A., & Stewart-Brown, S. (2013). Parenting interventions for the prevention of unintentional injuries in childhood (Review). *Cochrane Database of Systematic Reviews*(3). doi: 10.1002/14651858.CD006020.pub3.

Keyes, C. L. M. (2007). Promoting and protecting mental health as flourishing. *American Psychologist, 62*(2), 95-108. doi: 10.1037/0003-066X.62.2.95

Khaleque, A. (2014). Perceived parental neglect, and children's psychological maladjustment, and negative personality dispositions: A meta-analysis of multi-cultural studies. *Journal of Child and Family Studies*, 1-10. doi: 10.1007/s10826-014-9948-x

Kim, J., & Wiggens, M. E. (2011). Family-friendly human resource policy: Is it still working in the public sector. *Public Administration Review, 71*(5), 728-739. doi: 10.1111/j.1540-6210.2011.02412.x

Kirkham, C., Harris, S., & Grzybowski, S. (2005). Evidence-based prenatal care: Part I. General prenatal care and counseling issues. *American Family Physician, 71*(7), 1307-1316.

Kitzman, H. J., Cole, R., Yoos, H. L., & Olds, D. (1997). Challenges experienced by home visitors: A qualitative study of program implementation. *Journal of Community Psychology, 25*(1), 95-109.

Knaak, S. J. (2010). Contextualising risk, constructing choice: Breastfeeding and good mothering in risk society. *Health, Risk & Society, 12*(4), 345-355. doi: 10.1080/13698571003789666

Kumpfer, K. L., & Alvarado, R. (2003). Family strengthening approaches for the prevention of youth problem behaviours. *American Psychologist, 58*(6-7), 457-465.

Kurtines, W. M., Ferrer-Wreder, L., Berman, S. L., Cass Lorente, C., Silverman, W. K., & Montgomery, M. J. (2008). Promoting positive youth development: New directions in developmental theory, methods, and research. *Journal of Adolescent Research, 23*(3), 233-244. doi: 10.1177/0743558408314372

Kyle, I., & Kellerman, M. (1997). Case studies of Canadian family resource programs: Supporting families, children and communities.

La Placa, V., & Corlyon, J. (2014). Barriers to inclusion and successful engagement of parents in mainstream services: Evidence and research. *Journal of Children's Services, 9*(3), 220-234. doi: 10.1108/JCS-05-2014-0027

Lagarde, M., Haines, A., & Palmer, N. (2009). The impact of conditional cash transfers on health outcomes and use of health services in low and middle-income countries. *Cochrane Database of Systematic Reviews, 4*(CD008137).

Lam, C.-M., & Kwong, W.-M. (2014). Powerful parent educators and powerless parents: The 'empowerment paradox' in parent education. *Journal of Social Work, 14*(2), 183-195. doi: 10.1177/1468017313477779

Lam, C. M., & Kwong, W. M. (2012). The “paradox of empowerment” in parent education: A reflexive examination of parents' pedagogical expectations. *Family Relations, 61*(1), 65-74. doi: 10.1111/j.1741-3729.2011.00685.x

Layzer, J. I., Goodson, B. D., Bernstein, L., & Price, C. (2001). *National evaluation of family support programs: The meta-analysis* (Vol. A Final Report ). Cambridge, MA: Abt Associates, Inc.

Leathers, S. J., & Kelley, M. A. (2000). Unintended pregnancy and depressive symptoms among first-time mothers and fathers. *American Journal of Orthopsychiatry, 70*(4), 523-530. doi: 10.1037/h0087671

Lee, C. M., Stern, S. B., Feldgaier, S., Ateah, C., Gagné, M. H., Barnes, S., . . . Chan, K. (2014). The International Parenting Survey-Canada: Exploring access to parenting services. *Canadian Psychology, 55*(2), 110-116. doi: 10.1037/a0036297

Lee, E. L., Wilsie, C. C., & Brestan-Knight, E. (2011). Using Parent–Child Interaction Therapy to develop a pre-parent education module. *Children and Youth Services Review, 33*(7), 1254-1261. doi: 10.1016/j.childyouth.2011.02.024

Lerner, R. M. (2015). Promoting positive human development and social justice: Integrating theory, research and application in contemporary developmental science. *International Journal of Psychology, 50*(3), 165-173. doi: 10.1002/ijop.12162

Liggett-Creel, K., Barth, R. P., Mayden, B., & Pitts, B. E. (2017). The Parent University Program: Factors predicting change in responsive parenting behaviours. *Children and Youth Services Review, 81*, 10-20. doi: 10.1016/j.childyouth.2017.07.017

Lindsay, G., Cullen, M. A., Cullen, S., Totsika, V., Bakopoulou, I., Goodlad, S., . . . Mantovani, I. (2014). *CANparent trial evaluation: Final report: Research report.* (pp. 1-448). UK: Department for Education.

Lloyd, E. (1999) *What works in parenting education? Summary*. Essex: Barnardo's.

Lobb, R., Pinto, A. D., & Lofters, A. (2013). Using concept mapping in the knowledge-to-action process to compare stakeholders opinions on barriers to use of cancer screening among South Asians. *Implement Sci, 8*(37), 12. doi: 10.1186/1748-5908-8-37

Löfgren, H. O., Petersen, S., Nilsson, K., Ghazinour, M., & Hägglöf, B. (2017). Effects of parent training programmes on parents' sense of competence in a general population sample. *Global Journal of Health Science, 9*(7), 24-34. doi: 10.5539/gjhs.v9n7p24

Lounds, J. J., Borkowski, J. G., Whitman, T. L., Maxwell, S. E., & Weed, K. (2005). Adolescent parenting and attachment during infancy and early childhood. *Parenting, 5*(1), 91-118. doi: 10.1207/s15327922par0501_4

Loveman, E., Al-Khudairy, L., Johnson, R. E., Robertson, W., Colquitt, J. L., Mead, E. L., . . . Rees, K. (2015). Parent-only interventions for childhood overweight or obesity in children aged 5 to 11 years. *Cochrane Database of Systematic Reviews*(Issue 12. Art. No.: CD012008.). doi: 10.1002/14651858.CD012008.

Luse, A., Mennecke, B., & Townsend, A. (2012). Selecting a research topic: A framework for doctoral students. *International Journal of Doctoral Studies, 7*, 143-152.

Lykken, D. T. (2001). Parental licensure. *American Psychologist, 56*(11), 885-894.

Mansfield, P. (1982). Getting ready for parenthood: Attitudes to and expectations of having children of a group of newly-weds. *International Journal of Sociology and Social Policy, 2*(3), 28-39.

Manzeske, D. P., & Dopkins Stright, A. (2009). Parenting styles and emotion regulation: The role of behavioral and psychological control during young adulthood. *Journal of Adult Development, 16*, 223-229. doi: 10.1007/s10804-009-9068-9

Matusicky, C., & Crill Russell, C. (2009). Best practices for parents: What is happening in Canada? *Paediatric Child Health, 14*(10), 664-665. doi: 10.1093/pch/14.10.664

McBride, N., & Johnson, S. E. (2016). Fathers' role in alcohol-exposed pregnancies: Systematic review of human studies. *Am J Prev Med, 51*(2), 240-248. doi: 10.1016/j.amepre.2016.02.009

McCain, M., & Mustard, J. F. (1999). *Reversing the real brain drain: Early years study: Final Report*. Toronto, Ontario: Ontario Children's Secretariat.

McConnell, D., Breitkreuz, R., & Savage, A. (2012). Parent needs and family support service outcomes in a Canadian sample. *Journal of Social Work, 13*(5), 447-470. doi: 10.1177/1468017311434819

McDermott, D. (2002). *Theory and rationale for parenting education in schools*. Raton, FL: The Parenting Project.

McDermott, D. (2003). Building better human connections: Parenting/caring education for children and teens in school. *Childhood Education, 80*(2), 71-75. doi: 10.1080/00094056.2004.10521260

McDermott, D. (2014). Children, parents and teachers learning how to care more effectively. *Haiti Perspectives, 2*(4), 43-47.

McGaw, S., & Lewis, C. (2002). Should parenting be taught? *The Psychologist, 15*(10), 510-513.

Merriam-Webster. (Ed.) (2005). Springfield, MA: Merriam Webster.

Michaux, A. (2017). Support for new parents and babies in New South Wales: The importance of parenting support *Submission to the New South Wales Legislative Assembly Committee on Community Services* (pp. 69). Australia: Parenting Research Centre.

Miller, R. J., & Darlington, Y. (2002). Who supports? The providers of social support to dual-parent families caring for young children. *Journal of Community Psychology, 30*(5), 461-473. doi: 10.1002/jcop.10023

Miller, S., & Sambell, K. (2003). What do parents feel they need? Implications of parents' perspectives for the facilitation of parenting programmes. *Children & Society, 17*(1), 32-44. doi: 10.1002/chi.726

Minkler, M., Breckwich Vásquez, V., Chang, C., Miller, J., Rubin, V., Glover Blackwell, A., . . . Bell, J. (2008). Promoting healthy public policy through community-based participatory research: Ten case studies. USA.

Molina, M. C., Pastor, C., & Violant, V. (2011). Parental education as health protection factor in vulnerable childhood and adolescence. *Review of Research and Social Intervention, 34*, 38-55.

Molinuevo, D. (2012). *Parenting support in Europe*. Dublin: Eurofound.

Morawska, A., Heinrichs, N., & Sanders, M. R. (2011). *International Parenting Survey*. Brisbane, Australia: Parenting and Family Support Centre.

Mowder, B. A. (2005). Parent development theory: Understanding parents, parenting perceptions and parenting behaviours. *Journal of Early Childhood & Infant Psychology, 1*, 45-64.

Mullin, A. (2012). The ethical and social significance of parenting: A philosophical approach. *Parenting, 12*(2-3), 134-143. doi: 10.1080/15295192.2012.683339

National Academics of Sciences Engineering and Medicine. (2016). *Parenting matters: Supporting parents of children ages 0-8*. Washington, DC: The National Academics Press. doi 10.17226/21868.

National Collaborating Centre for Determinants of Health. (2010). *Building a business case for preventive home visiting for pregnant women and mothers of young children: A review of the literature*. Antignish, NS: National Collaborating Centre for Determinants of Health.

National Collaborating Centre for Determinants of Health. (2013). *Let's talk: Health equity.* Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.

National Research Council and Institute of Medicine. (2000). *From neurons to neighborhoods: The science of early childhood development.* Committee on integrating the science of early childhood development. In J. P. Shonkoff & D. A. Phillips (Eds.), *Board on children, youth, and families, commission on behavioural and social sciences and education.* Washington, DC: National Academy Press.

Nicolaides, K. H. (2011). Turning the pyramid of prenatal care. *Fetal Diagnosis and Therapy, 29*, 183-196. doi: 10.1159/000324320

Niles, S. G. (2012). *Super's life-space theory: A useful framework for achieving life balance*. Retrieved from http://www.calpro-online.org/eric/docs/niles/niles4.pdf.

Novak, J. D., & Canas, A. J. (2004). Building on new constructivist ideas and CmapTools to create a new model for education. *IX Taller Internacional de Software Educativo TISE*(MEMORIAS TISE 2004), 1-6.

O'Connor, T. G., & Scott, S. B. C. (2007). *Parenting and outcomes for children* (pp. 58). London, UK: Kings College London. Retrieved from http://www.jrf.org.uk/sites/files/jrf/parenting-outcomes.pdf.

Oldershaw, L. (2002). *A national survey of parents of young children*. Toronto, Ontario: Invest in Kids.

Olds, D., Sadler, L., & Kitzman, H. (2007). Programs for parents of infants and toddlers: Recent evidence from randomized trials. *Journal of Child Psychology and Psychiatry, 48*(3), 355-391.

Olds, D. L., Henderson, C., Tatelbaum, R., & Chamberlain, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics, 78*, 65-78.

Pålsson, P., Persson, E. K., Ekelin, M., Kristensson Hallström, I., & Kvist, L. J. (2017). First-time father's experiences of their prenatal preparation in relation to challenges met in the early parenthood period: Implications for early parenthood preparation. *Midwifery, 50*, 86-92. doi: 10.1016/j.midw.2017.03.021

Papoušek, H., & Papoušek, M. (2002). Intuitive parenting. In M. H. Bornstein (Ed.), *Handbook of parenting: Biology and ecology of parenting* (2nd ed., Vol. 2, pp. 183-203). Mahwah, NJ: Erlbaum.

Parens, H., Rose-Itkoff, C., Pearlman, M., Reid, K., Turrini, P., Fallon, T., . . . Scattergood, E. (2006). Into our fourth decade of prevention via parenting education: where we have been – where we are going. *International Journal of Applied Psychoanalytic Studies, 3*(1), 17-38. doi: 10.1002/aps.44

Parenting Research Centre. (2014). Productivity Commission Inquiry: Childcare and early childhood learning. *A Frameworks Research Report*. Australia: FrameWorks Institute.

Parenting Research Centre and Murdoch Childrens Research Institute. (2017). *Analysis summary: Raising community awareness of parenting*. Australia: Parenting Research Centre. Retrieved from https://www.parentingrc.org.au/publications/analysis-summary-raising-community-awareness-of-parenting/.

Parke, R. D., Coltrane, S., Duffy, S., Buriel, R., Dennis, J., Powers, J., . . . Widaman., K. F. (2004). Economic stress, parenting, and child adjustment in Mexican American and European American families. *Child Dev, 75*(6), 1632-1656. doi: 10.1111/j.1467-8624.2004.00807.x

Parke, R. D., McDowell, D. J., Kim, N., Killian, C., Dennis, J., Flyr, M., & Wild, M. N. (2002). Fathers' contributions to children's peer relationships. In C. S. Tamis-LeMonda & N. Carbrera (Eds.), *Handbook of father involvement: Interdisciplinary perspectives* (pp. 141-167). Mahwah, NJ: Erlbaum.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. D. (2007). Mental health of young people: A global public-health challenge. *Lancet, 369*, 1302-1313. doi: 10.1016/S0140-6736(07)60368-7

Pehrson, K. L., & Robinson, C. C. (1990). Parent education: Does it make a difference? *Child Study Journal, 20*(4), 221.

Pew Research Center. (2015). *Parenting in America: Outlook, worries, aspirations are strongly linked to financial situation*. USA: Author.

PFL Evaluation Team at the UCD Geary Institute for Public Policy. (2016). Preparing for Life: Early Childhood Intervention Final Report: Did Preparing for Life improve children's school readiness? Evaluation of the Preparing for Life Early Childhood Intervention

Programme. Dublin: UCD Geary Institute for Public Policy and Preparing for Life: working together for our children.

Pierce Keeton, C., Perry-Jenkins, M., & Sayer, A. G. (2008). Sense of control predicts depressive and anxious symptoms across the transition to parenthood. *Journal of Family Psychology, 22*(2), 212-221. doi: 10.1037/0893-3200.22.2.212

Pinheiro, P. S. (2006). *World report on violence against children*. New York: United Nations.

Pocock, B. (2005). Mothers; the more things change the more they stay the same. In M. Poole (Ed.), *Families: changing families, changing times* (pp. 113-134). Crows Nest, NSW: Allen & Unwin.

Ponzetti Jr., J. J. (Ed.). (2016). *Evidence-based parenting education: A global perspective*. New York: Routledge Taylor & Francis Group.

Popkin, M. H. (2014). Active parenting: 30 years of video-based parent education. *The Journal of Individual Psychology, 70*(2), 166-175. doi: 10.1353/jip.2014.0014

Price-Robertson, R., Smart, D., & Bromfield, L. M. (2011). Family is for life: Connections between childhood family experiences and wellbeing in early adulthood. *Family Matters, 85*, 7-17.

Public Health Agency of Canada. (2009). *What mothers say: The Canadian maternity experiences survey*. Ottawa, Ontario: Government of Canada.

Pujadas Botey, A., Vinturache, A., Bayrampour, H., Breitkruez, R., Bukutu, C., Gibbard, B., & Tough, S. (2017). Adults' knowledge of child development in Alberta, Canada: Comparing the level of knowledge of adults in two samples in 2007 and 2013. *Child Care in Practice, 23*(4), 404-416. doi: 10.1080/13575279.2016.1215292

Qi Wang, M. (2011). *The RealCare Baby Program: Evidence of efficacy. A Realityworks White Paper*. WI: Realityworks.

Racine, A. D. (2016). Buying a better baby: Unconditional income transfers and birth outcomes. *Pediatrics, 137*(6), 2. doi: 10.1542/peds.2015-4673

Radey, M., & Randolph, K. A. (2009). Parenting sources: How do parents differ in their efforts to learn about parenting? *Family Relations, 58*, 536-548. doi: 10.1111/j.1741-3729.2009.00573.x

Rao, H., Betancourt, L., Giannetta, J. M., Brodsky, N. L., Korczykowski, M., Avants, B. B., . . . Farah, M. J. (2010). Early parental care is important for hippocampal maturation: Evidence from brain morphology in humans. *NeuroImage, 49*(1), 1144-1150. doi: http://dx.doi.org/10.1016/j.neuroimage.2009.07.003

Rasmussen, P. R. (2014). The task, challenges, and obstacles of parenting. *The Journal of Individual Psychology, 70*(2), 90-113. doi: 10.1353/jip.2014.0010

Redding, E. (2002). The impossibility of parental licensure. *The American Psychologist, 57*(11), 987-988.

Reeves, R. V., & Howard, K. (2013). The parenting gap. Washington, DC: Center on Children & Families at Brookings.

Reeves, R. V., Sawhill, I., & Howard, K. (2013). The parenting gap. *Democracy: A Journal of Ideas*(30), 1-11.

Reich, S. (2005). What do mothers know? Maternal knowledge of child development. *Infant mental health journal, 26*(2), 143-156. doi: 10.1002/imhj.20038

Reichle, B., Backes, S., & Dette-Hagenmeyer, D. E. (2012). Positive parenting the preventive way: Transforming research into practice with an intervention for new parents. *European Journal of Developmental Psychology, 9*(1), 33-46. doi: 10.1080/17405629.2011.629037

Renkert, S., & Nutbeam, D. (2001). Opportunities to improve maternal health literacy through antenatal education: An exploratory study. *Health Promotion International, 16*(4), 381-388. doi: 10.1093/heapro/16.4.381

Reppucci, N. D., Britner, P. A., & Woolard, J. L. (1997). *Preventing child abuse and neglect through parent education*. Baltimore, MD: Paul H. Brookes.

Ridings, J. W., Piedra, L. M., Capeles, J. C., Rodríguez, M. J., Freire, F., & Byoun, S.-J. (2011). Building a Latino Youth Program: Using concept mapping to identify community-based strategies for success. *Journal of Social Service Research, 37*, 34-49. doi: 10.1080/01488376.2011.524514

Rikhy, S., Tough, S., Trute, B., Benzies, K., Kehler, H., & Johnston, D. W. (2010). Gauging knowledge of developmental milestones among Albertan adults: A cross-sectional survey. *BMC Public Health, 10*(1), 183-191. doi: 10.1186/1471-2458-10-183

Riley, E. P., Alejandra Infante, M., & Warren, K. R. (2011). Fetal alcohol spectrum disorders: An overview. *Neuropsychology Review, 21*(2), 73-80. doi: 10.1007/s11065-011-9166-x.

Rispoli, K. M., McGoey, K. E., Koziol, N. A., & Schreiber, J. B. (2013). The relation of parenting, child temperament, and attachment security in early childhood to social competence at school entry. *Journal of School Psychology, 51*(5), 643-658. doi: 10.1016/j.jsp.2013.05.007

Rodrigo, M. J., Almeida, A., Spiel, C., & Koops, W. (2012). Introduction: Evidence-based parent education programmes to promote positive parenting. *European Journal of Developmental Psychology, 9*(1), 2-10. doi: 10.1080/17405629.2011.631282

Rodrigo, M. J., Byrne, S., & Álvarez, M. (2011). Preventing child maltreatment through parenting programmes implemented at the local social services level. *European Journal of Developmental Psychology, 9*(1), 89-103. doi: 10.1080/17405629.2011.607340

Rosas, S. R. (2017). Group concept mapping methodology: Toward an epistemology of group conceptualization, complexity, and emergence. *Quality and Quantity, 51*, 1403-1416. doi: 10.1007/s11135-016-0340-3

Rosas, S. R., & Camphausen, L. C. (2007). The use of concept mapping for scale development and validation in evaluation. *Eval Program Plann, 30*(2), 125-135. doi: 10.1016/j.evalprogplan.2007.01.003

Rosas, S. R., & Kane, M. (2012). Quality and rigor of the concept mapping methodology: A pooled study analysis. *Eval Program Plann, 35*(2), 236-245. doi: 10.1016/j.evalprogplan.2011.10.003

Rowe, M. L. (2008). Child-directed speech: relation to socioeconomic status, knowledge of child development and child vocabulary skill. *Journal of Child Language, 35*(01), 185-205. doi: 10.1017/S0305000907008343

Royal College of Physicians and Surgeons of Canada. (2014). Early childhood development *Royal College Position Statement* (pp. 22): Author.

Salem, P., Sandler, I., & Wolchik, S. (2013). Taking stock of parent education in the family courts: Envisioning a public health approach. *Family Court Review, 51*(1), 131-148. doi: 10.1111/fcre.12014

Salmela-Aro, K., Mutanen, P., & Vuori, J. (2012). Promoting career preparedness and intrinsic work-goal motivation: RCT intervention. *Journal of Vocational Behaviour, 80*, 67-75. doi: 10.1016/j.jvb.2011.07.001

Sanders, M., Cann, W., & Markie-Dadds, C. (2003). Why a universal population-level approach to the prevention of child abuse is essential. *Child abuse review, 12*, 145-154. doi: 10.1002/car.797

Sanders, M., & Kirby, J. (2014). A public-health approach to improving parenting and promoting children's well-being. *Child Development Perspectives, 8*(4), 250-257. doi: 10.1111/cdep.12086

Sanders, M., & Woolley, M. L. (2005). The relationship between maternal self-efficacy and parenting practices: Implications for parent training. *Child Care Health & Development, 31*(1), 65-73. doi: 10.1111/j.1365-2214.2005.00487.x

Sanders, M. R., Cann, W., & Markie-Dadds, C. (2003). The Triple P-Positive Parenting Programme: A universal population-level approach to the prevention of child abuse. *Child abuse review, 12*(3), 155-171. doi: 10. 1002/car.798

Sanders, R., Lehmann, J., & Gardner, F. (2014). Parents' experiences of early parenthood - preliminary findings. *Children Australia, 39*(3), 185-194. doi: 10.1017/cha.2014.20

Santos, R. G., Chartier, M. J., Whalen, J. C., Chateau, D., & Boyd, L. (2010). *Effectiveness of the Roots of Empathy (ROE) Program in preventing aggression and promoting prosocial behaviour: Results from a cluster randomized controlled trial in Manitoba* (pp. 1). Winnipeg, Manitoba: Healthy Child Manitoba.

Santrock, J. W. (2007). *A topical approach to life-span development, third Ed* (Vol. Third Edition). New York: McGraw-Hill.

Sasso, T. K., & Williams, S. K. (2002). The effectiveness of The Parenting Curriculum: An evaluation of high school student's questionnaire responses. *Journal of Family and Consumer Sciences Education, 20*(2), 1-11.

Sawhill, I., Karpilow, Q., & Venator, J. (2014). The impact of unintended childbearing on future generations *Center on Children and Families paper* (pp. 1-30). Washington, DC: Brookings Institution. Retrieved from http://www.brookings.edu/research/papers/2014/09/12-impact-unintended-childbearing-future-sawhill.

Scattergood, S. (1986). Education for parenting. *Momentum, 17*(4), 42-44.

Scholer, S. J., Hudnut-Beumler, J., & Dietrich, M. S. (2012). Why parents value a brief required primary care intervention that teaches discipline strategies. *Clinical Pediatrics, 51*(6), 538-545. doi: 10.1177/0009922812439241

Schrader McMillan, A., Barlow, J., & Redshaw, M. (2009). *Birth and beyond: A review of the evidence about antenatal education*: University of Warwick/University of Oxford.

Schulz, M. S., Cowan, C. P., & Cowan, P. A. (2006). Promoting healthy beginnings: A randomized controlled trial of a preventive intervention to preserve marital quality during the transition to parenthood. *Journal of Consult Clin Psychol, 74*(1), 20-31. doi: 10.1037/0022-006X.74.1.20

Scott, S. (2012). Parenting quality and children's mental health: biological mechanisms and psychological interventions. *Current Opinion in Psychiatry, 25*(4), 301-306. doi: 10.1097/YCO.0b013e328354a1c5

Scott, S., Sylva, K., Beckett, C., Kallitsoglou, A., Doolan, M., & Ford, T. (2012). Should parenting programmes to improve children's life chances address child behaviour, reading

skills, or both? Rationale for the Helping Children Achieve trial. *European Journal of Developmental Psychology, 9*(1), 47-60. doi: 10.1080/17405629.2011.643172

Seay, A., Freysteinson, W. M., & McFarlane, J. (2014). Positive parenting. *Nursing Forum, 49*(3), 200-208. doi: 10.1111/nuf.12093

Sepa, A., Frodi, A., & Ludvigsson, J. (2004). Psychosocial correlates of parenting stress, lack of support and lack of confidence / security. *Scandinavian Journal of Psychology, 45*, 169-179. doi: 10.1111/j.1467-9450.2004.00392.x

Serbin, L. A., Cooperman, J. M., Peters, P. L., Lehoux, P. M., Stack, D. M., & Schwartzman, A. E. (1998). Intergenerational transfer of psychosocial risk in women with childhood histories of aggression, withdrawal, or aggression and withdrawal. *Developmental Psychology, 34*(6), 1246-1262.

Serbin, L. A., & Stack, D. (1998). Longitudinal studies of intergenerational continuity and the transfer of psychosocial risk [special section]. *Developmental Psychology, 34*(6), 1159.

Shapiro, C. J., Prinz, R. J., & Sanders, M. (2010). Population-based provider engagement in delivery of evidence-based parenting interventions: Challenges and solutions. *Journal of Primary Prevention, 31*, 223-234. doi: 10.1007/s10935-010-0210-z

Shaw, D. S., Owens, E. B., Giovannelli, J., & Winslow, E. B. (2001). Infant and toddler pathways leading to early externalizing disorders. *Journal of American Academy of Child and Adolescent Psychiatry, 40*(1), 36-43. doi: 10.1097/00004583-200101000-00014

Sher, J. (2016). *Missed periods: Scotland's opportunities for better pregnancies, healthier parents and thriving babies the first time . . . and every time A primer on preconception health, education and care* (pp. 45). Glasgow, Scotland: NHS Greater Glasgow and

Clyde (Public Health). Available at: www.nhsggc.org.uk/media/237840/missed-periods-j-sher-may-2016.pdf.

Sher, J. (2017). Making preconception health, education and care real. *International Journal of Birth and Parenting Education, 4*(4), 5.

Shirani, F., Henwood, K., & Coltart, C. (2011). Meeting the challenges of intensive parenting culture: Gender, risk management and the moral parent. *Sociology, 46*(1), 25-40. doi: 10.1177/0038038511416169

Shonkoff, J. P., & Levitt, P. (2010). Neuroscience and the future of early childhood policy: Moving from why to what and how. *Neuron, 67*(5), 689-691. doi: 10.1016/j.neuron.2010.08.032

Shorr, S. I. (1981). *The development and evaluation of a primary preventive parent education program for high school students.* (Doctoral dissertation), DePaul University, Ann Arbor. Retrieved from https://elibrary.ru/item.asp?id=7336065 ProQuest Dissertations & Theses A&I database.

Shulman, C. (2016). *Research and practice in infant and early childhood mental health*. Switzerland: Springer International Publishing. doi 10.1007/978-3-319-31181-4.

Shulruf, B., O'Loughlin, C., & Tolley, H. (2009). Parenting education and support policies and their consequences in selected OECD countries. *Children and Youth Services Review, 31*, 526-532. doi: 10.1016/j.childyouth.2008.10.010

Simons, R. L., Whitbeck, L. B., Conger, R. D., & Wu, C. I. (1991). Intergenerational transmission of harsh parenting. *Developmental Psychology, 27*, 159.

Skrypnek, B. J. (2008). Do parent education programs make a difference? *Family Connections, 12*(4), 4.

Smith, C. A., Cudaback, D. J., Goddard, H. W., & Myers-Walls, J. A. (1994). *National extension parent education model*. Manhattan, KS: Kansas Cooperative Extension Service.

Smith, P. B., Brown, J., Feldgaier, S., & Lee, C. M. (2015). Supporting parenting to promote children's social and emotional well-being. *Canadian Journal of Community Mental Health, 34*(4), 129-142. doi: 10.7870/cjcmh-2015-013

Smythe, S. (2004). Understanding family support programs. *Perspectives, 1*(1), 5-14.

Sommer, K., Whitman, T. L., Borkowski, J. G., Schellenbach, C., Maxwell, S., & Keogh, D. (1993). Cognitive readiness and adolescent parenting. *Developmental Psychology, 29*(2), 389-398.

Spiteri, G., Borg Xuereb, R. B., Carrick-Sen, D., Kaner, E., & Martin, C. R. (2014). Preparation for parenthood: A concept analysis. *Journal of Reproductive & Infant Psychology, 32*(2), 148-162. doi: 10.1080/02646838.2013.869578

Statistics Canada. (2013). *National Household Survey Focus on Geography Series-Manitoba*. Retrieved August 29, 2017 http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=2&GeoCode=46

Steinberg, L., & Morris, A. S. (2001). Adolescent development. *Annual Review of Psychology, 52*(1), 83-110. doi: 10.1146/annurev.psych.52.1.83

Steiner, A. M., Koegel, L. K., Koegel, R. L., & Ence, W. A. (2012). Issues and theoretical constructs regarding parent education for autism spectrum disorders. *Journal of Autism Development Disorders, 42*, 1218-1227. doi: 10.1007/s10803-011-1194-0

Stephenson, J., Heslehurst, N., Hall, J., Schoenaker, D. A. J. M., Hutchinson, J., Cade, J. E., . . . Mishra, G. D. (2018). Before the beginning: Nutrition and lifestyle in the preconception

period and its importance for future health. *Lancet, 391*, 1830-1841. doi: http://dx.doi.org/10.1016/S0140-6736(18)30311-8

Stewart-Brown, S. (2008). Improving parenting: The why and how. *Arch Dis Child, 93*(2), 102-104. doi: 10.1136/adc.2006.113522

Stolz, H. E., Vargas, L., Clifford, L. M., Gaedt, H. A., & Garcia, C. F. (2010). Evaluating "Parent Project": A multi-site inquiry. *Family Science Review, 15*(1), 2-12.

Stranger Hunter, M. (2017). Would you like to become pregnant in the next year? The one key question initiative in the United States. *International Journal of Birth Parenting Education, 4*(4), 1-4.

Streissguth, A. P., Bookstein, F. L., Barr, H. M., Sampson, P. D., O'Malley, K., & Kogan Young, J. (2004). Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects. *Journal of Developmental and Behavioral Pediatrics, 25*(4), 228-238.

Sumargi, A., Sofronoff, K., & Morawska, A. (2014). Evaluation of a brief format of the Triple P-Positive Parenting Program: A pilot study with Indonesian parents residing in Australia. *Behaviour Change, 31*(02), 144-158. doi: 10.1017/bec.2014.7

Super, D. E. (1980). A life-span, life-space approach to career development. *Journal of Vocational Behaviour, 16*, 282-298.

Svensson, J., Barclay, L., & Cooke, M. (2008). Effective antenatal education: Strategies recommended by expectant and new parents. *Journal of Perinatal Education, 17*(4), 33-42. doi: 10.1624/105812408X364152

Sweeny, K., Carroll, P. J., & Shepperd, J. A. (2006). Is optimism always best? Future outlooks and preparedness. *Current Directions in Psychological Science, 15*(6), 302-306. doi: 10.1111/j.1467-8721.2006.00457.x

Tani, F., Pascuzzi, D., & Raffagnino, R. (2017). The relationship between perceived parenting style and emotion regulation abilities in adulthood. *J Adult Dev, 25*(1). doi: 10.1007/s10804-017-9269-6

Taylor, J., Spencer, N., & Baldwin, N. (2000). Social, economic, and political context of parenting. *Arch Dis Child, 82*(2), 113-120. doi: 10.1136/adc.82.2.113

Teti, D. M., & Gelfand, D. M. (1991). Behavioural competence among mothers of infants in the first year: The mediational role of maternal self-efficacy. *Child Dev, 62*(5), 918-929.

Thomas, B., & Bhugra, D. (2014). Preparation for parenthood programme: Experiences from southern India. *International Review of Psychiatry, 26*(4), 493-499. doi: 10.3109/09540261.2014.924097

Trivette, C. M., & Dunst, C. J. (2014). Parenting skills: Community-based parent support programs. *Encyclopedia on Early Childhood Development* (Online ed.). Montreal, Quebec: Centre of Excellence for Early Childhood Development and Strategic Knowledge Cluster on Early Child Development.

Trochim, W. M. K. (1989). An introduction to concept mapping for planning and evaluation. *Eval Program Plann, 12*(1), 1-16. doi: 10.1016/0149-7189(89)90016-5

Trochim, W. M. K., Milstein, B., Wood, B. J., Jackson, S., & Pressler, V. (2004). Setting objectives for community and systems change: An application of concept mapping for planning a statewide health improvement initiative. *Health Promotion Practice, 5*(1), 8-19. doi: 10.1177/1524839903258020

Trocmé, N. M., Tourigny, M., MacLaurin, B., & Fallon, B. (2003). Major findings from the Canadian incidence study of reported child abuse and neglect. *Child Abuse Negl, 27*, 1427-1439. doi: 10.1016/j.chiabu.2003.07.003

Tugut, N., Tirkes, D., & Demirel, G. (2015). Preparedness of pregnant women for childbirth and the postpartum period: Their knowledge and fear. *Journal of Obstetrics and Gynaecology, 35*, 336-340. doi: 10.3109/01443615.2014.960375

Twentyman, C. T., & Plotkin, R. C. (1982). Unrealistic expectations of parents who maltreat their children: An educational deficit that pertains to child development. *Journal of Clinical Psychology, 38*(3), 497-503.

Underdown, A., & Barlow, J. (2012). Promoting infant mental health: A public health priority and approach. In L. Miller & D. Hevey (Eds.), *Policy issues in the early years* (pp. 45-60). Washington, DC: SAGE.

Utting, D. (2007). *Parenting and the different ways it can affect children's lives: Research evidence* (pp. 16). York: Joseph Rowntree Foundation.

Valdes-Vasquez, R., & Klotz, L. E. (2014). Using the concept-mapping method for empirical studies in construction research. *Journal of Construction Engineering Management*. doi: 10.1061/(asce)co.1943-7862

Vaughn, L. M., Jacquez, F., & McLinden, D. (2013). The use of concept mapping to identify community-driven intervention strategies for physical and mental health. *Health Promot Pract, 14*(5), 675-685. doi: 10.1177/1524839912462871

Vaughn, L. M., Jones, J. R., Booth, E., & Burke, J. G. (2017). Concept mapping methodology and community-engaged research: A perfect pairing. *Eval Program Plann, 60*, 229-237. doi: 10.1016/j.evalprogplan.2016.08.013

Venator, J., & Reeves, R. (2015). *The implications of inequalities in contraception and abortion*. Washinton, DC: Brookings Institution. Retrieved from

https://www.brookings.edu/blog/social-mobility-memos/2015/02/26/the-implications-of-inequalities-in-contraception-and-abortion/.

Verbiest, S., Kiko Malin, C., Drummonds, M., & Kotelchuck, M. (2016). Catalyzing a reproductive health and social justice movement. *Matern Child Health J, 20*, 741-748. doi: 10.1007/s10995-015-1917-5

Volmert, A., Kendall-Taylor, N., Cosh, I., & Lindland, E. (2016). *Cuing context: Mapping the gaps between expert and public understandings of effective parenting in Australia*. Washington, DC: FrameWorks Institute.

Waldfogel, J., & Washbrook, E. (2011). Early years policy. *Child Development Research, 2011*, 12. doi: 10.1155/2011/343016

Walker, R. E., Jones, J. R., & Burke, J. G. (2014). Concept mapping for community perceptions. In J. G. Burke & S. M. Albert (Eds.), *Methods for community public health research: Integrated and engaged approaches.* (pp. 171-194). New York, NY: Springer Publishing Company.

Wang, L., Wang, Y., & Wang, L. (2017). *Practice and research of parent education: Review and prospect*. Paper presented at the International Conference on Modern Education and Social Sciences, China. Retrieved from http://www.dpi-proceedings.com/index.php/dtssehs/article/view/12162.

Wang, M. T., & Sheikh-Khalil, S. (2014). Does parental involvement matter for student achievement and mental health in high school? *Child Dev, 85*(2), 610-625.

Ward, H., Brown, R., & Westlake, D. (2012). Introduction. In R. Brown, D. Westlake & H. Ward (Eds.), *Safeguarding babies and very young children from abuse and neglect.* London: Jessica Kingsley Publishers.

Waylen, A., & Stewart-Brown, S. (2010). Factors influencing parenting in early childhood: a prospective longitudinal study focusing on change. *Child: Care, Health and Development, 36*(2), 198-207. doi: 10.1111/j.1365-2214.2009.01037.x

Webster-Stratton, C., & Taylor, T. (2001). Nipping early risk factors in the bud: Preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at young children (0-8 years). *Prevention Science, 2*(3), 165-192. doi: 10.1023/A:1011510923900

Wei, Y., & Kutcher, S. (2011). Comprehensive school mental health: An integrated "school-based pathway to care" model for Canadian secondary schools. *McGill Journal of Education, 46*(2), 213-229. doi: 10.7202/1006436ar

Weller Meyer, B., Jain, S., & Canfield-Davis, K. (2011). The effect of parenthood education on self-efficacy and parent effectiveness in an alternative high school student population. *The Professional Counselor: Research and Practice, 1*(1), 29-40.

Wheeldon, J., & Faubert, J. (2009). Framing experience: Concept maps, mind maps, and data collection in qualitative research. *International Journal of Qualitative Methods, 8*(3), 68-83. doi: 10.1177/160940690900800307

Whitman, T. L., Borkowski, J. G., Keogh, D. A., & Weed, K. (2001). *Interwoven lives: Adolescent mothers and their children*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Whittaker, K. A., & Cowley, S. (2012). An effective programme is not enough: A review of factors associated with poor attendance and engagement with parenting support programmes. *Children & Society, 26*(2), 138-149. doi: 10.1111/j.1099-0860.2010.00333.x

Whittle, S., Simmons, J. G., Dennison, M., Vijayakumar, N., Schwartz, O., Yap, M. B. H., . . . Allen, N. B. (2014). Positive parenting predicts the development of adolescent brain structure: A longitudinal study. *Developmental Cognitive Neuroscience, 8*(0), 7-17. doi: 10.1016/j.dcn.2013.10.006

Widding, U. (2011). Problematic parents and the community parent education: Representations of social class, ethnicity, and gender. *Journal of Feminist Family Therapy, 23*(1), 19-38. doi: 10.1080/08952833.2011.548701

Williams, P., Barclay, L., & Schmied, V. (2004). Defining social support in context: A necessary step in improving research, intervention, and practice. *Qualitative Health Research, 14*(7), 942-960. doi: 10.1177/1049732304266997

Wilson, K., Barakat, M., Vohra, S., Ritvo, P., & Boon, H. (2008). Parental views on pediatric vaccination: The impact of competing advocacy coalitions. *Public Understanding of Science, 17*(2), 231-243. doi: 10.1177/0963662506067662

Winter, L., Morawska, A., & Sanders, M. (2012). The Knowledge of Effective Parenting Scale (KEPS): A tool for public health approaches to universal parenting programs. *Journal of Primary Prevention, 33*, 85-97. doi: 10.1007/s10935-012-0268-x

Zahn-Waxler, C., Duggal, S., & Gruber, R. (2002). Parental psychopathology. In M. H. Bornstein (Ed.), *Handbook of parenting: Social conditions and applied parenting* (2nd ed., Vol. 4, pp. 295-327). Mahwah, NJ: Lawrence Erlbaum Associates.

Zepeda, M., Varela, F., & Morales, A. (2004). Promoting positive parenting practices through parenting education. In N. Halfon, T. Rice & M. Inkelas (Eds.), *Building State Early Childhood Comprehensive Systems Series, No. 13* (pp. 1-40): National Center for Infant and Early Childhood Health Policy. Retrieved from https://eric.ed.gov/?id=ED496804.

Zoline, S. S., & Jason, L. A. (1985). Preventive parent education for high school students. *Journal of Clinical Child Psychology, 14*(2), 119.

## Appendix A: ENREB Approval

UNIVERSITY OF MANITOBA | Research Ethics and Compliance

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Email: humanethics@umanitoba.ca

PROTOCOL APPROVAL

**TO:** **Candace Bergeson** **(Advisor: Charlotte Enns)**
Principal Investigator

**FROM:** **Zana Lutfiyya, Chair**
Education/Nursing Research Ethics Board (ENREB)

**Re:** **Protocol #E2016:067 (HS19814)**
**"What can be done in Manitoba to prepare people for parenting?"**

**Effective:** February 22, 2017 **Expiry:** February 22, 2018

**Education/Nursing Research Ethics Board (ENREB)** has reviewed and approved the above research. ENREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.*

This approval is subject to the following conditions:

1. Approval is granted only for the research and purposes described in the application.
2. Any modification to the research must be submitted to ENREB for approval before implementation.
3. Any deviations to the research or adverse events must be submitted to ENREB as soon as possible.
4. This approval is valid for one year only and a Renewal Request must be submitted and approved by the above expiry date.
5. A Study Closure form must be submitted to ENREB when the research is complete or terminated.
6. The University of Manitoba may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans.*

**Funded Protocols:**
- **Please mail/e-mail a copy of this Approval, identifying the related UM Project Number, to the Research Grants Officer in ORS.**

## Appendix B: List of Possible Participants

| Organization | Name and Contact Information Available |
|---|---|
| Parent Child Coalitions | Provincial Coordinator & Parent Child Coalitions |
| Families First | Provincial Coordinator |
| Nobody's Perfect | Provincial Coordinator |
| Healthy Baby Community Support | Provincial Coordinator |
| Crime Prevention | Provincial Coordinator |
| Early Childhood Development | Program and Policy Consultant |
| Triple P Parenting | Provincial Coordinator |
| FASD Strategy | Program Directors |
| Metis Child and Family Service Authority | Contact CEO |
| First Nations of Southern Manitoba Child and Family Service Authority | Contact CEO |
| First Nations of Northern Manitoba Child and Family Service Authority | Contact CEO |
| General Child and Family Service Authority | Contact CEO |
| Manitoba Childcare Association | Executive Director |
| Family Resource Centres | Family Resource Centres |
| United Way – Family Resource Centres | CEO of United Way Winnipeg |
| Manitoba Association of Newcomers | Director |

**Appendix C: Email sent as Invitation to Participate to Administrator Group**


Research Project Title: What Can Be Done in Manitoba to Prepare People for Parenting?
Principal Investigator and contact information: Candace Bergeson
Research Supervisor and contact information: Dr. Enns

My name is Candace Bergeson and I am a doctoral student at the University of Manitoba, Winnipeg, Canada. This letter is a request for assistance with a research project I am conducting as part of my Doctoral degree at the University of Manitoba, Winnipeg. I would like to provide you with more information about this project that explores what could be done to in Manitoba to help people prepare for parenting.

The purpose of this study is to develop a framework for preparing people for parenting. Knowledge and information generated from this study may help other researchers, policy and program planners, community service providers, and most importantly – parents.

You are being invited to participate because of your knowledge of the needs of parents and of the supports and services available for parents in Manitoba. Although I am contacting you because of your role within [name of organization], I want to clearly state that I am asking you to share your views as an individual and not as an employee of [name of organization].

All records of the research will be kept confidential and only the researcher will know who has taken part in the study. If you chose to participate you will be assigned a code number by my research assistant ensuring your responses will not be linked with your name.

In this research, I will use The Concept System Global MAX $^{TM}$ software, a concept mapping online tool, to gather, combine, and visually present responses. Involvement in my research study will involve online tasks that will occur within approximately a four-month time frame. Although it would be appreciated if you could participate in each activity, I recognize that may not be possible. You can participate in one, two, or three of the activities and for each activity there is an honorarium recognizing your time and effort in the form of an online gift card that can be accessed with your code number following the close of the online forum. There is no remuneration for Task 3 (Reflection) although your thoughts and reflections on the results and your experience as a participant would be highly valued. I have outlined the tasks, the estimated time to complete the task, the timeframe to complete the task, and the remuneration (honorarium) for each task in the table below.

| Task | Time on Task | Time Frame for Task | Gift Card |
|---|---|---|---|
| **Task One - Brainstorming**<br>- answer non-identifying demographic questions<br>- generate responses to the focus prompt | 10 - 15 minutes | 2 weeks | $10 |
| **Researcher Activity – Create Statement List** | | 1 week | |
| **Task Two Part 1 – Sorting**<br>- group statements into similar ideas, label groups | 45 - 60 minutes | 3 weeks | $25 |
| **Task Two Part 2 – Rating**<br>- rate statements on importance and feasibility | 20 – 30 minutes | | $15 |
| **Researcher Activity – Analyze and Summarize** | | 8 weeks | |
| **Task Three – Reflection**<br>- watch webinar explaining and summarizing results<br>- share reflections on results and your experience as a participant in the outline provided | 60 minutes | 2 weeks | |
| **TOTAL** | **135 – 165 minutes** | **16 weeks** | **$50** |

Additionally, because of your leadership position within [name of organization] I would like to request your assistance in helping me reach direct service providers and parents involved with your organization. This would involve arranging for the distribution of an *Invitation to Participate to Service Providers* letter to people in your organization that work directly with parents indicating that you are passing my invitation on and not making the request for participation through you or your workplace. It would also involve arranging for the distribution of an *Invitation to Participate to Parents* flyer to people in your organization to post in their facility.

If you are interested in participating, please reply to this email. I will then send you a consent to participate form, additional information regarding approximate start dates, and forms to forward if you have agreed to assist me with distribution. There are no consequences if you choose not to take part in this study. If you require further information, please call me or send me an email with your questions. I would like to recruit 30 people in each participant group.

| Participation Options |
|---|
| I am willing to take part in this study. |
| I am willing to send an invitation to participate to people who work in my organization. |
| I am willing to send the parent invitation flyer to people who work within my organization. |

This study has been approved by the Education Nursing Research Ethics Board. If you have question, concerns or complaints about this project, you may contact the Human Ethics Coordinator (HEC).

Thank you for reviewing my request for your participation and assistance in this study.

Sincerely,
Candace Bergeson, MA, Doctoral Candidate

## Appendix D: Email sent as Invitation to Participate in Service Provider Group

UNIVERSITY OF MANITOBA

Research Project Title: What Can Be Done in Manitoba to Prepare People for Parenting?
Principal Investigator and contact information: Candace Bergeson
Research Supervisor and contact information: Dr. Enns

My name is Candace Bergeson and I am a doctoral student at the University of Manitoba, Winnipeg, Canada. I am presently working on my doctoral dissertation that will complete the requirements of this degree.

You are invited to participate in research that will explore what can be done in Manitoba to prepare people for parenting. As a person who has worked with parents you have information and experience that will help answer this research question.

In this research, I will use The Concept System Global MAX ™ software, a concept mapping online tool, to gather, combine, and visually present responses. Involvement in my research study will involve online tasks that will occur within approximately a four-month time frame. I have outlined the tasks, the estimated time to complete the task, the timeframe to complete the task, and the remuneration (honorarium) for each task in the table below.

| **Task** | **Time on Task** | **Time Frame for Task** | **Gift Card** |
|---|---|---|---|
| **Task One - Brainstorming**<br>- answer non-identifying demographic questions<br>- generate responses to the focus prompt | 10 - 15 minutes | 2 weeks | $10 |
| **Researcher Activity – Create Statement List** | | 1 week | |
| **Task Two Part 1 – Sorting**<br>- group statements into similar ideas, label groups | 45 - 60 minutes | 3 weeks | $25 |
| **Task Two Part 2 – Rating**<br>- rate statements on importance and feasibility | 20 – 30 minutes | | $15 |
| **Researcher Activity – Analyze and Summarize** | | 8 weeks | |
| **Task Three – Reflection**<br>- watch webinar explaining and summarizing results<br>- share reflections on results and your experience as a participant in the outline provided | 60 minutes | 2 weeks | |
| **TOTAL** | **135 – 165 minutes** | **16 weeks** | **$50** |

Although it would be appreciated if you could participate in each activity, I recognize that may not be possible. You can participate in one, two, or three of the activities and for each activity there is an honorarium recognizing your time and effort in the form of an online gift card that will be sent to you following the close of the online forum. There is no honorarium or remuneration for Task 3 (Reflection) although your thoughts and reflections on the results and your experience as a participant would be highly valued.

All records of the research will be kept confidential and only the researcher will know who has taken part in the study. If you chose to participate you will be assigned a code number by my research assistant ensuring your responses will not be linked with your name.

If you are interested in participating, please reply to this email. I will then send you a consent to participate form and additional information regarding approximate start dates. There will be no negative consequences for you or your place of employment if you choose not to participate. If you require further information, please call me or send an email with your questions. I would like to recruit 30 people.

This study has been approved by the Education Nursing Research Ethics Board. If you have question, concerns or complaints about this project, you may contact the Human Ethics Coordinator (HEC).

Thank you for reviewing my request for your participation in this study.

Sincerely,
Candace Bergeson, MA, Doctoral Candidate

## Appendix E: Flyer sent as Invitation to Participate in the Parent / Caregiver Group


What can be done in Manitoba to help people prepare for parenting?

Dear Parent and Caregiver,

My name is Candace Bergeson and I am asking you to participate in a research project that will bring together ideas about what people think can be done to help people prepare for parenting. **YOUR** perspective as a Parent and Caregiver is critical in helping me understand what is needed and what is possible.

I understand as Parents and Caregivers, you have very little free time to participate in a research study. I am doing all my research through an online forum to allow people to participate from their own home, at a time that works for them. Participating in my research project will involve online tasks that will occur within approximately a four-month time frame. I have outlined the tasks, the estimated time to complete the task, the timeframe to complete the task, and the remuneration (honorarium) for each task in the table below.

| **Task** | **Time on Task** | **Time Frame for Task** | **Gift Card** |
|---|---|---|---|
| **Task One - Brainstorming**<br>- answer non-identifying demographic questions<br>- generate ideas/responses to the focus prompt | 10 - 15 minutes | 2 weeks | $10 |
| **Researcher Activity – Create Statement List** | | 1 week | |
| **Task Two Part 1 – Sorting**<br>- group statements into similar ideas, label groups | 45 - 60 minutes | 3 weeks | $25 |
| **Task Two Part 2 – Rating**<br>- rate statements on importance and feasibility | 20 - 30 | | $15 |
| **Researcher Activity – Analyze and Summarize** | | 8 weeks | |
| **Task Three – Reflection**<br>- watch webinar explaining and summarizing results<br>- share reflections on results and your experience as a participant in the outline provided | 60 minutes | 2 weeks | |
| **TOTAL** | **135 – 165 minutes** | **16 weeks** | **$50** |

To ensure the privacy of all people who participate you will be given a Code number when you sign the Consent to Participate form.

Although it would be appreciated if you could participate in each activity, I recognize that may not be possible. You can participate in one, two, or three of the activities and for each activity

there is an honorarium recognizing your time and effort in the form of an online gift card that will be sent to you following the close of the online forum. There is no honorarium or remuneration for Task 3 (Reflection) although your thoughts and reflections on the results and your experience as a participant would be highly valued.

Interested Parents and Caregivers are invited to call Candace Bergeson (Principle Researcher) if you are interested in participating or would like to find out more information. I would like to recruit 30 people.

This study has been approved by the Education Nursing Research Ethics Board. If you have question, concerns or complaints about this project, you may contact the Human Ethics Coordinator (HEC).

Principal Investigator: Candace Bergeson
Research Supervisor: Dr. Enns

## Appendix F: Consent Letter


Research Project Title: What Can Be Done in Manitoba to Prepare People for Parenting?
Principal Investigator and contact information: Candace Bergeson
Research Supervisor and contact information: Dr. Enns

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully.

I am a doctoral student in the Faculty of Education, University of Manitoba and as part of my program I need to complete a research project. The purpose of this research project is to ask parents and people that work in organizations that provide services for parents, what they think can be done to prepare people for parenting. The collective experience will be used to create a framework of what could be done in Manitoba to prepare people for parenting. Additionally, the results of this research will be used as a part of my doctoral dissertation and may be publically presented in the form of a workshop, oral presentation, or published article.

Participation in my research study will involve online tasks that will be available for you to complete over approximately a four-month time frame.

**Task One:** I will send you a link to the online forum where you will enter your code. You will then be asked some non-identifying demographic questions (e.g., age). Next you will be asked to brainstorm ideas in response to the following focus prompt, "*To help people prepare for parenting, a specific service, support, or action would be . . .*". The brainstorming task typically takes between 10 and 15 minutes to complete and will be open for a two-week time frame. To thank you for your time and recognize your effort I would like to offer you a $10 online gift card for participating in the Brainstorming task.

**Task Two:** I will send you a link telling you that the second task is open online and available for you to complete within a three-week time frame. There are two parts to this second task. The first is the sorting activity where you will be asked to sort the statements into groups based on how you think they go together and name each of the groups you have created. The sorting activity usually takes about 45 to 60 minutes to complete. To thank you for your time and recognize your effort I would like to offer you a $25 online gift card for participating in the sorting activity.

The second part of Task Two is called rating. You will be asked to look at each of the statements in the list and rate them on how important and how feasible you think they are related to the

focus prompt (i.e., preparing people for parenting). The rating activity usually takes about 20 - 30 minutes to complete. To thank you for your time and recognize your effort I would like to offer you a $15 online gift card for participating in the rating activity.

**Task Three:** I will send you a link telling you that the third task is open online and available for you to access within a one-month time frame. You will be invited to watch a narrated PowerPoint® presentation where I will share the results of the study with you. You will have a chance to review the concept maps, see if they fit with your lived experiences, and provide your thoughts on the results. You will also be invited to provide feedback about your experience as a participant in this research project (a guided reflection workbook will be sent as an email attachment). The webinar will be about 30 minutes and it is expected that the time spent providing feedback will be about 15 minutes. Although I am not offering an honorarium for this final task, your thoughts and reflections on this project would be greatly appreciated.

There will be minimal risk in taking part in this study. Many participants in research studies of this nature find it interesting to be involved in a dialogue about parenting and value the opportunity to share their experiences.

The student researcher (Candace Bergeson) will not have access to your responses to the tasks. You will be assigned a code by my research assistant that you will use in all the online tasks. All records of the research will be kept confidential. I will keep all anonymized data separate from materials that have participant contact information by storing each in a separate locked file cabinet drawer at my home office. I will do everything possible to maintain your confidentiality but because I am using the internet to collect information, there is a chance that confidentiality cannot be fully protected. Nothing will be written in the final report that could in any way identify a particular participant. All electronic data will be protected by a password. All hard copy information will be kept in a locked filing cabinet at my home office. At the end of successfully completing and defending my dissertation, data will be disposed of in the following manner; electronic files will be deleted and hard copies of participant information will be shredded.

You will be sent by email a summary of the results of the concept mapping process.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate. In no way does this waive your legal rights nor release the researcher, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. There will be no repercussions for you or your place of employment. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Education Nursing Research Ethics Board. If you have concerns or complaints about this project, you may contact the Human Ethics Coordinator (HEC). A copy of this consent form has been given to you to keep for your records and reference.

Your participation in this study is appreciated.

Participant's name: _____

Participant email address to forward links to online forum and links to online gift cards:

_____

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

This consent form can be returned by scanning and emailing it to me or I can send you an addressed stamped envelope if you prefer to return it by mail. I will then add my signature and send you back a final copy for your records.

Sincerely,
Candace Bergeson, MA, Doctoral Candidate

## Appendix G: Demographic Questions Online


Please take a few moments to answer these general questions. You have the right to decline to answer any of the questions with no negative consequences. You can still participate even if you prefer not to answer these questions. Thank you for your time.

1. Are you participating in this study as a(n)?
   - Parent
   - Service Provider
   - Administrator

2. How would you describe where you live?
   - Rural Manitoba
   - Northern Manitoba
   - Urban Manitoba

3. What is your age?
   - 18 – 24 years
   - 25 – 34 years
   - 35 – 44 years
   - 45 – 54 years
   - 55 years or older

4. What is the highest degree or level of school you have completed?
   - Some high school, no diploma
   - High school graduate or equivalent (for example GED)
   - Some college or university, no degree
   - A college diploma
   - A university degree

5. What is your total annual household income (approximately)?
   - Less than $25,000
   - $25,000 - $49,999
   - $50,000 - $74,999
   - $75,000 - $99,999
   - Above $100,000

## Appendix H: ENREB Amendment Approval

UNIVERSITY OF MANITOBA | Research Ethics and Compliance

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Email: humanethics@umanitoba.ca

**AMENDMENT APPROVAL**

May 12, 2017

**TO:** **Candace Bergeson** **(Advisor: Charlotte Enns)**
Principal Investigator

**FROM:** **Zana Lutfiyya, Chair**
Education/Nursing Research Ethics Board (ENREB)

**Re:** **Protocol #E2016:067 (HS19814)**
**"What can be done in Manitoba to prepare people for parenting?"**

---

**Education/Nursing Research Ethics Board (ENREB)** has reviewed and approved your Amendment Request received on **May 12, 2017** to the above-noted protocol. ENREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

This approval is subject to the following conditions:

1. Approval is given for this amendment only. Any further changes to the protocol must be reported to the Human Ethics Coordinator in advance of implementation.
2. Any deviations to the research or adverse events must be submitted to ENREB as soon as possible.
3. Amendment Approvals do not change the protocol expiry date. Please refer to the original Protocol Approval or subsequent Renewal Approvals for the protocol expiry date.

## Appendix I: Task One - Brainstorming Email and Online Instructions


Subject: What can be done in Manitoba to prepare people for parenting? Please Contribute Your Knowledge!

Welcome,

I am writing to thank you for agreeing to participate in this study and to provide you with additional information about my research.

The goal of this project is to identify strategies that could be used to prepare people for parenting. These strategies may include specific ideas related to education, skill-building, program development, social and emotional support, employment demands/supports, or government policies. I am interested in what you think could be done to help people prepare for parenting. Your participation in all aspects of this activity is voluntary and your responses will be kept confidential.

I would like to invite you to participate in the first part of the process called brainstorming. It should take only about 10 to 15 minutes.

I am inviting parents and people who work in organizations that provide services to parents to take part in answering the following focus prompt:

***"To help people prepare for parenting, a specific service, support or action would be ..."***

Please submit your ideas using your **assigned username** and **password** at the following web page:
http://conceptsystemsglobal.com/PreparedForParenting/brainstorm

Shortly after the close of brainstorming, I will contact you with additional information about the second phase of data collection.

Questions? If you have any questions about the project, please do not hesitate to contact me.

Sincerely,
Candace Bergeson, MA, Doctoral Candidate

## Online Brainstorming Instructions

This link [http://conceptsystemsglobal.com/PreparedForParenting/brainstorm] will lead you to the online forum where you will be asked to insert your username and password. Enter the **username** and **password** that were sent to you (**do not use your email or your name**). Both the username and password are case sensitive.

Once you have logged-in, you will be asked to provide your consent that you are willing to participate in the project. This indicates that you are willing to participate in the online forum and is standard for concept mapping software.

You will then be taken to the project homepage where you will find links to each of the following activities:

- Participant Questions
  You will be asked to answer 5 non-identifying Participant Questions that will help organize and analyze the data. You can answer as many or as few of the questions as you are comfortable answering.

- Brainstorming Statements - - Enter as many ideas as you can. You can log back on to the site and add additional ideas any time during the two-week period.

## Appendix J: Brainstormed Statements

| | |
|---|---|
| 1 | To pay appropriately for those working in Family Resource Centres. Good quality and educated staff equals good quality support for parenting families. |
| 2 | Make sure that the most basic of needs are met for all parenting families. Shelter, food, etc. are critical to allow for good parenting. |
| 3 | Better dissemination of the supports and services that already exist for parents. |
| 4 | Parent support groups to generate and share parenting strategies. |
| 5 | Mandatory bi-weekly visits to doctor, public health nurse, or nurse practitioner for first 3 months of child's life. |
| 6 | Parenting mentors need to have knowledge about child development, parenting strategies, and how to talk with new parents. |
| 7 | Help people understand that parenting has a greater impact on society than anything else. |
| 8 | Find ways to raise the value placed on the work parents do. |
| 9 | Lobby the government to place real value on kids by increasing the support for parents and children. |
| 10 | Spread the message that parenting is learned and we all need to learn how to parent. |
| 11 | Increase public awareness of the critical, sensitive, and important nature of a child's first three years of life. |
| 12 | Increase public awareness of the critical and valuable role of parents. |
| 13 | Reduce shame and blame so people ask for help. |
| 14 | Every new parent should be assigned a parent mentor. |
| 15 | Parenting classes should be appropriate for everyone - considering different cultural parenting styles. |
| 16 | Parenting classes should be added to college and university courses. |
| 17 | Parenting classes should be taken by everyone in high school. |
| 18 | Finding a way to help parents before things go wrong. |
| 19 | Finding a way to stop judging and blaming parents when things go wrong. |
| 20 | Having a trained parenting visitor come to the house to provide suggestions and information - not just having someone come to see if you are doing things wrong. |
| 21 | Having time off work to attend parenting classes. |
| 22 | Child care provided when you take parenting classes. |
| 23 | Workplaces should make parenting classes part of their employee assistance programs. |
| 24 | Having a parent mentor to talk to that doesn't judge you. |
| 25 | more breastfeeding resources, support groups, information readily available |
| 26 | information on attachment parenting |
| 27 | ideas on how to balance new baby and life/home |
| 28 | easy access to all available financial help in one resource |
| 29 | tips on proper nutrition after birth |
| 30 | Incorporating parenting supports into employee benefits |
| 31 | Public health visits from nurse/social work to help with parenting |

| | |
|---|---|
| 32 | Internet-based child development videos |
| 33 | Provide child development/child care courses in high school with exposure to real children |
| 34 | Public Health visits should include parenting strategies and classes as well as physical health |
| 35 | Expansion of Family's First programs for all parents (not just at risk/low income) |
| 36 | Have a centralized portal with access to all parenting services in one place. |
| 37 | Screen all Expectant parents for any services they may need (mental health, alcohol/drug issues/housing, etc.) and provide them. |
| 38 | Baby boxes like those given to all expectant parents in Finland |
| 39 | early child development classes in high school |
| 40 | additional support for day care |
| 41 | have advocates available for those who have open files with CFS |
| 42 | extra financial support |
| 43 | free parenting classes / support groups |
| 44 | Mandatory parenting classes for first-time parents for baby's first year. Then optional classes for the next few years. |
| 45 | Provincial mandated parenting classes in the High School Curriculum. Health Care professionals or elders supporting families on 1st Nation Reserves. |
| 46 | connect every parent with public health upon finding out they are pregnant. |
| 47 | a health care professional that checks in with the parents in person each month until baby and then every other week after birth until 2 months. |
| 48 | creating a website with short videos for new parents on every common question and experience of new parents. IE: first bath; infant feeding; prepping bottle; common health concerns etc. |
| 49 | giving families a resource list of community resources in their area that they can use for information, baby classes, social outlet and more. |
| 50 | Home visits by a professional to check in on planning and prep for the new baby as well as mom's mental and emotional health. |
| 51 | Providing free and easy available parenting classes to those that are pregnant both online and in person using a variety of learning styles. |
| 52 | Ensuring proper services or planning help is available when mothers have to leave their community to have their baby. Proper financial and emotional support needed. No support Sets the groundwork for future parenting issues. |
| 53 | More programs built in to curriculum in schools where actual parents and babies are brought in and interact with students. Share experiences and stories. |
| 54 | Extend PHN postpartum follow up after birth to at least two months. Include weekly baby weight checks, PPD checks, parenting and early development checks. |
| 55 | Include mandatory gender-neutral "economics" classes in high school. Sewing, cooking, income tax prep, laundry skills, etc. |

| | |
|---|---|
| 56 | Trained parent supports to visit new parents in hospital before discharged. Similar to having lactation consultants available. These trained parent supports could supply initial information new parents can take home so they can reach out if needed |
| 57 | Develop an easy access app with general information on child development, potty training, breath feeding, etc. or links to credible service websites |
| 58 | Extension of Families First program by two or three years. |
| 59 | Mandatory parenting courses for identified 'at risk' families |
| 60 | provide opportunity monthly parenting courses focusing on child development and parent education |
| 61 | Teaching parenting classes in high school. |
| 62 | Set up a parenting website that has information on all aspects of parenting. This could include an online forum or chat group. |
| 63 | Set up an online newsletter that all expectant parents are informed of through doctors, prenatal classes or info provided at the hospital that parents can sign up for to get parenting info |
| 64 | Advertise on TV, radio and social media with parenting tips as they do with driving tips. Ideas like no screen time for kids under two, read to your infant, toddler and child daily, take a deep breath and count to three before reacting etc. |
| 65 | Make child development or family studies classes mandatory in high school. |
| 66 | Provide monthly parenting classes much like prenatal classes are provided to provide parents with information on what to expect at the current stage of their child's development and in upcoming stages. |
| 67 | use web-based methods of providing information with young people - websites, Facebook pages, and any other ways to provide information about preparing for parenthood, attachment, etc. |
| 68 | Having permanent holistic family spaces that are developmentally appropriate & include research-based activities offered for children/infants/families around health, spiritual/cultural practices, play, etc. Including access to health care services. |
| 69 | Offer prenatal courses that include information on child development & best practices in infant/early years child care, i.e.: research based regarding sleep, eating, play, screen etc. Just so that families who are expecting are able to have general info |
| 70 | Include courses on child development, compulsory in High Schools, to increase understanding & realistic expectation on infant/child behaviour. |
| 71 | concentrate on resource centres rather than time-limited programs so that parents have a consistent place to seek advice, vent, learn and play. |
| 72 | to support the building of relationships among parenting service providers and families |
| 73 | additional child care spaces, support for choosing to stay at home parents, prenatal classes geared towards mental health & social emotional |
| 74 | local prenatal class locations, additional support (e.g. Healthy Baby), |
| 75 | additional funding for parenting programs (e.g. Healthy Child Parent Child Coalition), funding for stay at home parents, |
| 76 | Refer to Healthy baby programs throughout the province. |

| | |
|---|---|
| 77 | Have a support or mentoring program from other mothers. |
| 78 | That primary doctors (family and prenatal) or PHN refer parents to specific programs in their area as a prescription. Refer to parent-child Coalitions, Family resource centres in the area. |
| 79 | Increase support services to remote/rural/northern communities; such as, mental health, counselling, recreational programming, medical, educational, etc. Anything for parents to become involved in a positive way. |
| 80 | Have a number parents can call for support or ideas similar to health links. Support existing best beginnings programs already running. Run classes on bonding with babies. Increase support services to remote/rural/northern communities; such as, mental |
| 81 | Have a number parents can call for support or ideas similar to health links. |
| 82 | Run parent support programs that include meal prep together, time for parents to talk and support or include presentations of interest while kids are with a child minder. This would help build peer supports among parents and awareness of supports |
| 83 | Support existing best beginnings programs already running |
| 84 | Include information on child self-esteem and stages of development to help parents understand developmental stages. This could help with parental expectations for behaviour |
| 85 | Run classes on bonding with babies |
| 86 | Make PHN's, home visitors, and direct service staff be accountable to do a good job. Building framework to gain quality feedback from clients would be valuable. |
| 87 | Make a parenting course (with focus on mental health) a mandatory credit course for jr/sr high students. Not just part of a health class, but its OWN course. |
| 88 | Increase support services to remote/rural/northern communities; such as, mental health, counselling, recreational programming, medical, educational, etc. Anything for parents to become involved in a positive way. |
| 89 | Increase availability of prenatal classes to all communities. |
| 90 | mandatory parenting programs and other supports for families who are at risk or high risk. This could include those who have open files with CFS, RCMP, etc. |
| 91 | Parenting helpline/supports accessible by phone at all time |
| 92 | In-home support and mentoring throughout all stages of child-rearing |
| 93 | schools teach life skills like parenting and relationships |
| 94 | teach parenting to all people |
| 95 | parent mentors to support new parents |
| 96 | detailed feeding and sleeping guides provided by the hospital when baby is discharged |
| 97 | financial support for parents who chose to stay home to raise their children |
| 98 | easy access to high quality child care, and subsidies for low income families. |
| 99 | expanded parental leave for fathers. |
| 100 | secure maternity leave with 100% of income paid during leave for lowest income earners. |
| 101 | information on positive parenting and discipline. |
| 102 | information on the benefits of being as screen-free as possible. |

| | |
|---|---|
| 103 | programs for new fathers with male mentors and father-focused programming. |
| 104 | increased EIA payments for pregnant mothers to improve nutrition and quality of life during pregnancy and as a new mother. |
| 105 | consultation with low income, newcomer and/or Aboriginal parents will give you the most important answers to this question. Unfortunately, the medium by which you are collecting your data excludes those most vulnerable and most in need of support. |
| 106 | baby boxes to support and recognize parents. |

## Appendix K: Split/Edited List of Statements with Keywords and Code Word

| | Split / Edit Statement | Keywords | Code Word |
|---|---|---|---|
| 1 | Appropriate pay for those working with parents (e.g. Family Resource Centres). | Appropriate pay workers | Resources |
| 1a | Have good quality and educated staff to support parenting families. | Quality staff | Standards |
| 2 | Make sure the most basic of needs are met for all parenting families. | Basic needs | Resources |
| 3 | Increase awareness of the supports and services that already exist for parents. | Increase awareness | Information |
| 4 | Parent support groups where you can share parenting strategies. | Support groups | Support |
| 5 | Mandatory bi-weekly visits to the doctor, the public health nurse, or the nurse practitioner for the first 3 months of child's life. | Mandatory health visits | Support |
| 6 | Having parenting mentors who have knowledge about child development. | Mentors | Support |
| 6a | Having parenting mentors who have knowledge about parenting strategies. | Mentors | Support |
| 6b | Having parenting mentors who know how to talk with new parents. | Mentors | Standards |
| 7 | Increase society's understanding of the impact of parenting. | Impact of parenting | Information |
| 8 | Find ways to raise the value placed on the work parents do. | Find ways to raise value | Information |
| 9 | Lobby the government to increase support for parents and children. | Increase gov't support | Support |
| 10 | Promoting the message that parenting is learned and we all need to learn how to parent. | Parenting is learned | Education |
| 11 | To increase public awareness of the critical, sensitive, and important nature of a child's first 3 years of life. | Early years awareness | Information |
| 12 | To increase public awareness of the critical and valuable role of parents. | Increase awareness parent role | Information |
| 13 | To reduce the stigma parents feel when they ask for help with parenting. | Stigma | Non-judgemental |
| 14 | Assigning a parent mentor for every new parent. | Mentor | Support |
| 15 | Having parenting classes that are sensitive to varied cultural parenting styles. | Cultural differences | Access |
| 16 | Parenting classes added to college and university programs. | Classes post secondary | Education |
| 17 | Parenting classes taken by everyone in high school. | Classes high school | Education |

| | | | |
|---|---|---|---|
| 18 | To find ways to connect with parents before things go wrong. | Connect before | Connections |
| 19 | Supporting (not punishing) parents in times of crisis. | Support not punishment | Non-judgemental |
| 20 | Having a trained parenting visitor come to the house to provide suggestions and information. | Trained home visitors | Standards |
| 21 | Supported time off work to attend parenting classes. | Time off | Resources |
| 22 | Child care provided when you take parenting classes. | Child care | Resources |
| 23 | Workplaces making parenting classes part of their employee assistance programs. | Classes part of EAP | Resources |
| 24 | Non-judgemental parent mentors. | Non-judgemental | Non-judgemental |
| 25 | More breastfeeding resources. | Breastfeeding | Resources |
| 25a | More parent support groups. | Support groups | Support |
| 25b | Make parenting information readily available. | Available information | Information |
| 26 | Better availability of information on attachment parenting. | Attachment information | Information |
| 27 | Teaching people how to balance a new baby with the other demands of home and life. | Teach balance | Education |
| 28 | Easy access to all available financial help in one resource centre. | Access to financial help | Access |
| 29 | To provide all parents with tips on proper nutrition after baby's birth. | Tips baby's nutrition | Education |
| 30 | Incorporating parenting supports into employee benefits. | Parent supports | Resources |
| 31 | Public health visits from a nurse or social worker to help with parenting. | Public health visits | Support |
| 32 | Internet based child development videos. | Internet information | Education |
| 33 | To provide child development courses in high school with exposure to real children. | Courses high school | Education |
| 33a | To provide child care courses in high school with exposure to real children. | Courses high school | Education |
| 34 | Public health visits should include parenting strategies. | Public health strategies | Education |
| 34a | Public health services should include information about parenting classes. | Public health parent class | Information |
| 34b | Public health visits should include information about physical health. | Public health baby health | Education |
| 35 | Expansion of Family's First programs for all parents and not just parents identified as being at risk or who have a low income. | Programs for everyone | Access |

| | | | |
|---|---|---|---|
| 36 | Having a centralized portal with access to all parenting services in one place. | Central resource | Access |
| 37 | Screening all expectant parents for any services they may need including mental health, alcohol/drug issues, and housing, etc. | Screen for prenatal needs | Support |
| 37a | To provide all expectant parents with services they may need including mental health, alcohol/drug issues, and housing, etc. | Provide needed services | Support |
| 38 | To provide all expectant parents with baby boxes like those given to all expectant parents in Finland. | Baby boxes | Resources |
| 39 | To teach early child development classes in high school. | Classes high school | Education |
| 40 | Additional support for day care. | Day care | Resources |
| 41 | Having advocates available for those who have open files with CFS. | Advocates | Support |
| 42 | Extra financial support. | Financial support | Resources |
| 43 | Free parenting classes. | Free classes | Resources |
| 43a | Parenting support groups. | Support groups | Support |
| 44 | Mandatory parenting classes for first-time parents for baby's first year. | Classes mandatory | Education |
| 44a | Optional parenting classes for first-time parents after they have completed mandatory ones in the first year of their child's life. | Classes optional | Education |
| 45 | Provincially-mandated parenting classes in the high school curriculum. | Mandated classes high school | Education |
| 45a | Health care professionals or elders supporting families in First Nation Communities. | Support First Nations | Access |
| 46 | To connect every parent with Public Health upon finding out they are pregnant. | Public health prenatal | Support |
| 47 | Having a health care professional that checks in with the parents in person each month until baby is born. | Prenatal checks | Support |
| 47a | Having a health care professional that checks in with the parents in person every other week after the baby is born until 2 months. | Postnatal checks | Support |
| 48 | Creating a website with short videos for new parents on every common question and experience of new parents (e.g., first bath, infant feeding, prepping a baby bottle, common health concerns, etc.) | Online videos | Education |
| 49 | Giving families a list of community resources in their area where they can access information, baby classes, social connection, etc. | Resource list | Information |

| | | | |
|---|---|---|---|
| 50 | Home visits by a professional to check in on the planning and preparation for the new baby. | Prenatal home visits | Support |
| 50a | Home visits by a professional to check in on mom's mental and emotional health. | Postnatal home visits | Support |
| 51 | Providing free and easily available parenting classes online to those that are pregnant using a variety of learning styles. | Online classes | Education |
| 51a | Providing free and easily available parenting classes in person to those that are pregnant using a variety of learning styles. | In person classes | Education |
| 52 | Ensuring proper services and support (financial and emotional) are available when mothers have to leave their community to have their baby. | Leave community to have baby | Resources |
| 53 | More programs built into curriculum in schools where parents and babies are brought in to interact with students, share their experiences, and share stories. | Classes high school | Education |
| 54 | To extend Public Health postpartum follow up after birth to at least two months. | Public health postnatal | Support |
| 54a | To extend Public Health services to include weekly baby weight checks. | Postnatal weekly check | Support |
| 54b | To extend Public Health services to include parenting strategies. | Public health strategies | Education |
| 54c | To extend Public Health services to include early developmental checks for baby. | Public health development checks | Support |
| 55 | To include mandatory gender-neutral life skills classes in high school. | Mandatory classes high school | Education |
| 56 | Trained parent support people to visit new parents in hospital to supply information about resources that parents can take home. | Information resources | Information |
| 57 | To develop an easy access computer app with general information on child development, potty training, breastfeeding, etc. | Online information | Information |
| 57a | Develop an easy access computer app with links to credible websites on child development, potty training, breastfeeding, etc. | Online links | Information |
| 58 | To extend the Families First program by two or three years. | Families First extension | Resources |
| 59 | Mandatory parenting courses for identified 'at risk' families. | Mandatory classes at risk | Education |
| 60 | To provide the opportunity for monthly parenting courses that focus on child development and parent education. | Monthly classes | Education |
| 61 | Teaching parenting classes in high school. | Classes high school | Education |

| | | | |
|---|---|---|---|
| 62 | To set up a parenting website that has information on all aspects of parenting. | Online information | Information |
| 62a | Set up a parenting website that includes an online forum or chat group. | Online forum | Information |
| 63 | To set up an online newsletter that all expectant parents are informed of either through their doctors or by hospital staff before they are discharged. | Online newsletter | Information |
| 64 | To advertise parenting tips on TV, radio, and social media. | Media information | Information |
| 65 | Making child development classes mandatory in high school. | Mandatory classes high school | Education |
| 65a | Making family studies classes mandatory in high school. | Mandatory classes high school | Education |
| 66 | To provide monthly parenting classes, like prenatal classes, to provide parents with information on what to expect at the current stage of their child's development and in upcoming stages. | Monthly classes | Education |
| 67 | Using web based methods to provide information about preparing for parenthood (e.g., websites, Facebook pages). | Online information | Information |
| 68 | Having permanent holistic family spaces that offer play activities to support development for infants and children. | Central place to meet | Support |
| 68a | Having permanent holistic family spaces that provide information about mental and spiritual health. | Central place information | Support |
| 68b | Having permanent holistic family spaces that provide information about access to health care services. | Central place information | Access |
| 69 | To offer prenatal courses that include information on child development and best practices in infant/early years child care (e.g., sleep, eating, play, and screen time etc.). | Prenatal classes | Education |
| 70 | Having compulsory courses on child development in high schools, to increase understanding and realistic expectations of infant and child behaviour. | Mandatory classes high school | Education |
| 71 | Concentration on resource centres rather than time-limited programs so that parents have a consistent place to seek advice and support. | Resource centres | Support |
| 72 | Building relationships among parenting service providers and families. | Relationships | Connections |
| 73 | Additional child care spaces. | Day care | Resources |
| 73a | Support for parents who chose to stay at home. | Support | Resources |
| 73b | Prenatal classes geared towards the mental health and social emotional well-being of the child. | Prenatal focus mental health | Education |

| | | | |
|---|---|---|---|
| 74 | Local prenatal class locations. | Local prenatal | Access |
| 74a | Additional support from programs like Healthy Baby. | Money programs | Resources |
| 75 | Additional funding for parenting programs. | Money programs | Resources |
| 75a | Additional funding for Healthy Child Parent Child Coalitions. | Money agencies | Resources |
| 75b | Funding for stay at home parents. | Money parent | Resources |
| 76 | Increased access to Healthy Baby programs throughout the province. | Access programs | Access |
| 77 | Support groups with other mothers. | Support groups | Support |
| 77a | Having mentoring programs from other mothers. | Mentors | Support |
| 78 | To have doctors or the Public Health Nurse refer parents to specific programs (e.g., Parent-Child Coalitions, Family Resource Centres) like a prescription. | Health referrals | Access |
| 79 | Increased support services to remote/rural/northern communities - including mental health, counselling, recreational programming, medical, educational, etc. | Equitable support | Access |
| 79a | To develop a plan to help parents become involved with helping systems in a positive way. | Positive relationships | Connections |
| 80 | Having a number parents can call for support or ideas - similar to health links. | Phone help line | Support |
| 80a | Continued support for existing best beginnings programs that are already running. | Continued program support | Resources |
| 80b | Having classes on bonding with babies. | Teach bonding | Education |
| 81 | Have a number parents can call for help. | Phone line | Support |
| 82 | Running parent support programs that include meal preparation together while child care is provided. | Programs with meal preparation | Support |
| 82a | Running parent support programs that include a time for parents to talk and support each other while child care is provided. | Programs with other parents | Support |
| 82b | Running parent support programs that include presentations of interest while providing child care. | Programs with child care | Support |
| 82c | To facilitate ways for parents to connect to build peer supports. | Peer connection | Support |
| 82d | Increased awareness of what supports are available for parents. | Awareness supports | Information |

| | | | |
|---|---|---|---|
| 83 | To support existing Better Beginnings programs that are already running. | Continued program support | Resources |
| 84 | To include information on child self-esteem in parenting programs. | Teach child self-esteem | Education |
| 84a | To include information on stages of development in parenting programs. | Teach child development | Education |
| 84b | To teach parents about typical development to help with parental expectations for child behaviour. | Teach typical development | Education |
| 85 | Tell parents about the importance of bonding with babies. | Tell about bonding | Information |
| 86 | Developing a system of accountability for Public Health Nurses's, home visitors, and direct service staff who work with parents. | Accountable service providers | Standards |
| 86a | Building a framework to gain quality feedback from clients on parenting services (i.e., public health, home visitors, direct service staff). | Feedback on services | Standards |
| 87 | Making a parenting course, with focus on mental health, a mandatory credit course for junior and senior high school students. | Mandatory classes high school | Education |
| 88 | Find ways to connect with rural and northern parents in a positive way. | Positive connections | Connections |
| 89 | To increase availability of prenatal classes to all communities. | Prenatal everywhere | Access |
| 90 | Mandatory parenting programs and other supports for families who are at risk including those who have open files with CFS, RCMP, etc. | Mandatory for at risk | Education |
| 91 | A parenting helpline accessible 24 hours a day. | Helpline | Support |
| 92 | In home support throughout all stages of child-rearing. | Home support | Support |
| 92a | In home mentoring throughout all stages of child-rearing. | Home support | Support |
| 93 | To have schools teach parenting as a life skill. | Teach students | Education |
| 93a | To have schools teach about relationships as a life skill. | Teach students | Education |
| 94 | To teach parenting to all people. | Teach all | Education |
| 95 | Parent mentors to support new parents. | Mentors | Support |
| 96 | Detailed feeding and sleeping guides provided by the hospital when a baby is discharged. | Teach feed and sleep | Education |
| 97 | Financial support for parents who chose to stay home to raise their children. | Money parents | Resource |
| 98 | Easy access to high quality child care. | Day care | Resource |
| 98a | Subsidies for low income families. | Money parents | Resource |
| 99 | Expanded parental leave for fathers. | Paternal leave | Resource |

| | | | |
|---|---|---|---|
| 100 | Secured maternity leave with 100% of income paid during leave for lowest income earners. | Maternal leave | Resource |
| 101 | Information on positive parenting and discipline. | Information positive parenting | Information |
| 102 | Information on the benefits of being as screen-free as possible. | Screen-free education | Education |
| 103 | Programs for new fathers with male mentors. | Mentors fathers | Support |
| 103a | Father-focused parent programming. | Programs fathers | Access |
| 104 | Increased employment income assistance payments for pregnant mothers to improve nutrition and quality of life during pregnancy and as a new mother. | Prenatal benefits | Resource |
| 105 | Consultation with the most vulnerable parents around their support needs. | Consult vulnerable | Support |
| 106 | Baby boxes to support parents with some basic supplies. | Baby boxes | Resources |
| 106a | Baby boxes to recognize parents. | Baby boxes | Connections |

| **Code Word Definitions** | |
|---|---|
| Education | a statement that has the intent of increasing parenting knowledge and skills |
| Support | supply with things necessary/needed |
| Resources | funding of programs and services, money for parents |
| Non-judgemental | remove stigma and judgements |
| Information | promote social value of parenting, importance, parenting information, media |
| Access | make something available for all, equity |
| Connections | building relationships, connecting people with service/providers |
| Standards | ensuring quality and accountability in services and supports |

## Appendix L: Statement Reduction

| EDUCATION | | |
|---|---|---|
| 1. | Make parenting classes mandatory for first-time parents during baby's first year. | |
| | 44 | Mandatory parenting classes for first-time parents for baby's first year. |
| 2. | Offer monthly parenting classes to teach parents about all stages of child development and parental expectations for child behaviour. | |
| | 44a | Optional parenting classes for first-time parents after they have completed mandatory ones in the first year of their child's life. |
| | 60 | To provide the opportunity for monthly parenting courses that focus on child development and parent education. |
| | 66 | To provide monthly parenting classes, like prenatal classes, to provide parents with information on what to expect at the current stage of their child's development and in upcoming stages. |
| | 80b | Having classes on bonding with babies. |
| | 84a | To include information on stages of development in parenting programs. |
| | 84b | To teach parents about typical development to help with parental expectations for child behaviour. |
| 3. | Make parenting courses mandatory for families with higher risk factors. | |
| | 59 | Mandatory parenting courses for identified `at risk` families. |
| | 90 | Mandatory parenting programs and other supports for families who are at risk including those who have open files with CFS, RCMP, etc. |
| 7. | Include information about parenting strategies during Public Health home visits. | |
| | 31 | Public health visits from a nurse or social worker to help with parenting skill. |
| | 34 | Public health visits should include parenting strategies. |
| | 54b | To extend Public Health services to include parenting strategies. |
| 8. | Include information about physical health during Public Health visits. | |
| | 34b | Public health visits should include information about physical health. |
| 9. | Provide detailed feeding and sleeping guides to parents when a baby is discharged from the hospital. | |
| | 29 | To provide all parents with tips on proper nutrition after baby's birth. |
| | 96 | Detailed feeding and sleeping guides provided by the hospital when a baby is discharged. |
| 10. | Implement provincially mandated parenting classes into existing or new high school curriculum. | |
| | 17 | Parenting classes taken by everyone in high school. |
| | 45 | Provincially-mandated parenting classes in the high school curriculum. |
| | 61 | Teaching parenting classes in high school. |
| | 65 | Making child development classes mandatory in high school. |
| | 70 | Having compulsory courses on child development in high schools, to increase understanding and realistic expectations of infant and child behaviour. |
| | 93 | To have schools teach parenting as a life skill. |
| | 94 | To teach parenting to all people. |
| 11. | Include mandatory gender-neutral life skills classes in high school. | |
| | 55 | To include mandatory gender-neutral life skills classes in high school. |

| | | |
|---|---|---|
| 12. | Offer child development courses in high school where parents and babies are brought into the school to interact with students. | |
| | 33 | To provide child development courses in high school with exposure to real children. |
| | 33a | To provide child care courses in high school with exposure to real children. |
| | 39 | To teach early child development classes in high school. |
| | 53 | More programs built into curriculum in schools where parents and babies are brought in to interact with students, share their experiences, and share stories. |
| 13. | Make family studies classes mandatory in high school. | |
| | 65a | Making family studies classes mandatory in high school. |
| 14. | Create mandatory child development courses with a focus on mental health. | |
| | 87 | Making a parenting course, with focus on mental health, a mandatory credit course for junior and senior high school students. |
| 15. | Teach students about relationships as a life skill. | |
| | 93a | To have schools teach about relationships as a life skill. |
| 16. | Add parenting classes to college and university programs. | |
| | 16 | Parenting classes added to college and university programs. |
| 17. | Develop prenatal courses that teach about child mental health and emotional well-being. | |
| | 73b | Prenatal classes geared towards the mental health and social emotional well-being of the child. |
| | 84 | To include information on child self-esteem in parenting programs. |
| 18. | Teach people how to balance a new baby with the other demands of home and life. | |
| | 27 | Teaching people how to balance a new baby with the other demands of home and life. |
| 20. | Develop online parenting classes and child development videos for expecting parents using a variety of learning styles. | |
| | 32 | Internet based child development videos. |
| | 48 | Creating a website with short videos for new parents on every common question and experience of new parents (e.g., first bath, infant feeding, prepping a baby bottle, common health concerns, etc.). |
| | 51 | Providing free and easily available parenting classes online to those that are pregnant using a variety of learning styles. |
| 23. | Educate parents on the benefits of helping your children be as screen-free as possible. | |
| | 102 | Information on the benefits of being as screen-free as possible. |
| 43. | Promote the message that parenting is learned and we all need to learn how to parent. | |
| | 10 | Promote the message that parenting is learned and we all need to learn how to parent. |
| 53. | Provide free prenatal classes on child development. | |
| | 51a | Providing free and easily available parenting classes in person to those that are pregnant using a variety of learning styles. |
| | 69 | To offer prenatal courses that include information on child development and best practices in infant/early years child care (e.g., sleep, eating, play, and screen time etc.). |

| SUPPORT | | |
|---|---|---|
| 5. | Implement mandatory Public Health visits at regular intervals until 2-3 months of age to monitor baby's health and mother's well-being. | |
| | 5 | Mandatory bi-weekly visits to the doctor, the public health nurse, or the nurse practitioner for the first 3 months of child's life. |
| | 47a | Having a health care professional that checks in with the parents in person every other week after the baby is born until 2 months. |
| | 50a | Home visits by a professional to check in on mom's mental and emotional health. |
| | 54 | To extend Public Health postpartum follow up after birth to at least two months. |
| | 54a | To extend Public Health services to include weekly baby weight checks. |
| | 54c | To extend Public Health services to include early developmental checks for baby. |
| 6. | Connect every person with Public Health upon finding out they are pregnant to support them with the planning and preparation for the new baby. | |
| | 46 | To connect every parent with Public Health upon finding out they are pregnant. |
| | 47 | Having a health care professional that checks in with the parents in person each month until baby is born. |
| | 50 | Home visits by a professional to check in on the planning and preparation for the new baby. |
| 26. | Have permanent family spaces that offer play activities to support development for infants and children. | |
| | 68 | Having permanent holistic family spaces that offer play activities to support development for infants and children. |
| 28. | Concentrate on resource centres rather than time-limited programs so that parents have a consistent place to seek advice and support. | |
| | 68a | Having permanent holistic family spaces that provide information about mental and spiritual health. |
| | 71 | Concentrate on resource centres rather than time-limited programs so that parents have a consistent place to seek advice and support. |
| 34. | Set up a parenting helpline that is accessible 24 hours a day like health links. | |
| | 80 | Having a number parents can call for support or ideas - similar to health links. |
| | 81 | Have a number parents can call for help. |
| | 91 | A parenting helpline accessible 24 hours a day. |
| 36. | Develop programs for new fathers with male mentors. | |
| | 103 | Programs for new fathers with male mentors. |
| 39. | Facilitate peer support groups for parents to meet with other parents. | |
| | 25a | More parent support groups. |
| | 43a | Free parenting support groups. |
| | 77 | Support groups with other mothers. |
| | 82 | Running parent support programs that include meal preparation together while child care is provided. |
| | 82c | To facilitate ways for parents to connect to build peer supports. |
| 42. | Lobby the government to increase support for parents and children. | |
| | 9 | Lobby the government to increase support for parents and children. |
| 60. | Share parenting strategies at parent support groups. | |
| | 4 | Parent support groups where you can share parenting strategies. |

| | | |
|---|---|---|
| | 82a | Running parent support programs that include a time for parents to talk and support each other while child care is provided. |
| | 82b | Running parent support programs that include presentations of interest while providing child care. |
| 62. | Provide all expectant parents with consultation on services they may need including mental health, alcohol/drug issues, and housing, etc. | |
| | 37 | Screening all expectant parents for any services they may need including mental health, alcohol/drug issues, and housing, etc. |
| | 37a | To provide all expectant parents with services they may need including mental health, alcohol/drug issues, and housing, etc. |
| | 105 | Consultation with the most vulnerable parents around their support needs. |
| 64. | Assign a parent mentor for every new parent who can offer support throughout all stages of child-rearing. | |
| | 6 | Having parenting mentors who have knowledge about child development. |
| | 6a | Having parenting mentors who share knowledge about parenting strategies. |
| | 14 | Assigning a parent mentor for every new parent. |
| | 77a | Having mentoring programs from other mothers. |
| | 92 | In home support throughout all stages of child-rearing. |
| | 92a | In home mentoring throughout all stages of child-rearing. |
| | 95 | Parent mentors to support new parents. |
| 66. | Support parents in times of crisis. | |
| | 41. | Having advocates available for those who have open files with CFS. |

| **RESOURCES** | | |
|---|---|---|
| 31. | Extend the Families First program by two or three years. | |
| | 58 | To extend the Families First program by two or three years. |
| 45. | Provide appropriate pay for those working with parents (e.g., Family Resource Centres). | |
| | 1 | Appropriate pay for those working with parents (e.g. Family Resource Centres). |
| 46. | Offer financial support for parents who chose to stay home to raise their children. | |
| | 73a | Support for parents who chose to stay at home. |
| | 75b | Funding for stay at home parents. |
| | 97 | Financial support for parents who chose to stay home to raise their children. |
| 47. | Expand parental leave for fathers. | |
| | 99 | Expanded parental leave for fathers. |
| 48. | Secure maternity leave with 100% of income paid during leave for lowest income earners. | |
| | 100 | Secured maternity leave with 100% of income paid during leave for lowest income earners. |
| 49. | Increase employment income assistance payments for pregnant mothers to improve nutrition and quality of life during pregnancy and as a new mother. | |
| | 104 | Increased employment income assistance payments for pregnant mothers to improve nutrition and quality of life during pregnancy and as a new mother. |
| 50. | Ensure workplaces provide for parenting classes as part of their employee assistance programs or benefits package. | |

| | | |
|---|---|---|
| | 21 | Supported time off work to attend parenting classes. |
| | 23 | Workplaces making parenting classes part of their employee assistance programs. |
| | 30 | Incorporating parenting supports into employee benefits. |
| 51. | Additional funding for Healthy Child Parent Child Coalitions. | |
| | 74a | Additional support from programs like Healthy Baby. |
| | 75a | Additional funding for Healthy Child Parent Child Coalitions. |
| 52. | Offer free parenting classes with child care provided. | |
| | 22 | Child care provided when you take parenting classes. |
| | 43 | Free parenting classes. |
| 54. | Increase funding for parenting programs. | |
| | 75 | Additional funding for parenting programs. |
| 55. | Expand breastfeeding resources. | |
| | 25 | More breastfeeding resources. |
| 56. | Increase availability of high-quality child care. | |
| | 40 | Additional support for day care. |
| | 73 | Additional child care spaces. |
| | 98 | Easy access to high quality child care. |
| 57. | Provide financial support so the most basic of needs are met for all parenting families. | |
| | 2 | Make sure the most basic of needs are met for all parenting families. |
| | 42 | Extra financial support. |
| | 98a | Subsidies for low income families. |
| 58. | Ongoing support for existing Better Beginnings programs. | |
| | 80a | Continued support for existing best beginnings programs that are already running. |
| | 83 | To support existing Better Beginnings programs that are already running. |
| 69. | Ensure proper services and support (financial and emotional) are available when mothers have to leave their community to have their baby. | |
| | 52 | Ensuring proper services and support (financial and emotional) are available when mothers have to leave their community to have their baby. |
| 70. | Provide all expectant parents with baby boxes like those given to expectant parents in Finland. | |
| | 38 | To provide all expectant parents with baby boxes like those given to all expectant parents in Finland. |
| | 106 | Baby boxes to support parents with some basic supplies. |

| **NON-JUDGEMENTAL** | | |
|---|---|---|
| 44. | Reduce the stigma parents feel when they ask for help with parenting. | |
| | 13 | Reduce the stigma parents feel when they ask for help with parenting. |
| | 19 | Supporting (not punishing) parents in times of crisis. |
| | 24 | Non-judgemental parent mentors. |

| INFORMATION | | |
|---|---|---|
| 4. | Provide more information to parents on bonding and attachment. | |
| | 26 | Better availability of information on attachment parenting. |
| | 85 | Tell parents about the importance of bonding with babies. |
| 19. | Set up a parenting website that includes an online forum and newsletter. | |
| | 62a | Set up a parenting website that includes an online forum or chat group. |
| | 63 | Set up an online newsletter that all expectant parents are informed of either through their doctors or by hospital staff before they are discharged. |
| 21. | Develop an easy access computer app with general information on child development and links to credible websites. | |
| | 57 | To develop an easy access computer app with general information on child development, potty training, breastfeeding, etc. |
| | 57a | Develop an easy access computer app with links to credible websites on child development, potty training, breastfeeding, etc. |
| | 62 | To set up a parenting website that has information on all aspects of parenting. |
| | 67 | Using web-based methods to provide information about preparing for parenthood (e.g., websites, Facebook pages). |
| 22. | Share parenting tips on the TV, radio and social media. | |
| | 25b | Make parenting information readily available. |
| | 64 | To advertise parenting tips on TV, radio, and social media. |
| 24. | Promote positive parenting and discipline. | |
| | 101 | Information on positive parenting and discipline. |
| 27. | Increase awareness of existing services and supports for parents. | |
| | 3 | Increase awareness of the supports and services that already exist for parents. |
| | 82d | Increased awareness of what supports are available for parents. |
| 35. | Ensure Public Health services include information about parenting classes. | |
| | 34a | Public health services should include information about parenting classes. |
| 40. | Increase society's understanding of the significance and impact of parenting. | |
| | 7 | Increase society's understanding of the impact of parenting. |
| | 11 | Increase public awareness of the impact of parenting during the early years. |
| | 12 | Increase public awareness of the critical and valuable role of parents. |
| 41. | Find ways to increase the value placed on parenting. | |
| | 8 | Find ways to raise the value placed on the work parents do. |
| 61. | Have trained parent support people to visit new parents in hospital to supply information about community resources in their area. | |
| | 49 | Giving families a list of community resources in their area where they can access information, baby classes, social connection, etc. |
| | 56 | Trained parent support people to visit new parents in hospital to supply information about resources that parents can take home. |

| ACCESS | | |
|---|---|---|
| 25. | Create central family resource centres where all parenting services can be easily accessed. | |
| | 28 | Easy access to all available financial help in one resource centre. |
| | 36 | Having a centralized portal with access to all parenting services in one place. |
| | 68b | Having permanent holistic family spaces that provide information about access to health care services. |
| 29. | Ensure prenatal classes are available in every community. | |
| | 74 | Local prenatal class locations. |
| | 89 | To increase availability of prenatal classes to all communities. |
| 30. | Increase access and support to Healthy Baby programs throughout the province. | |
| | 76 | Increased access to Healthy Baby programs throughout the province. |
| 32. | Expand Family's First programs for all parents and not just parents identified as being at risk or who have a low income. | |
| | 35 | Expansion of Family's First programs for all parents and not just parents identified as being at risk or who have a low income. |
| 33. | Have doctors or the Public Health Nurse refer parents to specific programs (e.g., Parent-Child Coalitions, Family Resource Centres) like a prescription. | |
| | 78 | To have doctors or the Public Health Nurse refer parents to specific programs (e.g., Parent-Child Coalitions, Family Resource Centres) like a prescription. |
| 37. | Offer father-focused parent programming. | |
| | 103a | Father-focused parent programming. |
| 38. | Ensure parenting classes are sensitive to varied cultural parenting styles. | |
| | 15 | Having parenting classes that are sensitive to varied cultural parenting styles. |
| 67. | Offer support for families in First Nations communities through health care professionals or elders. | |
| | 45a | Health care professionals or elders supporting families in First Nation Communities. |
| 68. | Increase support services to remote/rural/northern communities - including mental health, counselling, recreational programming, medical, educational, etc. | |
| | 79 | Increased support services to remote/rural/northern communities - including mental health, counselling, recreational programming, medical, educational, etc. |

| CONNECTIONS | | |
|---|---|---|
| 65. | Build relationships with parenting service providers and families. | |
| | 18 | To find ways to connect with parents before things go wrong. |
| | 72 | Building relationships among parenting service providers and families. |
| | 79a | To develop a plan to help parents become involved with helping systems in a positive way. |
| | 88 | Find ways to connect with rural and northern parents in a positive way. |
| | 106a | Baby boxes to connect with parents. |

| STANDARDS | | |
|---|---|---|
| 59. | Ensure people who support parents are educated and competent. | |
| | 1a | Have competent and educated staff to support parenting families. |
| | 20 | Having a trained parenting visitor come to the house to provide suggestions and information. |
| 63. | Ensure parenting mentors know how to talk with new parents. | |
| | 6b | Parenting mentors who know how to talk with new parents. |
| 71. | Develop a system of accountability for Public Health Nurses', home visitors, and direct service staff who work with parents. | |
| | 86 | Develop a system of accountability for Public Health Nurses', home visitors, and direct service staff who work with parents. |
| 72. | Build a framework to gain quality feedback from clients on parenting services (i.e., Public Health, home visitors, direct service staff). | |
| | 86a | Building a framework to gain quality feedback from clients on parenting services (i.e., public health, home visitors, direct service staff). |

## Appendix M: Task Two - Sorting and Rating Email and Online Instructions


Subject: What can be done in Manitoba to prepare people for parenting? Invitation to Participate in Next Phase of Activities.

Hello,

Recently, I asked you and other people in Manitoba to give me ideas that complete this prompt: "*To help people prepare for parenting, a specific service, support or actions would be . . .*".

I would like to thank you for contributing your knowledge about preparing people for parenting during the brainstorming phase. The knowledge contributed by you and others has been made into a statement set that will be used during this round of activities. As you may recall, I am using a methodology called concept mapping.

The concept mapping process takes a large amount of information from different sources and combines it into a simple picture. Your participation will help build a base of knowledge and a framework for understanding what parents need to be prepared for parenting.

I now ask you to take part in the next task: **The sorting and rating activities**. In the **sorting activity**, you'll group the ideas into categories that make sense to you, in terms of *how they are related* in meaning. In the **rating activities**, I ask you to rate how **important** you think each idea is in connection to **preparing people for parenting**. A second rating will ask you to rate how **possible** or **feasible** you think each idea is in connection to **preparing people for parenting**.

You may complete these activities by following this link:
http://conceptsystemsglobal.com/PreparedForParenting/sort/rate

It is important that I receive your input **by DATE** so that I can produce a robust map of conceptual categories. While you have about **four weeks** to complete these activities, please do not delay.

Following the close of the Sorting and Rating activities you will receive your gift card to thank you for sharing your knowledge and your time.

You will find detailed instructions for participating in the sorting and rating activities below this message. Thank you in advance for helping me with this research project.

With appreciation,
Candace Bergeson, MA, Doctoral Candidate

## Online Sorting and Rating Participation Instructions

To complete the sorting and rating activities, please visit the following website:

http://conceptsystemsglobal.com/PreparedForParenting/sort/rate

Sign in with your username and password (the same one you used in the Brainstorming activity). If you need assistance with your username or password contact my research assistant at cbergeson.assistant@gmail.com . Please note that all information you submit will remain confidential.

You will then be taken to the project homepage where you will find links to each of the following activities:

- Participant Questions
- Sorting
- Rating on Importance
- Rating on Feasibility

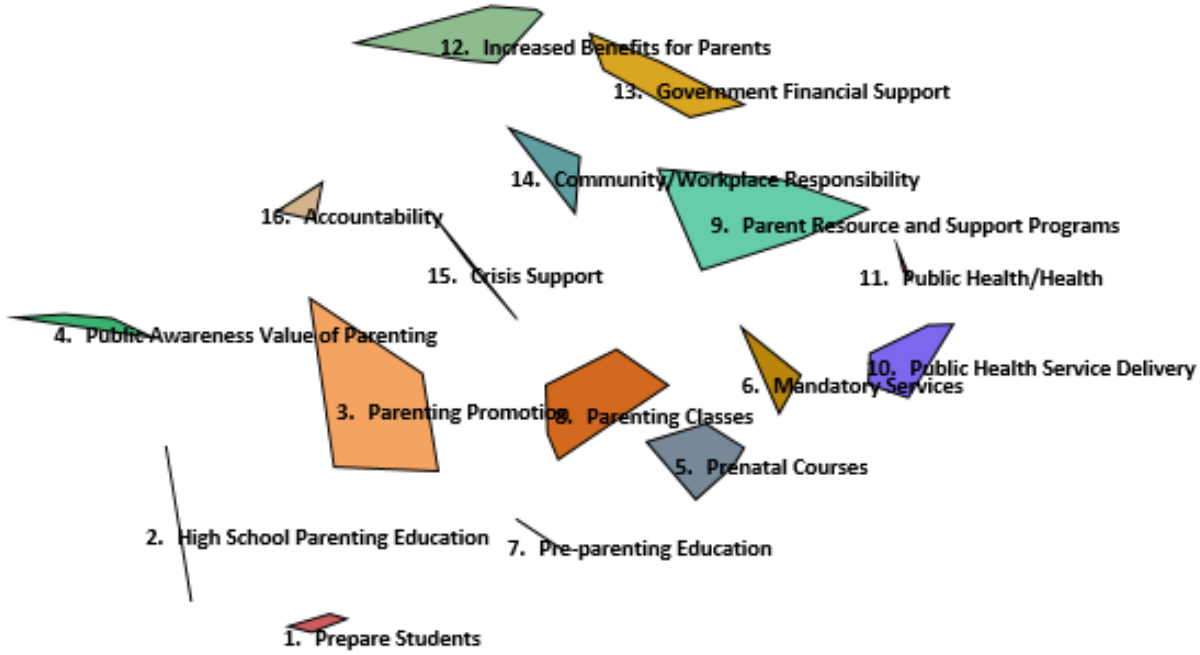
It is recommended that you begin with the Sorting activity. The Sorting activity will require approximately 30 – 60 minutes. The instructions are on the Sorting page and there is a toolbar just above the workspace where you can create new groups, edit group labels, and save your work. You will be prompted periodically to save your work but you can also click the save button as you progress through the task. Please note if you click the '**Save and Finish'** button in the Sorting activity **you cannot go back** and adjust your groups.

The Rating activity will require approximately 10 – 30 minutes. You will be asked to rate each statement twice. The first rating asks how important you think a statement is in preparing people for parenting. The second rating asks how feasible or possible you think the statement is in preparing people for parenting. If you click on the 'Show unrated statements only', the rating criteria remains directly above the statement you are working on.

It is not necessary to complete these activities in one sitting.

You may contact Candace Bergeson if you have any questions about these activities, or if you require technical assistance.

## Appendix N: Range of Cluster Solutions 15 to 2




| Merge | Cluster Solution | Clusters That Came Together |
|---|---|---|
| 16 to 15 | 15 | 14 + 15 |
| 15 to 14 | 14 | 5 + 6 |
| 14 to 13 | 13 | 10 + 11 |
| 13 to 12 | 12 | 7 + 8 |
| 12 to 11 | 11 | 1 + 2 |
| 11 to 10 | 10 | (14,15) + 16 |
| 10 to 9 | 9 | 12 + 13 |
| 9 to 8 | 8 | (5,6) + (7,8) |
| 8 to 7 | 7 | 3 + 4 |
| 7 to 6 | 6 | (10,11) + 9 |
| 6 to 5 | 5 | (12,13) + [(14,15) +16] |
| 5 to 4 | 4 | (1,2) + (3,4) |
| 4 to 3 | 3 | [(5,6)(7,8)] + [(10,11)(9)] |
| 3 to 2 | 2 | [(5,6)(7,8)(10,11)(9)] + [(12,13)(14,15)(16)] |

## Appendix O: Task Three - Webinar and Reflection Instructions


Subject: What can be done in Manitoba to prepare people for parenting? Invitation to Participate in Webinar and Feedback Activity.

Hello,

Recently, I asked you and other people in Manitoba to share your thoughts around what could be done to prepare people for parenting. I would like to thank you for contributing your knowledge and your time in assisting me with this research project.

I have developed a 20-minute narrated PowerPoint® presentation, where I go through the different concept maps that were generated and explain what each one means. You can access the PowerPoint® presentation on an Unlisted YouTube channel.

I have also developed a Reflection Workbook to accompany the PowerPoint® presentation. At different places in the PowerPoint® presentation you will be asked to share your thoughts on the results. I appreciate any and all feedback you can provide. If you have questions about the results or would like some clarification, please contact me.

Thank you for participating in this research study. Your time and effort have been greatly appreciated. Your contribution has helped us move forward in understanding the needs of parents in Manitoba.

Candace Bergeson, MA, Doctoral Candidate

# Reflection Workbook

## Preparation for Parenting

**Candace Bergeson**

**Focus Prompt**

"*To help people prepare for parenting, a specific service, support, or action would be . . .*".

**Final Statement Set – 72 unique ideas**

| | Statement |
|---|---|
| 1. | Make family studies classes mandatory in high school. |
| 2. | Add parenting classes to college and university programs. |
| 3. | Ensure prenatal classes are available in every community. |
| 4. | Develop programs for new fathers with male mentors. |
| 5. | Offer child development courses in high school where parents and babies are brought into the school to interact with students. |
| 6. | Include mandatory gender-neutral life skills classes in high school. |
| 7. | Increase availability of high-quality child care. |
| 8. | Provide all expectant parents with consultation on services they may need including mental health, alcohol/drug issues, housing, etc. |
| 9. | Facilitate peer support groups for parents to meet with other parents. |
| 10. | Expand Family's First programs for all parents and not just parents identified as being at risk or who have a low income. |
| 11. | Concentrate on resource centres rather than time-limited programs so that parents have a consistent place to seek advice and support. |
| 12. | Find ways to increase the value placed on parenting. |
| 13. | Ensure Public Health services include information about parenting classes. |
| 14. | Have trained parent support people to visit new parents in hospital to supply information about community resources in their area. |
| 15. | Promote the message that parenting is learned and we all need to learn how to parent. |

| | |
|---|---|
| 16. | Promote positive parenting and discipline. |
| 17. | Implement provincially mandated parenting classes into existing or new high school curriculum. |
| 18. | Develop online parenting classes and child development videos for expecting parents using a variety of learning styles. |
| 19. | Have doctors or the Public Health Nurse refer parents to specific programs (e.g., Parent-Child Coalitions, Family Resource Centres) like a prescription. |
| 20. | Offer monthly parenting classes to teach parents about all stages of child development and parental expectations for child behaviour. |
| 21. | Assign a parent mentor for every new parent who can offer support throughout all stages of child-rearing. |
| 22. | Reduce the stigma parents feel when they ask for help with parenting. |
| 23. | Lobby the government to increase support for parents and children. |
| 24. | Educate parents on the benefits of helping your children be as screen-free as possible. |
| 25. | Make parenting courses mandatory for families with higher risk factors. |
| 26. | Provide appropriate pay for those working with parents (e.g., Family Resource Centres). |
| 27. | Provide more information to parents on bonding and attachment. |
| 28. | Provide all expecting parents with baby boxes like those given to parents in Finland. |
| 29. | Ensure workplaces provide parenting classes as part of their employee assistance programs or benefits package. |
| 30. | Support parents in times of crisis. |
| 31. | Increase society's understanding of the significance and impact of parenting. |
| 32. | Create mandatory child development courses with a focus on mental health. |
| 33. | Increase access and support to Healthy Baby programs throughout the province. |
| 34. | Increase support services to remote/rural/northern communities - including mental health, counselling, recreational programming, medical, educational, etc. |
| 35. | Ensure people who support parents are educated and competent. |
| 36. | Include information about parenting strategies during Public Health home visits. |
| 37. | Develop a system of accountability for Public Health Nurses, home visitors, and direct service staff who work with parents. |
| 38. | Provide financial support so the most basic of needs are met for all parenting families. |
| 39. | Develop prenatal courses that teach about child mental health and emotional well-being. |
| 40. | Ongoing support for existing Better Beginnings programs. |
| 41. | Ensure parenting classes are sensitive to varied cultural parenting styles. |
| 42. | Teach students about relationships as a life skill. |
| 43. | Share parenting strategies at parent support groups. |
| 44. | Build relationships with parenting service providers and families. |
| 45. | Increase funding for parenting programs. |
| 46. | Implement mandatory Public Health visits at regular intervals until 2-3 months of age to monitor baby's health and mother's well-being. |
| 47. | Secure maternity leave with 100% of income paid during leave for lowest income earners. |
| 48. | Create central family resource centres where all parenting services can be easily accessed. |
| 49. | Make parenting classes mandatory for first-time parents during baby's first year. |

| | |
|---|---|
| 50. | Extend the Families First program by two or three years. |
| 51. | Share parenting tips on the TV, radio, and social media. |
| 52. | Provide detailed feeding and sleeping guides to parents when a baby is discharged from the hospital. |
| 53. | Build a framework to gain quality feedback from clients on parenting services (e.g., Public Health, home visitors, direct service staff). |
| 54. | Increase awareness of existing services and supports for parents. |
| 55. | Offer financial support for parents who chose to stay home to raise their children. |
| 56. | Additional funding for Healthy Child Parent Child Coalitions. |
| 57. | Increase employment income assistance payments for pregnant mothers to improve nutrition and quality of life during pregnancy and as a new mother. |
| 58. | Offer support for families living in First Nations communities through health care professionals or elders. |
| 59. | Expand breastfeeding resources. |
| 60. | Provide free prenatal classes on child development. |
| 61. | Develop an easy access computer app with general information on child development and links to credible websites. |
| 62. | Ensure parenting mentors know how to talk with new parents. |
| 63. | Set up a parenting website that includes an online forum and newsletter. |
| 64. | Expand parental leave for fathers. |
| 65. | Teach people how to balance a new baby with the other demands of home and life. |
| 66. | Ensure proper services and support (financial and emotional) are available when mothers have to leave their community to have their baby. |
| 67. | Offer free parenting classes with child care provided. |
| 68. | Set up a parenting helpline that is accessible 24 hours a day like health links. |
| 69. | Include information about baby's physical health during Public Health visits. |
| 70. | Connect every person with Public Health upon finding out they are pregnant to support them with the planning and preparation for the new baby. |
| 71. | Have permanent family spaces that offer play activities to support development for infants and children. |
| 72. | Offer father-focused parent programs. |

**1. Reflection Activity: Cluster Themes and Labels**

**Cluster 1**

| | |
|---|---|
| 4. | Develop programs for new fathers with male mentors. |
| 12. | Find ways to increase the value placed on parenting. |
| 16. | Promote positive parenting and discipline. |
| 22. | Reduce the stigma parents feel when they ask for help with parenting. |
| 27. | Provide more information to parents on bonding and attachment. |
| 31. | Increase society's understanding of the significance and impact of parenting. |
| 51. | Share parenting tips on the TV, radio, and social media. |
| 54. | Increase awareness of existing services and supports for parents. |
| 61. | Develop an easy access computer app with general information on child development and links to credible websites. |
| 63. | Set up a parenting website that includes an online forum and newsletter. |
| **Cluster 1 – Themes, Cluster Label, Comments** | |

**Cluster 2**

| | |
|---|---|
| 1. | Make family studies classes mandatory in high school. |
| 2. | Add parenting classes to college and university programs. |
| 5. | Offer child development courses in high school where parents and babies are brought into the school to interact with students. |
| 6. | Include mandatory gender-neutral life skills classes in high school. |
| 15. | Promote the message that parenting is learned and we all need to learn how to parent. |
| 17. | Implement provincially mandated parenting classes into existing or new high school curriculum. |
| 42. | Teach students about relationships as a life skill. |
| **Cluster 2 – Themes, Cluster Label, Comments** | |

**Cluster 3**

| | |
|---|---|
| 3. | Ensure prenatal classes are available in every community. |
| 8. | Provide all expectant parents with consultation on services they may need including mental health, alcohol/drug issues, housing, etc. |
| 9. | Facilitate peer support groups for parents to meet with other parents. |
| 18. | Develop online parenting classes and child development videos for expecting parents using a variety of learning styles. |
| 20. | Offer monthly parenting classes to teach parents about all stages of child development and parental expectations for child behaviour. |
| 24. | Educate parents on the benefits of helping your children be as screen-free as possible. |
| 25. | Make parenting courses mandatory for families with higher risk factors. |
| 32. | Create mandatory child development courses with a focus on mental health. |
| 39. | Develop prenatal courses that teach about child mental health and emotional well-being. |
| 41. | Ensure parenting classes are sensitive to varied cultural parenting styles. |
| 43. | Share parenting strategies at parent support groups. |
| 49. | Make parenting classes mandatory for first-time parents during baby's first year. |
| 60. | Provide free prenatal classes on child development. |
| 65. | Teach people how to balance a new baby with the other demands of home and life. |
| 67. | Offer free parenting classes with child care provided. |
| 72. | Offer father-focused parent programs. |
| **Cluster 3 – Themes, Cluster Label, Comments** | |

**Cluster 4**

| | |
|---|---|
| 13. | Ensure Public Health services include information about parenting classes. |
| 14. | Have trained parent support people to visit new parents in hospital to supply information about community resources in their area. |
| 19. | Have doctors or the Public Health Nurse refer parents to specific programs (e.g., Parent-Child Coalitions, Family Resource Centres) like a prescription. |
| 21. | Assign a parent mentor for every new parent who can offer support throughout all stages of child-rearing. |
| 36. | Include information about parenting strategies during Public H. home visits. |
| 46. | Implement mandatory Public Health visits at regular intervals until 2-3 months of age to monitor baby's health and mother's well-being. |
| 52. | Provide detailed feeding and sleeping guides to parents when a baby is discharged from the hospital. |
| 69. | Include information about baby's physical health during Public Health visits. |
| 70. | Connect every person with Public Health upon finding out they are pregnant to support them with the planning and preparation for the new baby. |
| **Cluster 4 – Themes, Cluster Label, Comments** | |

**Cluster 5**

| | |
|---|---|
| 10. | Expand Family's First programs for all parents and not just parents identified as being at risk or who have a low income. |
| 11. | Concentrate on resource centres rather than time-limited programs so that parents have a consistent place to seek advice and support. |
| 33. | Increase access and support to Healthy Baby programs throughout the province. |
| 34. | Increase support services to remote/rural/northern communities - including mental health, counselling, recreational programming, medical, education etc. |
| 48. | Create central family resource centres where all parenting services can be easily accessed. |
| 50. | Extend the Families First program by two or three years. |
| 58. | Offer support for families living in First Nations communities through health care professionals or elders. |
| 59. | Expand breastfeeding resources. |
| 71. | Have permanent family spaces that offer play activities to support development for infants and children. |
| **Cluster 5 – Themes, Cluster Label, Comments** | |

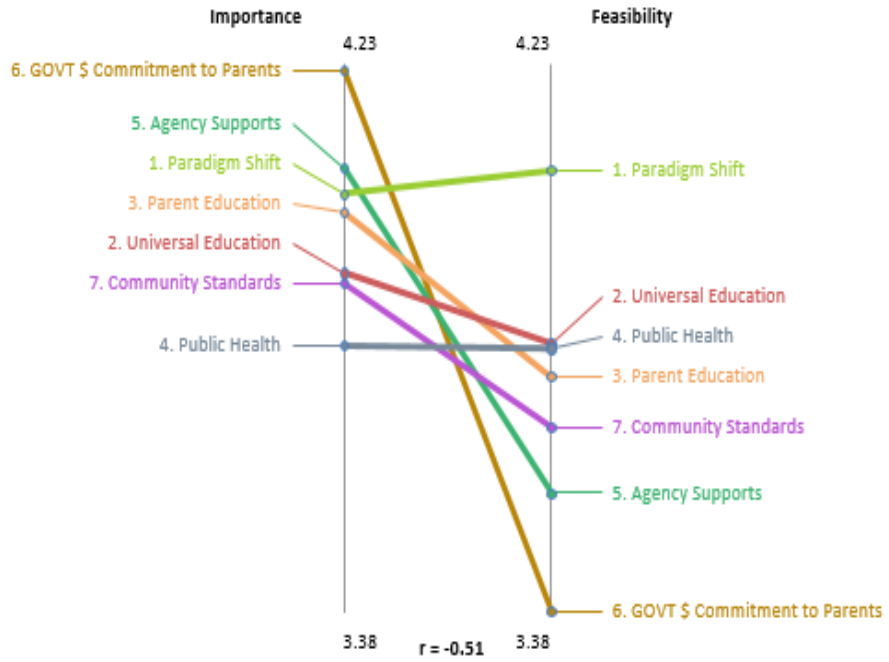
**Cluster 6**

| | |
|---|---|
| 7. | Increase availability of high-quality child care. |
| 23. | Lobby the government to increase support for parents and children. |
| 26. | Provide appropriate pay for those working with parents (e.g., Family Resource Centres). |
| 38. | Provide financial support so the most basic of needs are met for all parenting families. |
| 40. | Ongoing support for existing Better Beginnings programs. |
| 45. | Increase funding for parenting programs. |
| 47. | Secure maternity leave with 100% of income paid during leave for lowest income earners. |
| 55. | Offer financial support for parents who chose to stay home to raise their children. |
| 56. | Additional funding for Healthy Child Parent Child Coalitions. |
| 57. | Increase employment income assistance payments for pregnant mothers to improve nutrition and quality of life during pregnancy and as a new mother. |
| 64. | Expand parental leave for fathers. |
| 66. | Ensure proper services and support (financial and emotional) are available when mothers have to leave their community to have their baby. |
| **Cluster 6 – Themes, Cluster Label, Comments** | |

**Cluster 7**

| | |
|---|---|
| 28. | Provide all expecting parents with baby boxes like those given to Finland. |
| 29. | Ensure workplaces provide parenting classes as part of their employee assistance programs or benefits package. |
| 30. | Support parents in times of crisis. |
| 35. | Ensure people who support parents are educated and competent. |
| 37. | Develop a system of accountability for Public Health Nurses, home visitors, and direct service staff who work with parents. |
| 44. | Build relationships with parenting service providers and families. |
| 53. | Build a framework to gain quality feedback from clients on parenting services (e.g., Public Health, home visitors, direct service staff). |
| 62. | Ensure parenting mentors know how to talk with new parents. |
| 68. | Set up a parenting helpline that is accessible 24 hours a day like health links. |
| **Cluster 7 – Themes, Cluster Label, Comments** | |

**2. Reflection Activity: Cluster Ratings**




- Why do you think Government Funding was the most important but the least feasible?
- What are your thoughts about the other clusters? Was there a cluster you thought would have been higher on importance or on feasibility?
- Why do you think Public Health was rated as the relatively least important of the clusters?

**Twenty-One Statements in the Go-zone by Cluster**

| Cluster | Statement |
|---|---|
| Promotion of Parenting | 12. Find ways to increase the value placed on parenting.<br>16. Promote positive parenting and discipline.<br>27. Provide more information to parents on bonding and attachment.<br>31. Increase society's understanding of the significance and impact of parenting.<br>54. Increase awareness of existing services and supports for parents. |
| High School Parenting Education | 5. Offer child development courses in high school where parents and babies are brought into the school to interact with students.<br>15. Promote the message that parenting is learned and we all need to learn how to parent.<br>42. Teach students about relationships as a life skill. |
| Prenatal and Parent Education | 3. Ensure prenatal classes are available in every community.<br>8. Provide all expectant parents with consultation on services they may need including mental health, alcohol/drug issues, housing, etc.<br>39. Develop prenatal courses that teach about child mental health and emotional well-being.<br>41. Ensure parenting classes are sensitive to varied cultural parenting styles.<br>60. Provide free prenatal classes on child development.<br>67. Offer free parenting classes with child care provided. |
| Public Health | 36. Include information about parenting strategies during Public Health home visits. |
| Parent Resource and Support Programs | 58. Offer support for families living in First Nations communities through health care professionals or elders. |
| Government Funding | 7. Increase availability of high-quality child care.<br>23. Lobby the government to increase support for parents and children. |
| Community Supports | 30. Support parents in times of crisis.<br>35. Ensure people who support parents are educated and competent.<br>68. Set up a parenting helpline that is accessible 24 hours a day like health links. |

**3. Reflection Activity: Actionable Recommendations**

**Parents Matter Region**

1) Promote positive parenting and the importance of attachment and bonding.
2) Develop standards of competency for people who provide services to parents.
3) Increase awareness of existing services and supports for parents.
4) Provide support for parents in crisis.
5) Increase the value placed on parenting by raising awareness of the significance and impact on society.

**Education Region**

1) Promote the message that parenting is learned and we all need to learn how to parent.
2) Provide free prenatal classes in every community that include information on both physical and mental health development and well-being.
3) Include opportunities for students to interact with parents and children in the Family Life curriculum.
4) Prenatal consultations need to include a review of psychosocial functioning with necessary And appropriate resources made available.
5) Parenting classes need to be free, need to include free child care, and be sensitive to cultural parenting styles.

**Support Region**

1) Increase availability of high-quality child care.
2) Lobby the government to increase support for parents and children.

- What are your thoughts on these recommendations?
- Are there others you would like to see included in the final list?
- What about the order of priority? Should that change?
- What items would you like to see at the top?
- If you could make one recommendation happen, what would it be?

**4. Reflection Activity: Your Experience**

Was there anything you found difficult, challenging, or unclear?
What did you think of the online concept mapping approach?
Do you think the concept map reflects your perspective?
Do you think anything has been missed?
Overall, what was the experience like for you?
Other comments or ideas?