

Community Supports for Parents of Young Children: A Needs Assessment

by

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## **Abstract**

**Statement of the problem:** Supporting parents with young children has increasingly become an essential part of public policies. Manitoba Parent-Child Coalitions are tasked with identifying community needs and priorities related to community programs for families with young children and developing a sustainable plan for addressing community needs. The methods used to establish community needs and priorities vary considerably. Only a handful of the needs assessments (NA) related to community supports for parents found in the literature focused broadly on the needs of all parents at the community level. In addition, the nature and quality of the NA varied considerably, and parents were often not involved in the process. Use of a participatory NA process such as the Concerns Report Method (CRM) could provide communities with important information about the community support needs of parents with young children while involving parents in the decision-making process.

**Methods:** The CRM uses a mixed methods exploratory sequential research design. Phase 1 of the CRM, reflection on values and issues of importance, involved the use of several qualitative methods: a document review of existing community data and community supports, interviews and focus groups with parents (N=29) and service providers (N=11). The results of Phase 1 were used to develop a Community Concerns Report Survey for parents (N=319) and service providers (N=47) that was used in Phase 2 of the CRM, identifying community concerns. Logistic regression was used to determine the child and family characteristics that were associated with parent perceived community support needs.

**Results:** Existing community data revealed important socioeconomic differences across neighbourhoods, but the Early Development Instrument showed that kindergarten children from all socioeconomic backgrounds and neighbourhoods were not ready for school. The interviews and focus groups with community stakeholders revealed several areas of concern. Four themes emerged from this data: 1) Availability of/ access to community supports, 2) Barriers and facilitators to participation, 3) Parent and child transition periods, and 4) Making connections with parents/ service providers. The survey results extended our understanding of these issues and showed that parents and service providers prioritized community supports needs differently. Parents and service providers also had shared areas of concern that included child care and housing programs and services in the same building. Finally, very few of the child, parent, and family characteristics were associated with parent perceived needs and explained at best 16.8% of the variance.

**Conclusion:** Despite only examining the first two phases of the CRM, this study adds to the body of literature on use of the CRM in the context of identifying the community support needs of parents with young children. The NA process highlighted the strengths and limitations of the different methods used and the CRM as a methodology in determining community support needs. As well, the challenges associated with reconciling the different findings were discussed. Coalitions seeking to engage parents and service providers in a NA process should consider using the CRM to identify community support needs and priorities.

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## **Dedication**

*To my parents, Albert and Marlene Leclair,  
my first and greatest supporters*

*To my children, Elia and Franco,  
my inspirations and raison d'etre*

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## **Chapter 1: Introduction**

The early years of development from before birth to age six set the base for competence and coping skills that will affect learning, behaviour, and health throughout life (Doherty, 1997; Doherty, 2007; McCain & Mustard, 1999; McCain, Mustard, & Shanker, 2007; Shonkoff & Phillips, 2000). This knowledge coupled with the evidence that parents have a critical influence on children's development (Lally, Lurie-Hurvitz, & Cohen, 2006; Matusicky & Russell, 2009; Shonkoff & Phillips, 2000) has resulted in a growing recognition of the need for developing an early years strategy that supports young children and their parents (McCain et al., 2007; Oates, 2010; Rogers & Moore, 2003). In 1997, the National Children's Agenda (Human Resources and Development Canada, 1997) began the dialogue on a comprehensive strategy for Canadian children with the goal of ensuring that all children get the best possible start in life. In 2000, governments across Canada committed to improving and expanding early childhood development initiatives, building on existing investments (Government of Canada, 2001). The initiatives were focused on specific provincial/territorial needs, within four agreed upon areas: promoting healthy pregnancy, birth and infancy; improving parenting and family supports; strengthening early childhood development, learning and care; and strengthening community supports.

In 2001, as part of its early childhood development initiatives, Manitoba began funding parent-child coalitions across the province to promote and support community-based programs for young children and their parents (Healthy Child Manitoba, 2005). Parent-child coalitions are in keeping with an emerging

international trend focused on child-health partnerships (Jayaratne, Kelaher, & Dunt, 2010) or community-based initiatives that bring together service providers from different sectors and the community in developing community programs and services focused on improving parent and child outcomes. The government funds 26 parent-child coalitions; 25 coalitions are regional (12 regions outside Winnipeg and 13 community areas within Winnipeg) and one coalition serves the needs of Francophone communities across the province. The size of the region that each coalition serves varies with some covering large geographical areas of the province and others a community area within the city of Winnipeg.

Parent child coalitions are described as multi-stakeholder planning committees that meet regularly to discuss needs and priorities related to early childhood development initiatives and to develop a sustainable plan for addressing those needs in a manner appropriate to the community. Membership in the coalition is voluntary and the coalition's composition varies in each community (Healthy Child Manitoba, 2005). The coalitions are in place to support early childhood development and parenting activities that build upon existing programs or introduce new programs to address identified gaps in services or resources. The aim of each coalition is to bring together parents, school divisions, early childhood educators, health professionals and other community stakeholders to support positive parenting, improve children's nutrition and physical health, promote literacy and learning, and build community capacity.

Parent-child coalitions use a wide variety of service delivery models and offer a wide range of programs. Examples include centre-based models such as family

resource centres, home-based models such as home visiting programs and outreach services, workshops and training in parenting and literacy, community knowledge exchange forums, and mobile services such as book and toy lending libraries.

Activities of the parent-child coalition are to be based on community needs and priorities determined through community consultation. As coalitions have very few guidelines on methods for establishing community needs and priorities, the degree of consultation and the methods used to gather information on community needs and priorities vary considerably among coalitions.

The implementation of a participatory community needs assessment (NA) process could assist Parent Child Coalitions in establishing needs and priorities related to community supports for parents with young children. A participatory NA process involves a systematic approach to gathering data to determine specific population needs, in which a researcher and community stakeholders share the responsibility for the process. This process in turn guides more effective planning and implementation strategies to ensure that responsive services are available (J. Ross & Jaafar, 2006; Schriner & Fawcett, 1988a; Suarez Balcazar, Martinez, & Casas Byots, 2005; Turnbull, 1999).

Utting (2009) reported that NA related to community supports for parents of young children is underdeveloped. The research literature on assessing the support needs of parents with young children at a community level is limited relative to the amount of information on assessing the needs of individual parents and children who are typically in contact with a particular service (Axford, Green, Kalsbeek, Morpeth, & Palmer, 2009; Kellett & Apps, 2009; Utting, 2009). Axford (2010) stated

there is “an unhelpful but recurring tendency in the children’s services to know a lot about a tiny proportion of children and very little about most children and, as a result, to plan for the few at the expense of the many” (p.250). In addition, the perspectives of parents in establishing needs and priorities at a community level are often absent (Axford, 2010; Johnson, Akister, McKeigue, & Wheater, 2005; Pinnock & Garnett, 2002; Utting, 2009). Thus, our understanding and assessment of the community support needs of parents and young children is often inadequate and incomplete (Axford, 2010; Klett-Davies, Skaliotis, & Wollny, 2008; Utting, 2009).

Finally, a growing recognition of the need for universal community supports for young children and their parents, along with targeted community supports, suggests that all parents and young children need some form of support (Bremberg, 2006; Johnson et al., 2005; Matusicky & Russell, 2009; McConnell, Breitkreuz, & Savage, 2012; Moran & Ghate, 2005; Muhajarine, Anderson, Lysack, Guhn, & Smith, 2012). Universal community supports are intended for all parents and young children, whereas targeted community supports are limited to young children who are more vulnerable to poor developmental outcomes and their parents.

Often, the presence of certain child and family characteristics or risk factors are used to identify families who could benefit most from these programs and services (Boivin & Hertzman, 2012; Japel, 2008; Moran, Ghate, & Van Der Merwe, 2004). However, little is known about the influence of child and family characteristics on parents’ perceived need for community supports. Knowledge of the factors that may influence parents perceived needs could provide important information for the planning and delivery of programs and services. Knowing if

certain parents are more likely to perceive a community support as a need is helpful in identifying parents who feel their needs are not being met.

### **Research Purpose and Objectives**

The primary purpose of this research study was to apply and evaluate part of an existing NA process, the Concerns Report Method (CRM), to determine its potential in identifying community support needs of parents with young children at a community level. The CRM has not been used to assess the community support needs of this population. It is a mixed methods research approach that uses a multiphase participatory process for establishing agendas for community change from the perspective of individuals who share a common issue (Schriner & Fawcett, 1988b; Suarez Balcazar et al., 2005). The specific objectives of this study were:

- 1) To summarize what we know from existing community level data about the community supports needs of parents with young children (newborn to 6 years) in one community area;
- 2) To describe parents' and service providers' perspectives on the current strengths and gaps in community supports for parents with young children and determine what their perspectives can add to the information gathered from the existing community data;
- 3) To determine how the quantitative findings from a sample of a population of parents and service providers extend the themes generated through interviews and focus groups with parents and service providers on community supports for parents with young children in one community area;

- 4) To evaluate the extent to which parents' and service providers' perspectives on community supports strengths and needs differed; and
- 5) To evaluate the extent to which parents' perspectives of needs differed based on child and family characteristics.

Determining the community supports needs of parents with young children can help ensure that all children get the best start in life. Equipping families with the tools needed to enhance and promote their child's development is an important aspect of many community programs and services. However, ensuring that the community supports offered are addressing the needs and priorities of parents with young children is often more difficult. This study highlights a NA process that can assist in determining the community support needs of parents with young children at the community level, the importance of examining multiple perspectives and how need may differ based on child and family characteristics.

## **Chapter 2: Literature Review**

This literature review will provide an overview of community supports for parents with young children: What are they, who could benefit, and what role can child-health partnerships and community development play in enhancing parent and child outcomes? In addition, the current state of NA in the planning and development of community supports for parents with young children at a community level will be discussed, along with the importance of including parents' views. Conducting a participatory community level NA that includes multiple perspectives and determining if certain child and family characteristics are associated with need may provide important information for the planning and implementation of services that are responsive to the needs and priorities of parents with young children.

### **Community Supports for Parents with Young Children: What Are They?**

Parents have far-reaching influence upon child development through direct interactions and influence over the environment in which their children develop (Barlow & Underdown, 2005; Sameroff, 1998; Shonkoff & Phillips, 2000). Parents define the resources available to their children, and largely decide in which programs and services their children participate (Boivin & Hertzman, 2012). The ways in which parents' raise their children and the life circumstances affecting parenting practices are strongly associated with children's outcomes (Shulruf, 2005; Tremblay, Boivin, & Peters, 2008). Stable and caring relationships with caregivers, who encourage children to explore and learn while ensuring their safety

and transmitting cultural values, are essential to the health and well-being of young children (Shonkoff & Phillips, 2000).

Supporting parents with young children is an essential part of public policies focused on building better societies (Lally et al., 2006; Marmot et al., 2010; Shulruf, O'Loughlin, & Tolley, 2009; Utting, 2009). Comprehensive early childhood development policy would ensure that educational programs for children were complemented by the availability of a broad range of programs and services for parents. To obtain the most effective results, the scope of services should be broadly focused on the health and well-being of the whole family (Shulruf et al., 2009; Utting, 2009). In addition, “applying a public health perspective to child and family intervention, a relatively new, innovative, and potentially paradigm-shifting approach is to adopt population-wide strategies that seek to optimize impact and reach larger segments of the child/family population” (Prinz & Sanders, 2007).

While several definitions of community supports for parents with young children have been proposed in the literature, not all are congruent. There is, however, consensus that community supports for parents of young children are developed in a context where the primary purpose, both for policy and practice, is to improve outcomes for their children (Axford, 2010; Pinnock & Garnett, 2002; Utting, 2009). Hence, for the purpose of this study, community supports for parents with young children are programs and services that provide parents with support in promoting child health, development, and behaviour and/or building parent competencies and capacities (Bremberg, 2006; Layzer, Goodson, Bernstein, & Price, 2001; Munro, 2009; Trivette & Dunst, 2009). They may be child focused, parent

focused, or parent-child focused. These initiatives include a range of approaches such as home visiting, parent training/education, parent/child programs, child care, preschool programs, to name a few. They focus on facilitating informal community support networks; offering semi-formal programs and services often provided through community-based organizations, and generally non-profit organizations; and providing formal supports consisting of organized programs and services offered in many instances by government agencies or government agencies in partnership with non-profit organizations (Ghate & Hazel, 2004; Johnson et al., 2005; Moran & Ghate, 2005).

### **Community Supports for Parents with Young Children: Who Could Benefit?**

Recent reports suggest approximately 30% of Manitoba's preschool children are vulnerable or not ready for school in at least one area of development (physical health and well-being, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge) (Brownell et al., 2012; Santos, Brownell, Ekuma, Mayer, & Soodeen, 2012). These findings are similar to other provinces (Human Early Learning Partnership, 2013; The Offord Centre for Child Studies, 2010). When considering which parents and young children could benefit from community supports, one must examine the literature on risk factors often associated with children's poor developmental outcomes in the short-term (e.g., school readiness) and the long-term (e.g., educational and occupational attainment).

Parents and young children who present with certain risk factors are often the recipients of targeted community supports that focus on families with greater

needs. Developmental theory suggests that factors at the child, family and community levels all play a role in influencing children's development (Bronfenbrenner, 1979). This section will examine the various risk factors associated with poor developmental outcomes at each of these levels. In addition, specific subgroups of the parent population, who do not necessarily exhibit these risk factors but whose circumstances may require community supports, will also be examined.

### **Child factors.**

According to Statistics Canada (2008) approximately 2% of children between the ages of 0 to 4 years have a disability, and this number increases to 4% for children 5 to 9 years of age. Children with disabilities are often at greater risk for poor developmental outcomes or school readiness and in need of specialized targeted programs and services. Many of these children are born with conditions that impact their development from birth such as children with cerebral palsy, spina bifida, down's syndrome, fetal alcohol spectrum disorder, and muscular dystrophy, to name a few. Others experience delays as they age and their disability becomes more apparent such as children with autism, developmental coordination disorder, and attention deficit disorder. In addition, many very low birth weight children go on to experience disabilities (Schendel et al., 1997). Santos et al. (2012) found that over half of children with very low birth weight (less than 1500 grams) were not ready for school in one or more domains on the Early Development Instrument (EDI) (Janus & Offord, 2007). In comparison, only 28% of children with a normal

birth weight were vulnerable. A child's health status at birth is an important factor associated with poor developmental outcomes (Santos et al., 2012).

### **Family factors.**

Growing up in a single-parent household is associated with poor child outcomes. Children from single-parent families have higher rates of poverty and lower levels of educational and vocational attainment than children who grow up with both parents (Biblarz & Raftery, 1999; DeLeire & Kalil, 2002). Children from single-parent homes are also more likely to engage in substance use (Carlson, 2006; DeLeire & Kalil, 2002) and in sexual activity at a younger age (Davis & Friel, 2001). They are also more likely to be single, teen mothers (Kiernan & Cherlin, 1999; Wu, 1996), and to experience the disintegration of their romantic relationships (Amato & DeBoer, 2001; Kiernan & Cherlin, 1999). Marriage failure, which results in single-parenthood, strongly influences children's risk of developing cognitive, social, and emotional problems (Biblarz & Gottainer, 2000; Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000).

A mother's mental health has a significant effect on her children's developmental outcomes. Maternal mental health conditions are associated with an increased risk of socio-emotional and behavioural problems in their children (Goodman & Gotlib, 1999; Moses-Kolko & Roth, 2004). Campbell et al. (2009) reported that adolescents whose mothers depressive symptoms were in the chronic, elevated, and stable subclinical latent classes had more internalizing and externalizing problems and acknowledged engaging in more risky behaviour than adolescents of never-depressed mothers. Maternal depression has been associated

with: less ability to attend to the needs of the child, decreased sensitivity, use of coercive strategies, physical maltreatment, and parental dissatisfaction (McLoyd, 1998). Therefore, support for mothers with mental illness is essential.

Mother's educational attainment is also strongly associated with children's developmental outcomes. Research has shown that maternal education level alone is positively associated with a child's vocabulary skills and academic achievement (Hoddinott, Lethbridge, & Phipps, 2002; Willms, 2002). To et al. (2004) using data from the National Longitudinal Survey of Children and Youth (NLSCY) found that children from low-income households who have a mother with low educational attainment had the greatest odds of experiencing poor developmental attainment. Japel (2008) using the Quebec Longitudinal Study of Child Development data found that family income, mother's education, and child's health at five months had particular importance for later adaptation. Park, Fuhrer and Quesnel-Vallee (2013) reported that maternal education is associated with major depressive episodes in early adulthood, independent of paternal education and other early-life and early adult risk factors. Hence, mother's education has important implications for children's developmental outcomes.

Low maternal education is also more common among teenage mothers (Mollborn & Dennis, 2012). While several studies have examined the outcomes for teenage mothers and their children, many have focused on perinatal outcomes in children with fewer studies examining later health and development (Shaw, Lawlor, & Najman, 2006). Researchers have found that children born to teenage mothers tend to have lower educational achievement (Levine, Emery, & Pollack, 2007;

Mollborn & Dennis, 2012; Moore, Morrison, & Greene, 1995; Shaw et al., 2006), more behavioural and cognitive concerns (Mollborn & Dennis, 2012), and poorer reading ability and psychological well-being (Moore et al., 1995; Shaw et al., 2006); initiate sexual activity early (Levine & Pollack, 2002; Moore et al., 1995); and are more likely to be involved in criminal activity, smoke, and consume alcohol (Shaw et al., 2006). However, teenage mothers are also typically of lower socioeconomic status (Mollborn & Dennis, 2012).

Using Manitoba provincial administrative data, researchers have found that youth whose family was on income assistance, whose mother was a teen when she had her first child, and/or involved with child welfare services were most vulnerable to poor outcomes later in life (Brownell et al., 2010; Santos et al., 2012). Jutte et al. (2010) found that children of teen and prior teen mothers were at greater risk for hospitalizations, high hospital use, academic failure, welfare, and being a teen mother. While there is still widespread debate, Mollborn and Dennis (2012) noted that socioeconomic status accounted for many disparities among teenage mothers' children for both parenting behaviours and child outcomes, suggesting that young maternal age alone was not largely responsible for children's poor outcomes.

The links between poverty and health have been firmly established through several longitudinal studies, and the association between poverty and children's development is well documented in the literature beginning early in life (Boivin & Hertzman, 2012; Brownell et al., 2012; D. Ross & Roberts, 1999; Santos et al., 2012; Shonkoff & Phillips, 2000). Statistics Canada (2009) reported that 1 in 7 or 14%

(based on low income cut-off before tax) of Canadian children lived in poverty. Among Canadian provinces, the percentage was highest in Manitoba at 18.8%. Researchers have consistently reported that children from the lowest socio-economic families are most vulnerable to harm and developmental issues (Boivin & Hertzman, 2012; Brooks-Gunn, Duncan, & Brillo, 1999; Brooks-Gunn & Duncan, 1997; Brownell et al., 2010; Brownell et al., 2012; McLoyd, 1998; Santos et al., 2012; To et al., 2004).

While the prevalence of poor outcomes is highest among children living in poverty, children vulnerable to poor developmental outcomes are not limited to lower socioeconomic groups. A larger number of children from middle and higher income families are also vulnerable because they represent a greater percent of the total population. One of the major findings from the NLSCY is that children in all socioeconomic classes in Canada are vulnerable (McCain et al., 2007; Willms, 2002). Japel (2008) reported similar findings from the Quebec Longitudinal Study of Child Development. As well, results in Manitoba from the EDI demonstrated that while larger proportions of children from the most disadvantaged families were not ready for school, greater numbers of children not ready for school were from middle and higher income socioeconomic families. "The majority of vulnerable children in kindergarten, nearly two-thirds, were not poor socioeconomically." (Santos, 2009) (p.9)

Epidemiological studies indicate that other family factors are also powerful early predictors of developmental outcomes in children. However, unlike the factors already discussed, many of these family characteristics are more difficult to

establish, as they require extensive family observation or assessment. Recent research has revealed that children who have significant frequent and/or prolonged adversity such as chronic abuse, neglect, caregiver substance abuse or mental illness, and/or family economic hardship, without adequate adult support, experience “toxic stress” – frequent, prolonged activation of the body’s stress response systems (Harvard Centre on the Developing Child, 2012). The potential consequences of significant adversity and toxic stress in early childhood have implications not only for child development but can lead to a wide range of physical and mental impairments later in life (Shonkoff, 2012).

Boivin and Hertzman (2012) spoke of early adversity, particularly in relation to children from lower socioeconomic families, referring to “both short-term, dramatic events such as discrete episodes of physical abuse or sexual abuse, as well as the chronic stressors that children encounter as they navigate their daily lives (e.g., harsh parenting, parental depression, parental substance use, and deprivation within the home and community)” (p.7). The research suggested the more severe the adversity, the more negative the outcome (Boivin & Hertzman, 2012). However, not all children who encounter early adversity experience later problems; there is not one path from early adversity to poor health outcomes. A wide range of factors including genetics and community level social support appear to moderate the effects of early adversity (Boivin & Hertzman, 2012).

Parenting does matter and some parenting styles are better than others at enhancing positive social, emotional and cognitive outcomes for children (Bornstein & Bornstein, 2007; Canadian Council on Learning, 2007; Russell, 2003a).

O'Connor and Scott (2007) in a review of the literature on parenting and child outcomes found that the quality of the parent-child relationship is significantly associated with learning skills and achievement, social competence, children's own views of themselves, aggressive externalizing behaviour and delinquency, depression, anxiety, and other internalizing problems, and high-risk health behaviours. A lack of a warm, positive relationship with parents; insecure attachment; harsh, inflexible, or inconsistent discipline practices; inadequate supervision of and involvement with children all increase the risk that children will develop major behavioural and emotional problems (Bornstein & Bornstein, 2007; Loeber & Farrington, 2000; MacQueen, Curran, Hutton, & Whyte, 2007).

Chao and Willms (2002) analyzed data from the NLSCY and found an association between an authoritative parenting style and lower likelihood of child vulnerability. Baumrind (1967) characterized authoritative parenting as warm, responsive, encouraging, monitoring, and reasonable limit setting. Authoritarian (strict rules, harsh punishment, and little warmth), permissive (responsive but lack rules and discipline) and inconsistent parenting styles were associated with poorer outcomes for children. Chao and Willms (2002) reported that approximately one third of Canadian parents of preschool and school-aged children used the authoritative parenting style suggesting that two thirds of all parents with young children could benefit from parent education and training. Researchers have found that parenting styles seem to have a larger impact on child outcomes than family income (Chao & Willms, 2002; Dooley & Stewart, 2007; Willms, 2002).

Sameroff (1998) found that independent of socioeconomic status, parents' level of stress, ability to manage stress and respond effectively to children's needs had a significant effect on the cognitive development and mental health of children. While lower socioeconomic families tend to live with more acute and chronic family stress (Hertzman & Boyce, 2010; Repetti, Taylor, & Seeman, 2002), Ghate and Hazel (2004) reported that a diminished capacity to cope with stress, coupled with a tendency to show extreme responses to stress enhanced the risk of developing parenting difficulties and poor child outcomes.

### **Community factors.**

The availability of social supports is important to children's developmental outcomes. Social supports can reduce parenting stress and the adverse effect of stressors on parenting behaviours (Crnic, Greenberg, & Slough, 1986). Belsky (1984) conceptualized social support as a key contextual determinant of parenting. He outlined three main sources of social support: the marital relationship, the work setting, and the social network of extended family, friends and neighbours; all of which could be sources of stress or help to mediate stress in the parent-child relationship. A general lack of community cohesion, reliance on family relationships, and neighbourhood programs are important factors in poor childhood outcomes (Coulton, Korbin, Su, & Chow, 1995; Dunst, Leet, & Trivette, 1988; Sampson, Raudenbush, & Earls, 1997).

Garbarino and Kostelny (1992) reported that communities with increased instability and lower levels of participation in organizations had an increased incidence of child maltreatment, while communities with increased stability along

with formal and informal support systems had lower levels of child maltreatment. Caughy, O'Campo, and Brodsky (1999) suggested that high levels of community involvement might be associated with improved health outcomes by resulting in higher resource availability in the neighbourhood or through empowering residents to access services as individuals. They found that high community involvement was a protective factor for low birth weight, regardless of mother's educational attainment.

Kohen, Leventhal, Dahinten and McIntosh (2008) used Canadian longitudinal data to explore the mechanisms through which characteristics of neighbourhood residences are associated with preschoolers' verbal abilities and behaviour problems. They found that neighbourhood disadvantage was associated with less neighbourhood cohesion. However, not all affluent neighbourhoods had high cohesion and not all disadvantaged communities had poor cohesion. Lower neighbourhood cohesion was in turn associated with poorer family functioning and higher levels of maternal depression. They found that both neighbourhood and family mechanisms play an important role in explaining how neighbourhood structural disadvantage impacts young children's outcomes. Lower neighbourhood cohesion may interfere with processes that promote parenting associated with child competence and positive adjustment. Living in a neighbourhood with low cohesion may negatively impact on parents' mental health and family functioning by providing a less supportive environment in which to raise children.

The research suggests that families who lack social supports could benefit from formal community support programs (Corter & Arimura, 2006). Developing

social capital within communities and the ability of parents to make use of the social supports available are important to child outcomes (Jack & Jordan, 1999). Involving parents in a process that provides them with an opportunity to participate in decisions about the types of programs and services offered to parents and young children in their community may also help to develop social capital within communities and enhance parents' abilities to make use of the community supports available.

### **Other parent subgroups.**

Another important group of parents needing community support are working parents, particularly employed mothers who are still the primary caregivers for children in most households. Availability of and access to quality child care plays an important role in children's developmental outcomes (McCain, Mustard, & McCuaig, 2011; McCartney, 2007). The number of children being cared for outside of the home has been increasing for the past 25 years (Canadian Council on Learning, 2008). Several factors have been contributing to a growing reliance on non-parental care such as more women engaged in the workforce and more lone-parent families. Child care provides an important community support for all parents, but in particular families with two working parents or a single working parent. In Manitoba, 70% of mothers with children less than six years were in the workforce with only 20% able to access a licensed child care space (McCain et al., 2011).

The literature on the importance of community supports for fathers has grown exponentially over the past couple of decades, along with our knowledge that father's involvement has a positive influence on children's social, behavioural, and

psychological outcomes (Allen & Daly, 2002; Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008). Increased knowledge of the important influence that fathers have on their children's development (Allen & Daly, 2002; Sarkadi et al., 2008) has created greater awareness of the need for parent supports that focus on fathers as well as mothers (Utting, 2009). The needs of mothers have traditionally been the focus of research and services for parents. However, with more mothers in the workforce, more fathers are choosing to stay home with their children in the early years, or are playing a larger role in caregiving. When developing and implementing support services for fathers, service providers cannot assume that fathers will need and access the same services as mothers (Utting, 2009). Programs and services that address the needs and concerns of fathers should be provided within a sustainable framework of broader community supports for parents.

Given the emphasis of community supports on building capacities and competencies and the importance of the first year of a child's life to development, parents of young children are often an important target group. For many parents, the transition to parenthood is a major life event (Hanna, Edgecombe, & Jackson, 2002). Many parents describe this transition as stressful and challenging (Cooke & Barclay, 1999; Matthey & Barnett, 1999). Hogg and Worth (2009) reported that parents found the early days of parenting quite difficult. This period involves major emotional and social adjustments for parents (Matthey, Morgan, & Healy, 2002). Hudson, Elek and Fleck (2001) found that a positive experience throughout this transition into their new roles contributes to the parent's mastery and confidence and may influence the parents' relationship with their child over time. A program

delivered early in a family's development has a greater chance of being effective (Samuelson, 2010). While for some parents the transition is easier with subsequent children, supporting parents in the establishment of early parent-child relationships is important for children's later social, emotional and school functioning (Appleyard & Berlin, 2007).

Increasing evidence related to the various factors associated with child developmental outcomes has added to the policy debate on universal versus targeted approaches to programs and services for young children and their parents. Targeted initiatives to promote the development of children and support parents are restricted generally to families and children with identifiable risk factors that suggest children are vulnerable to poor developmental outcomes. Universal initiatives are those aimed at all families and children wishing to use them (Doherty, 2007). Doherty (2007) suggested that based on the mounting evidence, targeting programs solely for families at risk will miss a substantial number of families and young children with difficulties. Chao and Willms (2002) found that both positive and negative parenting practices occur in lower and higher socioeconomic families and favoured a universal program rather than one targeted to at-risk families.

Moran, Ghate and van der Merwe (2004) suggested that universal services should be made available to entire communities for parenting problems and needs at the "less severe end of the spectrum" (p.7) of parenting difficulties, while targeted services should be restricted to those parents with more complex types of parenting difficulties.

A universal to targeted approach views services along a continuum that begins with information and education that all parents can access, to targeted services for specific parent groups, and, finally, to compulsory programs where the safety of children is at issue (Utting, 2009). Marmot et al. (2010) suggested that to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that are proportionate to the level of disadvantage - an approach the authors called "proportionate universalism"(p.9). This strategy responds to the needs of young children and parents from all backgrounds while investing more heavily in those who demonstrated the greatest need. Muhajarine et al. (2012) stated,

For far too long, programs have been provided in a manner that trades off universal accessibility against addressing special needs or special populations. This is counter to the evidence accumulated over the last several decades, which shows that vulnerable children live in families with specific socio-economic needs as well as in families across the socio-economic spectrum (p. 9)

A large body of research has emerged examining the effectiveness of universal and targeted community supports for parents and young children. While the effectiveness of parent support programs is not the primary focus of this study, it is important to know what works when conducting a NA related to parent support programs. Knowing the programs that have good evidence, the components that appear to be most successful, and the populations that are most likely to benefit are important when considering which programs to implement at a community level.

Using programs that have established evidence should be considered before implementing programs that have not been evaluated. Appendix A includes a synthesis of the evidence on the most common approaches discussed in the parent support literature: parent education/training programs, home visiting programs, parent-child programs, and early learning experiences and child care, all of which are offered in a variety of different ways.

While the type, duration, and level of intensity will vary, many parents need community support programs at some point in their parenting role (Birnbaum, Russell, & Clyne, 2007; Ghate & Hazel, 2004; Hogg & Worth, 2009; Matusicky & Russell, 2009; Moran et al., 2004). Therefore, this study will seek to engage all parents of young children in describing and determining parent's perceptions of the current strengths and gaps in community supports. In addition, the factors known to influence who could benefit from community supports as outlined in this section: child with a disability or health concern, marital status, mother's health, mother's education, mother's age, family income, parental stress, social supports, mother's employment status, parent relationship to child, and first time parent will be considered in association with parent identified needs. Other important factors that were discussed such as: parenting style, maltreatment/neglect, substance use, and neighbourhood cohesion are beyond the scope of this study.

### **Community Supports for Parents with Young Children: Child-Health Partnerships and Community Development**

This section will discuss the effectiveness of an emerging international trend towards child-health partnerships (Jayaratne et al., 2010) or community-based/area-based initiatives that bring together service providers from different

sectors and the community in developing community programs and services focused on improving parent and child outcomes. These partnerships will be considered in conjunction with community development approaches. In addition, factors contributing to parent engagement in programs and services will be reviewed.

The past decade has seen an increase in the development of partnerships between service providers from different sectors and the community to improve the quality of outcomes for parents and children (Jayaratne et al., 2010). Green, Daniel, and Novick (2001) stated that partnerships and coalitions are necessary for the development of prevention and health promotion programs or research as no one agency has the resources, access, and trust relationships to address all of the community determinants of health. Jayaratne et al. (2010) defined child-health partnerships as, “A comprehensive organizational framework made up of two or more local partnering agencies working towards a common objective of ensuring the physical and social development of young children” (p.2). Through a review of the literature, they examined the effectiveness of these partnerships in contributing to service delivery or use, positive early childhood development, and improvements in parents and/or families.

The authors identified 11 child-health partnership programs in four countries, of which Healthy Child Manitoba was one. The other programs included: Sure Start (UK), Every Child Matters (UK), First 5 California (USA), Early Head Start (USA), Toronto First Duty (Canada), Families First (Australia), Stronger Families and Communities (Australia), Every Chance for Every Child (Australia), and Best Start

(Australia). A majority of partnership programs focused on children and parents/caregivers. Some of the partnership programs targeted children in the early years, while others included children up to 14 years. Many focused on the most disadvantaged areas/communities or disadvantaged subgroups within a community and encouraged family involvement.

Seven of the 11 partnership programs evaluated their outcomes. Healthy Child Manitoba was not included among these programs. In several instances, the evaluation of the child-health partnerships was quite robust. Four used quasi-experimental studies (Sure Start, Every Child Matters, Toronto First Duty, and Best Start), one used a randomized controlled trial (Early Head Start), and two used a mixed methods approach (Families First and Stronger Families and Communities).

Four out of the five partnership programs that evaluated access reported improved access to child health services for children and families and better use of services by parents and families (Best Start, Sure Start, Families First, and Toronto First Duty). Six of the partnership programs evaluated child and parent outcomes. Three out of the five partnership programs that evaluated child outcomes reported positive effects in literacy, nutrition and eating habits (Every Child Matters, Early Head Start and Toronto First Duty) and two of the five (Early Head Start and Toronto First Duty) reported positive outcomes on cognitive, social, emotional, and language development. Interestingly, all three of these partnership programs included centre-based service delivery. Five out of six partnership programs (Sure Start, Every Child Matters, Early Head Start, Toronto First Duty and Stronger Families and Communities) reported improved parenting outcomes. In the Every

Child Matters program, better parenting was found to lead to child social improvements. In the Stronger Families and Communities program, the development of local partnerships among agencies lead to improved family outcomes and better community well-being. Two out two partnerships (Every Child Matters and Best Start) reported increased immunization rates.

Three out of the four partnership programs that evaluated costs were found to be cost-effective. One (Stronger Families and Communities) reported greater short and long term cost-benefit ratios. Another (Toronto First Duty) found the costs of early years integrated services were no different than non-integrated services. And the other (Sure Start) conducted a descriptive cost-effectiveness analysis. No one child-health partnership model emerged as better than the others as each was developed to meet the needs and context of the communities that they served.

Other Canadian child-health partnership programs have been discussed in the literature. Better Beginnings, Better Futures (BBBF) was a community-based project for young children and their families living in eight lower-income neighbourhoods in Ontario (Peters et al., 2004). In keeping with a community development approach, the project engaged parents and other community members in a variety of opportunities to participate in decision-making and leadership activities to strengthen community cohesion and foster local capacity.

Results of the project showed that children living in project neighbourhoods showed significantly lower rates of emotional problems (anxiety and depression) and improved social skills (self-control and cooperative behaviour), compared to children from equally disadvantaged neighbourhoods not participating in the

project. Children had more timely immunizations at 18 months and benefited from reduced smoking rates in the home, higher rates of breastfeeding, and improved dietary intake than the comparison neighbourhood children. Project parents reported an improved quality of life. As well, there were higher levels of volunteerism in project neighbourhoods. Peters et al. noted that the cost of \$1000 per child incurred in the project was far lower than those reported in successful early childhood programs offered in the United States. These programs typically provided fewer program components to a smaller number of children. Peters et al. noted that changes in these communities required long-term evaluation to determine their full impact.

Community Action Programs for Children (CAPC) began as a core component of the Canadian government's Child Development Initiative (Boyle & Willms, 2002) and supports community-based groups and coalitions that provide programs and services addressing the health and development of vulnerable children from birth to 6 years of age, and their families (Public Health Agency of Canada [PHAC], 2010). In 2008, there were approximately 450 CAPC projects operating in more than 3,000 communities in Canada (PHAC, 2011). CAPC uses a community development process to identify and respond to the needs of women and children placing a strong emphasis on partnerships and community capacity building.

To evaluate the program, a probability sample of CAPC families (N=1407 parents and N=1308 children) was matched to families with a similar family structure, income, and parent education who had completed the NLSCY (N=1651 parents and N=1651 children). Researchers found selective improvements in the

health and functioning of families participating in CAPC. As well, there was significant variation between CAPC programs in the achievement of some beneficial effects, specifically maternal mood and family functioning. However, after adjusting statistically for differences in initial status between the CAPC and NLSCY controls, the observed or unadjusted benefits favouring CAPC participants were no longer present (PHAC, 2010).

A subsequent multi-method meta-evaluation that used both quantitative and qualitative data collected over five years found that CAPC had been successful in making a difference for children, families, and communities (PHAC, 2010). Researchers used an evaluation framework based on key program objectives to determine the impact in relation to families at risk, child development, and population health approaches. Findings revealed that the programs were reaching their target populations of families living in conditions of risk with the majority affected by multiple risks. CAPC had positive effects on children's development and school readiness and a positive effect on parental self-improvement and parenting knowledge and skills. Improvements in community capacity were also observed through parent participation and involvement, improved accessibility to programs, increased leadership and a sense of community, and improvements in collaborations among organizations. CAPC demonstrated potential cost savings that were linked to the overall impacts on education, health and social system costs (PHAC, 2010).

While the evaluation used multiple sources of regional data, which is considered a strength for meta-evaluation, many outcomes were measured

differently in each region making it difficult to determine national outcomes. As well, the lack of a control group did not allow for comparisons with families who did not participate in the CAPC programs. The authors concluded that the use of multiple methodologies and synthesizing the findings from various methods were important when evaluating health promotion initiatives.

Melhuish et al. (2007) attempted to identify factors and processes that might account for variation in the impact on child/family functioning within a child-health partnership program. In the case of Sure Start Local Programmes (SSLPs), the degree of local autonomy, combined with the lack of specification of how program aims were to be achieved, meant that it was difficult to evaluate fidelity of the intervention. Therefore, they examined proficiency in realizing the 18 principles that were the basis for SSLPs. They found some modest association between program implementation and effectiveness for child and parenting outcomes.

Programs more proficient in putting guiding principles into practice had a positive impact on children and parenting. More empowerment in programs was related to greater positive outcomes for parents and children. The authors concluded that strengthening program activities relevant to empowerment should improve their effectiveness in influencing parenting. Program characteristics found to support empowerment included community groups and parents being involved in the planning and delivery of services; parent representation; staff training opportunities; clear exit strategies for users; services to include self-help groups; evidence that staff and users are learning together; and evidence of mutual respect for all parties. As no intervention is likely to be universally effective, discovering the

program elements that account for variation in effectiveness is critical. Melhuish et al. provided a novel approach to examining these elements.

Buysse, Wesley and Skinner (1999) used qualitative methods to assess community change following the implementation of a community development process that focused on improving the quality and accessibility of child care and early intervention programs. They concluded that there were two aspects of community development that held particular promise for empowering parents and creating more responsive systems: creating a community planning team to identify and carry out change strategies and developing and testing new ways of giving parents a voice in shaping community reforms.

These aspects facilitated the development of relationships among parents and service providers and allowed for the sharing of ideas, experiences to plan and implement community reforms. They gave parents a stronger voice and leadership role in the development of early childhood services to better meet their needs. They served as springboards for additional community initiatives identified by parents. Finally, community members exhibited an increased awareness of community needs and resources related to early childhood interventions. However, child outcomes were not reported (Buysse et al., 1999)..

Buysse et al. (1999) proposed that community development holds widespread appeal in public health and offers a well-established framework for supporting health promotion initiatives and expanding innovations to encompass partnerships with families and the community. Community development offers a process for implementing change with respect to shared decision making with parents and

other community members. The fundamental premise is that when communities are given the opportunity to work out their own problems, they will find solutions that will have more lasting effects than when they are not involved in such problem-solving (Lindsey, Shields, & Stajduhar, 1999). It is important to note that the majority of parent-child partnerships evaluated were delivered to disadvantaged families or families living in disadvantaged neighbourhoods. Much less research has focused on the use of these models with less disadvantaged families/neighbourhoods.

### **Parent engagement**

While much work has been done related to the development of parent support programs and services, little is known about the extent to which community supports are meeting the needs of many parents. As a result, much more research is needed to identify effective ways of working with and supporting parents in their efforts to raise their children (Layzer et al., 2001; Moran et al., 2004; Shulruf et al., 2009). The research continues to demonstrate that attracting parents and engaging them with programs remains a challenge (Layzer et al., 2001; Moran et al., 2004; Moran & Ghate, 2005).

Parent engagement was a limiting factor across many programs and services reviewed (Gomby, 2005; Layzer et al., 2001; Moran et al., 2004; 2005; Olds, Sadler, & Kitzman, 2007). Almost every review of parent supports lamented the challenges of engaging and retaining parents in programs and services. Offering effective programs is not enough to engage parents in community support services (Whittaker & Cowley, 2012). Exploring for whom the programs are effective and the

context in which they are best delivered must be considered (Corter & Arimura, 2006).

Drummond (2005) summarized some of the barriers to engagement of parents in community support programs. They included service fragmentation, narrow mandates, power differential among providers and parents, and hours of availability. Whittaker and Cowley (2013) suggested that finances and health, and the program design, content and/or delivery were barriers to engagement. Katz et al. (2007) reported that parents' lack of knowledge of local services was a primary reason for lack of engagement, along with the fit between the needs and expectations of parents and the provision of services. Time pressures, particularly for single parents and working parents (Katz et al. 2007; Whittaker & Cowley, 2013), transportation, and geographical location (Drummond, 2005; Katz et al., 2007) were important physical and practical barriers. Social barriers such as culture and language were found to limit engagement of immigrant and refugee parents (Drummond, 2005; Katz et al. 2007). Parents with disabilities experienced difficulty physically accessing parent support services. Fathers failed to engage, as they perceived the available services were not relevant or geared to their needs. Parents living in poverty were also more likely not to engage in parent support programs and services for a variety of reasons ranging from high levels of stress, lack of education and confidence, and increased mobility (Katz et al., 2007).

Katz (2007) also found suspicion and stigma were barriers to parent engagement in community support programs. Given the stigma and suspicion often associated with parent support, Moran et al. (2004) recommended that it would be

beneficial to make programs and services universally available to help “normalize” support, increase rates of access, and facilitate early intervention. Moran et al. (2004) supported primary prevention through universal interventions for whole communities with targeted programs for parents and children with greater needs. Evidence from universal approaches to parent support on outcomes for parents and children are promising, but require ongoing evaluation (Moran et al., 2004; Nowak & Heinrichs, 2008).

Trivette and Dunst (2009) reported that community-based parent support programs offered in a family-centred manner increased parents' sense of parenting confidence and competence. Participatory, empowering practices that actively involved parents in deciding what knowledge was important to them and how they wanted to acquire information had the greatest positive effect on parents' sense of competence and confidence. Services that pay attention to relational factors such as building rapport with parents before beginning and ensuring that parent feedback is sought as part of the process and incorporated into changes to the service are more effective (Moran et al., 2004). Suggesting that how parenting support is delivered matters as much as what is delivered. Gomby (2005) stated the programs should seek parents' input to ensure that the programs and services being offered are meeting families' needs.

Based on the findings from their review, Layzer et al. (2001) concluded that there is no single effective program model for parent supports, and the effects are not evenly distributed across different models and service delivery strategies. Moran and Ghate (2005) found that our knowledge of what works in parenting

support is patchy. In reality, many of the programs and services are small grassroots efforts, offered within communities, many of which are not evaluated. Most of the research is on programs delivered in the United States and focused on short-term rather than long-term outcomes. While we are beginning to understand which programs are effective for some populations, the evidence is still inconclusive for many groups and programs. In addition, little attention has been paid to critical points across childhood and how services can respond to changing family circumstances (J. Law, Plunkett, Taylor, & Gunning, 2009).

Community support should be responsive to parent needs and involve parents in their development (J. Law et al., 2009; Trivette & Dunst, 2009). Service providers need to be clear about the relevance of the program content and delivery methods, and supports need to match with family identified needs (Whittaker & Cowley, 2012). Those engaged in the delivery of programs and services for parents and young children also serve as an important link to different forms of community supports that will meet the needs of parents with young children (J. Law et al., 2009; Whittaker & Cowley, 2012). A multi-strategy approach that draws on the best available evidence and seeks to empower parents will best enable communities to ensure healthy futures for children. No single program can meet the diverse developmental needs of all children. A more promising approach targets a range of needs with a continuum of services that have documented effectiveness and involve multiple stakeholders in their development and implementation.

Furthermore, unless programs are designed in ways that reliably ensure parental investment in the services and corresponding behaviour change, they will

fail to achieve their anticipated outcomes (Olds et al., 2007). Correspondingly, some of the suppositions about the kinds of programs and services that are truly helpful to parents for enhancing the development of their children may need to be re-examined (Layzer et al., 2001). Actively consulting with families and involving parents in planning local services and setting agendas is an important step towards enhancing community supports for parents and children (Pinnock & Garnett, 2002; Utting, Rose, & Gillan, 2001; Utting, 2009). “Community-based parenting programmes are more likely to be successfully embedded if parents are involved in their implementation.” (J. Law et al., 2009, p. 311). Knowing what works is also important in determining what to offer.

### **Current State of Needs Assessment for Parent Support**

Reviere, Berkowitz, Carter, and Ferguson (Reviere, Berkowitz, & Carter, 1996) described a NA as “a systematic and ongoing process of providing useable and useful information about the needs of the target population – to those who can and will utilize it to make judgments about policy and programs” (p.6). It is viewed as both a form of applied research and a political process (Hancock & Minkler, 1997; Marti-Costa & Serrano-Garcia, 1983).

The concept of need is complex (Doyal & Gough, 1991; Finlayson, 2006; Witkin & Altschuld, 1995) and can be used in different contexts in very different ways. Bradshaw (1972) has illustrated how different perspectives of need can be expressed. Need can be measured by calculating the demand for services (expressed need), or by examining the services provided to a certain population and using this information as the basis to determine the type of services required in another

community with a similar population (comparative need), or by asking individuals what they want (felt need), or by experts using existing data to determine need relative to a particular standard (normative need) (Bradshaw, 1972). Each perspective of need contributes valuable information for planners or policy makers, which adds to the depth and breadth of understanding of need. However, no perception of need is sufficient on its own.

Need cannot be measured adequately by selecting only one of these approaches given that each is limited and provides only one facet of the phenomenon (Axford, 2010). Expressed need focuses primarily on individuals receiving or waiting for services, capturing to some extent the demand for services. However, not every parent who needs a service, receives or is waiting for that service (Axford, 2010).

Comparative need looks beyond service-users or those on waiting lists. Nonetheless, it bases estimates of need on existing service provision for similar populations without taking into account that the level of service provision in the reference population may not be the appropriate amount or type of service needed for the population. Furthermore, depending on the nature of the need, there may not be information available from another comparable community/population.

Felt need relies on individual perception of need and subjective views of a situation. Hence, not all individuals with similar circumstances would necessarily feel the same about their needs. Felt need can be overstated if individuals have high expectations or understated if individuals have little knowledge or poor perception of a particular service.

Finally, normative need relies on professionals, policy makers, or researchers to establish a desirable standard and compare individuals or families to that standard. Those individuals or families that are below the standard are said to be in need of support and special services. Nevertheless, normative needs are not absolute. They are likely to change as knowledge, technology and values change. In addition, despite the best evidence to establish norms, professionals or policy makers do not always interpret or implement standards uniformly.

Witkin and Altschuld (1995) considered the difference between need as a noun and need as a verb. Need as a noun refers to a gap or discrepancy between a present state and a desired end state or condition. It is like a problem or a concern. Need as a verb refers to solutions, a means to an end or what is required to modify the discrepancy. Witkin and Altschuld (1995) explain that often what a person may say he or she needs is in fact the solution to the underlying problem or concern. Many NAs confound the two meanings of need. In conceptualizing need as a verb or as solutions, the underlying issues or concerns may not be identified and limit the opportunity to explore and examine a range of possible solutions for the community (Altschuld & Witkin, 2000).

The nature and quality of the NA on parent supports has varied considerably. Some of the studies have relied solely on qualitative methods (Birnbaum et al., 2007; Bloomfield et al., 2005; Hogg & Worth, 2009; Kellett & Apps, 2009; Miller & Sambell, 2003; Roche et al., 2005), used convenience samples (Cutler & Gilderson, 2002), did not report their sample size (Central Okanogan Early Childhood Development Plan, 2007), or used a small sample size (Anderson et al., 2000).

Axford (2009) concluded that many NA conducted in children's services were of poor quality and should not be relied upon as a basis for planning services. For example, those found to be of poor quality used small non-representative sample sizes, provided no information about non-response or the response rates, were biased toward people with positive experiences, had poor research questions, provided no description of their methodology, had poor data collection methods or no details of the methods, had poor data analysis or no information on analysis, and/or offered no recommendations or interpretation of the findings. In addition, many relied solely on qualitative data and lacked the perspectives of the various levels of stakeholders.

Axford (2009) stated that qualitative studies are more useful in the context of larger quantitative studies that included normative data. He indicated that at the very least NAs should include clear and transparent reporting of methods and results to allow for establishing the quality and usefulness of the findings. Some of the NA recently completed in a Canadian context were of high quality and addressed many of these concerns (Devolin et al., 2013; McConell et al., 2012; Russell et al., 2011; Wilson et al., 2011); however none of the studies included the perspectives of more than one stakeholder group.

There is a lack of clear direction on how to conduct and integrate the assessment of parent support needs into local services (Utting, 2009). In addition, the absence of specific indicators makes it more difficult for local areas to assess collective support needs and to plan support services more effectively at a community level. Determining the community support needs of parents is a

challenge when the intent of the policy and practice is to realize better outcomes for children. Improving the quality of NA on community supports for parent of young children will result in more rigorous studies that provide critical information for difficult decisions related to the distribution of scarce resources. Methodologically rigorous NA helps to identify gaps in services and prioritize and justify decisions. They provide baseline information that can be used to assess the effectiveness of services, evaluate policy, and strengthen public accountability (Axford, 2010). If the results indicate that significant unmet needs remain, this information can be used to suggest alternative strategies or policies.

Stakeholders have an important role to play in defining the issues and addressing the concerns that arise from the NA process. Involvement of stakeholders in the process is critical to increasing the uptake of results and utilization of the findings (Green & Mercer, 2001). Pinnock and Garnett (2002) identified the principal sources of information for NA should include: the perspectives of service users –past, present and future; population data on risk factors associated with poor outcomes for children and families, the perspectives of experts or service providers, and research evidence on effective approaches.

Witkin and Atschuld (1995) suggested that stakeholders exist at three levels of need: service recipients (primary level), service providers (secondary level), and organizational resources and inputs (tertiary level). They state that NA should always be directed toward service recipients; data collected should relate to the problems faced by service recipients, not service deliverers, as one cannot infer that solving the problems of service deliverers will address the needs of service

recipients. However, often in NA service deliverers or resources and inputs are the primary focus of the NA.

A paucity of research has focused on the needs of parents with young children (Birnbaum et al., 2007; Ghate & Hazel, 2004; Johnson et al., 2005; Roche et al., 2005; Utting, 2009). Parents of young children, as recipients or potential users of community support services, need to be consulted far more widely than currently occurs in many communities (Axford et al., 2009; Axford, 2010; Axford, 2006; Johnson et al., 2005; Klett-Davies et al., 2008; Rogers & Moore, 2003). Of the small number of NAs related to parent supports found in the literature, only a handful focused broadly on the needs of all parents at the community level (Axford & Whear, 2008; Community Action Toward Children's Health [CATCH], 2007; Devolin et al., 2013), and two at the national level (Birnbaum et al., 2007; Russell, et al., 2011).

Other NAs concentrated on parents of children who were already using a service (Hogg & Worth, 2009; McConnell et al., 2012; Wilson, Thompson, McConnachie, & Wilson, 2012), or the support needs of a specific subset of the parent population with young children, such as mothers of a certain age (Carolan, 2007), children one year of age (McKellar, Pincombe, & Henderson, 2006; Roche et al., 2005), families at risk (Anderson, Lennox, Petersen, & Wailoo, 2000; Fernandez, 2007) or parents of children with disabilities (Cutler & Gilderson, 2002; Palisano et al., 2010). These approaches to NA emphasize the needs of a few parents without considering the needs of the broader population of parents of young children.

One NA focused on the views of both parents and service providers (Bloomfield et al., 2005). Other NAs focused solely on the perspectives of service providers without considering parents views (Kellett & Apps, 2009; Wilson et al., 2012). Historically, service agencies or governmental units conducted NAs to gather feedback on the demand for services currently provided or being considered (Schriner & Fawcett, 1988a). The focus typically did not permit consideration of community strengths or problems not being directly addressed by existing or planned services/programs. There was a tendency to overlook issues of importance to community members. They often asked only about residents' satisfaction with various services and not about the importance of these services. As a result, participatory approaches to NA have emerged, drawing on principles of community building and community development (Kretzman & McKnight, 1993; Hancock & Minkler, 2007; Schriner & Fawcett, 1988b).

### **A Participatory Approach to NA: The Concerns Report Method**

A participatory approach to NA involves researchers working in collaboration with service providers and other community stakeholders in the development and implementation of the NA process (J. Ross & Ben Jaafar, 2006). Participatory research is systematic enquiry that engages community stakeholders as partners in the research process and recognizes the unique strengths that each brings (Green et al., 2001; Israel, Schulz, Parker, & Becker, 1998; Minkler, 2004). Participatory research is an approach to research as opposed to a specific methodology that begins with a research topic of importance to the community.

Green et al. (1996) defined participatory research as “the systematic enquiry, with the collaboration of those affected by the issue being studied, for the purpose of education and taking action or effecting social change.” Jagosh et al. (2012) described participatory research as the “co-construction of research”. It involves quality research with a high level of scientific rigour with those affected, not on or about those affected (Macauley & Salsberg, 2009). Wallerstein and Duran (2010) discussed the values or drivers in participatory research approaches in public health, one of which was translating knowledge into action. This value or driver is congruent with the focus of the proposed study in that the intent is primarily for research to improve the delivery and management of community supports for parents to address the needs of the parents and young children.

The benefits of participatory NA include clarification of program and service objectives, stakeholder support for specific decisions, increased stakeholder belief in the credibility of the NA, greater understanding of program concepts, respect for the diversity of stakeholder perspectives, and organizational learning (Preskill, Zukerman, & Matthews. B., 2003; Turnbull, 1999). Marti-Costa and Serrano-Garcia (1983) suggested that a participatory NA process can be used to facilitate the modification of social systems so they become more responsive to community needs. They outlined the importance of including multiple sources of data, and the limitations of using only “no contact with participants” (p.80) techniques. These data include for example demographic records, census data, and social indicators and make the assumption that community needs and problems that appear in official statistics are representative of community problems. The major limitation of

this form of data is the “lack of direct mobilization potential” (p.81) of the community of interest. Since community stakeholders are not involved in the NA process, they may have no knowledge of the NA or the information gathered, hence, their involvement in contributing to the solutions or participating in efforts to address the concerns will be limited.

“Contact with the agency or community” (p. 81) techniques included a variety of data collection methods such as surveys, interviews, focus groups with stakeholders that respond to the goal of mobilizing the community and raising their awareness of the concerns or issues. Marti-Costa and Serrano-Garcia stated that combining the two techniques is the best alternative in a NA process as “they combine high mobilization potential with the more traditional criteria of representativity, validity and reliability” (p. 82).

Several challenges are also associated with engaging the community in the NA process. Key among them are partnership, methodological (Allison & Rootman, 1996; Israel et al., 1998) and ethical issues (Minkler, 2004), all of which are interrelated. A large amount of time is required to negotiate the research process and partner relationships, which can lead to project delays, missed funding opportunities, and burnout (Caldwell, Zimmerman, & Isichei, 2001; Flicker, Savan, Kolenda, & Mildenberger, 2008; Israel et al., 1998; Minkler, 2004). There may be differences of opinion on the best research design and methods that can lead to less relevant outcomes (Allison & Rootman, 1996; Israel et al., 1998; Minkler, 2004; Sullivan et al., 2001). As well, community members may not be prepared to invest their time and energy into a process that they feel provides little direct benefit to

them. This may be especially true in disadvantaged communities where individuals are struggling to meet their basic needs (Cornwall & Jewkes, 1995).

A major challenge is determining who represents the community in the process (Israel et al., 1998; Minkler, 2004). Communities are far from homogeneous; they tend to be diverse and complex, making it more difficult to hear all perspectives and involve all segments in the research process, especially the most marginalized groups (Cornwall & Jewkes, 1995; Israel et al., 1998; Turnbull, 1999). Competing demands or community needs may emerge depending on the groups consulted. When the research does not address issues of relevance to some groups, as not all needs can be addressed, the level of community involvement in the process may change as enthusiasm and motivation wane (Cornwall & Jewkes, 1995; Minkler, 2004).

Despite the challenges, applying a participatory NA process is in keeping with child-health partnerships, or the approach used by Manitoba Parent Child Coalitions. This approach focuses on the development of partnerships between service providers from different sectors and the community to improve the quality of outcomes in child health. The application of a participatory NA process could assist in developing or further enhancing these partnerships while also assisting in identifying the needs and priorities of the parents and young children that they serve. However, only two of the NA on community supports for parents that were found in the literature discussed using a participatory approach (CATCH, 2007; Cutler & Gilderson, 2002). This particular approach warrants further application

and discussion in the identification of the community support needs of parents with young children.

The Concerns Report Method (CRM) is an example of a participatory approach to NA. Schriner and Fawcett (1988a) described the CRM as a “competence-building approach” (p. 306) to NA. The CRM is a systematic participatory process for setting agendas for community change from the perspective of those who share a common issue. The CRM goes beyond being a NA methodology. It has been conceptualized as an agenda setting, capacity building, and empowering approach as participants take control of decisions that impact their lives (Schriner & Fawcett, 1988b; Ludwig-Beymer et al., 1996; Suarez-Balcazar et al., 2005). The CRM has a clear grounding in theories of empowerment, self-help, and community development (Ludwig-Beymer et al., 1996; Schriner & Fawcett, 1988a).

A participatory approach to research emphasizes the praxis cycle of social action that includes critical reflection, action planning, and implementation (Suarez-Balcazar et al., 1996; Balcazar, Garcia-Iriarte & Suarez-Balcazar, 2009). This praxis cycle builds upon Freire’s (1971) praxis framework of an ongoing interaction between reflection and action that is achieved through a process of critical awareness with the community. This approach is useful for consultation with community coalitions or groups pursuing local improvements such as Parent-Child Coalitions.

The CRM was developed in partnership with Independent Living agencies serving people with disabilities in the 1980’s (Fawcett et al., 1988). The CRM has been used to identify community concerns of low-income families (Schriner &

Fawcett, 1988a), Americans with physical disabilities (Suarez-Balcazar, Bradford & Fawcett, 1988; Nary, White, Buddy & Vo, 2004), older adults, individuals with multiple sclerosis (Finlayson, 2006) and Hispanic immigrants (Ludwig-Beyer et al., 1996; Suarez-Balcazar, Martinez & Casas-Byots, 2005) among other applications.

There are many reasons to consider using the CRM with a community. The CRM gets community members involved in the decision-making process early, increasing their likelihood of getting and remaining actively involved. The process of getting the community to think about and identify their concerns allows community members to take ownership and define what they see as most important. The CRM is a reliable, systematic, and easy to use way to gather information about the community (Balcazar, Garcia-Iriarte, & Suarez-Balcazar, 2009; Fawcett et al., 1988; Finlayson, 2006; Nary et al., 2004). It helps coalition and community members recognize how they see their community, both the strengths and weaknesses. It provides useful information and direction for various stakeholders. The process and outcomes keep an organization's agenda from only reflecting the interests of service providers (Ludwig Beymer et al., 1996; Suarez Balcazar, 2005). Use of this approach with the Parent Child Coalition will allow for the incorporation of parents' views in the development of community supports.

### **Incorporating Parents' Views in the Development of Community Supports**

The importance of seeking parents' views for program and service development cannot be overstated. Their views highlight the inadequacies of present provisions and point to future improvements (McKellar et al., 2006; Roche et al., 2005). If we truly want to support parents of young children, they must

engage in and feel supported by the services offered. The services must be appropriate to parents' self-identified needs, and not merely reflect political or professional agendas for what it is felt parents ought to do or be (Ghate & Hazel, 2004). Unfortunately, the views of parents about the kinds of community support programs and services they would find useful are largely absent from the literature (Ghate & Hazel, 2004; McKellar et al. 2006, Roche et al., 2005).

The few studies that have focused on the needs of the broader population suggest that many parents do not feel supported in their role. Birnbaum et al. (2007) conducted focus groups designed to obtain information on the supports "ordinary" parents of young children felt they needed in their role as parents. Results from their research indicated that parents did not feel that the community was meeting their needs. Most parents felt there was a substantial gap between what they expected and needed and what was actually available, often leaving parents feeling isolated and on their own until children reached school age. Parents consistently requested programs that were flexible, age specific, and unstructured that provided opportunities for support from other parents. While programs and services were important to parents of young children, they also felt that supportive attitudes and beliefs of the community toward parenting were equally as important.

A follow-up to the study conducted by Birnbaum et al. (2007), consisted of a national survey of 2554 Canadian parents on the need for and possible benefit from two types of parent supports: social supports and community resources and programs. Only half of parents felt they received enough practical and emotional

support as new parents and the majority did not feel valued or supported in their role within the larger social context of Canada.

Oldershaw (2002), in a Canadian survey of 1643 parents of young children, found similar results. Only about half felt supported in their parenting role by their spouse or partner, by their own parents, and by their extended family and friends. Only a quarter felt supported by their community. Generally, parents also rated universal, informal, unstructured, flexible community resources and programs as very important such as playgrounds and libraries, public places to meet other families, drop-in centres, and family resource centres. Parents also rated arenas, recreation centres, athletic instruction programs, organized sports leagues, and instructional creative arts classes fairly highly. Parent-child programs and organized playgroups were appealing to most parents. Parents were least likely to find parent education or training to be very important. The use of programs and resources was significantly greater among parents who felt their neighbourhood community was very supportive.

Ghate and Hazel (2004) in the United Kingdom used a nationally representative face-to-face sample of 1754 parents of children from low socioeconomic backgrounds to conduct a survey. They reported significant levels of unmet need among parents who wished they had additional support. Parents reported that services often worked to their own agenda, reflecting what professionals thought families needed or what agencies were able to provide without meeting parents' own, self-defined needs. Ghate and Hazel (2004) concluded that in order to improve services there needed to be greater diversity in

the services available to parents and a proactive approach to raising parents' awareness of available services. Service providers needed to address multiple problems with multiple solutions, and the community needed to endorse a broad approach that builds on strengths and tackles weaknesses.

Hogg and Worth (2009) sought to inform the development of services through the use of parents' perspectives of effective supports. Parents identified social support was critical to successful adaptation to parenting. Many parents viewed postnatal support and toddler groups were very important for facilitating new social networks. However, lack of engagement with these programs was common in parents with depression, parents with more children or vulnerable children, lone parents, and young mothers. Therefore, other types of supports, such as home visiting and groups lead by professionals also needed to be offered (Hogg & Worth, 2009).

Oldershaw (2002) found that most parents felt parenting was the most important thing they do. However, they did not know much about child development and lacked confidence in their parenting skills. While parents felt they had the most influence on their child's social, emotional, and intellectual development, they were uncertain about how to promote development in these areas. No parent subgroup (fathers, socio-economic disadvantage, single mothers, mother's employment status, experience in the parenting role, and age of first-time parent) was notably higher in knowledge of child development or confidence in their parenting role. Contrary to prevailing views, mothers did not know more about parenting than fathers, experienced parents did not know more or have more

confidence than inexperienced parents, and parents with more education and income did not know more about child development than parents with less education and income. Knowledge and confidence were found to be significantly associated with parenting behaviour. Parents of young children who had more knowledge of child development and more confidence in their parenting role were more likely to engage in positive parenting.

Canada's family support programs and services remain highly fragmented and families face an ever-expanding mix of unconnected options with diverse eligibility criteria, and payment requirements (McCain et al., 2007). Overlapping mandates, disjointed service hours, and eligibility barriers make it difficult for parents to know what is available (Atkinson Charitable Foundation, 2004; Mayer & Fahreen, 2006). Furthermore, large gaps in service exist along with duplication of services (Organisation for Economic Co-Operation and Development, 2006).

Parents need to know about and have access to community programs to benefit from the services. Not knowing if a service is available would greatly impact a parent's sense of perceived need. Parents may not know a program or service exists, and view it as a gap in community supports. Therefore, parents' knowledge of the availability of programs and services will be analyzed in conjunction with parent perceived needs. In addition, parents' use of a service can be viewed as an expressed need. Parents who report using a particular program or service are suggesting that the program or service is meeting a particular need. Parents' use of a particular program or service will also be analyzed in conjunction with parent perceived need. Involving parents not only at a program level, but also at the community level, is

part of the solution to creating greater awareness of available supports and developing programs and services that will meet the needs of parents and young children.

### **Summary of Rationale for Study**

Early childhood development is a determinant of health and plays a critical role in competence and coping skills that will affect learning, behaviour, and health throughout life. Recent research has shown that many of the children not ready for school come from all socioeconomic backgrounds. Knowing that these children are not limited to low income families has created a push for targeted programs and services that are part of a universal approach. This approach would respond to the needs of children and parents from all backgrounds while investing more heavily in those who demonstrate the greatest need.

Child-health partnerships, of which Healthy Child Manitoba is one, that bring service providers from various sectors together with the community to plan and implement services offer an important approach to the development and implementation of community supports for parents and young children. The use of a participatory NA process such as the CRM is compatible with this approach and warrants further investigation in relation to the identification of the community supports needs of parents with young children.

When examining the body of literature on NA and parent support programs, most NAs have not focused on the broader range of parents. Therefore, little is known about the extent to which community supports are meeting the needs of many parents. In addition, the quality of many NAs is lacking. The research

continues to demonstrate that attracting parents and engaging them in programs remains a challenge. Hence, unless programs are designed in ways that reliably ensure parental engagement, they will fail to meet their outcomes. Re-examining assumptions about the kinds of programs and services that are truly helpful to parents for enhancing the development of their children and involving parents in this process is an important step to addressing these concerns.

A review of the literature revealed several factors that may influence parent's perceived need for community support. The factors that will be considered in this study include: child with a disability or health concern, mother's health status, mother's education, marital status, mother's age, family income, parental stress, social supports, mother's employment status, parent relationship to child, first time parent, knowledge of availability of services, and use of a program or service. Family support programs and services developed with input from parents of young children can be a catalyst for children, families, and communities. While the nature of the support that parents want and need may vary across communities and among subpopulations within the community, local efforts to ensure that all parents feel and are supported have the potential to make critical contributions to healthy child development and build stronger communities.

## **Chapter 3: Theoretical Perspective, Methodology, and Methods**

### **Guiding Conceptual Framework**

Consistent with the literature that demonstrated the importance of parent engagement, the proposed study was guided theoretically by empowerment theory (Rappaport, 1981). Empowerment theory assumes that organizing and/or supporting community groups in their identification of important concerns and issues, and in their ability to plan and implement strategies to mitigate their concerns and resolve their issues can lead to positive social change (Labonte, 2007). Empowerment refers to the process of helping people to gain influence over events and outcomes that matter (Fawcett et al., 1995), attain mastery of control through problem definition, and obtain more power over decisions. Empowerment is strengthened through critical consciousness, or conscientization, a concept from Brazilian educator Paulo Freire (1971). Freire (1971) proposed a process of continuous reflection and action that contained a cycle of listening-dialogue-action. Through structured dialogue, group participants listened for the issues contained in their own experiences, discussed common problems, looked for root causes and the connections among the problems and devised strategies to help transform their reality. “Conscientization is the consciousness that comes through the social analysis of conditions and people’s role in changing those conditions.” (Minkler & Wallerstein, 2003)

Empowerment theory provided the most appropriate guiding conceptual framework for the proposed study for several reasons. First, empowerment supports change with respect to shared decision-making among parents and other

community members and supports the building of stronger alliances among community residents. Second, parenting support should be accessible and responsive to specific needs and parents should be involved in their development. Empowerment theory supports this process. Third, empowering parents emphasizes recognizing parents as experts on their own children, encourages confidence in their ability to solve parental issues, and gives parents a voice in shaping community-based initiatives for parents and children. Fourth, raising awareness of the concerns of parents of young children, and developing solutions requires a process of critical consciousness with the community. Finally, the aim of parent child coalitions, the group that assisted in facilitating the study, is to develop activities based on community needs and priorities determined through community consultation, a process in keeping with empowerment theory.

### **Methodology**

This study used an exploratory sequential mixed methods research design (Creswell & Plano Clark, 2011) to complete a single instrumental case study of a NA guided by the Concerns Report Method (CRM) (Schriner & Fawcett, 1988a). The project spanned a two-year period. The following details the research design and activities.

Mixed methods research draws on the strengths of qualitative and quantitative methodologies by combining both in a single research study to increase breadth and depth of understanding (Creswell & Plano Clark, 2011). Mixed methods research facilitates a more comprehensive understanding of the research problem than either approach alone allows; the combined results are greater than the sum of their

individual results. An exploratory sequential mixed methods research design begins with the collection and analysis of qualitative data in the first phase and builds on the exploratory results in a second quantitative phase to determine if the quantitative findings extend the initial qualitative exploratory findings (Creswell & Plano Clark, 2011).

As discussed previously, the participatory approach of the CRM is in keeping with the Parent Child Coalitions' mandate to bring stakeholders together to support and promote community-based programs for parents with young children using a community development approach.

The CRM has five methodological phases:

- Phase 1: Reflection on Values and Issues of Importance;
- Phase 2: Identify Community Concerns;
- Phase 3: Brainstorm Ideas and Identify Solutions;
- Phase 4: Action Planning and Action Taken;
- Phase 5: Monitoring and Feedback.

The primary purpose of the study was to apply and evaluate Phases 1 and 2 of the CRM to determine its potential in identifying community support needs of parents with young children. Phases 3, 4, and 5 of the CRM focus on solutions and actions once needs and strengths have been identified and can last several years. The student researcher carried out phases 3, 4 and 5 in conjunction with the Parent Child Coalition but separate from this doctoral dissertation.

The exploratory sequential design began with the collection and analysis of qualitative data through document review, interviews, and focus groups with

parents and service providers in the first phase of the CRM (Reflection on Values and Issues of Importance). The intent of the first phase was to begin to examine existing community data and programs and services, and to explore parent and service providers' views on community supports for parents with young children. The second phase of the CRM (Identifying Community Concerns) used the exploratory results from phase one to develop a Concerns Report Survey. The Concerns Report Survey was used to determine if the findings extended the initial qualitative findings from Phase 1 and to prioritize needs and identify community strengths. Both of the phases are further described in the subsequent sections. In a single instrumental case study, the researcher focuses on an issue or concern, and then selects one bounded case to illustrate this issue (Stake, 1995). For the purpose of this study, the case was a geographic community and the issue was community supports for parents of young children.

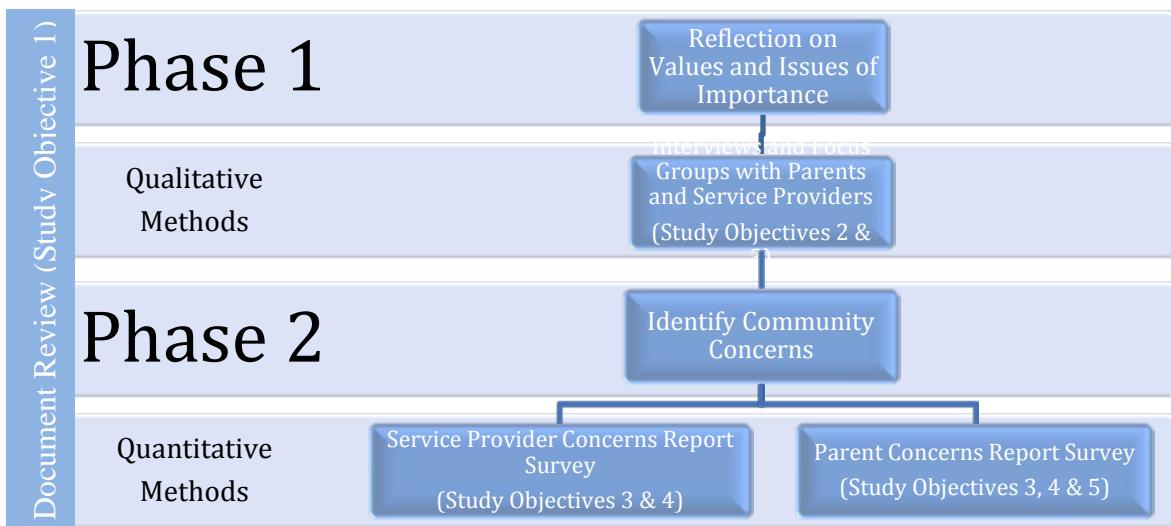
A NA team comprised of parent child coalition members, including the student researcher, planned and implemented the CRM. The parent child coalition did not wish to designate a separate committee for the NA, but rather have all members be part of the process. Members of the NA team participated in all phases of the NA to varying degrees, the detail of which will be provided in each phase of the process. Ethical approval for the study was obtained from the University of Manitoba Health Research Ethics Board (approval # H2011:023 and H2011:318)(See Appendix B).

## **Methods.**

Several research methods were used to complete Phases 1 and 2 of the CRM.

Figure 1 describes the research methods used and the study objectives that correspond with each method.

**Figure 1: Research Methods**



### **Phase 1: Reflection on values and issues of importance – Qualitative Methods.**

#### ***Document Review (Study Objectives 1 & 2).***

The NA team completed a document review to summarize what was already known from existing community level data about the community supports needs of parents with young children. The document review began in Phase 1 of the CRM and continued throughout the research study. New documents were added as they became available. Documentation is a particularly rich source of information. A document is a written, audio, or visual image record (Bowling, 1997) that can be used to generate ideas about important questions to pursue through focus groups

and interviewing (Patton, 2002). The information gathered can also provide important insights into the topic of study.

*Document acquisition and sampling.*

Published information on parents and children in the community of study was gathered. Snowball sampling was used to collect documents from individuals working for governmental and non-governmental agencies that provided programs and services for young children and their parents. Snowball sampling is used for document review when a list of documents with the information being sought is not available (Bowling, 1997). The researcher was also aware of many documents of relevance to the community because of her previous research on the topic and the relationship she had developed with the Parent Child Coalition over a few years. The Coalition circulated documents via e-mail that related to early childhood development issues.

As Mogalakwe (2006) suggested, the authenticity, credibility, representativeness and meaning of the document were all considered in the selection of documents for the review process. For example, documents produced and distributed through government, a government agency, post-secondary educational institution, school division, research centre, or a known community organization were deemed to be authentic and credible as the evidence was genuine, of reliable and dependable origin, and provided an accurate account of the information related to the community. The representativeness of the document content was also considered. The sampling frames, selection procedures, methods of data collection and analysis needed to provide information that was representative

of the community of interest. Finally, the meaning of the document had to be clear and comprehensible. As well, the context in which the documents were produced needed to be specified in order for the reader to interpret and assess the meaning of the information provided.

Documents that included general socio-demographic information about the community were included in the review. In addition, documents that provided information at the community level on: fetal and newborn health; children's (0 to 6 years) health care utilization; children's use of social, educational, and municipal programs and services; children with disabilities, medical conditions, and mental health issues; and children's school readiness were sought. As well, documents that provided information at the community level about parents of young children newborn to seven years such as socio-economic characteristics, marital status, age at birth of child, type of births, health status, lifestyle choices during pregnancy, use of social services, and pre-natal and post-natal use of health care services. The student researcher remained open to the discovery of additional information related to parents and young children that was relevant to identifying community support needs and concerns for this population. When possible, information on how children, parents, or the community were similar or different from Winnipeg or Manitoba was also collected. In addition, information about the types of programs and services offered to parents with young children in the community and their location was collected throughout the research process.

*Documents.*

The information was obtained primarily from Census Data specific to the community area, the Winnipeg Regional Health Authority (WRHA) Community Health Assessment Report (2010), the Manitoba Centre for Health Policy reports - *Manitoba Child Health Atlas Update* (Brownell et al., 2008), and Healthy Child Manitoba's - the *Early Development Instrument - Community Report* (Healthy Child Manitoba, n.d.). Additional reports were included later in the process – How are Manitoba Children Doing (Brownell et al., 2012) and Perinatal Services and Outcomes in Manitoba (Heaman et al., 2012) - as they provided updated information relevant to parents and young children living in the community of interest. Several other provincial documents were available but did not provide information at the community level. Information on programs and services was located in a variety of documents; many were created at the community level and circulated among members of the Parent Child Coalition using the e-mail distribution list.

*Data collection.*

The student researcher contacted members of the Parent Child Coalition and other service providers via e-mail or met with them face-to-face to inquire about the documents that they used to inform the development of programs and services for parents with young children in the community area of interest. The researcher reviewed each document to determine if it contained information related to the group of interest. Relevant information related to the identification of the needs and strengths in community supports for parents with young children was extracted and recorded in a separate Word document.

Census data were used to determine community characteristics such as the general demographic and socioeconomic conditions of the community. Much of this information was available through the City of Winnipeg website or included in the other reports that were reviewed. The Manitoba Centre for Health Policy's Manitoba Child Health Atlas Update (Brownell et al., 2008) and the Winnipeg Regional Health Authority's Community Health Assessment (2010) were both rich sources of information that offered a variety of data at the community level. Socioeconomic characteristics and community and social services available to families with young children, characteristics of mothers giving birth, types of births (preterm, caesarean vaginal), infant mortality and stillbirths, rates of health care utilization for children, child prescription use, and prevalence of childhood chronic conditions were collected from these documents. The student researcher included Winnipeg and Manitoba proportions or rates when available in order to compare the similarities and differences. Many of the documents reviewed reported this information and calculated if the community's rates or proportions were statistically different from Winnipeg and/or Manitoba.

Finally, the student researcher obtained reports from the Healthy Child Manitoba website on the children's Early Development Instrument (EDI) results for the community of interest. The EDI is administered every other year in Manitoba with kindergarten children, to determine developmental areas of concern for children entering school in the community. The EDI is used to assess community outcomes in five domains of child development: physical health and well-being, social competency, emotional maturity, language and thinking skills, and

communication skills and general knowledge. It has been implemented in all school divisions across Manitoba (Healthy Child Manitoba, 2005). The child's kindergarten teacher completes the EDI checklist for each student later in the school year after getting to know him/her. The EDI is a population level measure that does not diagnose a child's developmental problems. The results are used to identify communities who have greater proportions of vulnerable children and can assist in determining communities in greater need of early childhood development programs and services to improve child outcomes (McCain et al., 2007). Many communities currently rely on this data when planning community support services for parents with young children. The proportion of children very ready on the EDI domains, not ready on the EDI domains, not ready on the EDI subdomains, and school readiness by neighbourhood were extracted.

*Document analysis.*

The researcher completed directed content analysis (Hsieh & Shannon, 2005) of the data extracted from the documents using the categories outlined above to organize the data while remaining open to emerging categories. All of the data was considered as a whole and then, coded and categorized by topic/population. This information was then summarized in tables to create a profile of families with young children living in the community of interest. Over the course of the study, data was added to the tables based on newer information that was made available. A written description of the information in the tables was also developed to provide more context and highlight any of the similarities or differences with Winnipeg or Manitoba.

A summary report outlining the potential concerns or issues for parents and young children in the community of interest was prepared for the Parent Child Coalition and service providers (See Appendix C). This information was used to provide an overview of the issues and concerns that would be of relevance to identifying the support needs of parents with young children in the community.

***Semi-Structured Interviews (Study Objectives 2 and 3).***

Much qualitative research is interview based (Flick, 2001; Silverman, 2001). Qualitative interviewers aim to go below the surface of the topic being discussed, explore what people say in as much detail as possible, and uncover new areas or ideas that were not anticipated at the outset of the research (Creswell, 1994; Flick, 2001). Interviews can also serve to clarify other sources of information.

***Focus Groups (Study Objectives 2 and 3).***

Focus groups allow for the thoughtful discussion of a topic of interest to the group and researcher. The informal group discussion atmosphere of the focus group interview structure is intended to encourage participants to speak freely and completely about behaviours, attitudes and opinions they possess related to the topic. This technique provides an opportunity for the kind of probing and follow-up that is common in individual interviews, but also allows participants to hear the views of others (Witkin & Altschuld, 1995).

The purpose of the interviews and focus groups was to describe service providers' and parents' perspectives on the current strengths and gaps in community supports for parents with young children and determine what their

perspectives can add to existing community level data obtained through the document review.

*Sampling and recruitment.*

*Service providers.*

This phase of the research project used purposive and snowball sampling. In purposive sampling, the researcher seeks to involve participants with certain characteristics. Based on their knowledge of a particular group, researchers select potential participants who they believe may have the knowledge and attributes they are seeking for the study (Patton, 2002). Service providers from community organizations involved in the delivery of programs and services to children newborn to 6 years of age and their parents in the community of interest were invited to participate.

The researcher sought individuals working within a variety of programs and services such as health care, early childhood education, parent education, and social services. Service providers had to have at least one-year experience working with parents and young children in the community of interest. Recruitment letters (see Appendix D) were distributed through the Parent Child Coalition and the Community Action Network e-mail distribution lists. Individuals were invited to participate and to share the letter with other community organizations and service providers working with parents and young children in the community of interest. The letter outlined the nature of the research project and asked interested individuals to contact the student researcher for further information.

*Parents.*

Purposive sampling was used to ensure that participants were varied with respect to certain characteristics. The NA team wished to include a range of parents with young children. In keeping with the guiding conceptual framework, this sampling approach allowed parents with various characteristics to have a voice in the NA process. While equal representation across the characteristics was not sought, the following demographics were considered when recruiting the sample: parent age, parent relationship to child, age of child, marital status, employment status, income, level of education, number of children.

Parents had to live in the community of interest to participate in the interviews. Parents of children ages 0 to 6 years were recruited from a wide range of organizations, facilities, and community programs (e.g., family resource centres, home visitor programs, primary health care clinics, licensed day care centres, community centres, churches, local grocery stores, YM-YWCA, libraries, local shopping mall). Recruitment letters (See Appendix E) and posters (See Appendix F) that described the study were circulated to the various organizations and programs via e-mail or delivered in person by members of the NA team (e.g., handout to parents, posted on bulletin boards, inserted in newsletters). The NA team also placed an advertisement in the local newspaper (See Appendix F). Recruitment materials informed potential participants about the study and provided them with the student researcher's name and contact information. A fifteen-dollar honorarium was provided to participants for their time.

The data generated and saturation of categories achieved through content analysis dictated the final sample size. The student researcher was uncertain initially how many participants would need to be recruited; in the end, 40 individuals participated in a total of 12 interviews and four focus groups.

*Participants.*

*Service providers.*

Sixteen service providers contacted the student researcher to enquire about the interviews. Three participants were interviewed individually and eight participants were interviewed in dyads. The remaining participants were not able to arrange an interview within the time frame for this phase of the study. Table 1 provides an overview of service provider characteristics.

**Table 1: Service provider demographics (N=11)**

Demographic Characteristics	N (%)
Profession	
Nurse	3 (27.3)
Early Childhood Educator	4 (36.3)
Social Worker	1 (9.1)
No formal training	3 (27.3)
Years Experience in Current Position	
1-5 years	5 (45.4)
6-10 years	3 (27.3)
11+years	3 (27.3)
Years Experience Working with Parents/Young Children	
10 years or less	3 (27.3)
11-15 years	2 (18.2)
16-20 years	2 (18.2)
20+ years	4 (36.3)

All service providers were female. Early childhood educators and nurses made up the majority of this group. The largest proportion of respondents (45.4%) had

been in their current position for 1 to 5 years; however, many (36.3%) had over 20 years of experience working with parents and young children.

*Parents.*

Thirty-five parents contacted the student researcher regarding the interviews/focus groups, and a total of twenty-nine parents participated in the interviews or focus groups. Those who did not participate either did not live in the community of interest or could not arrange a suitable time to meet for an interview. Individuals were interviewed if they could not attend the scheduled focus group but still wanted to participate in the research study. Five parents were interviewed. The remaining parents participated in one of four focus groups ranging in size from 3 to 10 participants.

Table 2 provides an overview of the parent participants. When recruiting parent participants, the student researcher included more parents from lower socioeconomic status as many of the programs and services for parents and young children in the community are targeted at this population. In addition, they are often more difficult to engage in parent-child programs (Ghate & Hazel, 2004; Gomby, 2005). Most parents were married (83%), born in Canada (90%), and mothers (90%). The majority were between 30 to 39 years of age (55.2%) and had an infant less than one year of age (44.8%). The median number of children was 2, with 65.5% having only one child. The average age of the youngest child was 1.67 years. Most parents worked full-time (37.9%) and had a high school (41.4%) or university (41.4%) education.

**Table 2: Parent demographic characteristics (n=29)**

Demographic Characteristics	N (%)
Parent Age	
<20 years	3 (10.3)
20-29 years	10 (34.5)
30-39 years	16 (55.2)
Age of Youngest Child (median)	1
<1 year	13 (44.8)
1-2 years	8 (27.6)
3-4 years	7 (24.1)
5+ years	1 (3.4)
Employment Status	
Full-time	11 (37.9)
Part-time	5 (17.2)
Unemployed/Stay at Home	9 (31.1)
Maternity Leave	4 (13.8)
Family Income	
<\$40,000	11(37.9)
\$40,000-\$69,999	5 (17.2)
\$70,000-\$89,999	7 (24.2)
\$90,000+	4 (13.8)
missing	2 (6.9)
Education	
<High school	1 (3.4)
High school	12 (41.4)
College	4 (13.8)
University	12 (41.4)

*Data collection.*

Informed consent was obtained prior to commencing all interviews (See Appendix G & H) and focus groups (See Appendix I). In addition, socio-demographic information was collected from both service providers (See Appendix J) and parents (See Appendix K) to guide the gathering of pertinent participant information. The student researcher conducted the interviews with parents and service providers at a time and location of the participant's choosing and held parent focus groups in a private, safe community setting that the participants could easily access. Interviews took 45 to 90 minutes to complete, and focus groups took 90 to 120 minutes to

complete. The service provider semi-structured interview guide is included in Appendix L. The parent semi-structured interview/focus group guide is included in Appendix M. Typed detailed field notes were recorded immediately following interviews and focus groups to describe the environment, content observed, the researcher's impressions, analysis (e.g., researcher's questions, tentative hunches, trends in data, and emerging patterns), and problems or challenges that arose.

*Data analysis.*

Digitally recorded parent and service provider interviews and focus groups were transcribed verbatim by a transcriptionist into an electronic (Word<sup>TM</sup>) format. All identifying information was removed upon creation of the electronic format. The student researcher reviewed all of the transcripts for completion. An inductive approach to content analysis was taken. Using this approach, the student researcher immersed herself in the transcripts to identify themes that would seem meaningful to the producer of each message.

Creswell (2003) suggested several steps to engage the researcher in a systematic process of analyzing text.

Step 1. Organize and prepare the data for analysis.

Step 2. Read through all the data.

Step 3. Begin detailed analysis with a coding process. Creswell suggested using the process developed by Tesch (1990) i) Get a sense of the whole. Read through all of the transcripts carefully. ii) Pick one document. Go through it, to find out what it is about. Think about the underlying meaning of the information, and type thoughts in the margin of the document. iii) When this task has been completed for several

documents, make a list of all topics. Group together similar topics. Form these topics into columns that might be arranged as major topics, unique topics, and leftovers.

iv) Take the list and go back to the data. Abbreviate the topics as codes and type the codes next to the appropriate segments of the text. v) Find the most descriptive wording for the topics and turn them into categories. Group topics together that relate to each other. vi) Make a final decision on the abbreviation for each category and alphabetize these codes. vii) Assemble the data material belonging to each category in one place and perform a preliminary analysis. viii) If necessary, recode the existing data.

Step 4. Use the coding process to generate a description of the categories or themes for analysis.

Step 5. Advance how the description and themes will be represented in the qualitative narrative, typically a narrative passage is used to convey the findings of the analysis.

Step 6. Make an interpretation or meaning of the data.

The student researcher completed the qualitative data analysis of the interviews, focus groups and field notes, reviewed the categories and themes generated from the analysis with her supervisor, and summarized the findings for the NA team. The NA team met to review the findings, which were used to develop the Parent and Service Provider Concerns Report Surveys.

### **Trustworthiness.**

Issues related to credibility, dependability, confirmability, and transferability were addressed in this study (M. Law & McDermid, 2007).

### ***Triangulation.***

Several authors recommended the use of triangulated methods, the use of three or more methods, to enhance the validity of the findings (Bowling, 1997; Creswell & Miller, 2000; Flick, 2001; Patton, 2002). Once a proposition has been confirmed by more than one independent measurement process, the level of uncertainty surrounding it is reduced. To enhance dependability and credibility, the information obtained using document review, interviews, focus groups, and field notes were triangulated. Transcripts were compared to field notes, and any additional non-verbal cues were incorporated to ensure accuracy of interpretation. In addition, individual viewpoints and experiences were verified against others creating a rich picture of the attitudes, needs, and behaviours of participants through the use of a wide range of informants, another method of triangulation.

### ***Member checking.***

One method recommended to enhance the trustworthiness of qualitative research is member checking. Member checking was used to establish credibility and dependability of the findings. The student researcher mailed each participant a summary of the themes and categories gleaned from the transcripts. Participants were asked to review the themes and categories to determine if they reflected their thoughts/ideas. Members were asked to respond to the student researcher in writing, via e-mail, or telephone with any comments, changes and, or additions they wished to provide within two weeks of receiving the summary. Member checking was used to solicit the views of participants regarding the credibility of the findings and interpretations. Two parents phoned the student researcher to discuss

additions to the categories or elaborations on existing categories. One category was added as a result of the discussion with one parent and another was expanded to include another group of parents. The addition of these two categories did not change the subsequent theming of the data. One parent sent an e-mail indicating she felt the themes and categories reflected her thoughts/ideas. Three of the service providers contacted the student researcher. Two of the service providers called the student researcher to indicate they felt the summary reflected their thoughts/ideas. Another service provider met in person with the student researcher to clarify some of the key points listed in the summary. While the discussion assisted in clarifying the information provided to the service providers, it did not change the subsequent theming of the data.

***Prolonged engagement.***

Through prolonged engagement in the topic area and field, the student researcher and NA team engaged in reflection and development of the findings in order to address issues of credibility and dependability. While the student researcher was primarily responsible for the data collection and analysis, the findings were discussed with the NA team throughout the process. The student researcher participated in monthly Parent Child Coalition meetings and discussed findings throughout the process. Prior to beginning data collection and analysis, the student researcher had worked with the Parent Child Coalition for three years, and the data collection took another two years to complete. The student researcher continues to be involved with the Parent Child Coalition and the community of interest.

***Audit trail and thick rich description.***

Confirmability of findings was achieved through development of an audit trail, or a recording of thoughts, decisions, and actions throughout the data collection and analysis process. Field notes were used to record the process of the interviews and focus groups. A research log of all activities was developed along with a data collection chronology and recording of the data analysis procedures. Transferability speaks to the notion of whether or not the findings from a study can be applied to other situations. Providing thick, rich, descriptions of participants and providing a full description of all the contextual factors impinging on the inquiry or the boundaries of the study assisted in addressing issues of transferability (Shenton, 2004). As well, the researcher endeavored to describe the setting, the participants, the data collection methods, and the themes of the study in rich detail throughout the presentation of the results using direct quotes from participants. The facts from the document review were supplemented by more detailed descriptions of parent and service provider's experiences in the community. The student researcher attempted to provide as much detail as possible, so that the reader could understand the credibility of the account. Lincoln and Guba (1985) suggested that the researcher must ensure sufficient information is provided for the context to allow the reader to determine if the findings are transferable to other contexts.

***Researcher reflexivity or position of the researcher.***

Creswell and Miller (2000) described researcher reflexivity as a process where researchers consider their assumptions, beliefs, biases, actions and inactions that may shape their inquiry throughout the research process. Creswell and Miller

(2000) discussed the importance of bracketing or suspending researcher biases as the study proceeds. Finlay (2002) discussed that reflexivity at a minimum “means acknowledging the existence of researcher bias and explicitly locating the researcher within the research process” (p.536). Reflexivity involves an ongoing internal conversation and critical self-evaluation of the researcher’s “positionality” as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome (Berger, 2013). Therefore, the student researcher explored her impact on the research process, and the influence the research process had on her throughout the study.

The student researcher played multiple roles while engaged in the research process. She was not only a doctoral student, but a parent of two young children, a resident of the community of interest, an academic who conducts research, and had worked as a pediatric occupational therapist or service provider. She was also Caucasian, middle-class, an older first-time mother (over 35 years old when first child was born), and employed full-time. She had affiliations to both of the primary groups that were the focus of the study and could be referred to as a complete member researcher (Adler & Adler, 1994) or an insider (Dwyer & Buckle, 2009). Being an insider can allow for greater acceptance, trust, and openness among participants; they may be more willing to share their experiences assuming the interviewer shares a common understanding or can personally relate to their experience (Dwyer & Buckle, 2009). However, she was also profoundly aware that holding membership in a group does not denote complete sameness within the group. In addition, this shared status can impede the research process of which the

student researcher was particularly mindful throughout the study. To address some of the potential challenges the insider position creates, the student researcher employed several techniques throughout the process.

She was cognizant that all of her roles would have an influence on the interview and focus group discussions. As a parent researching other parents, the researcher was exploring the meanings of the participants' experiences while simultaneously living her own experiences as a new parent in the community of interest. As a service provider, she had worked with families with young children, mostly parents of children with disabilities, and had experienced firsthand the challenges of providing supports to parents and young children. Given these roles, she approached the study with some knowledge about the subject that allowed her to address certain topics more easily or delve further into topics, as she was equipped with insights and the ability to understand implied content, and was more sensitized to certain dimensions of the data.

The student researcher also held certain beliefs and assumptions going into the research process. In keeping with the theoretical framework of empowerment, the student researcher believed that all parents should have a voice in the decision-making process and be involved in the planning and development of programs and services that are intended to address the needs of families with young children in the community. Her training as an occupational therapist emphasized the importance of family centred service delivery, and her work with families in remote northern communities highlighted the need for models of service delivery that involved the community in the planning and delivery of services. The student

researcher also assumed that the socioeconomic status of parents would influence perceived needs or concerns related to community supports. Given the need for greater supports for families at risk, the student researcher anticipated that parents of lower socioeconomic status would have perceived needs that differed from parents of middle and higher socioeconomic status. In the same way that parents from middle and higher socioeconomic status would have different perceived needs.

In an attempt to minimize the influence of the various roles, beliefs, and assumptions, introductory comments were scripted and were the same for all interviews and focus groups. The researcher shared with participants the various roles that she played and indicated that she was participating in the process as a researcher. To protect the integrity of the data, the student researcher consciously limited her input and comments throughout the interviews and focus groups, in order to reflect on, summarize and synthesize participants' statements. She focused on the facilitation and process while further exploring participants' comments using the semi-structured interview guide. She paid particular attention to when parents or service providers would fail to explain their individual experience perhaps assuming the researcher's familiarity with participants' realities. The student researcher would have to be conscious and attentive to this process and ask participants to elaborate on their experiences. Because of her insider position, she had to be constantly aware and reflecting on how her presence and how who she was may have shaped the conversation as well as explain to participants that while she may have shared an experience, everyone experienced it differently, and she wanted to learn their experiences. In addition to maintaining awareness of her own

responses and body language throughout the interviews and focus groups, the researcher remained aware of the participant's emotional responses and body language to discussion as well as her own. This information was gathered in field notes and incorporated into transcripts to ensure accuracy of interpretation.

Disciplined bracketing and reflection with a close awareness of personal biases and perspectives were employed during analytical and interpretive discussions to try to limit any preconceptions and biases (Tufford & Newman, 2012). The use of field notes and discussions about the data analysis with the student's doctoral advisor and the NA team assisted in accessing researcher preconceptions and biases. The student researcher always attempted to be open, authentic, honest, deeply interested in the experience of participants, and committed to accurately and adequately representing their experience. During the data collection and analysis process, the researcher constantly and deliberately worked to maintain separation between her experiences and the participants' experiences, curbed the drive to compare experiences and to impose her experiences on participants, examined herself, and documented her reactions in field notes.

### **Ethical Considerations**

Ethical standards were upheld and maintained throughout the project with particular attention to respectful interactions that protected the well-being of participants in research. All participants had an opportunity to ask the researcher questions about their involvement in the study prior to consenting to being involved. Participants could withdraw from the study at any time during the

process. Written consent was obtained from all participants prior to enrolment in the study. All information was kept confidential. All data were stored on the student investigator's password protected computer. Given the time frame to complete the study and the requirements of some publishers to keep the data for longer periods, all data will be kept on the student researcher's password protected computer for ten years. Standards as agreed upon in a proposal to the University of Manitoba Health Research Ethics Board were upheld in recruitment, consent, confidentiality, and sensitivity to participants' well-being.

### **Phase 2: Identify Community Concerns - Quantitative Methods.**

Based on the initial document review, interviews, focus groups, and field notes, the student researcher in consultation with the NA team developed the Parent and Service Provider Concerns Report Surveys.

#### ***Concerns Report Surveys (Study Objectives 3, 4 & 5).***

Cross-sectional surveys were used to address if the findings helped to extend the initial qualitative findings, to evaluate the extent to which parents' and service providers' perspectives on community supports strengths and needs differed, and the child and family characteristics that influence parents' perceived needs. Surveys are a useful and efficient tool for learning about people's opinions and behaviours. The characteristics of a large group of individuals can be estimated with confidence by collecting information from a smaller sample of respondents selected randomly from carefully defined populations (Dillman, Smyth, & Christian, 2009). The Concerns Report Survey is a unique feature of the CRM. It provides a Need Index

that is used to establish priorities for action based on survey participants' identified community strengths and needs.

*Sample and recruitment.*

*Services providers.*

As there was no complete list of service providers working with parents and children in the community, a convenience, snowball sample of service providers working with parents and children newborn to 6 years in the community was used. A link to the on-line Service Provider Concerns Report Survey was sent to service providers through the Community Parent Child Coalition and Community Action Network e-mail distribution lists. Representatives from health, housing, education, government, police services, social services, child care, education, and other community organizations that provided programs and services for young children and their parents in the community were included on the e-mail distribution lists. The exact number of individuals on the e-mail distribution lists was unknown and there are several cross listings on the two lists. Recipients of the letter were asked to forward the e-mail to other individuals, organizations who they knew worked with parents and young children in the community.

*Parents.*

The student researcher made a request to the Manitoba Health Information Privacy Committee to assist with mailing out information related to the survey to a random sample of households in the community with children newborn to 6 years of age. To create the selection cohort, children born between January 1<sup>st</sup>, 2006 and December 31<sup>st</sup>, 2011 within the Community Area were identified. Multiple children

in the qualifying age group who were part of the same household were identified by grouping by current mailing address; where more than one qualifying child was part of the same household (as demonstrated by living at the same address), only one of these children (chosen at random) was included in the selection cohort. Normal exclusions (individuals with cancelled registration for any reason, and exclusion of individuals who have requested that Health not include them in future mail-outs) were applied.

Children in the selection cohort were also assigned an income quintile using the postal code of their current mailing address. These income quintiles were assigned using a Manitoba-specific postal-code-to-income-quintile walkway created using census income data, which was developed by the Manitoba Centre for Health Policy and shared with Manitoba Health. Due to limitations of the data, an income quintile could not be assigned to every postal code of residence of every child. As the number of children/households for which this was the case was relatively small (65 children out of 4,143, from 46 households out of 3,098) and there were valid reasons for exclusion, these children were excluded from the selection cohort. Manitoba Health indicated that potential reasons for exclusion included the following: an identified income quintile was rural, not urban; a postal code was present for which the income quintile was not available because it was implemented after the postal code-income quintile walkway was created; or a postal code was present for which the income quintile was not available because an income quintile could not be reliably assigned due to geo-demographic reasons.

### *Participants.*

Stratified selection of potential participants was performed using SAS's built-in SURVEYSELECT procedure, with income quintiles used as the stratifying variable. As instructed by the student researcher, Table 3 outlines the numbers of households that were selected from each quintile for the mail out. Families in the two lowest income quintiles were oversampled to ensure good representation from this group, as lower income families tend to have lower response rates on surveys (Dillman, Eltinge, Groves, & Little, 2002; Mohadjer & Choudhry, 2002).

**Table 3: Number of households selected from each quintile**

Income Quintile	Minimum	Maximum	Mean	Households	% of households	# for mail out	% of total households
U1	14,640.00	42,407.00	34,658.62	529	17	450	85
U2	42,463.00	54,866.00	48,604.02	353	12	300	85
U3	54,878.84	68,490.00	61,586.92	493	16	320	65
U4	68,696.00	87,313.78	77,480.25	885	29	575	65
U5	87,355.00	406,531.00	116,002.59	792	26	515	65
Total				<b>3,052</b>	<b>100</b>	<b>2,160</b>	<b>71</b>

### *Service Providers.*

Fifty service providers responded to the Service Provider Concerns Report Survey. Given the use of a convenience sample, it was not possible to calculate a response rate for service providers. Three participants did not respond to over 95% of the questions; they had discontinued the survey after only responding to a few questions. Therefore, these respondents were deleted from the analysis. Forty-seven service providers completed most of the on-line Service Provider Concerns Report Survey. Table 4 provides an overview of the service provider characteristics.

The majority of service providers were female (89.36%). Early childhood educators (34.0%) were the most represented group of service providers who

responded to the survey. The largest proportion of respondents (29.8%) had been in their current position for 6 to 10 years; however, many (42.6%) had over 20 years of experience working with parents and young children.

**Table 4: Service provider demographic characteristics**

Demographic Characteristics	N (%)
Profession	
Early Childhood Educator	16 (34.0)
Nurse	10 (21.3)
Teacher	10 (21.3)
Social Worker	2 (4.3)
No formal training	4 (8.5)
Unknown	5 (10.6)
Years Experience in Current Position	
<1 year	3 (6.4)
1-5 years	8 (17.0)
6-10 years	15 (29.8)
11-20 years	10 (21.2)
20+ years	12 (25.5)
Years Experience Working with Parents/Young Children	
1-5 years	2 (4.3)
6-10 years	8 (17.0)
11-15 years	9 (19.1)
16-20 years	6 (12.8)
20+ years	20 (42.6)
Unknown	2 (4.3)

*Parents.*

The primary caregiver for the child/children in the household was asked to respond to the survey. One survey was collected per household. Using a confidence interval of  $\pm 5$  with a 95% confidence level, the expected sample was 341 parents out of a total 3,052 households. To maximize the number of respondents, the student researcher sent the survey to 2,160 households. This number was selected based on the costs for the mail out and the funding available for the study. Three hundred and twenty five parents responded to the Parent Concerns Report Survey. Five

participants did not respond to over 90% of the questions; they had discontinued the survey after only responding to a few questions. Therefore, they were deleted from the analysis. One parent respondent indicated her youngest child was 7 years 3 months, so she was removed from the analysis as the survey targeted parents with children newborn to less than seven years of age.

Three hundred and nineteen parents were included in the final analysis. Based on the total number of households (3,052) that could have participated in the survey, this sample is accurate within  $\pm 5.2$  percentage points 95% of the time. The parent response rate was 14.8%, which is very in keeping with the 15 % response rate generally received from Manitoba Health survey mail outs (personal correspondence, L. Labine, November 18, 2011). Consumers of survey results are cautioned to view response rates as informative, but to recognize that these rates do not necessarily differentiate reliably between accurate and inaccurate data (Groves, 2006). Table 5 provides an overview of the child, parent and family characteristics of the respondents.

The majority of respondents were mothers (86.2%). The average age of respondents was 35.24 years (SD 5.65 years) and ranged from 20 to 70 years. One of the respondents was a child's adoptive mother, but also his grandmother. A decision was made to not eliminate her from the analysis as she was the child's parent and no age limit had been set for a parent's inclusion in the study. Most respondents were married or living common-law (92.8%) and the remaining respondents were lone parents (7.2%).

Respondents had an average number of 1.92 children with a range of 1 child to 8 children. The average age of the youngest child was 2.71 years (ranged from 1 month to 6.75 years). The average age of the child in families with only one child was 2.51 years (ranged from 4 months to 6.75 years). Nine percent of respondents identified that at least one child had a health concern such as a physical disability, mental health problem, or severe medical condition.

Eleven percent of parents who responded to the survey identified they had a health concern such as a physical disability, mental health problem or severe medical condition. The majority of mothers were employed full time (37.0%) and were university educated (56.1%). Eighteen percent of the respondents indicated that the mother was on maternity leave. Just over half of respondents (55.4%) had a family income of \$75,000 or above before taxes, whereas, one fifth (20.7%) of respondents had a family income below \$60,000 before taxes or the low-income cut-off. The parent sample was fairly representative of the parents with young children living in the community.

*Data collection.*

When developing the questions for the Parent and Service Provider Concerns Report Surveys, the student researcher became aware of a national study conducted by Russell et al. (2011). The Phase 1 findings from the current study were similar to the questions included in the national survey that had been administered to 3006 Canadian parents. Hence, in consultation with her advisor and the NA team, the student researcher contacted the authors and with permission used 18 core

questions with several sub-questions out a total of 39 core questions that had been included in the national survey.

**Table 5: Child, parent, and family characteristics of survey respondents and comparison to community demographics**

Demographic Characteristics	Survey Sample N (%)	Community %
Marital Status		
Married/Common-law	296 (92.8)	85 <sup>t</sup>
Lone parent families	23 (7.2)	6.7*-15.9 <sup>t</sup>
Number of children	Median = 2	
1 child	107 (33.6)	44.2 <sup>t</sup>
2 children	155 (48.6)	41.0 <sup>t</sup>
3+ children	56 (17.6)	14.8 <sup>t</sup>
Missing	1 (0.3)	
Child health concern		
Yes	29 (9.1)	
No	284 (89.3)	
Missing	5 (1.6)	
Parent health concern		
Yes	35 (11.0)	
No	284 (89.0)	
Missing	0	
Mother's Employment Status		Female Employment Rate (25+yrs) <sup>t</sup>
Full-time	118 (37)	41.9
Part-time	60 (18.8)	37.6
Unemployed/Stay at Home	83 (26.0)	35.3
Maternity Leave	57 (17.9)	
Missing	1 (0.3)	
Mother's Education		
High school or Less	46(14.4)	
College	72 (22.6)	
University	179 (56.1)	
Missing	22 (6.9)	
Family Income		
<\$40,000	38 (11.9)	17 <sup>E</sup>
\$40,000-\$59,999	28 (8.8)	12 <sup>E</sup>
\$60,000-\$74,999	47 (14.7)	16 <sup>E</sup>
\$75,000-\$99,000	85 (26.6)	29 <sup>E</sup>
100,000+	92 (28.8)	26 <sup>E</sup>
Missing	29 (9.1)	

\* based on the Prenatal Services and Outcomes in Manitoba Report (2012)

<sup>t</sup> based on Winnipeg's Neighbourhood Profiles (2006)

<sup>E</sup> Based on Manitoba Health data (2006)

The final service provider Concerns Report Survey included nine core questions with several sub-questions (See Appendix N). The final parent Concerns Report Survey consisted of a total of 58 core questions with several sub-questions (See Appendix O). The service provider survey took approximately 10 minutes and the parent survey took approximately 20 to 25 minutes to complete. The items addressed the primary concerns of the community as identified in phase 1. The survey was pilot tested with a small group of parents with children newborn to 6 years of age prior to distribution to the larger community and a small group of service providers working with parents and young children outside of the community of interest.

Each survey included a section that was used to generate the Need Index and would be considered the Concerns Report Survey of the CRM. The CRM produces a prioritized list of strengths and needs that can facilitate agenda setting and inform policies, services, and programs. The information can also provide evidence for planning new services. Strengths are considered survey items that the majority of respondents rate high in importance and in satisfaction while concerns or service needs are survey items that the majority of participants rate high in importance and low in satisfaction on how the community is addressing the issue (Finlayson, 2006; Suarez Balcazar et al., 2005).

This section of the survey asked respondents to rate the importance and their satisfaction with a variety of community supports for parents with young children on a scale of 1 (not important or not satisfied) to 10 (very important or very satisfied). Parents and service providers responded to the same statements for this

section. Parents were also asked to state if they had participated in the community supports within the past year, and service providers were asked to indicate if they were involved in the delivery of any of the community supports listed. In addition to the Concerns Report Survey items, parents were asked to respond to several other questions that related to family and child characteristics, potential barriers to program participation, preferred time for programs, social supports, attitudes toward parenting, knowledge of child development, and sources of information or advice about child development or parenting.

The student researcher had planned on using Dillman's method (Dillman et al., 2009) for the survey mail-out, in an attempt to ensure a good response rate. However, Manitoba Health only allows two mail-outs: one invitation to participate in the survey and one reminder. They also permitted the student researcher to send participants a personalized, advance-notice letter. The purpose of this letter was to inform participants that they had been selected for the survey and would be receiving a survey within the next two weeks (See Appendix P). This letter differs from an invitation to participate as it lets participants know that they have been selected and will be receiving an invitation. This letter helps to identify the purpose of the survey and establish its legitimacy (Dillman et al., 2009). Manitoba Health also included with all mail outs a letter to establish the legitimacy of the survey (See Appendix Q). This letter let participants know that they were not required to complete the survey and could contact them to be removed from future mail outs.

The advance letter was sent to participants in late April 2012. Within two weeks of mailing the advance letter, all members of the sample received a letter

with a link to the on-line survey and the student researcher's phone number or e-mail address if they would like a paper copy of the survey mailed to them with return postage (See Appendix R). Approximately two weeks after the letter with the survey link was sent, a follow-up reminder letter was sent to all members of the sample (See Appendix S). The letter thanked those that had already responded and requested a response from those who had not yet completed the survey. Data collection for the survey closed in mid-July 2012.

Using the Parent Child Coalition and Community CAN's e-mail distribution lists, the student researcher sent a letter asking service providers working with parents and young children 0 to 6 years to participate in the on-line survey and to share the e-mail with other organizations (See Appendix T). The initial invitation was sent in early May 2012. A link to the survey was included in the e-mail. Approximately two weeks after the initial invitation, a follow-up reminder e-mail was sent thanking organizations/individuals for sharing the survey link with their staff and inviting those who had not yet completed the survey to please do so (See Appendix U). This process was repeated two more times at which point the survey was discontinued around mid-July 2012.

#### *Data Analysis.*

SPSS Version 22.0 was used to enter and analyze the data collected from the survey. Descriptive statistics were used to describe the sample. Missing values analysis was performed using SPSS to determine the best approach for analyzing the missing data. The three service provider and five parent respondents who failed to complete 90% or more of the survey items were considered as a unit nonresponse

and were removed from the analysis as suggested by Leeuw, Hox and Huisman (2003). Item nonresponse was analyzed using listwise deletion. Lynch (2003) suggested listwise deletion is acceptable when 5 to 10 % of a variables values are missing.

A 3X4 contingency table was created for each Concerns Report Survey item (See Figure 2). The data included in Figure 2 are for illustrative purposes only and are not the actual data used to calculate a Need Index Score for this study. The 10 point scale was grouped into three categories: 1,2,3 = not important or not satisfied; 4,5,6, 7 = somewhat important or somewhat satisfied; 8,9,10 = very important or very satisfied; and N/A was anyone who responded not applicable for satisfaction on any item. Cross tabulation of importance and satisfaction ratings for each item were calculated to examine the overall concerns of the respondents. A Need Index was calculated for each statement as follows: the proportion of respondents who state that an item is very important was calculated, the proportion of respondents who state they are very satisfied with the item was calculated, and Need index = proportion of respondents that state the survey item is very important – proportion of respondents that state they are very satisfied with the item.

The range of scores on the need index can range from +100, which indicates a very high need (i.e., the issue is very important to everyone, but no one is very satisfied), to -100, which indicates a very low need (i.e., the issue is not important, yet everyone is very satisfied). A score of zero on this score range indicates that needs are being addressed (i.e., there is a balance), or alternatively it is a community strength. To evaluate the extent to which service providers' and parents'

perceptions of needs and strengths differ, a need index was generated separately for each group and compared.

**Figure 2: Need index calculation**

$$\begin{aligned}\text{Need index} &= \text{proportion who state item is very important} \\ &\quad - \text{proportion who state very satisfied with item} \\ \text{Need index} &= 268/296 \times 100 = (90.5) \\ &\quad - 185/296 \times 100 = (62.5) \\ &= 28\end{aligned}$$

	N/A	Not satisfied	Somewhat satisfied	Very satisfied	Total
Not important	1	2	1	0	4
Somewhat important	7	2	5	10	24
Very important	17	30	46	175	268
Total	25	34	52	185	296

To evaluate the extent to which parent's perceptions of need differed based on child and family characteristics (e.g., income, age of parent, marital status, mother's education, and mother's employment status), two possible approaches were considered: binomial logistic regression and multinomial regression. Multinomial regression would involve creating three different categories: need, neutral, and strength. Need included: very important and not satisfied, somewhat important and not satisfied, and very important and somewhat satisfied. Strength included: somewhat important and somewhat satisfied, somewhat important and very satisfied, and very important and very satisfied. The neutral category would consist of those respondents who indicated an issue was not important or not applicable in terms of their level of satisfaction.

A binomial logistic regression would involve creating two categories: need and strength. The neutral category responses would be discarded for this analysis. Some of the limitations of this approach were a smaller sample size for the analysis and potential sample bias as the entire sample would not be included in the analysis. However, logistic regression would determine factors associated with parent perceived need or strength without interpretation of the findings in relation to a reference group as in multinomial regression. Determining a reference category for multinomial regression analysis and translating these results to the community proved challenging. The importance of the neutral category was difficult to establish in relation to the focus of the needs assessment and research objectives (i.e., we were most interested in needs and strengths of the community). Hence, logistic regression was used to model Need/Strength as the outcome variable for programs and services that scored greater than 50 on the Need Index. There is no established cut-off point for decisions related to need on the Need Index. Greater than fifty percent was chosen as it indicates that more than 50% of survey respondents felt the issue was a concern.

Based on the literature review, Chi square for categorical variables or Eta for continuous variables were used to determine the association between parent perceived need and several child and parent variables. The variables included: child with a disability or health concern, mother's health, mother's age, mother's education, mother's employment status, marital status, first time parent, family income, social supports, parental stress, parents' knowledge of availability of programs/services, and use of the program/service. Only the variables that were

significantly associated with parent perceived need were included in the logistic regression model. Variables were tested for multicollinearity prior to being included in the model using a correlation matrix and again in the regression model using Eigenvalues, variance proportions, and Condition Indexes as suggested by Leech, Barrett and Morgan (2011).

Results were presented as odds ratios together with 95% confidence intervals. The assumptions of observations being independent and independent variables being linearly related to the logit were checked and met for all models. The overall significance of each model was tested using model chi square, Hosmer Lemeshow goodness of fit test (H-L Test), and Nagelkerke's R<sup>2</sup>. A casewise listing of the residuals was also examined for each model to determine if there were outliers.

## **Chapter 4: Results**

### **Phase 1: Reflecting on Values and Issues of Importance to the Community**

#### **Document Review (Study Objective 1).**

##### ***Existing Community Data.***

One purpose of the document review was to summarize what we know from the existing community level data about the community supports needs of parents with young children. The community has 18 neighbourhoods and is divided into North and South neighbourhood clusters. This community is known as predominantly middle class, but the data would suggest otherwise for some neighbourhoods. Table 6 provides an overview of the general socioeconomic conditions in the community.

While the overall median family income of the community is greater than Winnipeg and Manitoba's, the North has a median family income approximately \$23,000 lower than the South and almost \$6,000 less than Winnipeg. The North of the community has two neighbourhoods that rank among the six lowest median household incomes that are not in the inner city and one neighbourhood that is 12<sup>th</sup> poorest of all neighbourhoods in Winnipeg (Epp-Koop, n.d.). Solely looking at the median family incomes of the neighbourhood clusters, North and South, is a little misleading as well. Table 7 lists the neighbourhoods in the community in order of median family income from lowest to highest. While the North has all of the neighbourhoods with the lowest median family incomes, middle and higher income families are in neighbourhoods in the North and the South.

**Table 6: General socioeconomic conditions**

Indicators	Community					Winnipeg					Manitoba														
<b>Total Population (2010)</b>	65,287					697,274					1,230,270														
	North		South																						
	26,734		38,533																						
<b>High School Completion (2005/06)</b>	88.4%					78.7%					77.7%														
<b>Highest level of education attained (25 to 64 yrs, 2006)</b>	<H.S 11 %	H.S. 26 %	Trad 10 %	Oth 22 %	Univ 31 %	<H.S 15 %	H.S. 26 %	Trad 10 %	Oth 19 %	Univ 30 %	<H.S 20 %	H.S. 25 %	Trad 11 %	Oth 19 %	Univ 24 %										
Economic Families Living Below Low Income Cut-Offs (LICO)(2006)	11%					15%					12%														
<b>Median Family Income (2006)</b>	\$69828 North \$56108					\$62959 South \$79311					\$60754														
<b>Unemployment Rate (2006)</b>	4.5%					5%					8.5%														
<b>Housing Affordability (2006) (households spending 30% or more of income on shelter)</b>	Tenants 39 %			Owners 11%		Tenants 37%			Owners 12%		Tenants 35%			Owners 11%											

H.S = High School; Trad=Trades; Oth=Other; Univ=University. The information contained in this table was obtained from the WRHA *Community Health Assessment Report* (2009) and the City of Winnipeg Neighbourhood profiles (2007).

**Table 7: Neighbourhood, Median family and household incomes by Geographical Area**

Neighbourhood	Median Family Income* (2006 Census)	Median Household Income* (2006 Census)	Area
Alpine Place	\$38,369	\$26,448	North
Worthington	\$44,515	\$33,071	North
Lavallee	\$44,533	\$32,437	North
Varennes	\$51,361	\$40,352	North
Glenwood	\$54,605	\$48,677	North
St. George	\$56,341	\$46,152	North
Norberry	\$57,929	\$52,198	North
Meadowood	\$70,843	\$58,678	South
Elm Park	\$71,848	\$59,359	North
Vista	\$73,688	\$73,539	South
Pulberry	\$74,478	\$59,354	North
River Park South	\$76,694	\$70,832	South
St. Vital Perimeter	\$80,829	\$78,173	South
Minnetonka	\$81,218	\$75,223	South
Dakota Crossing	\$84,209	\$74,644	South
Kingston Crescent	\$100,015	\$90,375	North
Normand Park	\$113,210	\$111,898	South
Victoria Crescent	\$116,632	\$124,105	North

\*Based on data in the City of Winnipeg Community Area Profiles

Table 8 provides information on the number of children 0 to 9 years living in the community neighbourhoods. The South had more children in these age groups than the North. The number of children in each neighbourhood ranged from 65 to 1415. The neighbourhoods with the largest number of children in this age range were Dakota Crossing (N=1415) and River Park South (N=1135) in the South. Both of these neighbourhoods were in the middle to high range for median family income. Neighbourhoods with the least number of children were: Kingston Crescent (N=65) and Victoria Crescent (N=85) in the North and Normand Park (N=75) and Vista

(N=90) in the South. Three of these neighbourhoods had the highest median family incomes: Kingston Crescent, Norman Park and Victoria Crescent.

**Table 8: Population of Children 0-9 years by Neighbourhood, Age, and Gender**

Neighbourhood (median family income ranking – lowest to highest)	0-4 years		5-9 years		Total (% of neighbourhood population)
	Male	Female	Male	Female	
North St. Vital	690	690	645	670	2695 (10.2)
Alpine Place (1)	95	45	70	60	270 (7.7)
Worthington (2)	125	175	165	140	605 (11.1)
Lavallee (3)	85	50	35	25	195 (15.6)
Varennes (4)	25	85	40	40	190 (16.1)
Glenwood (5)	100	105	85	65	355 (9.7)
St. George (6)	40	55	80	40	215 (8.5)
Norberry (7)	45	20	15	30	110 (8.5)
Elm Park (9)	40	60	45	60	205 (12.1)
Pulberry (11)	115	65	75	145	400 (8.8)
Kingston Crescent (16)	20	10	15	20	65 (10.2)
Victoria Crescent (18)	5	35	10	35	85 (12.7)
South St. Vital	930	905	1,140	1,065	4040 (11.5)
Meadowood (8)	175	200	165	155	695 (11.7)
Vista (10)	25	15	30	20	90 (6.5)
River Park South (12)	270	270	325	270	1135 (10.5)
St. Vital Perimeter (13)	50	35	65	50	200 (12.0)
Minnetonka (14)	75	105	85	145	410 (9.4)
Dakota Crossing (15)	325	275	430	385	1415 (13.7)
Normand Park (17)	0	0	40	35	75 (10.9)
Total	1620	1595	1785	1735	6735 (10.9)
	3215		3520		

Based on 2006 Census data and included in the Winnipeg Community Area Profiles.

As indicated in Table 9, 18.2% of children living in the North were in families receiving income assistance, compared to 5% in the South. The proportion of children living in families receiving income assistance in the North was significantly greater ( $p \leq 0.05$ ) than the Manitoba average, while the proportion of children living in families receiving income assistance in the South was significantly smaller ( $p \leq 0.05$ ) than the Manitoba average. The prevalence of children in care in the

community was significantly lower ( $p \leq .05$ ) than the Manitoba average; however, two times more children in the North were in care than children in the South. As well, more than two times the number of families were receiving services from Child and Family Services in the North than the South, a proportion that was also significantly greater ( $p \leq .05$ ) than the Manitoba average.

**Table 9: Socioeconomic characteristics, community, and social services available to families living in the community**

Indicators	Community		Winnipeg	Manitoba
Newborns born to families with financial difficulties (2003-2006)	10.5%		19.5%	
Children living in families receiving income assistance (0-17 yrs) (per 100) (2004/05-2005/06)	North	South	16.6%	13.2%
	18.2 <sup>t</sup>	5.3% <sup>t</sup>		
Crude rate of child care spaces (0-12 yrs) (per 1000) (2006)		125.2	132.0	104.24
Prevalence of Children in Care (0-17 yrs) (2001/02-2003/04)	1.5% <sup>t</sup>	2.2%	3.3%	3.3%
Prevalence of Children in Families Receiving services from CFS (0-17 yrs) (2001/02-2003/04)	0.7%	8.2%	12.9%	11.5%
Lone-Parent Families (2006)	Male 18%	Female 82%	Male 17%	Female 83%
Families who screened positive on Families First Screen (2003-2006)		24.0%	19%	81%

<sup>t</sup> statistically different from Manitoba average ( $p \leq 0.05$ )

The information contained in this table was obtained from the MCHP report *Manitoba Child Health Atlas Update* (2008) and the *WRHA Community Health Assessment Report* (2010). The WRHA obtained the data from the Families First screening process. Public Health nurses collected information from almost all families with newborns to determine if a family required any additional community supports. Screening positive on the Families First Screen suggests that a family requires additional community supports such as a home visitor or additional visits from the Public Health nurse.

Table 10 provides information on mothers giving birth in the community in comparison to mothers in Winnipeg. Mothers in the community were significantly

**Table 10: Characteristics of mothers giving birth in the community**

<b>Indicators</b>	<b>Community</b>	<b>Winnipeg</b>
Women giving birth with <High School Education (2007/2008-2008/2009)	6.4% <sup>†</sup>	15.8%
Women giving birth who are lone parents (2007/08-2008/09)	6.7% <sup>†</sup>	13.3%
Women who were socially isolated during postpartum (culture, language, or geography) (2007/08-2008/09)	3.3%	4.2%
Women giving birth who received income assistance (2007/08-2008/09)	9.1% <sup>†</sup>	17.7%
Women who received healthy baby prenatal benefit (2006/07-2007/08)	17.4% <sup>‡</sup>	26.6%
Women who participated in Healthy Baby community support program (2006/07-2007/08)	9.8% <sup>‡</sup>	11.6%
Live births to teen mothers aged 19 and younger (2001/02-2008/09)	2.7% <sup>‡</sup>	6.7%
Live births to women age 35 and older (2007/08-2008/09)	19.9% <sup>‡</sup>	16.7%
Live births to women age 35 and older for the first time (2005/06-2008/09)	5.9% <sup>‡</sup>	4.4%
Maternal Alcohol Consumption during pregnancy (2007/08-2008/09)	10.0% <sup>‡</sup>	13.1%
Maternal Smoking during pregnancy (2007/08-2008/09)	11.5% <sup>‡</sup>	18.0%
Maternal illicit drug use during pregnancy (2007/08-2008/09)	1.8% <sup>‡</sup>	4.5%
Late initiation of prenatal care (2007/08-2008/09)	16.6% <sup>‡</sup>	23.1%
Inadequate prenatal care using R-GINDEX (2007/08-2008/09)	4.1% <sup>‡</sup>	7.7%
Prenatal psychological distress (2007/08-2008/09)	9.0%	8.4%
Breastfeeding initiation (2007/08-2008/09)	89.0%	82.5%
Postpartum psychological distress(2007/08-2008/09)	14.9%	14.3%

<sup>†</sup> Statistically different from Winnipeg rate (p<0.01)

The information contained in this table was obtained from the Manitoba Centre for Health Policy Report entitled *Perinatal Services and Outcomes in Manitoba*

more likely to have a high school education, have a partner/spouse, not receive income assistance, not be a teen, be 35 years or older, and not consume alcohol, smoke, or use illicit drugs during pregnancy. They were also significantly less likely to initiate prenatal care late or have inadequate prenatal care. Births in the

community were not statistically different from the Winnipeg or Manitoba rates and the infant mortality rate in the community was statistically lower than the Winnipeg and Manitoba rates (Heaman et al., 2012).

Data from the Child Health Atlas (Brownell et al., 2008) revealed that health care utilization among children in the community was statistically different from Manitoba for most indicators. The community had a higher proportion of children immunized at 1 year (2003-05) and 2 years (2002-04), less injury hospitalizations per 10,000 children 0 to 19 years (2001-06) and lower hospital episode rates per 1000 children 0 to 19 years (2005-06) (Brownell et al., 2008). Infants aged less than one year were less likely to have a hospital admission for lower respiratory tract infection (2003/04-2005/06). Children newborn to five years of age living in the community were less likely to have hospital based dental extraction (2001/02-2005/06) than Manitoba children newborn to five years of age. The community children (0-19 years) were more likely to have 50% of their visits to the same physician (2005/06) in comparison to Manitoba children.

In 2005/06, children five to 19 years of age living in the community were more likely to be prescribed a psychostimulant, and children newborn to 19 years of age living in the community were more likely to be prescribed a narcotic analgesic than Manitoba children (Brownell et al., 2008). They were also more likely to have a diagnosis of attention deficit hyperactivity disorder (5-19 years) but had similar prevalence of asthma, diabetes, and autism spectrum disorder (5-9 years) as Manitoba children.

***Early Development Instrument (EDI).***

The Early Development Instrument (EDI) is a population-based measure used to determine readiness for school of kindergarten children at a community level. The EDI consists of five general domains of child development (physical health & well-being, social competence, emotional maturity, language skills & thinking, communication skills & general knowledge) and 16 sub-domains (Janus & Offord, 2007). Community EDI results can, along with other sources of information, help inform the types of community programs and services made available to support families with young children. EDI reports are produced for each community and shared with the Parent Child Coalitions. As part of the NA process, the Parent Child coalition invited all service providers to attend a community meeting to discuss the 2008/09 EDI results (Healthy Child Manitoba, n.d.) and the community's needs and strengths based on the data.

In the community, the average score for girls on all EDI domains was significantly higher than the average score for boys. Children who did not have English as an Additional Language (EAL) or French as an Additional Language (FAL) tended to have significantly higher average scores on the EDI domains compared to children with EAL/FAL, as did non-aboriginal children compared to aboriginal children living in the community. However, socio-economic status, and not Aboriginal identity, determined the lower EDI scores for Aboriginal children.

Table 11 outlines the proportion of children in the community that were very ready on the EDI domains. The proportion of children very ready on the language skills & thinking domain was significantly lower in the community than the

Manitoba 2005/06 baseline based on a three-year trend of data collection. However, social competence and communication skills & general knowledge had more than 30% of children Very Ready reflecting a strength, but they were similar to the Manitoba baseline.

**Table 11: Proportion of children Very Ready (top 30<sup>th</sup> percentile) on EDI Domains**

Indicator	Community	Manitoba Baseline (2005/06)
Physical Health & Well-being	26.9	32.1
Social Competence	34.4	33.9
Emotional Maturity	25.0	28.2
Language Skills & Thinking	24.9†	30.0
Communication Skills & General Knowledge	33.3	33.9
More than 30% of children Very Ready on one of the above domains reflects a strength		
One or more domains	62.8	62.4
Two or more domains	42.3	43.3

† Significantly lower, based on three year trend of data collection ( $p \leq 0.05$ )  
The information contained in this table was obtained from the Healthy Child Manitoba EDI Community Report (2008/09)

At the same time, as outlined in Table 12, the proportion of children not ready on the social competence domain was significantly higher in the community than the Manitoba 2005/06 baseline. In addition, emotional maturity and communication skills & general knowledge had more than 10% of children Not Ready reflecting a need. The proportion of children not ready or in the bottom 10<sup>th</sup> percentile in 1 or more domains was 28.4 %, similar to the Manitoba baseline.

The community had a significantly higher proportion of children who had met few or no developmental expectations on six out of 16 EDI sub-domains (gross and fine motor skills, responsibility and respect, approaches to learning, anxious and fearful behaviour, aggressive behaviours, and complex literacy) and had a

significantly lower proportion who had met few or no developmental expectations on three subdomains (physical readiness for school day, basic numeracy, and communication skills and general knowledge) in comparison to the Manitoba 2005/06 baseline.

**Table 12: Proportion of children Not Ready (bottom 10<sup>th</sup> percentile) on EDI Domains**

Indicator	Community	Manitoba Baseline (2005/06)
Physical Health & Well-being	10.5	11.3
Social Competence	10.3†	8.7
Emotional Maturity	13.6	11.9
Language Skills and Thinking	8.7	12.5
Communication Skills and General Knowledge	11.7	11.2
More than 10% of children Not Ready on one of the above domains reflects a need		
One or more domains	28.4	28.6
Two or more domains	14.7	14.4

† Significantly higher, based on three year trend of data collection (p≤0.05)

The information contained in this table was obtained from the Healthy Child Manitoba EDI Community Report (2008/09)

Table 13 lists the neighbourhoods from lowest to highest median family income along with the geographical area and number of children assessed on the 2008/09 EDI. The number of children assessed on the EDI in each of the neighbourhoods ranged from <7 to 122. Two neighbourhoods had <7, Kingston Crescent in the North and Norman Park in the South, and one neighbourhood in the North, Victoria Crescent, had only 7 children assessed. All of these neighbourhoods had the highest median family incomes when compared to other neighbourhoods in the community. Two neighbourhoods with the largest number of children assessed were in the South: River Park South (N=122) and Dakota Crossing (N=103), both of which were in the middle to high range for median family income when compared

to other neighbourhoods in the community. The remaining neighbourhoods had between 10 and 53 children assessed on the EDI.

**Table 13: Neighbourhood, Geographical Area, and Number of Children Assessed on EDI**

Neighbourhood*	Area	# of Children Assessed on EDI (2008/09)
Alpine Place	North	23
Worthington	North	51
Lavallee	North	21
Varennes	North	15
Glenwood	North	30
St. George	North	18
Norberry	North	12
Meadowood	South	53
Elm Park	North	16
Vista	South	12
Pulberry	North	45
River Park South	South	122
St. Vital Perimeter	South	10
Minnetonka	South	31
Dakota Crossing	South	103
Kingston Crescent	North	<7
Normand Park	South	<7
Victoria Crescent	North	7
Total		~580

\*Arranged from lowest to highest median family income

Table 14 describes neighbourhood school readiness. Of the 18 neighbourhoods, two neighbourhoods had no reported data due to a low number of children (Kingston Crescent and Normand Park). The neighbourhoods in the North had approximately 245 kindergarten children assessed on the EDI in 2008/09, and the neighbourhoods in the South had approximately 335 kindergarten children.

None of the neighbourhoods had a large percentage of children not ready on all five domains, and only one neighbourhood, Lavallee, with 21 children in

**Table 14: School Readiness by Neighbourhood Based on 2008/09 EDI Results**

Neighbourhoods with large % of children <b>Not Ready</b> (reflects a need in area of development)		Neighbourhoods with large % of children <b>Very Ready</b> (reflects a strength in area of development)	
<b>Physical Health &amp; Well-being</b>			
Lavallee (N) Worthington (N)	Norberry (N) Minnetonka (S)	Glenwood (N) Vista (S)	Norberry (N)
<b>Social Competence</b>			
Alpine Place (N) Varennes (N) Lavallee (N) Minnetonka (S)	Pulberry (N) Meadowood (S) River Park South (S)	Glenwood (N) Meadowood (S) Vista (S)	Perimeter South (S) Dakota Crossing (S) Victoria Crescent (N)
<b>Emotional Maturity</b>			
Lavallee (N) Varennes (N)	Pulberry (N) River Park South (S)	St. George (N) Meadowood (S)	Vista (S) Victoria Crescent (N)
<b>Language Skills and Thinking</b>			
Alpine Place (N)	Lavallee (N)	Pulberry (N) Vista (S)	Perimeter South (S) Victoria Crescent (N)
<b>Communication Skills and General Knowledge</b>			
Alpine Place (N) Worthington (N)	River Park South (S) Minnetonka (S)	St. George (N) Glenwood (N) Victoria Crescent (N)	Norberry (N) Pulberry (N)

(S) = South; (N)=North

The information contained in these tables was obtained from the Healthy Child Manitoba EDI Community Report (2008/09). Neighbourhoods are arranged in order of median household income from lowest to highest.

kindergarten that was located in the North had a large percentage of children not ready on four of five EDI domains. This neighbourhood had the third lowest median family income. The South had two neighbourhoods, Minnetonka (N=31) and River Park South (N=122), and the North had one neighbourhood, Alpine Place (N=23), with a large percentage of children not ready on three domains. Almost half of the kindergarten children in the South had two neighbourhoods in the South with a large percentage of children not ready on three domains. These neighbourhoods were in the middle to high median family income range when compared with other neighbourhoods in the community.

Three neighbourhoods in the North had a large percentage of children not ready on two domains: Worthington (N=51), Varennes, (N=15), and Pulberry (N=45). One neighbourhood in the North had a large proportion of children not ready and very ready, Norberry (N=12), on one of the domains (physical health & well-being). Another neighbourhood in the South also had a large proportion of children not ready and very ready, Meadowood (N=53), on one of the domains (social competence). One neighbourhood in the North did not fall in either category on any of the domains, Elm Park (N=16). A large proportion of children in the South and the North were not ready on the EDI. Similarly, a large proportion of children from the North and South were very ready on the EDI domains. The most recent community EDI results were not available at the time of completing this study. The EDI 2010/11 results were released in April 2014 and the findings from the 2012/13 EDI assessments were expected to be released in June 2014.

## **Summary**

The document review revealed several important characteristics about the community's parents and young children. There were more people and children living in the South than the North. There were socioeconomic differences between the North and South. While, both the North and South had middle and higher median family income neighbourhoods, all of the neighbourhoods with lower median family incomes were in the North.

Compared to mothers in Winnipeg, fewer mothers giving birth in the community had risk factors that would suggest their children were vulnerable to poor developmental outcomes. Most of the health care utilization indicators for

children in the community were better than for Manitoba children, but there were higher rates of attention deficit hyperactivity disorder and prescribed psychostimulants and narcotic analgesics for children in this community.

A significantly higher proportion of children in the community were not ready on one of the EDI domains (social competence), compared to the Manitoba baseline. As well, more than 10% of children were not ready on three additional domains (physical health & well-being, emotional maturity, and communication skills and general knowledge). Neighbourhoods in the North and South had large percentages of children not ready on these domains.

***Programs and services for parents with young children in the community.***

*Programs and services located in the North.*

There are four family centres in the community that are part of the School Division: Varennes, St. George, Lavallee, and Victor Mager. They are all located in schools in the North in four of the lowest income neighbourhoods, Worthington, Varennes, Lavallee, and St. George, and offer programming weekday mornings and/or afternoons two to three days a week. Programming is during school hours, with the exception of one centre that offers drop-in gym time one night a week. (Louis Riel School Division, 2013a). The programs are for parents with children newborn to five years of age. Some of the programs include: school readiness, stay and play, Parent-Child Mother Goose and other early literacy programs, community kitchens, Nobody's Perfect parenting programs, How to Talk so Kids will Listen, parent discussions, baby signing, parent first aid, and parent crafts.

The Rene Deleurme Centre is located in Lavallee next to one of the community schools and offers a variety of school division programs (Louis Riel School Division, 2012). The Newcomer Family Reception Centre is located at this site. It offers newcomer families supports during their transition. All families who have arrived in Canada during the past four years are requested to visit the centre. The Centre staff provide newcomer families with links to important resources in the community, an initial reception, educational assessment, school and neighbourhood orientation, and other informational services. They also offer support for English as an additional language. A child care centre is also located at this site; however, it is not solely for newcomer families.

The Salvation Army also has a multicultural family centre, located in the neighbourhood with the lowest median family income - Alpine Place, that offers a variety of programs and services for parents with young children. They have a program for women who are either pregnant or have an infant under 1 year old that meets weekly. The program focuses on issues that new moms face and provides bus tickets and milk coupons to participants. Fathers are also welcome to attend. In addition, they offer a moms 'n tots group that meets weekly and provides free child care. The program offers information, support, nutritional snacks, and plans outings for moms and children. They also have a women's support group that has speakers on women's issues and plans outings. Free child care for preschoolers is provided during the program (CONTACT Community Information, n.d.).

The community has a YM-YWCA that provides programs for parents with young children who are members or who want to pay a drop-in fee (YM-YWCA,

n.d.a). It is located in the Elm Park neighbourhood. The YM-YWCA also offers subsidized memberships for low-income families. Y Neighbours is a program for mothers with children up to six years of age looking to meet other mothers in the community (YM-YWCA, n.d.b). They get together weekly at a location in the community to hear guest speakers on a range of subjects and partake in group outings. Child care is provided during the meeting. There are two Y Neighbours groups in the community. At the time of conducting the study, both had a waiting list.

A newly established Birth Centre, located in Varennes neighbourhood, opened in the community in October 2011. The primary focus of the Centre when it initially opened was to provide women living in the Health Region an alternative to home and hospital-based births (Women's Health Clinic, 2013). Only midwives provide clinical and birthing services to women having a normal and uncomplicated pregnancy. Once the birthing program was more established, the programs expanded to include prenatal classes, post-partum supports such as Coping with Change Education Workshops for new mothers, counselling services, and early literacy programs. The programming is bilingual in French and English. The programs and services are for families throughout the city and not just for families living in the community.

*Programs and services located in the South.*

One of the community child care centres with sites all over the community offers additional programming for parents with young children, Site for Parent and Child Education (SPACE), at two school sites in neighbourhoods in the South,

Meadowood and Vista. They have stay and play programs two mornings a week and one of the sites offers an afternoon program once a week (Morrow Avenue Child Care, n.d). Two additional family centres, located in the Meadowood neighbourhood, offer drop-in programming for tenants living in two different subsidized housing complexes (Family Dynamics, 2014). Programming at these sites varies, but the core programs include community kitchens, family fun nights, drop-in programs, public access computers, and breakfast clubs.

The Youville Centre is a non-profit community health centre located in the Meadowood neighbourhood that offers diverse services some of which are for parents with young children. Staff include dieticians, community health nurses, a counsellor, physician, community development worker, health educators, and an outreach worker (Youville Centre, n.d.). Nurses are available free of charge without an appointment five days a week to discuss a variety of health issues and other topics such as: parenting issues, feeding baby, providing support and information about stress, anxiety and depression.

Youville Centre also offers the Baby and Me program for women who are 25 years of age or younger, pregnant or who have a child up to 12 months of age. This program is subsidized by Healthy Child Manitoba and run by an outreach worker, community health nurse and nutritionist. The program is a weekly drop-in that offers healthy snacks, milk coupons, and bus tickets. It is run out of a church in the South close to Youville Centre. Youville Centre also offers breastfeeding supports. They include: a weekly breastfeeding clinic and drop-in, and breastfeeding telephone support. At the time of conducting the NA, prenatal classes were offered

on weekends and weekday evenings, as well as prenatal classes for young parents less than 25 years of age at Youville Centre. These classes are now being offered at the Birthing Centre.

*Programs and services located throughout the community.*

In addition to the family centres, there are 11 nursery school programs in the community two of which are located in the North. These preschool programs all have a fee and are offered part-time typically for half days. There are 28 licensed child care centres with approximately 1000 spaces for infants, preschoolers, and school age children - 11 are located in the South and 17 are located in the North - and 35 licensed family or group child care homes with approximately 230 spaces - 23 are located in the South and 12 are located in the North. This information was available through the Government of Manitoba on-line licensed child care search website (Manitoba Family Services and Labour, n.d.). The crude rate of spaces per 1000 children 0 to 12 years in 2006 showed that there were spaces for approximately 12% of children. The listing of licensed child care programs in the community in 2014 would suggest the rate has not really changed . There are 18 public schools offering half-day kindergarten in the community (Louis Riel School Division, 2013b), 10 are located in the South, and one school that is part of the Manitoba Francophone School Division that offers full day kindergarten located in the South.

Triple P Positive Parenting Programs are offered through Healthy Child Manitoba in communities throughout the province. Several practitioners and educators in the community have been trained to offer different levels of Triple P to

parents seeking assistance. A website provides some basic information about Triple P and resources for parents. In addition, the program offers one-on-one sessions for everyday parenting concerns, seminars for large groups of parents, and group sessions for more serious problems (Healthy Child Manitoba, 2014). Seminars are offered infrequently in the community and rely on service providers trained to facilitate the program to offer the sessions. Parents wanting to find a program in their community can call a phone line for assistance. The province introduced this phone line following completion of the survey. The phone line also offers parenting assistance from trained counsellors.

Nobody's Perfect Parenting program is a parent education and support program for parents of children from birth to age five. The program is designed for parents who have difficulty accessing information such as parents who are young, single, low income, have limited formal education, or experience social or cultural isolation. The program is free of charge and is offered on occasion at the Youville Centre in the South and at the Family Centres and the Birthing Centre in the North.

The Public Health Nurses that service the community are co-located in the Youville Centre and offer information on nutrition, breastfeeding, information, support, and education on care of infants, children and parenting issues. They screen families for eligibility for the Families First Home Visitor program and oversee the home visitors that work with families at risk. This program is offered through Healthy Child Manitoba to families at-risk across Manitoba. Developmental screening is offered to families participating in the Families First program. The Public Health Nurses also offer immunizations and developmental screening to

children who attend Youville Centre. In addition to the Youville Centre staff and public health nurses, there are approximately forty family physicians and four pediatricians based at medical clinics in the community (The College of Physicians and Surgeons Manitoba, 2014).

The community has several green spaces, parks and playgrounds. One of the city's largest parks is located in the North. There are two public libraries, one in the North and one in the South that offer early literacy programs that are operated by the City of Winnipeg. There are six community clubs - two in the South and four in the North, four outdoor wading pools – three in the North and one in the South - one outdoor pool in the North, and three indoor civic skating rinks – two in the South and one in the North - all operated by the City of Winnipeg. In addition, several programs are offered through the Winnipeg Leisure Guide that may or may not be offered in the community, but in which community residents can participate.

## **Summary**

Overall, many of the poorest neighbourhoods in the North had community supports intended for families in these neighbourhoods, but not limited to these families, available at no cost. Fewer community supports were available at no cost in the South; however most of the nursery school programs were located in the South. There were more child care centres in the North and more family/home-based child care providers in the South. Parent training programs were offered on an ad hoc basis through various agencies in the North and South. There appeared to be a good mix of recreational programs and services available in the community with more community centres and pools located in the North and more indoor skating rinks in

the South. Both the North and the South had a library. One of the city's largest parks was located in the North of this community.

**Interviews, focus groups, and field notes (study objectives 2 and 3).**

The transcripts from the parent and service provider interviews, focus groups, and field notes were used to describe parents' and service providers' perspectives on the current strengths and gaps in community supports for parents with young children newborn to less than seven years of age and determine what their perspectives could add to the existing community level data. The parent and service provider transcripts were analyzed together as the intent was to use the qualitative findings to generate items for the Concerns Report Survey sent to both parents and service providers. The data was not analyzed based on certain parent characteristics as we wanted to know the issues at a community level. Several categories emerged from the data that were grouped into four themes:

- 1) Availability of /Access to Community Supports for Parents
  - a. Information and Education
  - b. Types of Programs and Services
- 2) Barriers and Facilitators to Participation in Community Supports
- 3) Parent and Child Transition Periods, and
- 4) Making Formal and Informal Connections with Parents and Service Providers

Throughout this section, P# will be used to denote a direct quotation from a parent participant and SP# will be used to denote a direct quotation from a service provider participant.

### ***1) Availability of/access to community supports for parents.***

Availability of and access to community supports for parents with young children was a prominent theme that emerged from the interview and focus group data. Parents and services providers discussed availability of and access to information and education on: child development, breastfeeding, parenting skills and discipline, and nutrition. They also discussed types of programs and services for parents with young children such as: child care, health care services, post natal after child's first year supports, universal programs, programs for fathers, programs in community schools, early identification, mental health programs for parents, and recreational programs. Each will be explored in greater detail in this section.

#### *a. Information and education.*

##### *Child development.*

Some parents spoke of the lack of information/education on child development and the developmental milestones. As one mother stated, "Even though every child is different it's still nice to know what you should be working on." (P18) While many parents sought out this information on their own using a variety of sources, they would have liked to receive some of this information through prenatal and postnatal programs and services. As one mother commented, "there's not enough resources on the internet for that, like it's a bunch of different mumbo jumbo all over." (P13) Service providers spoke about the lack of programs that focus on sharing general information about child development. As one stated, "There isn't something if the mom wants to learning more about development and where do they go for that." (SP5)

*Breastfeeding.*

While not an issue raised by fathers, many mothers and service providers spoke about the importance of information/education on breastfeeding. The availability of lactation consultants and the Public Health Nurses as well as a breastfeeding support group and the breastfeeding hotline were mentioned as important sources of information/education for many mothers. Some mothers also talked about not having the support when they needed it. "I found it hard to find support for breastfeeding." (P13) Another mother indicated, "I wished I had had some help with my breastfeeding until I found out that Youville had a lactation consultant." (P8) Once the resources were located mothers reported they found them to be very helpful.

Mothers also expressed that it did not matter if it was your first child or your fourth when it came to breastfeeding as their experiences with their children had all been different. They may have experienced no difficulties breastfeeding with their first child and then had difficulty with their second or third child. Mothers also spoke about the pressure they felt if they were having difficulty with breastfeeding. They knew the benefits to their child and felt like they had to make it work despite their struggles. As one mother stated, "I felt like the worst mom ever because I couldn't do it." (P14) Many mothers who reported not being able to breastfeed shared these feelings.

*Parenting skills and discipline.*

Parents and service providers discussed the need for greater availability and access to information and education on general parenting skills and discipline. "Like

if there was a course [on parenting], if there was something I could go to, an information night or something, like that would be fine but I didn't see that on there [parent information sheet]." (P5) They wanted to be able to attend sessions or discuss their concerns about sleep routines, addressing behavioural issues, and other parenting challenges. Service providers also spoke about parenting education.

"There are very little parenting programs to refer people to in the community."

(SP4) Some parents spoke of accessing the Triple P tip sheets from the Healthy Child Manitoba website. A parent hotline was thought to be a good idea for addressing parent issues/concerns as well. Service providers spoke of the need for the hotline in relation to experiences they had with parents of young children. As one service provider indicated,

...parents with young children um its generally they're busy so they're crisis oriented, so we've tried to offer parenting things, but for them...committing to something it's just like... however they want to be able to have somewhere they can phone and say you know my daughter's biting at daycare and I don't know what to do. (SP1)

Parents had mixed feelings about a hotline "I think that would be great, that hotline would be great." (P1) Although some parents were less enthusiastic saying, "parenting is about strategies and approaches and a lot of it has to do with values," (P10) so they would be somewhat reluctant to use the hotline as their values or philosophy on parenting may differ.

*Nutrition.*

Some parents also indicated they wanted more information on when to feed their children solids and what to feed them. One mother spoke of it “as the hardest thing that I’ve had to deal with through my son’s entire life is the feeding...I don’t even know the words, I’m so lost in what I’m supposed to be doing.” (P12).

Many knew of the information available when starting their baby on solids, but they wanted more information on nutrition for their toddlers. For example, some mothers spoke about not knowing what to do with picky eaters and others spoke about being concerned about childhood obesity and ensuring their children knew about making healthy food choices.

That’s one of the things that on the way here when I think about lack of things that I find personally available in the area is a place to go or resource available that truly talks about our children’s food, the health, what we put into our bodies. (P8)

*Changing and abundance of information.*

Many parents also spoke about the changing nature of the information they received during different pregnancies. What was not acceptable for the first child was acceptable for the second or third child. For example, as one mother stated, “with my first son they weren’t allowed to have egg yolk until they were a year or egg whites, and then by the time I had my second they could eat the whole egg.” (P22)

While the need for education and information was discussed related to many different areas of parenting and child development, parents also spoke about feeling

overwhelmed by the abundance of information available to parents “I mean there’s so many like there’s books written and like websites and ...” (P6) and the conflicting opinions from parents and experts. As one mother said, “Everywhere you go somebody’s telling me something different.” (P15) As another parent participant indicated, “Wading through the information too and trying to find things or trying to figure out whose advice to take.” (P3) Other parents spoke of ignoring all of this information and advice and doing what they felt was right for them. “You know you take what is important and then with a breadth of kindness you blow the rest away...” (P8)

For some parents, their confidence increased as they became parents for the second time or as their child grew older and they felt more confident in their approach to parenting. As one parent affirmed,

I think the same thing like once I found I have my routine and once I felt comfortable then it goes a lot easier in confidence right, the more confidence I have with what I’m doing, like with my second child it was so much easier to jump back into everything really and having my first child was like my whole world changed... (P4)

Parents also talked about learning from one another. As one parent stated, “that’s been huge for helping me decipher what kind of parent I want to be,” (P8) when discussing spending time talking about parenting with other mothers. She went on to say, “I can’t imagine where I would be without that...especially I think just the weekly interaction with other mothers.”(P8).

*b. Types of programs and services.*

*Child care.*

Most parents and some services providers spoke of needing more information on child care services for their children." I guess a program or some sort of guidance to tell you to look for daycare and how things go." (P1) At the time of completing the interviews and focus groups a central registry was not yet in place for licensed child care spaces in Manitoba. Parents still had to phone each centre individually and place their child on individual waiting lists. For many parents, discovering that there were long waitlists for child care services came as a surprise.

Many parents indicated finding child care for their children was one of the greatest challenges they faced. They spoke about not knowing how difficult accessing child care would be until they began searching for a spot for their child. Parents spoke of needing to put their child on a waitlist as soon as they were pregnant knowing they would likely still not get a spot by the time they were ready to return to work. One mother spoke of the child care waitlist saying, "The idea that you have to call a daycare prior to conceiving your child and put your hypothetical child on a wait list is pretty ridiculous." (P27) Another mother spoke of having found child care for her son when he was a baby, but then they moved and could not find anything for him despite having lived in the new community for over three years.

I found it was very stressful to find a daycare. We moved to this area three years ago and we had a really good daycare... and now we can't find a daycare here so I have to drive all the way to his old daycare

everyday... go drop him off and pick him up. And also because he is going to be school age next year, go to kindergarten but because we can't find a daycare here which means he pretty much has to attend the school in the old community. (P1)

One mother "started paying three months before we needed the spot" (P10) to secure a spot for her son prior to returning to work. Another mother recalled her experience "you know what guys if you're looking for daycare you got to take that one day or two days every three months and go through the whole list, there's seventy-five people I had to call and I still don't have daycare for September." (P15)

For some parents, not having child care meant they could not return to work and had to stay at home with their child. One mother spoke of her child care arrangement not working out. "I think she only gave us like five days, it wasn't even a full two weeks and she was like, this isn't going to work, so I ended up staying home. " (P3) Many parents were relying on child care being available when they returned to work, but they discovered otherwise when they sought it out. Parents returning to work after their maternity leave expressed that the uncertainty related to finding a child care spot placed additional stress on them during their maternity leave and in many instances consumed a good portion of their time and energy during this period. One mother said, "Once I finished my maternity leave then to find a daycare to send my son, I found that was quite stressful. "(P2) Casual child care was also mentioned as another important support for parents.

...it would be nice if I had the occasional time to, or um like a daycare centre that was not uh like a drop-in daycare or something so I could like drop them off for four hours or something. (P7)

*Healthcare services.*

Access and availability to healthcare services was also mentioned in the interviews and focus groups with parents. Some of the parent participants had a child with a disability and spoke about how accessing therapy services for their child had been difficult. "And now we're speech therapy, we're at every four months but that took us a year and a half to get in." (P7) Other parents spoke about using Health Links to assist in making decisions about their child's care as an alternative to waiting for care.

I use Health Links quite a bit just cause I don't want to go to the doctor, how many hours and you wait in line so I use Health Links especially when they were younger quite regularly... you know should I go to the hospital, shouldn't I, so I used it a lot when they were young. (P4)

Service providers also spoke about families in the community who were not able to access a physician for their child.

*Post-natal supports.*

Parents and service providers discussed the availability of post-natal supports. Several parents indicated that they were pleased with the supports available to them from the Public Health nurse or home visitors. One mother talked about a visit from the Public Health nurse saying,

it took any anxiety that we had and kind of just, this is normal like you know...it was helpful, very helpful when you're transitioning, cause when we were leaving the hospital I was like oh my God they're going to just let us walk out of here. (P10)

Others were not as pleased,

I found like public health nurse didn't come, like the one time I phoned her and needed her to come she cancelled and she like, oh you don't really need me, and I was just like, well I'm crying here, I feel like a horrible mom, I need you and she wouldn't come. (P14)

While all families were eligible for a limited number of visits from the Public Health nurse immediately following the birth of their child, only families who screened positive on the Families First Screen were eligible for support from a home visitor. For these parents, the visits were not always seen as helpful. As one young mother stated,

I just felt like having the health nurse there I wanted things to be clean and tidy since I was a teen mom I didn't want anybody to be judging me in that way and I just found it more stressful than helpful a little bit.  
(P14)

A young father talked about his experiences with postnatal supports and said, I found that the health nurses and all that in these programs actually helped to keep my sanity a little bit, you know... to have people tell you that yes you are doing good, or let you know things that you can improve on, it really does help.(P19)

Many parents who were not eligible for a home visitor suggested they would have appreciated the additional supports for the first few months after their baby's birth as they found this period to be a very stressful time. Services providers also spoke about the postnatal supports offered through the public health nurse as a community strength. As one service provider stated, "the strength is because we do get those postpartum referrals so it's a huge number of families that we do get, and that's our way into a family." (SP5)

*Programs after child's first year.*

Parents and service providers also discussed the types of programs and services that they felt were lacking in the community. Several parents suggested there was greater availability of community supports for parents and young children in the first year; however, they felt locating programs and services after their child was one year old was much more difficult. Service providers also spoke about this issue saying, "Sometimes the issue is the age of the group stopping at one year of age and you know where do moms go?" (SP5)

*Public places for parents.*

Many participants also spoke about the lack of places that parents could take their child to play and meet other parents. As one mother indicated, "I always thought they needed something more for like the zero to five age group where you could go and visit with other adults, but still bring your kids with you." (P4). Parents also expressed the importance of having unstructured activities where they could meet other parents and drop-in when they were able, as opposed to having to register and commit to attending weekly.

It would be nice to have something that's not structured but they can just go play... it would be nice if there was just a large group of other parents and kids and so you get that network, that's what I would like, I would love it. (P6)

Some parents spoke about finding these types of opportunities and the importance of having an indoor space to let their child play especially in the winter. Service providers also spoke about offering less structured groups as a way to engage families. "I mentioned before about the format of group. You know go towards more informal relaxed and also what they [parents] want." (SP5)

*Universal programs.*

Some mothers also discussed feeling like the programs and services that were offered in the community were not really for them. As one mother indicated, "There's a kind of a gap for us middle class folk...when you think about where programming is it's in the areas that are all identified as high needs kind of thing." (P27) Service providers spoke about gaps in programs and services for older moms, as well. They felt this group was often overlooked when it came to services as the focus of many programs and service is on young mothers and lower income families. As one service provider said about older mothers, "I think also that the culture, we just assume well they're educated people, they don't need anything." (SP1)

*Programs for fathers.*

Parents and service providers also spoke about the lack of programs and services that were geared to fathers of young children. Participants spoke about providing fathers with a place to connect with other fathers and their children. As

one mother stated, "I think a daddy night with kids." (P1) One father spoke of his challenges with finding a group for dads stating, "I think that is a challenge for a stay at home dad just to find a group of dads, like they have their group of mom's right, yeah and I haven't been able to find that." (P28) Some of the community supports were designed for mothers and were not as inviting or welcoming to fathers limiting the programs and services in which fathers could participate. One mother said,

I signed up to be part of X group and there was a wait list and they called me like just before I was about to go back to work...but my husband's going to be a stay at home dad, and they said yeah, we don't take dads.

(P29)

*Programs in community schools.*

Parents discussed wanting to attend programs at their community school prior to their child starting school. While some schools in the community have family centres that parents can attend with their young children, many do not. As one mother stated, "the thought of him not, or us not stepping foot in that school that's two blocks away until he's ready to go to kindergarten is like kind of creepy to me."

(P10) Parents commented on the importance of having programs "in the local schools that are easier access." (P22) Service providers also spoke about the challenges that offering programs in community schools can create for some families. As one stated,

If you're working for aboriginal families for example where you're offering your program may be a barrier for them. If it's in an elementary school you know just the challenges of, of walking into a school that's

um, they're unfamiliar with and you know there's some hurt involved and other things from their background, so that um making those connections and making those relationships first so that's it's easier to, but yet what a wonderful way to make your children feel welcome in a school environment is bringing them as a preschooler and just learning that you know that school is a fun place and it's a safe place. (SP3)

In addition, the school closes in the summer and the programming ends for two months. For many families the loss of this support can be difficult.

*Early identification.*

Some of the service providers raised the issue of early identification of children with developmental delays and developmental screening as an area that required additional resources. While some children had ongoing contact with service providers in the community and were screened regularly, many were not.

So that's the interesting thing is when you do get involved with Families First and nurses notice, oh Johnny isn't talking or you know but otherwise if they weren't with the program they wouldn't know. That's huge. And you want to catch them before they get into the school system.

(SP5)

*Mental health programs.*

Service providers also spoke about the lack of availability of mental health programs for parents. They had worked with parents of young children in need of services for addiction, depression, and other mental health concerns. They often felt at a loss to know how to direct these families to the appropriate services and

indicated there was very little available in the community to help these families. “There are a lot of mental health issues.” (SP7) They felt this was particularly true for the lower-income families with whom they worked.

*Parent and tot fitness programs.*

One group of parents, mothers in particular, indicated they wanted to be able to exercise with their child. “I wish they had more mommy and me exercise classes.” (P13). They would have liked to be able to remain physically active after having their child and wanted a place to go with the baby to do some physical activity. These parents felt that very few fitness facilities or exercise classes were welcoming of mothers and babies.

*Recreational programs for children.*

Many parents also felt it was important to be able to register their child for organized sports, instructional swimming, skating, or exercise programs and creative arts classes. However, the public facilities in which many of these types of programs were offered were situated outside of the community as they were offered through the City of Winnipeg Leisure Guide.

***2) Barriers and facilitators to participation in community supports for parents.***

Parents and services providers also talked about the barriers and facilitators to participation in community supports. Several emerged from the discussions: finding information about available programs and services, cost of programs, times programs are offered, child care at programs, and transportation.

*Finding out about available community supports.*

Most parents and many service providers suggested that finding information about the available community supports was difficult. Service providers spoke about needing to promote community supports for parents more effectively.

I think you know we're certainly addressing those things, but promotion, like how do parents get to know what's out there. (SP3)

One of the community health clinics was mentioned often in the interviews/focus groups. Many parents were not aware of the scope of services the clinic offered the community. As one participant stated, "People think it's just for birth control or pregnancy test or something, like they don't know it's more than that" (P23) referring to the prenatal and parenting classes, breastfeeding clinic, and access to community health nurses, public health nurses, a nutritionist, an outreach worker, a community developer, that were also available. Service providers also spoke about the clinic and the nature of the services offered as a community strength.

Parents talked about needing a central location to access the information about programs and services that were available locally. "The one thing I always wanted was just a central website of something where you go in, what is there to go to." (P6) "An easier way to find the information for those programs would be helpful." (P9) Some parents talked about not knowing where to go to find out about programs and services available to parents with young children.

*Cost of programs and waiting lists.*

Some parents and service providers discussed the cost of some programs as prohibitive for many families. One parent stated, "Other kinds of things that I would

like to take but it's through the Leisure Guide sometimes I find that it's expensive."

(P9) A few of the parents expressed their frustration with the limited number of spots in some programs and viewed them as a barrier to participation. As one parent said, "I mean the spots are so I mean you had to be there the day registration started, oh the Leisure Guide is brutal, if you don't get the like ten spots." (P6)

Another stated, "On the day of the registration it's like, you had to be first in line otherwise you were on a wait list." (P10) This parent summed up some of the barriers saying, "money and how easy you can find it and maybe the locations." (P9)

*Time programs are offered.*

Parents and services providers discussed that the times that many of the programs and services for parents and young children were offered did not work for families with two working parents or single parents who worked full-time as the vast majority of programming was offered during the day, particularly the free programs. Many parents suggested that community supports for parents of young children should also be offered in the evening and on weekends to make them more accessible to all families. "I agree there's so many programs that I want to join, but they're all during the day, and so I just don't do it." (P4) Service providers also felt, there has to be a shift in, in thinking and in time and commitment and resources to offer programming when parents are available, so evenings and Saturday mornings are you know for both like you know for moms and dads. (SP3)

*Child care available at programs.*

Parents and service providers also spoke about making child care available at the various programs and services aimed at parents with young children. They felt this would facilitate their participation and provide some mothers with a much needed break. As one mother stated, "I like the things that you can go to once in a while like the kids can go play and give the moms a break, there's not a lot like that..." (P25) All of the service providers spoke of the importance of offering child care when discussing engaging parents in programs; "offering child care is huge." (SP2)

*Transportation.*

Service providers talked about transportation as a barrier to accessing programs and services, particularly for low-income families. The weather posed additional challenges. As one service provider said in relation to transportation being an issue, "oh that's the number one thing...and they've got two, three kids and they don't have a vehicle, and we put weather with that, like that's huge." (SP5) Some of the parents also felt transportation could be an issue, but they also talked about not minding the challenges it posed when attending programs that they truly enjoyed and where they felt comfortable. As one parent stated, "Yeah, I enjoyed those gym days like especially in the winter time, like I take the bus, one bus got me there great, I can get off, go there, do our thing and then take the bus and go back home." (P22)

### ***3) Parent and child transition periods.***

Parents spoke about the transition into parenthood and the challenges that came with being a new parent. For many mothers, balancing many roles and returning to work following maternity leave were difficult transitions. As well, children's transition into school and the preparations involved were discussed.

#### *Parenthood.*

Parents spoke about several different transitions during the newborn to school entry period. They spoke about the need for assistance with transitioning into parenthood. Parents valued the prenatal support they had received but felt there was not enough emphasis and information for first time parents on what to expect and what to do with baby when they got home.

Like we took prenatal classes... and I think the most valuable information was I think she did one hour of what to do with the baby after [you get home] and then parents were asking more questions about after then before.. (P4)

Many parents talked about feeling overwhelmed after the birth of their child. For example, one mother spoke about when she came home with her daughter, "it just seemed overwhelming, it was like what's the first thing we do and we just didn't know where to even start." (P6) Many parents and service providers also discussed the importance of family supports in assisting with the transition. One mother confirmed,

When you have built in babysitters like the grandparents, I mean you know you feel comfortable leaving the kids with them... you know it was

relaxing, you knew they were being looked after and so you could take a break... (P7)

Parents discussed the difficulty they sometimes experienced finding time for each of their children and their spouse/partner, and the additional stress balancing these roles could place on their relationships. One mother said, "I've had a really hard time maintaining a healthy relationship with my boyfriend and a good relationship with my son. It's hard to balance, it's definitely a big adjustment." (P14)

Mothers also spoke about the lack of time they found for themselves when they were trying to manage family and work schedules in addition to other roles and responsibilities. Many mothers spoke of feeling guilty taking time for themselves and not spending this time with their children or family – "Finding time for myself is hard. I feel guilty." (P17)

#### *Back to work.*

Parents who were returning to work full-time after having a baby spoke of the difficulty with this transition. Mothers did not feel prepared to leave their child when the time to return to work arrived. Many of these mothers spoke of the need for a program that could assist with the transition back to work and connecting them with other working mothers who were experiencing many of the same issues. As one mother indicated,

I don't know if there is a program out there that helps with that transition and that first year back to work...I wish somebody would have sat down with me and said you know you're entire life is about to change

again, here's a list of things, you know they do that when you have a baby. (P27)

Several mothers spoke about the difficulty with "with trying to balance work and life, working full-time." (P10). As one single mother stated about her transition back to work, "Just feeling guilty and feeling like I should have more energy and I should be spending more time with her and you know wishing that I didn't have to work and things like that..." (P27) Many also spoke about not being able to do the roles as well as they wanted to, "I just remember being you know incredibly frustrated that I, you know wasn't being efficient with any of my roles." (P29) Balancing the demands of their various roles was challenging for many parents.

*School readiness.*

Preschool and get ready for school programs for young children in the community were discussed in almost all of the focus groups and interviews. Parents felt it was important to assist children with the transition to school.

So you know you're doing all the little workbooks at home and making sure that they're on speed for kindergarten but that's, and now with my second one we're going into that same phase, I'm like should I be home taking her to preschool or helping her or you know you kind of feel guilty about that. (P4)

They wanted to ensure their children had the knowledge and skills needed to start school and wanted programs and services that could assist with this preparation. Parents spoke of registering their child for a preschool program, despite already being in a child care program. Parents also spoke about the need for full day

kindergarten and wrap-around services that did not require their child to change environments when s/he started or finished class. As one mother stated,

The transition for both parents working isn't in sync anymore with the half-day kindergarten and the half-day preschools, like all of those kinds of things, in order to be able to access those things you really need to have somebody that staying at home. (P27)

The transition from preschool child care to school age child care was very stressful for many parents as they often had to change child care centres and had not anticipated this move. As one mother reported,

...kindergarten was a nightmare, I had paid a driver to drive my child back and forth from daycare to school, cause I couldn't get home at noon, and then so I was paying daycare and driver... and my husband's like you're crazy to have a driver (chuckle) and I'm going well what choice do we have. (P4)

Another parent felt very fortunate that her child attended child care in the same school where she would be attending kindergarten.

They go visit you know the Before and After School program room and they know the kindergarten teacher already and, so you know I feel that she's you know learning her alphabet and her numbers and all those things so she's ready for school and I think it will be a very easy transition for her. I don't think she'll see it as any different cause she'll be at the same place, dropped off at the same time... (P4)

#### ***4) Making formal and informal connections with parents and service providers.***

The final theme that emerged from the data was making connections. Parents and service providers spoke about the importance of making connections with other parents. For service providers, making connections with the families that they served was also important. Many of the connections discussed were in the context of participation in community programs and services. For example, mothers and service providers spoke about the social aspect of the breastfeeding support group. As one mother stated, “it was a social outing and place to be.” (P10) Some of the mothers spoke of the friendships that were formed. Many mothers continued to connect and meet socially outside the group and had found important supports among the mothers in this group. One mother recounted her experience with the group saying,

It was pretty stunning how quickly we created relationships and friendships... But I even think that our lives would be so different if we hadn't even shown up on the day that we first said... we're getting together on Friday for lunch, can you make it.” (P27)

Some mothers discussed learning about many of the programs and services from other mothers. One mother referred to it as an “underground network of communication that you could go to one thing and they'd say well have you heard about this.” (P6) Many mothers indicated that they had learned about the various programs and services available to them when they connected with one service that would refer them on to others, “if I don't know where a place is, then as long as I know one they'll direct me to a whole bunch.” (P8)

Service providers spoke of the importance of engaging young mothers prenatally in programs and services as this could lead to greater participation in postnatal programs and services. As one service provider stated,

our experience is similar to some of the literature around Family First that um young pregnant moms that connect with that program prenatally have better outcomes and stay with it longer than if they connect with them postnatally and our own experience is that they feel far more threatened once that baby comes cause they assume that everyone's judging what kind of parent they're going to be. (SP1)

Most of the parents who had attended the Baby and Me program spoke about the difficulty they had when they were no longer eligible to attend. They had built good relationships with the staff and other mothers through this program. Baby and Me is a program for pregnant mothers and mothers with newborns to children one year of age. The program targets young mothers from lower socioeconomic status. For parents whose children were too old to attend the program, they found it was very difficult to replace. As one mother stated, "I think it was the graduating, I found that was always the hardest and saddest... leaving Baby and me, cause there was nothing to take its place." (P23) Service providers also spoke of the difficulties some parents experienced when their programs ended and the importance they placed on creating a safe and inviting environment for parents at their programs.

I think the big part of why they feel connected is we put a lot of effort into how we structure that class to really help them make connections

with other young people and with us and to feel like we're a safe place to come and talk about everything and anything. " (SP1)

Participants were also quite specific in stating that parents wanted to meet other parents who were similar to them. Mothers and service providers talked about how often in their experience they were more likely to attend a program or service when they knew there would be other parents who had similar experiences and circumstances. As one service provider stated,

...a lot of them will go and they'll come back and say yeah I wasn't really comfortable there, they were all older moms, or they were all moms that didn't speak English and I just sat there... there really is nobody at these family centres they connect with. (SP2)

Many of the young mothers spoke about not feeling comfortable attending programs that included older married mothers. As one young mother stated,

I know there's like groups and stuff, but I find that they're for like parents who are married and established and they kind of judge younger parents, they don't judge you like to your face but you feel awkward, you get the looks... (P17)

Mothers talked about wanting to socialize with mothers like them. "I wish I could get out with like other moms around my age and in my somewhat social like socioeconomic status... find somebody in the same situation as you." (P12)

Mothers and service providers spoke about the need to connect with other mothers in the group if they were to return to a program/service or continue to

engage. As one mother indicated, she did not continue attending a program as “I didn’t necessarily connect with anyone in there, so you know... I didn’t find anyone that I’d like want to hang out with.” (P10) This service provider summed it up beautifully stating, “I think it’s that power of needing that connection with people and we underestimate that.” (P1) Others spoke about finding it easier if they went with a friend, “It’s just going, it’s easier when you have people to go with cause then you don’t feel like a total outsider.”(p22) As one service provider stated, “There’s safety in numbers.” (SP1)

Many of the service providers discussed creating connections with the families and their children, developing trust, and creating safe environments as an essential part of the success of their programs. Once these connections were established with staff, families were more likely to attend their programs and “start to connect with each other and network with each other” (SP7) creating additional supports outside the program. Two of the service providers spoke about the importance of creating relationships with the families that attended their community school. “The primary focus is our school families.” (SP7) As one of the service providers indicated, “My job description is to bridge the gap between families and school.” (SP7) They both viewed themselves as outreach workers for the school and would engage with the families in their community using a variety of methods. They talked about “door knocking”, “cold calls” (SP8) to the families’ homes and writing down names and numbers when they met new families at community events, so they could connect with them again.

Several themes emerged from the focus group and interview data. They included: 1) availability of and access to community supports - information/education, types of programs and services, 2) barriers and facilitators to participation in community supports, 3) parent and child transition periods, and 4) making formal and information connections with parents, service providers, and resources. In keeping with the CRM, these findings were used to generate the questions for the Concerns Report Survey used in Phase 2 of the study.

## **Phase 2 – Identify Community Concerns**

### **Parent and service provider surveys.**

#### ***Parent and service provider need indices. (study objectives 3 & 4)***

A Parent Need Index and a Service Provider Need Index were calculated based on responses to statements in the Concerns Report Surveys. Recall that scores on the Need Index can range from +100, indicating a very high need (i.e., the issue is very important to everyone, but no one is very satisfied), to -100, indicating a very low need (i.e., the issue is not important, yet everyone is very satisfied). A score of zero indicates that needs are being addressed or alternatively, a community strength (i.e., there is a balance – the level of importance is similar to the level of satisfaction).

Table 15 compares the Parent Need Index with the Service Provider Need Index of programs/services for parents of young children. Table 16 compares the Service Provider Need Index with the Parent Need Index. Each Need Index is colour coded with white for the top 10 programs and services, light grey for the programs and services that ranked 11-20, mid-grey for the programs and services that ranked

21 to 30 and dark grey for the remaining programs and services. Service providers had 15 items on their Need Index that scored above 50, whereas parents had only six items that scored above 50. These differences are outlined in Table 17.

For parents, the highest priorities were: 1) child care centres, 2) family child care providers, 3) casual child care, 4) programs and services offered in community schools, 5) preschool programs, and 6) programs and services housed in the same building. For service providers, the highest priorities were: 1) programs that help identify children with developmental concerns, 2) workshops or programs to learn about handling parenting challenges, 3) programs for fathers of young children, 4) programs that offer child care, 5) a doctor for children, 6) casual child care, 7) parenting classes or general parenting improvement sessions, 8) programs that provide transportation, 9) programs that help new parents with the transition into parenthood, and 10) regular informal get togethers with neighbours, 11) programs on nutrition for young children, 12) child care centre, 13) programs and services housed in the same building, 14) family child care providers, and 15) 24-hour parent hotline for advice about parenting issues/concerns.

Table 18 outlines the areas of shared concern for parents and service providers based on the Need Index scores of both groups. They shared four areas that had a Need Index score greater than 50. These included: child care centres, family child care providers, casual child care, and programs and services housed in the same building.

**Table 15: Comparison of Parent Need Index with Service Providers Need Index**

Parent (N=319)		Service Provider (N=47)		Program/Service
Rank	Need Index	Rank	Need Index	
1	67.00	12	57.80	Child care / daycare centre
2	63.30	14	56.80	Family child care / daycare provider
3	62.60	6	64.50	Casual child care
4	54.50	16	48.90	Programs in my community school
5	53.30	28	34.80	Preschool for 3, 4 year olds
6	50.10	13	57.80	Variety of programs and services housed in the same building
7	46.90	27	35.50	Instructional creative arts classes for children
8	45.70	2	71.20	Workshops to learn about handling parenting challenges
9	44.30	15	55.60	24 hour parent hotline for advice about parenting issues
10	43.80	32	27.30	Instructional swim, skating or exercise programs for children
11	43.40	4	66.70	Parent programs that offer child care so that parents can attend
12	42.40	9	62.20	Programs to help parents with the transition into parenthood
13	42.40	38	17.80	Organized sports leagues for children (i.e., soccer, hockey, etc.)
14	40.40	1	72.80	Programs that identify children with developmental concerns
15	40.30	17	48.90	Drop-in programs for parents with young children
16	40.10	25	37.80	Organized playgroups
17	37.90	33	26.70	Get ready for school programs for 3 and 4 year olds
18	37.60	18	47.70	Programs that assist parents with the transition back to work
19	37.30	21	44.40	Parent-child early literacy programs
20	36.80	7	64.50	Parenting classes or general parenting improvement sessions
21	36.80	19	46.70	Programs that offer early supports to parents after baby's birth
22	36.10	23	42.20	Parent-child programs that focus on healthy child development
23	36.00	20	44.50	Drop-in medical clinic
24	34.20	3	67.40	Programs for fathers of young children
25	34.00	11	60.00	Programs on nutrition for young children
26	32.30	26	37.80	Playgrounds
27	31.70	35	26.60	Public places where parents can interact with other parents
28	31.30	29	31.80	Arenas and community / recreation centres
29	30.10	5	65.90	A doctor for your child(ren)
30	28.10	34	26.70	Parent & Tot or Baby & Me fitness classes
31	24.40	10	61.40	Regular informal get-togethers with neighbours
32	22.40	31	28.90	Centres where you can meet other families
33	18.00	8	64.40	Programs that provide transportation to the program
34	17.20	37	24.50	Libraries
35	14.10	36	26.60	Breastfeeding, lactation support programs
36	13.40	22	44.40	Home visitor support programs
37	6.80	24	40.00	Internet chat groups or online forums
38	4.40	30	31.10	Prenatal childbirth preparation classes

**Table 16: Comparison of service providers Need Index and parents need index**

Service Provider (N=47)		Parent (N=319)		Program/Service
Rank	Need Index	Rank	Need Index	
1	72.80	14	40.40	Programs that identify children with developmental concerns
2	71.20	8	45.70	Workshops to learn about handling parenting challenges
3	67.40	24	34.20	Programs for fathers of young children
4	66.70	11	43.40	Parent programs that offer child care so that parents can attend
5	65.90	29	30.10	A doctor for your child(ren)
6	64.50	3	62.60	Casual child care
7	64.50	20	36.80	Parenting classes or general parenting improvement sessions
8	64.40	33	18.00	Programs that provide transportation to the program
9	62.20	12	42.40	Programs to help parents with the transition into parenthood
10	61.40	31	24.40	Regular informal get-togethers with neighbours
11	60.00	25	34.00	Programs on nutrition for young children
12	57.80	1	67.00	Child care / daycare centre
13	57.80	6	50.10	Variety of programs and services housed in the same building
14	56.80	2	63.30	Family child care / daycare provider
15	55.60	9	44.30	24 hour parent hotline for advice about parenting issues
16	48.90	4	54.50	Programs in my community school
17	48.90	15	40.30	Drop-in programs for parents with young children
18	47.70	18	37.60	Programs that assist parents with the transition back to work
19	46.70	21	36.80	Programs that offer early supports to parents after baby's birth
20	44.50	23	36.00	Drop-in medical clinic
21	44.40	19	37.30	Parent-child early literacy programs
22	44.40	36	13.40	Home visitor support programs
23	42.20	22	36.10	Parent-child programs that focus on healthy child development
24	40.00	37	6.80	Internet chat groups or online forums
25	37.80	16	40.10	Organized playgroups
26	37.80	26	32.30	Playgrounds
27	35.50	7	46.90	Instructional creative arts classes for children
28	34.80	5	53.30	Preschool for 3, 4 year olds
29	31.80	28	31.30	Arenas and community / recreation centres
30	31.10	38	4.40	Prenatal childbirth preparation classes
31	28.90	32	22.40	Centres where you can meet other families
32	27.30	10	43.80	Instructional swim, skating or exercise programs for children
33	26.70	17	37.90	Get ready for school programs for 3 and 4 year olds
34	26.70	30	28.10	Parent & Tot or Baby & Me fitness classes
35	26.60	27	31.70	Public places where parents can interact with otherparents
36	26.60	35	14.10	Breastfeeding, lactation support programs
37	24.50	34	17.20	Libraries
38	17.80	13	42.40	Organized sports leagues for children (i.e., soccer, hockey, etc.)

**Table 17: Comparison of Parent and Service Provider Concerns based on the Need Index Scores >50**

Parent Concerns*	Service Provider Concerns*
1) child care centres 2) family child care providers, 3) casual child care, 4) programs and services offered in community schools 5) preschool programs 6) programs and services housed in the same building	1) programs that help identify children with developmental concerns 2) workshops or programs to learn about handling parenting challenges 3) programs for fathers of young children 4) programs that offer child care 5) a doctor for children 6) casual child care 7) parenting classes or general parenting improvement sessions 8) programs that provide transportation 9) programs that help new parents with the transition into parenthood 10) regular informal get togethers with neighbours 11) programs on nutrition for young children 12) child care centre 13) programs and services housed in the same building 14) family child care providers 15) 24 hour parent hotline for advice about parenting issues/concerns

**Table 18: Shared Areas of Concerns for Parents and Service Providers based on the Need Index Scores >50**

Parent Concerns*	Service Provider Concerns*
1) child care centres 2) family child care providers 3) casual child care 6) programs and services housed in the same building	12) child care centre 14) family child care providers 6) casual child care 13) programs and services housed in the same building

For parents, community strengths or items with a Need Index score of less than 25 were: prenatal classes, internet chat groups or online forums, home visitor support, breastfeeding supports, libraries, programs that provide transportation,

centres where you can meet other families, and regular informal get together with neighbours. For service providers, community strengths or items with a Need Index score less than 25 were: organized sports leagues for children and libraries. These differences are outlined in Table 19.

**Table 19: Comparison of Parent and Service Provider Strengths based on the Need Index Scores <25**

Parent Strengths*	Service Provider Strengths*
1) prenatal classes 2) internet chat groups or online forums 3) home visitor support, 4) breastfeeding supports 5) libraries 6) programs that provide transportation 7) centres where you can meet other families 8) regular informal get together with neighbours	1) organized sports leagues for children 2) libraries

***Potential barriers to program participation.***

In addition to responding to questions about importance and satisfaction with the availability of programs and services for parents and young children in the community, parents were also asked to indicate the extent to which they disagreed completely (1) to agreed completely (10) with various statements about potential barriers to program participation. These questions were from the national survey developed and implemented by Russell et al. (2011). Table 20 includes a summary of the statements and the average or mean, the standard deviation, and the median of all responses.

The majority of parents agreed with only a few potential barriers to participation. Many parents indicated that to some extent it was difficult to find out what programs or activities were available in the community (Mean=6.24, S.D.=

$\pm 3.17$ , median=7) and that programs and activities they would consider attending were offered at inconvenient times (Mean=5.98, S.D.=  $\pm 3.13$ , median= 7). Several parents also agreed that the programs they would have liked to attend had waiting lists (Mean=5.83, S.D.=  $\pm 3.24$ , median= 6) or were not appealing/did not address their needs (Mean=5.49, S.D.=  $\pm 3.02$ , median= 6).

Parents did not agree with many of the potential barriers to participation. Most parents did not agree that they or their child would not benefit from the programs and activities offered in the community (Mean=2.52, S.D.=  $\pm 2.24$ , median= 2; Mean=2.33, S.D.=  $\pm 2.15$ , median= 1) or that that the programs and activities were not in keeping with their cultural values and beliefs (Mean=2.24, S.D.=  $\pm 2.25$ , median= 1). Most parents also did not agree that programs were over organized and rigid (Mean=2.77, S.D.=  $\pm 2.19$ , median= 2) or disorderly and poorly organized (Mean=3.48, S.D.=  $\pm 2.61$ , median=3).

While not a representative sample given the small number of fathers (N=42) included in the analysis, when fathers' responses were analyzed separately, they were more likely to agree that activities were not set up for Dads (Mean=6.0; SD $\pm 3.3$ ). Fathers did not agree as strongly that others felt Dads did not know what they were doing (Mean=4.34; SD=3.39) or about not feeling welcome at community programs (Mean=3.97; SD $\pm 3.14$ ). The means for each of these statements were much lower when calculated for the entire sample.

**Table 20: Parent responses to potential barriers to participation in programs and services**

Statement	Mean	S.D	Median
<b>Difficult to find out what programs or activities are available in my community.</b>	6.24	3.17	7
Programs and activities that I would consider attending in my community are offered at inconvenient times.	5.98	3.13	7
<b>Many of the programs that I want to attend have waiting lists.</b>	5.83	3.24	6
Have not found very many programs and activities in my community that are appealing/address my needs.	5.49	3.02	6
<b>Seldom have time to take part in local programs and activities.</b>	5.15	2.78	5
Registration process is too difficult for activities and programs I would consider attending in my community.	5.04	3.24	5
<b>Would like to get more involved in programs and activities in my community, but I don't know how.</b>	4.98	3.27	5
Most of the local programs and activities for parents and children are not set up for Dads.	4.78*	3.27	4
<b>Seldom have the energy to take part in local programs and activities.</b>	4.67	2.80	4
The local programs offered are too expensive.	4.48	3.05	4
Do not share same values and interests as those who attend the activities and programs in my community.	3.82	2.66	3
Programs and activities that I would consider attending in my community are too hard to get to.	3.66	2.92	3
<b>Too many of the local programs and activities that I want are disorderly and poorly organized.</b>	3.48	2.61	3
When I attend, I feel like most people think Dads don't know what they are doing with young children.	3.48	3.00	2
<b>Feel too much pressure to be the perfect parent when I go to programs and activities in my community.</b>	3.36	2.58	2
If I take part, I'll be asked to help others in return and I don't have the time or energy to do this.	3.19*	2.49	2
When I go to a program or activity in my community, I get too much unwanted advice about parenting.	3.11*	2.31	2
Dads really aren't welcomed at many of the local programs and activities.	3.03	2.78	2
<b>Get nervous when people I don't know are friendly with me or my children.</b>	2.77*	2.33	2
Too many of the local programs that I want are over organized and rigid.	2.77*	2.19	2
Find the people running most of the programs and activities in my community unfriendly/unwelcoming.	2.68*	2.31	2
<b>Do not think that I would benefit from the programs and activities offered in my community.</b>	2.52*	2.24	2
<b>Do not think that my child would benefit from the programs and activities offered in my community.</b>	2.33*	2.15	1
<b>Programs and activities offered in my community are not in keeping with my cultural values and beliefs.</b>	2.24*	2.25	1

SD = Standard Deviation

\*Not normally distributed (skewness  $\geq 1$ )

Parents were also asked their preferred times to participate in programs/services for parents and young children. One third of respondents (37.3%) preferred weekdays, but several respondents also indicated they preferred weekends (33.6%) followed by weekday evenings (29.2%). When analyzed in conjunction with parent characteristics, mother's employment status was associated with preferred time ( $\chi^2=74.207$ ;  $p<.001$ ), but family income was not ( $\chi^2=13.986$ ;  $p=0.302$ ). Table 21 outlines parents preferred times based on these parent characteristics.

**Table 21: Parents Preferred Times for Programs/Services and Parent Characteristics**

Parent Characteristics	Preferred Times (%)			
	Weekday morning	Weekday evening	Weeknight	Weekend
All parents	23.1	14.2	29.2	33.6
<b>Mother's Employment Status</b>				
Full time	6.3	4.5	37.8	51.4
Part-time	32.7	18.2	25.5	23.6
Stay at home	41.3	14.7	30.7	13.3
Maternity Leave	22.6	30.2	11.3	35.8
<b>Family Income</b>				
>\$40,000	8.3	19.4	38.9	33.3
\$40,000-\$59,999	23.1	19.2	15.4	42.3
\$60,000-\$74,999	26.1	13.0	32.6	28.3
\$75,000-\$99,999	30.6	14.1	28.2	27.1
\$100,000+	20.9	12.1	26.4	40.7

### ***Parents' general attitudes toward parenting.***

Parents were also asked a series of questions that related to their general attitudes toward parenting. They indicated the extent to which they agreed or disagreed with each statement using a 10-point scale, where 1 meant they *disagreed completely* and 10 meant they *agreed completely*. These questions were also from the national survey by Russell et al.(2011). Table 22 outlines parents' responses.

**Table 22: Parent responses to statements about children and parenting**

Statement	Mean	S.D	Median
Being a parent is the most important thing I can do.	9.16*	1.48	10
I enjoy being a parent most of the time.	9.1*	1.26	10
When I first became a parent, I felt I received enough emotional support.	7.26	2.71	8
After our first child, I felt confident in my ability to be a good parent.	7.24	2.37	8
When I first became a parent, I felt I received enough practical support.	7.02	2.72	8
I often feel under stress when I don't have enough time.	6.61	2.67	7
Before our first child, I felt very prepared for parenthood.	6.12	2.73	7
I often feel overwhelmed by all that I have to accomplish in a day.	5.77	2.7	6
I feel I'm constantly under stress trying to accomplish more than I can handle.	5.22	2.82	5
I feel that I make a lot of mistakes in caring for my children.	4.41	2.78	4
I don't know how to handle difficult situations with my child.	4	2.54	3

SD = Standard Deviation

\*Not normally distributed (skewness  $\geq 1$ )

Parents overwhelmingly agreed that being a parent was the most important thing they could do and that they enjoyed being a parent most of the time. Many parents agreed that they often felt under stress when they did not have enough time. Most parents also felt they had received enough emotional and practical support and felt confident in their ability to be a good parent. Parents agreed more than they disagreed that they felt very prepared for parenthood. Parents were least likely to agree that they did not know how to handle difficult situations with their child and that they made a lot of mistakes while caring for their child.

Parents were also asked to indicate the extent to which they agreed that their parents had been helpful to them on a scale of one (disagree completely) to ten (agree completely). The median response was 9. Using the same scale, they were

also asked to indicate the extent to which family and friends had been helpful. The median response was 8. Two thirds (65.2%) of respondents indicated that someone, besides them or their spouse took care of their child(ren) each week.

***Parents' knowledge and sources of information about child development.***

Again, using questions from the national survey by Russell et al. (2011), parents were asked about their knowledge of four main areas of child development: 1) Physical development 2) Emotional development 3) Social development, and 4) Intellectual development. Parents reported they knew most about physical development (62.8%) and least about emotional development (53.3%).

**Table 23: Parent responses to sources for information or advice about child development or parenting**

Sources of Information (%)	Very regularly	Fairly regularly	Once in a while	Hardly Ever	Never	N/A
Spouse / partner	58.6	17.2	10.5	2.9	2.2	3.2
The Internet	26.8	22.9	32.8	7	4.5	0.6
Mother	22.6	21.7	26.1	12.7	5.7	5.7
Friends	21	27.1	35.7	8	2.2	1
Books or magazines	14.3	25.2	36.6	11.1	4.5	0.3
Your God / religion	10.8	7	11.5	7	39.8	18.2
Other relatives	9.6	16.6	27.1	19.4	15.6	5.7
Your child's doctor	8.6	22.9	45.5	13.1	3.5	1.3
Mother in-law	4.8	11.5	23.2	19.7	26.8	8.9
Info lines (e.g., HealthLinks)	4.1	9.2	32.2	28	18.5	1.9
Father	2.9	10.5	16.9	21.7	29.9	12.7
Child care provider	2.9	12.8	22.3	11.8	24.8	20.4
Television programs	1.9	7.3	24.8	29.9	28.7	1.9
Neighbours	1.6	3.2	16.9	19.1	49.4	4.5
Community parenting programs	0.6	5.4	19.7	21	43.9	4.1
Father in-law	0.3	2.9	9.6	18.5	44.6	18.8

Respondents were also asked whom they turned to for advice or information about child development and/or parenting. Table 23 outlines their responses.

Parents reported they were more likely to turn to their spouse (58.6%), followed by the Internet (26.8%), their mother (22.6%), and then friends (21%). Community parenting programs were among the least likely to be consulted for advice or information very or fairly regularly, along with neighbours and child care providers.

### **Summary.**

The Need Indices that were generated using the parent and service provider concerns report surveys revealed that parents and service providers did not share many of the same priorities related to programs and services for parents with young children. Child care was need #1, #2, and #3 of the top six priorities for parents.

Programs and services offered in community schools, preschool programs, and programs and services housed in the same building were the next three priorities. Four of these were among service providers highest priorities; preschool programs and programs in community schools were not. Parents and service providers did not share the same perspectives on community strengths.

Many parents agreed that finding out what programs and activities were available in the community was difficult and that the times many programs and services were offered were inconvenient. Parents were equally divided on preferred times for programs and services with many preferring weekday evenings and weekends, times different from many program offerings. In addition, mother's employment status was associated with preferred times. Parents overwhelmingly reported that being a parent was the most important thing they could do and enjoyed being a parent most of the time. However, many also reported feeling under stress and knowing the least about a child's emotional development. Parents

turned to a variety of sources for information about child development and parenting with a spouse and the Internet amongst the most likely; however, one of the least likely was community parenting programs.

***Associations between family characteristics and parent perceived needs (study objective 5).***

Based on the literature review, 18 variables from the survey data were chosen to examine during the statistical modeling to determine their relationship with parents' perceptions of need: child with a disability or health concern, mother's mental health, mother's age, mother's education, mother's employment status, marital status, number of children, family income, social supports, parental stress, parents' knowledge of availability of programs/services, and use of the program/service. While the geographical areas of the community (North and South) were examined using the existing community data, given the median family income variability across neighbourhoods within the neighbourhood clusters (North and South), the student researcher decided that income should be analyzed at an individual level rather than at the neighbourhood cluster level when considering factors potentially associated with parent perceived needs related to community supports. Table 24 defines the 18 variables. Only the top six concerns on the parent Need Index that had a score of 50 or greater were examined.

**Table 24: Definition of variables**

Predictor variables	Definition
Child_health	Child with a physical and/or mental disability and/or a serious medical condition
Parent_health	Parent with a physical and/or mental disability and/or a serious medical condition
Parent_age	Survey respondent's age
Child1age	Age of the youngest child in the family
Number_children	The number of children in the family including any children currently away at school or temporarily living away from home
Mother_education	Mother's highest level of educational attainment. It was divided into three categories: 1= high school or less, 2= college and other, 3=university
Mother_employment	Mother's employment status at the time of responding to the survey. It was divided into three categories: 1=full time, 2= part-time, 3=unemployed/stay at home
Marital_status	Parent's marital status was grouped into two categories:1= married/common-law, 2=single, separated, divorced
Family_Income	The total family income before taxes. It was divided into five categories: 1<\$40,000, 2= \$40,000-\$59,999, 3 = \$60,000-\$74,999, 4= -\$75,000-\$99,999, 5 = \$100,000+
Social_support	Parents were asked to respond to the statements "When I first became a parent, I felt I received enough emotional support. When I first became a parent, I felt I received enough practical support." Respondents were asked to indicate the extent to which they agreed with these statements on a scale of 1(disagree completely) to 10 (agree completely). A composite score of the two statements was calculated for the analysis.
Parental_stress	Parents were asked to respond to the statements "I often feel overwhelmed by all that I have to accomplish in a day. I feel I'm constantly under stress trying to accomplish more than I can handle. I often feel under stress when I don't have enough time. " Respondents were asked to indicate the extent to which they agreed with these statements on a scale of 1(disagree completely) to 10 (agree completely). A composite score of the three statements was calculated for the analysis.
Availability_programs	Parents were asked to respond to the statement "It is difficult to find out what programs and services are available in my community." And indicate the extent to which they agreed with it on a scale of 1(disagree completely) to 10 (agree completely)
Use_child care_	Indicates if parent used a child care centre for their child(ren) in the past year.
Use_family_child care	Indicates if parent used a family child care provider for their child(ren) in the past year.
Use_casual	Indicates if the parent used casual child care for their child(ren) in the past year.
Use_preschool	Indicates if the parent involved their child in a preschool program in the past year.
Use_sup_com_school	Indicates if the parent used community supports with their child in their community school.
Use_onestop	Indicates if the parent accessed a variety of community supports for parents and young children housed in the same building (e.g., public health, child care, parenting programs) in the past year.

*Parent need # 1: Child care centres.*

Table 25 provides an overview of the means or proportions, standard deviations, if applicable, and associations for family, parent and child characteristics related to parent need #1. Only three variables had a significant relation and were used to determine their association with parent perceived need for child care

**Table 25: Means or proportions, standard deviations, and associations for family characteristics related to parent need #1: Child care centres**

Variable	Need (n=176)		Strength (n=58)		t or $\chi^2$	p
	M	SD	M	SD		
Availability_programs	6.63	3.07	5.29	3.10	2.80	<b>0.006</b>
Respondent age	36.21	5.93	36.59	4.95	-0.434	0.665
Age youngest child	2.49	1.67	3.33	1.84	-3.08	<b>0.003</b>
Social_support	14.06	5.024	13.80	5.265	0.326	0.745
Parental_stress	18.13	7.57	18.11	6.48	0.018	0.985
Number_children	N	%	N	%	3.437	0.179
1 child	66	28.3	18	7.7		
2 children	87	37.3	27	11.6		
3+ children	22	9.4	13	5.6		
Mother_employment	N	%	N	%	6.135	<b>0.047</b>
Full-time	111	47.4	26	11.1		
Part-time	33	14.1	15	6.4		
Unemployed/Stay at home	32	13.7	17	7.3		
Child_health	N	%	N	%	0.461	0.497
Yes	14	6.1	3	1.3		
No	159	69.4	53	23.1		
Parent_health	N	%	N	%	0.001	0.980
Yes	18	7.7	6	2.6		
No	158	67.5	52	22.2		
Mother_education	N	%	N	%	3.436	0.179
High school or less	22	9.6	8	3.5		
College or other	40	17.5	20	8.8		
University	109	47.9	29	12.7		
Family Income (before taxes)	N	%	N	%	4.796	0.309
<\$40,000	16	7.2	11	4.9		
\$40,000-\$59,999	15	6.7	6	2.7		
\$60,000-\$74,999	25	11.2	10	4.5		
\$75,000-\$99,999	47	21.1	13	5.8		
\$100,000+	63	28.3	17	7.6		
Marital_status	N	%	N	%	0.69	0.793
Married/Common-law	162	69.2	54	23.1		
Single/Separated/Divorced	14	6.0	4	1.7		
Used a child care centre in past year	N	%	N	%	0.122	0.727
Yes	59	25.2	18	7.7		
No	117	50.0	40	17.1		

Bolded values are significant ( $p < .05$ ); N=84 respondents who were neutral, excluded from analysis

centres (#1): age of youngest child, availability, and mother's employment status. When all three variables were considered together in the logistic regression model, they were significantly associated with parent perceived need for child care centres ( $\chi^2=19.337$ , df=4, N= 222, p=0.001; H.L. Test,  $\chi^2=9.242$ , df=8, p=0.322). Nagelkerke's R<sup>2</sup> of .124 indicated that the model accounted for 12.4% of the variance in whether parents' perceived need for child care centres can be predicted from the linear combination of the three independent variables.

Table 26 presents the odds ratios, which suggest that the odds of perceiving child care centres as a need decreased 20% for each year the age of the youngest child increased and increased 112% for each unit increase in parent respondent agreement (10 being the highest level of agreement) with the statement "It is difficult to find out what programs and services are available in my community."

Mother's employment status was not significant.

**Table 26: Odds ratios for parent need #1: Child care centre**

Predictors	B	Sig.	Exp(B)	95% C.I. for EXP(B)	
				Lower	Upper
<b>Child1age</b>	<b>-.229</b>	<b>.015</b>	<b>0.796</b>	<b>.662</b>	<b>.956</b>
<b>Availability</b>	<b>.111</b>	<b>.032</b>	<b>1.117</b>	<b>1.010</b>	<b>1.236</b>
Mothers_employ		.063			
Mothers_employ (1)	.872	.028	2.391	1.097	5.210
Mothers_employ (2)	.256	.576	1.291	.527	3.165

Bolded values are significant (p<.05)

#### *Parent need #2: Family child care providers.*

Table 27 provides an overview of the means or proportions, standard deviations, if applicable, and associations for family, parent and child characteristics related to parent need #2. Only three variables had a significant relation and were used to determine their association with parent perceived need for family child care

providers (#2): age of youngest child, availability, and use of family child care providers in past year. When all three variables were considered together, they

**Table 27: Means or proportions, standard deviations, and associations for family characteristics related to parent need #2: Family child care providers**

Variable	Need (n=176)		Strength (n=58)		t or x2	p
	M	SD	M	SD		
Availability of programs	6.57	3.048	5.54	3.211	-2.306	<b>0.022</b>
Respondent age	35.37	6.056	35.11	4.583	-0.311	0.756
Age of youngest child	2.49	1.662	3.26	1.862	3.119	<b>0.002</b>
Social_support	13.91	5.141	14.03	5.324	-0.165	0.869
Parental_stress	17.98	7.584	18.60	6.588	-0.592	0.555
Number_children	N	%	N	%	0.527	0.768
1 child	60	25.8	25	10.7		
2 children	81	34.8	33	14.2		
3+ children	22	9.4	12	5.2		
Mother_employment	N	%	N	%	3.036	0.219
Full-time	99	42.3	35	15.0		
Part-time	31	13.2	20	8.5		
Unemployed/Stay at home	34	14.5	15	6.4		
Child_health	N	%	N	%	0.151	0.698
Yes	12	5.2	4	1.7		
No	150	65.5	63	27.5		
Parent_health	N	%	N	%	0.178	0.673
Yes	17	7.3	6	2.6		
No	147	62.8	64	27.4		
Mother_education	N	%	N	%	0.568	0.753
High school or less	20	8.7	8	3.5		
College or other	38	16.6	20	8.7		
University	101	44.1	42	18.3		
Family Income (before taxes)	N	%	N	%	0.926	0.921
<\$40,000	15	6.8	9	4.1		
\$40,000-\$59,999	16	7.2	6	2.7		
\$60,000-\$74,999	25	11.3	12	5.4		
\$75,000-\$99,999	44	19.8	17	7.7		
\$100,000+	54	24.3	24	10.8		
Marital_status	N	%	N	%	0.109	0.742
Married/Common-law	152	65.0	64	27.4		
Single/Separated/Divorced	12	5.1	6	2.6		
Used family provider in past year	N	%	N	%	8.907	<b>0.003</b>
Yes	57	24.4	39	16.7		
No	107	45.7	31	13.2		

Bolded values are significant (p<.05); N=84 respondents who were neutral, excluded from analysis

were significantly associated with parent perceived need for family child care providers ( $\chi^2=20.941$ , df=3, N= 223, p<0.001; H.L. Test,  $\chi^2=9.420$ , df=8, p=0.308). Nagelkerke's R<sup>2</sup> of .126 indicated that the model accounted for 12.6% of the variance in whether parents' perceived need for family child care providers was associated with the linear combination of the three independent variables.

Table 28 presents the odds ratios, which suggest that the odds of perceiving family child care providers as a need decreased 22% for every year the age of the youngest child increased. Parents who had not used a family child care provider in the past year were 2.4 times more likely to consider it a need compared to parents who had used a family child care provider in the past year. A parent's level of agreement with the statement "It is difficult to find out what programs and services are available in my community" was not significantly associated with the other two variables in the model.

**Table 28: Odds ratios for family child care provider as a need**

Predictors	B	Sig.	Exp(B)	95% C.I.for EXP(B)	
				Lower	Upper
Availability	.074	.128	1.077	.979	1.184
<b>Child1age</b>	<b>-.252</b>	<b>.004</b>	<b>.777</b>	<b>.653</b>	<b>.925</b>
<b>Use_Family_child care</b>	<b>0.875</b>	<b>.004</b>	<b>2.400</b>	<b>1.314</b>	<b>4.382</b>

Bolded values are significant (p<.05)

*Parent need #3: Casual child care.*

Table 29 provides an overview of the means or proportions, standard deviations, if applicable, and associations for family, parent and child characteristics related to parent need #3. Only two variables had a significant relation and were used to determine their association with parent perceived need for casual child care (#3): age of youngest child and availability. When both variables were considered

together, the model was significant ( $\chi^2=7.986$ , df=2, N= 195, p=0.018; H.L. Test,  $\chi^2=9.522$ , df=8, p=0.300); however, as outlined in Table 29, neither of the variables was significantly associated with parent perceived need for casual child care when both variables were included in the model.

*Parent need #4: Programs in their community school.*

Table 31 provides an overview of the means or proportions, standard deviations, if applicable, and associations for family, parent and child characteristics related to parent need #4. Only two variables, availability and use of programs in their community school, had a significant relation and were used to determine their association with parent perceived need for programs in their community school (#4). Both were significantly associated with parent perceived need for programs in their community school ( $\chi^2=24.750$ , df=2, N= 187, p<0.001; H.L. Test,  $\chi^2=8.441$ , df=7, p=0.295). Nagelkerke's R<sup>2</sup> of .168 indicated that the model accounted for 16.8% of the variance in whether parents' perceived need for programs in their community school was associated with the two independent variables.

Table 32 presents the odds ratios, which suggest that the odds of perceiving supports in one's community school as a need increases 120% for every unit increase in parent respondent agreement (10 being the highest level of agreement) with the statement "It is difficult to find out what programs and services are available in my community". Parents who did not use supports in their community school were 2.9 times more likely to perceive supports in their community school as a need compared to parents who had used supports in their community school in the past year.

**Table 29: Means or proportions, standard deviations, and associations for family characteristics related to parent need #3: Casual child care**

Variable	Need (n=161)		Strength (n=44)		t or x <sup>2</sup>	p
	M	SD	M	SD		
Availability of programs	6.64	3.182	5.48	2.990	-2.127	<b>0.035</b>
Respondent age	35.04	5.990	35.36	5.181	0.322	0.747
Age of youngest child	2.53	1.646	3.15	1.925	2.124	<b>0.035</b>
Social_support	14.13	5.173	13.80	5.037	0.379	0.705
Parental_stress	157	18.24	44	18.75	-0.408	0.684
Number of children	N	%	N	%	2.0051	0.367
1 child	57	27.9	11	5.4		
2 children	78	38.2	22	10.8		
3+ children	26	12.7	10	4.9		
Mother's employment status	N	%	N	%	1.845	0.398
Full-time	91	44.4	20	9.8		
Part-time	35	17.1	11	5.4		
Unemployed/Stay at home	35	17.1	13	6.3		
Child_health	N	%	N	%	0.016	0.899
Yes	12	5.9	3	1.5		
No	147	72.8	40	19.8		
Parent_health	N	%	N	%	0.722	0.396
Yes	18	8.8	7	3.4		
No	143	69.8	37	18.0		
Mother_education	N	%	N	%	0.397	0.820
High school or less	25	12.5	6	3.0		
College or other	36	18.0	12	6.0		
University	95	47.5	26	13.0		
Family Income (before taxes)	N	%	N	%	2.896	0.575
<\$40,000	17	8.8	9	4.7		
\$40,000-\$59,999	16	8.3	4	2.1		
\$60,000-\$74,999	22	11.4	6	3.1		
\$75,000-\$99,999	45	23.3	10	5.2		
\$100,000+	50	25.9	14	7.3		
Marital_status	N	%	N	%	0.129	0.720
Married/Common-law	149	72.7	40	19.5		
Single/Separated/Divorced	12	5.9	4	2.0		
Used casual child care in the past year	N	%	N	%	1.830	0.176
Yes	26	12.7	11	5.4		
No	135	65.9	33	16.1		

Bolded values are significant (p<.05); N=110 respondents who were neutral, excluded from analysis

**Table 30: Odds ratios casual child care as a need**

Predictors	B	Sig.	Exp(B)	95% C.I.for EXP(B)	
				Lower	Upper
Availability	.098	.076	1.103	.990	1.230
Child1age	-.195	.103	.823	.673	1.007

Bolded values are significant (p<.05)

**Table 31: Means or proportions, standard deviations, and associations for family characteristics related to parent need #4: Supports in community school**

Variable	Need (n=120)		Strength (n=75)		t or $\chi^2$	p
	M	SD	M	SD		
Availability of programs	7.04	2.933	5.17	3.285	-4.074	<b>&lt;0.001</b>
Respondent age	35.83	5.476	35.29	4.970	-0.691	0.490
Age of youngest child	2.73	1.755	3.17	1.71	1.723	0.086
Social_support	14.20	4.893	14.53	5.181	-0.448	0.654
Parental_stress	18.40	7.389	17.81	7.437	0.534	0.594
Number of children	N	%	N	%		
1 child	31	16.0	23	11.9	0.574	0.751
2 children	64	33.0	39	20.1		
3+ children	24	12.4	13	6.7		
Mother's employment status	N	%	N	%	3.589	0.166
Full-time	68	35.1	33	17.0		
Part-time	21	10.8	20	10.3		
Unemployed/Stay at home	30	15.5	22	1.3		
Child_health	N	%	N	%	0.392	0.531
Yes	11	5.7	5	2.6		
No	107	55.7	69	35.9		
Parent_health	N	%	N	%	0.181	0.671
Yes	10	5.1	5	2.6		
No	110	56.4	70	35.9		
Mother_education	N	%	N	%	0.158	0.924
High school or less	17	9.0	10	5.3		
College or other	34	18.1	21	11.2		
University	63	33.5	43	22.9		
Family Income (before taxes)	N	%	N	%	7.480	0.113
<\$40,000	16	8.7	8	4.3		
\$40,000-\$59,999	7	3.8	8	4.3		
\$60,000-\$74,999	17	9.2	18	9.8		
\$75,000-\$99,999	34	18.5	23	12.5		
\$100,000+	39	21.2	14	7.6		
Marital_status	N	%	N	%	0.181	0.671
Married/Common-law	110	56.4	70	35.9		
Single/Separated/Divorced	10	5.1	5	2.6		
Used supports in community school in the past year	N	%	N	%	12.10	<b>0.001</b>
Yes	21	10.8	30	15.4		
No	99	50.8	45	23.1		

Bolded values are significant ( $p < .05$ ); N=124 respondents who were neutral, excluded from analysis

**Table 32: Odds ratios for supports in community school as a need**

Predictors	B	Sig.	Exp(B)	95% C.I. for EXP(B)	
				Lower	Upper
<b>Availability</b>	<b>.181</b>	<b>&lt;0.001</b>	<b>1.199</b>	<b>1.086</b>	<b>1.323</b>
<b>Use_Progs_com_school</b>	<b>1.066</b>	<b>.003</b>	<b>2.904</b>	<b>1. 484</b>	<b>5.825</b>

Bolded values are significant ( $p < .05$ )

*Parent need #5: Preschool programs.*

Table 33 provides an overview of the means or proportions, standard deviations, if applicable, and associations for family, parent and child characteristics related to parent need #5. Only three variables, availability, age of youngest child, and use of preschool programs, had a significant relation and were considered with whether parents indicated preschool programs in their community was a need (#5).

When all three variables were considered together, they were significantly associated with parent perceived need for preschool programs in their community ( $\chi^2=22.546$ ,  $df=3$ ,  $N= 213$   $p<0.001$ ; H.L. Test,  $\chi^2=11.799$ ,  $df=8$ ,  $p=0.160$ ).

Nagelkerke's  $R^2$  of .135 indicated that the model accounted for only 13.5% of the variance in whether parents' perceived need for preschool can be predicted from the linear combination of the three independent variables.

Table 34 presents the odds ratios for preschool programs as a need. The odds of perceiving preschool as a need increases 112% for every unit increase in parent respondent agreement (10 being the highest level of agreement) with the statement "It is difficult to find out what programs and services are available in my community". Parents who had not used preschool programs were 2.3 times more likely to perceive a need for preschool programs compared to parents who had used preschool programs in the past year. The remaining variable, age of youngest child, was not significant when considered with the two other variables.

**Table 33: Means or proportions, standard deviations, and associations for family characteristics related to parent need #5: Preschool programs**

Variable	Need (n=128)		Strength (n=93)		t or x <sup>2</sup>	p
	M	SD	M	SD		
Availability of programs	6.85	3.021	5.56	3.073	-3.076	<b>0.002</b>
Respondent age	35.57	5.803	35.79	5.590	0.286	0.775
Age of youngest child	2.66	1.715	3.30	1.696	2.766	<b>0.006</b>
Number of children	1.94	0.843	2.03	0.961	0.780	0.436
Social_support	13.92	5.370	14.70	4.889	-1.091	0.277
Parental_stress	17.58	7.663	18.49	6.75	-0.906	0.366
Number of children	N	%	N	%	0.678	0.713
1 child	39	17.7	24	10.9		
2 children	65	29.5	52	23.6		
3+ children	23	10.5	17	7.7		
Mother's employment status	N	%	N	%	2.512	0.285
Full-time	69	31.4	40	18.2		
Part-time	26	11.8	25	11.4		
Unemployed/Stay at home	33	15.0	27	12.3		
Child_health	N	%	N	%	0.550	0.458
Yes	9	4.1	9	4.1		
No	118	54.1	82	37.6		
Parent_health	N	%	N	%	0.158	0.691
Yes	16	7.2	10	4.5		
No	112	50.7	83	37.6		
Mother_education	N	%	N	%	2.040	0.564
High school or less	19	8.8	18	8.4		
College or other	32	14.9	23	10.7		
University	72	33.5	50	23.3		
Family Income (before taxes)	N	%	N	%	0.561	0.967
<\$40,000	16	7.7	12	5.8		
\$40,000-\$59,999	11	5.3	9	4.3		
\$60,000-\$74,999	18	8.7	16	7.7		
\$75,000-\$99,999	36	17.3	24	11.5		
\$100,000+	39	18.8	27	13.0		
Marital_status	N	%	N	%	0.082	0.775
Married/Common-law	117	52.9	86	38.9		
Single/Separated/Divorced	11	5.0	7	3.2		
Used preschool in the past year	N	%	N	%	16.518	<b>&lt;0.001</b>
Yes	32	14.5	48	21.7		
No	96	43.4	45	20.4		

Bolded values are significant (p<.05); N=97 respondents who were neutral, excluded from analysis

**Table 34: Odds ratios for preschool programs as a need**

Predictors	B	Sig.	Exp(B)	95% C.I. for EXP(B)	
				Lower	Upper
<b>Availability</b>	<b>.114</b>	<b>.017</b>	<b>1.121</b>	<b>1.021</b>	<b>1.231</b>
Child1age	-.136	.130	.873	.733	1.041
<b>Use_preschool</b>	<b>.832</b>	<b>.009</b>	<b>2.298</b>	<b>1.234</b>	<b>4.281</b>

Bolded values are significant (p<.05)

*Parent need #6: Community supports in one building.*

Table 35 provides an overview of the means or proportions, standard deviations, if applicable, and associations for family, parent and child characteristics related to parent need #6. The final model considered the association between mother's employment status and parents' perceived need for community supports housed in the same building (#6). The variable was significantly associated with parent perceived need for a variety of programs and services for parents and young children housed in the same building ( $\chi^2=8.208$ , df=2, N= 173, p=0.017; H.L. Test,  $\chi^2=2.456$ , df=1, p=0.117). Nagelkerke's R<sup>2</sup> of .045 indicated that the model accounted for 4.5% of the variance in whether parents' perceived need for a variety of community supports for parents and young children housed in the same building was associated with mother's employment status.

Table 36 presents the odds ratios that suggested families with a mother who was employed full-time were 2.24 times more likely to perceive a variety of community supports for parents and young children housed in the same building was a need compared to mother's who stayed at home. There was no significant difference in perceived need for community supports housed in the same building when comparing families with a mother who worked part-time and families with a mother who stayed at home.

**Table 35: Means or proportions, standard deviations, and associations for family characteristics related to parent need #6: Community supports in one building**

Variable	Need (n=106)		Strength (n=67)		t or x <sup>2</sup>	p
	M	SD	M	SD		
Availability of programs	5.40	2.716	6.66	3.094	-1.261	0.209
Respondent age	34.3	7.288	35.04	4.887	-0.449	0.654
Age of youngest child	2.66	1.248	2.79	1.764	-.0233	0.816
Social_support	13.86	4.781	14.61	4.985	-0.980	0.329
Parental_stress	18.08	7.141	17.90	7.662	0.159	0.874
Number of children	N	%	N	%	2.596	0.273
1 child	35	20.3	18	10.5		
2 children	56	32.6	34	19.8		
3+ children	14	8.1	15	8.7		
Mother's employment status	N	%	N	%	8.183	<b>0.017</b>
Full-time	66	38.2	27	1.6		
Part-time	16	9.2	18	10.4		
Unemployed/Stay at home	24	13.9	22	12.7		
Child_health	N	%	N	%	0.105	0.746
Yes	8	4.7	6	3.5		
No	96	56.5	60	35.3		
Parent_health	N	%	N	%	0.094	0.760
Yes	11	6.4	6	3.5		
No	95	54.9	61	35.3		
Mother_education	N	%	N	%	0.567	0.753
High school or less	16	9.6	10	6.0		
College or other	30	18.0	17	10.2		
University	54	32.3	40	24.0		
Family Income (before taxes)	N	%	N	%	4.022	0.403
<\$40,000	12	7.4	8	4.9		
\$40,000-\$59,999	11	6.7	5	3.1		
\$60,000-\$74,999	13	8.0	10	6.1		
\$75,000-\$99,999	27	16.6	26	16.0		
\$100,000+	35	21.5	16	9.8		
Marital_status	N	%	N	%	0.158	0.691
Married/Common-law	98	56.6	63	36.4		
Single/Separated/Divorced	8	4.6	4	2.3		
Used community supports in one building in the past year	N	%	N	%	0.568	0.451
Yes	5	2.9	5	2.9		
No	101	58.4	62	35.8		

Bolded values are significant (p<.05); N=140 respondents who were neutral, excluded from analysis

**Table 36: Odds ratios for a variety of community supports for parents and young children housed in the same building as a need**

Predictor	B	Sig.	Exp(B)	95% C.I.for EXP(B)	
				Lower	Upper
<b>Mothers_employ</b>		<b>0.018</b>			
<b>Mothers_employ (1)</b>	<b>0.807</b>	<b>0.031</b>	<b>2.241</b>	<b>1.078</b>	<b>4.657</b>
<b>Mothers_employ (2)</b>	-.205	0.651	0.815	0.335	1.980

Bolded values are significant ( $p < .05$ )

**Table 37: Summary of Variables Significantly Associated with Parent Perceived Needs**

Parent Perceived Need	Variables Significantly Associated ( $p < 0.05$ )	R <sup>2</sup>
Child care centre	Child1Age, Availability	12.4%
Family child care	Child1Age, Use_Family_child care	12.6%
Casual child care	Child1Age, Availability	N.S.
Supports in community schools	Availability, Use_Progs_com_School	16.8%
Preschool programs	Availability, Use_Preschool	13.5%
Community supports in the same building	Mothers_employ	4.5%

A summary of the survey variables significantly associated with the six parent perceived needs is outlined in Table 37. Only six of the 18 variables analyzed were significantly associated with parent perceived need. Use of the community support accounted for three of the six variables. Age of the youngest child, perceived knowledge of availability of programs and services, and mother's employment status were the other variables that were associated with parent perceived need. The models accounted for 4.5% to 16.8% of the variance in whether parents' perceived need was associated with the variables.

## **Chapter 5: Discussion**

The primary purpose of this study was to apply and evaluate part of an existing NA process, the Concerns Report Method (CRM), to determine its potential in identifying community support needs of parents with young children at a community level. Only the first two phases of the CRM were applied and evaluated: 1) reflection on values and issues of importance and 2) identify community concerns. None of the publications on the CRM found in the literature focused on the identification of community supports for parents with young children.

Use of the CRM to identify community support needs of parents with young children at a community level highlighted several important points related to the study objectives: 1) importance of using existing data to gather information about the community support needs of parents with young children, 2) value added in seeking parent and service providers perspectives, 3) importance of Concerns Report Survey to help extend the exploratory qualitative findings, 4) differences in perceived need among parents and service providers, 5) characteristics that may influence parents' perceived needs, and 6) the strengths and limitations of each of the methods (document review of existing data and community supports, interviews, focus groups, surveys) and the CRM methodology. Each of these points will be further discussed in this chapter.

### **Study Objective 1**

Study objective 1 focused on summarizing what we know from existing community level data about the community support needs of parents with young children. The use of existing data revealed socioeconomic differences between the

two community neighbourhood clusters (North and South). Examining the information at a neighbourhood level provided a better sense of the make-up of these two clusters. While the poorest neighbourhoods were in the North, both the North and South had middle and higher median family income neighbourhoods. Relative to the city and the province, the existing data indicated that mothers giving birth in the community were significantly less likely to have many of the risk factors that would make children vulnerable to poor developmental outcomes. As well, the health care utilization rates of children in the community were better than other Manitoba children. These indicators were not reported for the North and South neighbourhood clusters or at the neighbourhood level. This data used in conjunction with the socioeconomic information would suggest that overall most mothers and children in the community were doing well. However, many families and children living in the neighbourhoods with lower median family incomes in the North would be considered vulnerable and could benefit from targeted community supports.

The importance of early learning opportunities for young children, particularly those who are vulnerable, is well established in the literature (Heckman, Grunewald & Reynolds, 2006; Reynolds & Temple, 2008). The existing data suggested that the crude rate for child care spaces for children 0 to 12 years provided a space for approximately 12% of children (Brownell et al., 2008). These findings would suggest that child care may be an issue for families in the community, more specifically for dual and single working parent families. There were no statistics on the availability of preschool programs in the community, but a review of the licensed preschool programs suggested that there were fewer preschool spaces than

child care spaces in the community suggesting that preschool programs may also be a need.

A review of the programs and services offered in the community considered in conjunction with the information on socioeconomic status revealed that the neighbourhoods with the lowest median family incomes in the North all had family centres/drop-in programming in their neighbourhood. All four of the School Division's family centres were in schools in the poorest neighbourhoods in the North (Lavallee, Worthington, Varennes, St. George). One could presume that the decision to place the family centres in these schools was based on the socioeconomic status of families living in these neighbourhoods. Another family centre, run by the Salvation Army, was located in the poorest neighbourhood in the community (Alpine Place). None of the family centres/drop-in programs were exclusively for parents in these neighbourhoods, with the exception of the centres situated in two low-income housing complexes in a neighbourhood in the South (Meadowood). The socioeconomic status of families attending the family centres was not available to the student researcher. This information would have been helpful in determining if the programs and services offered at the family centres were reaching the most vulnerable families in their neighbourhoods or surrounding neighbourhoods.

In addition to the family centres situated in these neighbourhoods, the provincial program Families First supports vulnerable families and children in the community. The screening process used with almost all families in the province who deliver their baby in a hospital helps to identify the families and children at risk in

the community. However, not all families who could benefit from this service participate in the program (Healthy Child Manitoba, 2010). There was no existing data on the families who were participating in this community support other than the community indicators that highlighted 15.4% of families in the community screened positive for this program between 2003-2006, compared to 24% for Winnipeg.

The EDI data revealed that the community had more than 10% of children not ready on three domains: physical health & well-being, emotional maturity, and communication skills & general knowledge, outlining a need in these areas. In addition, a significantly higher proportion of children were not ready on the social competence domain compared to the Manitoba baseline. A large proportion of children in neighbourhoods in the South and North were not ready on the EDI. In this community, two middle to high income neighbourhoods in the South that included a quarter of the kindergarten children in the community had a large percentage of children not ready on three EDI domains, along with two of the poorest neighbourhoods in the North with smaller numbers of kindergarten children. Similarly, a large proportion of children from neighbourhoods in the North and South were very ready on the EDI.

The existing data provided some explanation for the large percentage of children in neighbourhoods in the North who were not ready on the EDI domains, given the strong association between family income and EDI developmental outcomes (Santos et al., 2012); children from lower income families are proportionately more vulnerable to poor developmental outcomes. Population-

based findings from the EDI indicated that children from all socioeconomic backgrounds are not ready for school with the majority being from middle and higher income families because there are numerically more children in these families (Brownell et al., 2012; Santos, 2009; Santos et al., 2012). Other research indicates that factors such as parenting style, maternal mental health, family dysfunction, neighbourhood cohesion, social supports, parent stress, and/or quality of child care may play a role for these children. However, research to date in Manitoba has not focused on many of these factors as they are not readily available in administrative data sets, which are often used to examine EDI developmental outcomes.

Based on the community's EDI findings, the Parent Child Coalition could conclude more community supports were needed for parents with young children living in neighbourhoods with large percentages of children not ready on the EDI domains. However, the issue with solely focusing on the neighbourhoods with the largest percentage of children not ready on the EDI was that the community risked not addressing the needs of children from low, middle, or high income families who were also not ready or considered vulnerable but did not live in the identified neighbourhoods. All of these children also required early identification and interventions that would support positive outcomes for families and children.

EDI data are gathered to inform decisions related to the development of community supports and to identify community strengths and needs related to children's school readiness (Healthy Child Manitoba, n.d.). The EDI identified where problems existed related to school readiness, but it did not identify what could be

done to address the concerns, (Early Child Development Mapping Project, 2013), or the community supports for parents with young children that could address children's school readiness. Knowing what to do to address the problems presents a challenge for many communities (Varmuza & Coulman, 2013).

Considered all together, the existing data would suggest that proportionate universalism (Marmot et al., 2008) should be the approach taken to deliver community supports for parents with young children in this community, as solely providing community supports to low-income families would miss a large number of families with young children that also needed supports. Considered in conjunction with the existing data and research evidence, determining parents and service providers perceived community support needs and priorities for parents with young children in this community would further enhance the planning and delivery of community supports for parents with young children. The interviews, focus groups, and surveys focused on these aspects of the NA.

### **Study Objectives 2 and 3**

Study objective 2 was to describe parents' and service providers' perspectives on the current strengths and gaps in community supports for parents with young children and determine what their perspectives could add to the information gathered from the existing community data. Study objective 3 was to determine if the quantitative findings from a larger sample of a population of parents and service providers extended the themes generated through interviews and focus groups with parents and service providers on community supports for parents with young children in one community area. While the intent of the CRM is not to distinguish

between the findings from the qualitative and quantitative phases, the student researcher was interested in knowing how the quantitative findings extended the initial qualitative exploratory findings. Particularly given the reliance of many communities on only using qualitative methods to determine community needs (Axford, 2011).

The results of the NA in relation to objectives 2 and 3 will be discussed in this section. The qualitative themes and categories will be used to organize the discussion of the main findings from the various methods (document review, interviews, focus groups and surveys). The extent to which the methods complemented, supplemented, differed, or duplicated one another's findings will be discussed within each of the categories.

### **Barriers and facilitators to participation in community supports for parents.**

***Finding out about available community supports.***

In Phase 1 of the CRM, parents and service providers discussed barriers and facilitators to participation in community supports. Parents were often not sure what was available or what was offered. When asked about the barriers to programs and services on the parent survey, the statement parents agreed with most was "It is difficult to find out what programs or activities are available in my community" (mean=6.24, S.D. 3.1, median=7). These findings are similar to those reported by others (Atkinson Charitable Foundation, 2004; Birnbaum et al., 2007; Coe, Gibson, Spencer, & Stuttaford, 2008; Devolin et al., 2013; Dietrich Leurer, 2009; Ghate & Hazel, 2004; Mayer & Fahreen, 2006). The existing community level data did not highlight that finding out about available community supports was a need. The

qualitative data highlighted this issue; however, it could not quantify the extent to which parents in the community felt this was a barrier to participation.

In the interviews and focus groups, parents and service providers discussed the use of a central website to access information on community supports. The parent survey revealed that after a spouse/partner, the Internet was the second most likely source for parenting information or advice, followed closely by friends. Devolin et al. (2013) also reported that parents preferred mode of delivery to receive parenting information was the Internet. These findings were inconsistent with other researchers who found that health care providers were a major source of information for parents, more so than the Internet (Oldershaw, 2002; Rikhy et al., 2010). Most parents, in the current study, indicated that they consulted with their child's health care provider only once in a while. This inconsistency may be related to a period/historical effect or to the method of data collection (i.e., our survey was done via the Internet, others used a mail survey).

Given the large increase in Internet accessibility and use over the past five years (Statistics Canada, 2013), exploring the Internet as a method of communicating information to parents warrants examination. When asked about Internet forums or chat groups on the survey, parents indicated this was not a need. However, social media, such as Facebook, is another method that has gained tremendous popularity in the past few years with over 19 million Canadians logging on (Canadian Press, 2013). A literature review on the effectiveness of the use of social media indicated increasing interest in using social media as a tool for public

health communications; however, little research has evaluated its effectiveness (Schein, Wilson, & Keelan, n.d.).

Based on the results from the interviews, focus groups and the parent survey, the Coalition has been exploring the best way to use the website and social media to connect parents with the supports offered in the community. Other methods of sharing information also need to be explored for families who do not have Internet access in their homes.

***Times programs are offered.***

During the interviews and focus groups, parents and service providers also spoke about the times community supports were offered. Several working parents found the times were not convenient and precluded their attendance at many of the programs. The second most common barrier for parents who responded to the parent survey was “Programs and activities that I would consider attending in my community are offered at inconvenient times” (mean=5.98, S.D.=3.13, median=7). Other research has found that the times community supports are offered can be a barrier for families (Russell et al., 2011). When asked their preferred times to participate in programs, parents in this study were almost equally divided between weekdays (37.3%), weekends (33.6%) and weekday evenings (29.2%), suggesting no one time will work for all parents. Devolin et al. (2013) also found that parents were divided and no one time seemed to be highly favoured over others.

In our parent survey, mother’s employment status was associated with preferred time for programs with full-time working mothers preferring weekends (51.4%) and weeknights (37.8%). The existing data did not indicate the percentage

of mothers with young children in the community that worked full-time; however, the provincial statistics suggested that around 70% of mothers with children 0 to 6 years were in the workforce (full or part-time)(McCain et al., 2011). Given this high proportion and that many of the parent support services offered in the community of interest were on weekdays, one could deduce that the times programs were offered were not meeting the needs of many parents with young children in the community. The times that community supports are offered to parents with young children warrants further discussion with the Coalition. The community needs to consider offering community supports at various times through the day and week.

***Providing transportation and offering child care at programs.***

In Phase 1 of the CRM, parents and service providers spoke about the importance of providing transportation for families who did not have a vehicle and offering child care at programs to facilitate parent attendance. On the survey, service providers ranked offering child care at programs so that parents could attend #4 (NI=66.7) and providing transportation to programs #8 (NI= 64.4), compared to priority #11 (offering child care, NI=43.60) and # 33 (providing transportation, NI=18) respectively, for parents.

Neither of these issues was apparent based on the existing data. However, a review of the literature had shown that barriers to parent engagement included structural barriers such as the provision of child care and distance to the venue, among others (Dumka, Garza, Roosa, & Stoerzinger, 1997; Katz et al., 2007; Snell-Johns, Mendez, & Smith, 2004). For many low-income families transportation can be a significant barrier (Dumka et al., 1997; Snell-Johns et al., 2004).

The qualitative sample for the interviews and focus groups had a higher number of low-income parents that may have influenced the qualitative findings. The survey sample had a higher proportion of middle and higher income families, who likely did not have to rely on public transportation to attend programs and services. So while offering transportation was not a high priority for many families in this community, it should be offered to lower income families to facilitate their participation. Offering child care on site is also important if facilitating parent participation in programs and services is the goal, though it was not among parents' highest priorities. Hence, service providers in the community that offer child care within their programs to increase parent engagement in community supports might find that this alone is not enough for many parents.

Generally speaking, the existing data that were analyzed in the document review and a review of the programs and services did not identify the barriers and facilitators to parents' participation in community supports. This information was primarily gleaned from the interviews, focus groups and surveys. However, based on some of the community's characteristics such as the percentage of working mothers and the overall socioeconomic status of the families, some of these findings could have been inferred from the existing data.

### **Availability of/access to community supports.**

#### *Information/education.*

##### *Child development.*

In the interviews and focus groups, many parents indicated they lacked knowledge/information on child development. Service providers also felt parents

needed more information on developmental milestones and expectations. Parents were asked on the survey about their knowledge of four main areas of child development. They reported knowing the least about child emotional development (53.3%) and the most about physical development (62.8%). These findings are consistent with other studies (Oldershaw, 2002; Rikhy et al., 2010).

The EDI results showed that emotional maturity was the developmental area with the highest percentage of children not ready in the community. Parents' reported lack of knowledge of this area of development might have influenced this outcome. The existing data did not indicate that parents had limited knowledge of these areas of development, but the data clearly highlighted developmental concerns in this area. In this instance, the survey data provided some additional information about parents in the community that may be related to the EDI results.

The survey findings also suggested that more could be done at a community level to increase parents' knowledge and understanding of emotional development and other areas of development. Parents with greater knowledge of child development and confidence in their parenting have been found to be more likely to have positive parenting (Russell et al., 2011) that results in better outcomes for children (Chao & Willms, 2002). Oldershaw (2002) found that contrary to what many might assume, no parent sub-group (fathers versus mothers, lower versus higher education or income, more or less experience as a parent, younger or older mother) had more knowledge of child development or greater confidence in their parenting skills, so all parents should be the focus of any efforts to increase knowledge of child development.

Solely providing information and education about child development has not been found to change children's behaviours or parent's skills and behaviours.

Learning about child development has been less critical to positive parent and child outcomes than translating this information into tangible, parenting behaviours and skills (Kaminski, Valle, Filene & Boyle, 2008). Hence, this type of information would be best delivered within the context of community supports that provide opportunities to translate the information into the daily interactions of parents and children, which tends to be the focus of many parent training programs.

*Parenting.*

In Phase 1 of the CRM, parents and service providers also spoke of the lack of information/education on parenting. They discussed the limited opportunities to engage in parenting programs or groups in the community and that very few programs offered support for addressing parenting challenges. A review of the programs and services supported this view as parenting programs were offered on an ad hoc basis in the community and relied on community networks to advertise the programs to families attending other community programs. However, this method of advertising only reaches parents already connected with these programs and services, which limits the potential reach of the program. Therefore, it was not surprising that on the survey, parents reported they were less likely to rely regularly on community parenting programs for information and advice about child development and parenting. Oldershaw (2002) also found that parents were less likely to rely on community parenting programs for information and advice on parenting.

Despite parents reporting that they did not rely on community parenting programs, parents ranked formal supports such as parenting classes to address challenges and a parent hotline #8 (45.70) and #9 (44.30) respectively, suggesting they were a need for many parents. Service providers ranked parenting information and education within their highest priorities for the community (#2- handling parenting challenges, NI=71.20; #7- general parenting classes, NI=64.50; and #15- parent hotline, NI=55.60). The existing data did not speak to the need for parent training supports, and until more recently the literature on parent training supports has focused mostly on parents and children experiencing difficulties. There has been an upstream shift in parenting supports with some programs being made available universally to all parents as a method of primary prevention, and tailoring the type of support offered based on the parent and child's needs (Sanders & Prinz, 2008).

Following completion of the survey, the province introduced a parent hotline that is available province-wide to all parents - making it a universal support. The uptake of this service has been more limited than expected (personal communication, Wendy Church, March 27, 2014). Knowledge of availability of programs was the primary barrier to participation for many parents in our survey, which may be influencing uptake of this support. Other literature has discussed the stigma associated with accessing parenting support programs as a barrier (Moran et al., 2004). Given support for parenting challenges and a parent hotline were identified as needs for many parents in the community, knowing if parents in the community were accessing the parent hotline could assist with further development and planning of parenting supports in the community.

### ***Types of programs and services.***

During Phase 1 of the CRM, parents and service providers had many suggestions about the types of programs and services that they would like to see offered in the community to meet a need or gap. They spoke about the need for more child care, recreational programs, early identification of developmental delays, programs for fathers, and programs in community schools, among others. All of these topics were included in the Concerns Report Surveys.

#### ***Child care.***

During the interviews and focus groups, parents discussed the lack of information on, availability of, and access to child care, a finding that was also strongly supported on the Parent Concerns Report survey. All forms of child care – centres (#1, NI=67.00), family providers (#2, NI=63.30), and casual (#3, NI=62.60), - were the top three priorities parents identified as community concerns. Service providers ranked child care among their top priorities as well based on a NI of 50 or greater: casual child care (#6, NI=64.50), child care centres (#12, NI=57.80), and family child care (#14, NI=56.80). Two thirds of the parent survey respondents indicated that someone besides them or their spouse took care of their children each week.

Child care was clearly an important issue for parents. The review of the existing data and programs and services in the community also supported these findings. This issue was also apparent in the interviews and focus groups, but not to the same extent. Service providers who responded to the survey also recognized child care was a priority for families, but they had other areas of greater concern.

Stable and affordable child care options were identified as parent concerns in other Canadian studies (Birnbaum et al., 2007; CATCH, 2007). In our parent survey, 56% of mothers worked full/part-time and 18% were on maternity leave. The result of this shortage of licensed child care spaces is that many children in the community who needed child care may not have been receiving quality child care.

Many authors have argued that the federal government is not spending enough on child care (Kershaw, 2011; Liu, 2012; Organisation for Economic Co-Operation and Development, 2006; Trefler, 2009) and that current government policies and decisions are not attentive to the high need that exists among parents with young children (Eggleton & Keon, 2009; Kershaw, 2011; Liu, 2012; McCain et al., 2011). Our findings suggested that parents in this community would agree. Other successful international models that include universal child care require evaluation for applicability in Manitoba, but such application will require recognition of the value of the investment (Alexander & Ignjatovic, 2012; Kershaw, 2011; Liu, 2012; Trefler, 2009). Given the high priority accorded to child care for parents and service providers, the Coalition is examining how it can help to address this issue for parents in the community.

*Recreational programs.*

Parents and service providers also spoke about access to and availability of recreational programs for young children such as swimming, skating, sports leagues, and creative arts during the interviews and focus groups. Many spoke of issues with waitlists for these programs. Parents also indicated waitlists could be a barrier to participation (Mean=5.83, S.D.=3.24, median=6) on the survey. When

asked about recreational programs on the Concerns Report Surveys, two ranked in the parents top 10 (#7-Creative arts, NI=46.9; #10-Swim, skate, exercise, NI=43.8; #13-organized sports leagues, NI=42.4) and were a much higher priority than for service providers (#27-Creative arts, NI=35.5; #32-Swim, skate, exercise, NI=27.3; #38-Organized sports leagues, NI=17.8). Russell et al. (2011) found that parents ranked recreational programs high in importance, just after playgrounds and libraries when considered in conjunction with other community supports for parents with young children. Research also supports the importance of recreational programs for enhancing child development (E. Thomas, 2006).

The majority of recreational programs in the community are offered through the municipality at community centres and other public facilities. Registration for many of these programs is very competitive with programs filling up as soon as registration opens, particularly swimming and skating programs. Information about these programs is widely advertised throughout the city through Leisure Guides distributed via several different methods, such as billboards, city newspapers, and on-line at the City's website. This student researcher was not aware of any existing data on availability and use of civic recreational programs within each of the community areas, and the data that were included in the document review did not indicate that this might be a need for parents with young children at a community level.

Furthermore, a large proportion of our sample was considered middle class. Other research has highlighted that many middle class parents feel compelled to enrol their young children in extra-curricular recreational activities. Enrichment

activities were thought to be “one response to the anxiety and a sense of responsibility experienced by middle-class parents as they attempt to ‘make-up’ a middle-class child in a social context where reproduction [the outcome] appears uncertain” (Vincent & Ball, 2007, p.1061). None of the recreational programs were, however, among parents’ and service providers’ highest priorities, so should not be a focus of the Coalition at this time.

*Early identification of developmental concerns.*

Service providers, more so than parents, raised the issue of early identification of children with developmental concerns during the interviews and focus groups in Phase 1. However, as discussed earlier, parents did speak about the lack of information/education on child development and their lack of knowledge related to child development during the interviews and focus groups. Based on the survey results, developmental screening was the number one priority for service providers (NI=72.8) and priority #14 (NI=40.4) for parents.

The EDI findings revealed that almost 30% of children in the community were not ready on one or more developmental domains and 15% were not ready on two or more. The EDI data suggested that more could be done in the community to identify children early and to provide the supports needed to enhance developmental outcomes prior to school entry. Early developmental screening can identify children at risk for developmental concerns and can facilitate referral to early intervention. A growing body of literature suggests that, without early identification and intervention, children vulnerable to poor developmental

outcomes have a reduced chance of leading healthy and productive lives (Doherty, 2007; McCain et al., 2007; Williams & Holmes, 2004).

While the EDI is a population level assessment and is not intended for individual assessment, teachers can use the findings to refer children for further assessment. Waiting until kindergarten, however, to identify children with developmental concerns is often too late. Given the EDI results for the community and parents reported lack of knowledge on certain areas of child development, this is an area that requires further discussion among parents and service providers at the community level.

*Programs for fathers.*

During the interviews and focus groups, parents and service providers discussed the issue of offering programs and services for fathers of young children. Based on the survey responses, service providers ranked programs for fathers #3 (NI=67.4), whereas parents ranked them #24 (NI=34.2). Perhaps if more fathers had responded to our survey, this issue may have been a higher priority, but fathers made up only 13% of the sample. While not a representative sample given the small number of fathers (N=42) included in our analysis, when fathers' responses were analyzed separately, they were more likely to agree that activities were not set up for Dads, but less likely to agree with not feeling welcome at community programs or that others felt Dads did not know what they were doing.

Many fathers are taking a more active role in parenting, and research suggests that their educational and support needs may differ from mothers (Russell et al., 2011; Utting, 2009). Several researchers have discussed the importance of offering

programs specifically for fathers (McKellar et al., 2006; Russell, 2003b; Utting, 2009) and the service providers in our community agreed. However, our parent sample did not feel it was a priority at this time, which may limit parent engagement in these programs. The disparate ranking between parents and services providers suggests that more dialogue needs to occur among these stakeholders before investing limited resources in this support.

*Health care services.*

Some parents and service providers who participated in the interviews and focus groups spoke of the need for more physicians/pediatricians for families with young children in the community. However, responses to the Concerns Report Survey suggested that service providers felt this was a far greater need than parents. Service providers ranked a doctor for children as their #5 (NI=65.90) priority for parents, and parents ranked a doctor for their children at #29 (NI=30.10). Service providers who participated in the survey may have been interacting with more families who did not have a family doctor. Almost 100% of parents indicated on the survey that having a doctor was very important; however only 30% were not very satisfied, suggesting that it was still a need for one third of the sample.

The existing data on the health care utilization rates of children in the community would not suggest that this was a need. Sixty percent of children had 50% of visits to the same physician, which was in keeping with Winnipeg's average, and statistically higher than the average for Manitoba. In addition, annual physician visit rates were similar to those for the city and province. As well, childhood

immunization rates were statistically higher at 1 and 2 years compared to Manitoba rates. But, despite similar or better health care utilization rates for children in the community, not all families have access to a primary care provider.

Current provincial policy is working on addressing this issue for all communities. The province has committed that all Manitobans will have access to a family doctor by 2015 (Manitoba Health, n.d.). To address this issue, the provincial government has launched a Family Doctor Finder Program for all Manitobans looking for a family doctor. The province has also focused on alternative approaches to care such as Quick Care Clinics where minor health care issues can be managed by a nurse practitioner and one will soon be opening in the community of study. Given all the focus and effort currently placed on addressing this issue at a provincial and regional level, the Coalition could focus on other priority areas at this time.

*Community supports for parents of young children in community schools.*

The interviews and focus groups with parents and service providers revealed that offering community supports for parents with young children in community schools was thought to be important. Programs offered in community schools (#4, NI=54.5) and housing several community supports for parents with young children in one building or one-stop-shops (#6, NI=50.1) were high priorities for parent respondents. Service providers ranked one-stop-shops a high priority as well (#13, NI=57.8) and community supports in community schools a slightly lesser priority (#16, NI=48.9). Other research has identified that the development of central places in the community dedicated to meeting the needs of young children and their

caregivers (CATCH, 2007) and offering programs and services in the neighbourhood (Devolin et al., 2013) were a priority for communities.

Emerging evidence supports integrated early childhood service delivery models or hub models that incorporate regulated child care, kindergarten, and family support services into a single, accessible program, located in primary schools and coordinated with early intervention and family health services (Corter & Pelletier, 2010; Corter & Peters, 2011; McCain et al., 2007; McCain et al., 2011; McCuaig, 2012; Patel & Corter, 2013). Corter and Pelletier (2010) discussed the importance of early childhood service integration as a means to various ends: child development, school readiness, prevention of later problems and promotion of healthy life-long development, healthier parenting, and work-family balance.

While it is possible, but highly unlikely, that the parent survey respondents were knowledgeable of the evidence supporting integrated services in community schools, this approach intuitively seemed to make sense for parents and was felt to be a priority for the community. There have been some attempts at integrated services in the community, but they fall short of the Toronto First Duty model (See Appendix A p. 289 for details of the Toronto First Duty model). The Francophone school division in the province has adopted an integrated model for French speaking parents or those parents wishing to send their children to all French school, but these services are only available to select families in the community.

The existing data did not identify one-stop-shops or offering programs in community schools as a need, but it did identify the neighbourhoods in the North and the South that could benefit most from this approach to service delivery based

on the EDI results. While it may not be feasible to offer community supports for parents with young children in all of the community schools, all the neighbourhoods with the lowest median family incomes had some community supports in their community school. However, only one of four had a child care program for preschoolers. The neighbourhoods in the South with large percentages of children not ready on the EDI, did not have family centres in their neighbourhoods or in their community schools; however they did have preschool child care programs in their community schools.

Some progress has been made in Manitoba through the integration of several ministries that form the Healthy Child Committee of Cabinet, but more needs to be done in developing policies that support greater integration of early childhood service delivery in the communities. Recently, the Manitoba Child Care Association and the Child Care Coalition of Manitoba launched a campaign calling on the province to develop an integrated system of early learning and child care (Manitoba Child Care Association & Child Care Coalition of Manitoba, 2014). In Manitoba's recently released Early Childhood Development Framework (Healthy Child Manitoba, 2013), a key recommendation includes support for inter-sectorial collaboration and integrated services. However, the details for achieving this recommendation were not included in the policy document. The government has also indicated that all new schools built in the province must include child care space; however this policy will not help communities with several existing schools already in place.

The Coalition is focused on better integration of community supports for parents with young children in the community and financially supports the family centres in the community through its annual budget. Based on the results of the NA, the Coalition is exploring ways to enhance existing community supports in neighbourhood schools that have started to implement this approach and other neighbourhood schools that could benefit from this approach, such as those with a large percentage of children not ready on the EDI.

### **Transitions.**

Parents and service providers also spoke about the transition into parenthood and the challenges that came with being a new parent and balancing roles. As well children's transition into school was discussed. Parent and service provider's responses to programs and services dealing with transitions on the Concerns Report Surveys differed in terms of their NI scores, but the rankings were fairly similar for many of the items.

### **Parenthood.**

During the interviews and focus groups, parents and service providers talked about the need for more supports during the transition into parenthood. Programs delivered early in a family's development have a greater chance of being effective (Samuelson, 2010). Parents reported putting much more emphasis on preparing for the birth of the baby in prenatal classes than on preparing for taking care of the baby after birth, findings that were consistent with other research (Carolan, 2007). Parents ranked prenatal programs #38 (NI=4.40) and early home visitor supports #36 (NI=13.40) among their lowest priorities on the survey suggesting they were

community strengths. Those parents who felt it was very important were equally satisfied with these programs. Service providers ranked prenatal programs #30 (NI=31.10) and home visitor supports #22 (NI=44.40). Parents ranked the transition into parenthood at #12 (NI=42.4); whereas service providers ranked this item #9 (NI=62.2).

Other studies have reported parents felt they needed more supports with the transition into parenthood and did not feel adequately prepared for parenting; this was especially true for first time parents (Bloomfield et al., 2005; Carolan, 2007; Hogg & Worth, 2009). Most of the parents who participated in the interviews and focus groups were first time parents (66%) with young infants under one year of age (45%), whereas only 44% of our survey sample were first time parents and they had older children (Mean age=2.51 years). Programs focusing on the transition to parenthood may have more relevance for first time parents with very young children who were a subset of the parent population that responded to the survey. As well, many of the existing programs and services in the community were for first time parents and deemed to be a strength (e.g., Public Health Nurse visit, prenatal classes, Healthy Baby, breastfeeding support) suggesting perhaps the need was being met for many parents through these programs.

Parents' attitudes about parenting might also have influenced these results. The parent survey revealed that most parents felt they received enough emotional and practical support when they first became a parent. As well, most parents reported that for their first child, they felt very prepared for parenthood. This may explain why, based on the survey results, supports during the transition to

parenthood were not among parents highest priorities; however a fairly high proportion of parents did identify supports during the transition to parenthood as a need (NI=42.2).

There was nothing in the existing data that would suggest parents in this community might experience a more difficult transition into parenthood than parents in other communities. Most of the maternal health indicators for the community were similar to the city or better. Fifteen percent of families screened positive on the Families First Screen, a rate much lower than the city at 24%. The existing data indicated that 14.9% of mothers' experienced postpartum psychological distress, a rate similar to the city at 14.3%. The indicators did not state the point at which either of these percentages might be a problem or concern for the community or the impact they might have on the transition to parenthood.

The community did have more women 35 years of age or older giving birth (19.9%) compared to the city (16.7%). There was a sense during the interviews and focus groups that older mothers may experience the transition to parenthood differently than younger parents and require different community supports for this transition. Recent research in this area indicated that the children of older mothers had better health and development later in life than children of younger mothers (Sutcliffe, Barnes, Belsky, Gardiner, & Melhuish, 2012).

### ***Back to work.***

For many mothers, balancing their roles and returning to work following maternity leave were difficult transitions that were discussed during Phase 1 of the CRM. Despite having different NI scores, parents (NI=37.6) and service providers

(NI=47.7) ranked programs that assist parents with the transition back to work the same at #18. Devolin et al. (2013) reported that parents ranked the importance of information/resources related to balancing work and family #27 of 43 with 87% indicating it was somewhat or very important.

Feldman, Sussman, and Zigler (2004) found that perceived low-quality child care predicted worse adjustment to the return to work following maternity leave. Many of the parents in Phase 1 spoke about the stress associated with trying to find child care prior to returning to work. Some mothers did not return to work for this reason. The lack of licensed child care spaces for the children in the community has important implications for the many parents, particularly mothers, making the transition back to work. However, programs focused on assisting mother's with the transition back to work were not perceived to be a need for the community at this time. Focusing on the issue of child care in the community may also make this transition less difficult for many mothers.

### ***Preschool***

In the interviews and focus groups, parents and service providers identified that more needed to be done to prepare children for the transition to school. However, parents and service providers differed greatly on the Concerns Report Surveys related to preschool programs for three and four year olds, with parents indicating it was a high priority (#5, NI=53.3) and service providers indicating it was not (#28, NI=34.8). Get ready for school programs were ranked much lower at #17 (NI=37.9) for parents and #33 (NI=26.7) for service providers. Devolin et al.

(2013) reported parents ranked school readiness 15<sup>th</sup> with 92% indicating it was very important or somewhat important.

The implementation of the EDI province wide has certainly put greater emphasis on the importance of school readiness and highlighted the need for better preparation of children for school. The EDI results for this community would support the need for greater opportunities for early learning experiences for children. Preschool programs are one means of achieving this goal. However, the extent to which parents are aware of the EDI and the community findings are unknown. Despite perhaps not knowing this information, parents had their own concerns about preschool programs for their children. It is also important to note that how parents interpreted preschool programs was uncertain as preschool was not defined on the survey. Some parents may have felt full-time preschool was needed versus part-time.

Many parents in the interviews and focus groups spoke about the challenge part-time preschool programs posed. For many families with a single parent or both parents who work full-time, half-day programs were not feasible. However, despite having full-time child care, some parents reported also sending their child to preschool, as they were not sure their child care program was preparing their child for the school environment. This concern may explain why both child care and preschool were priorities for families.

There were eleven part-time preschool programs available in the community, nine of which were in the South, and one of these was only for families wishing to enroll their child in the French language school. The number one recommendation

in Manitoba's Early Childhood Development Framework (2013) is to strengthen universal access to quality early learning opportunities for children. The policy document did not, however, define quality early learning opportunities or how the recommendation will be achieved. Others have found that school readiness and later school performance are linked with children's preschool and child care experiences (Barnett, Lamy, & Jung, 2005; Cleveland, Corter, Pelletier, Colley, & Bertrand, 2006; NICHD Early Child Care Research Network, 2006; Shonkoff & Phillips, 2000). As well, a successful transition to school is important to children's future educational and behavioural development (Cleveland et al., 2006; Reynolds & Temple, 2008; Romano, Babchishin, Pagani, & Kohen, 2010). Quality preschool experiences are especially important for children from lower income families (Reynolds & Temple, 2008). Considering the research evidence and knowledge of the communities' socioeconomic differences revealed in the existing data, providing greater quality early learning opportunities for children living in the poorest neighbourhoods in the North should be a priority for the community when looking to address this need identified in the parent survey.

### **Making connections.**

Parents also talked about the importance of making connections with other parents, service providers, and resources in Phase 1 of the CRM. Service providers discussed the importance of making connections with and for families through community support programs. This was particularly true for the families that they worked with who were at greatest risk for poor outcomes. Parents and service providers felt that for families who did not feel as supported by family and friends,

engaging with formal support services could be essential for making informal connections with other parents. McConnell et al (2012) also found that family support services created points of connection for many families. They argued that the opportunity for informal social networking through formal support services should be valued as much as the program.

When asked about informal supports on the survey, service providers ranked informal get togethers with neighbours (#10, NI=61.4) a much higher priority than parents (#31, NI=24.4). Service providers felt parents connecting more with other parents in their neighbourhood was a priority, but parents did not agree. This difference in priorities may be due to the types of families with whom service providers most often worked, and the types of families responding to the survey. As discussed earlier, many service providers who participated in the interviews indicated that they worked mostly with vulnerable families that they felt needed more informal supports, in addition to the formal community supports offered to parents with young children. This may also have been true for service provider survey respondents. Furthermore, as previously discussed, most parents who participated in our survey reported relying less on community parenting programs and also reported feeling very supported by their parents, extended family, and friends. Several indicated they received enough practical and emotional support when they became a parent.

Many service providers (#35, NI=26.6) and parents (#27, NI=31.7) felt public places where parents and children could interact with other families were not a priority. Organized playgroups had similar NI scores but were ranked differently

among parents and service providers (parents -#16, NI=40.1; service providers - #25, NI=37.8), but again not among their highest priorities, suggesting that for many parents, they did not need more informal supports.

Devolin et al. (2013) also found that parents relied more on informal social supports than formal social supports such as parenting programs led by service providers. Good levels of social support are important for positive parenting (Russell et al., 2011), decrease social isolation, provide reassurance, and improve parental confidence (Kane, Wood, & Barlow, 2007; Miller & Sambell, 2003). Overall, the families in our community reported having good informal support; however the use of different questions or a standardized questionnaire on social supports might have revealed different information.

In summary, the findings from the interviews, focus groups, and Concerns Report Surveys with parents and service providers offered additional insights into their perceptions of the strengths and needs related to community supports for parents with young children that supplemented and complemented the existing data. The existing data highlighted the neighbourhoods with the greatest needs in the North based on the median family incomes and the need for targeted community supports. The maternal and child health indicators suggested that the community had many strengths in comparison to the city. The EDI identified neighbourhoods in the North and South with the largest percentage of children not ready for school. The concept of proportionate universalism for the delivery of community supports to parents with young children emerged based on the EDI findings; however there was no indication from the existing data about what should be done to address

these needs, or what could be done in addition to the community supports that were already being offered. All of the findings from the existing data needed to be considered when interpreting the results from the interviews, focus groups, and surveys.

The two phases of the CRM served different purposes. The qualitative phase was meant to reflect on issues of importance to the community and generate issues that could be included in a community survey. One of the study objectives was to determine the extent to which the quantitative findings extended the initial qualitative exploratory findings. Only six of the items included in the Concerns Report Survey were considered high priorities for parents, whereas fifteen were considered high priorities for service providers. The survey prioritized community concerns from the perspective of parents and service providers and quantified parents perceived barriers to participation, attitudes toward parenting, and sources for information on parenting and child development based on a larger representative sample, something that could not be achieved with the qualitative data or the existing data alone. The qualitative data also extended the information gathered from the quantitative data. In many instances, referring back to the interviews and focus groups provided important information to help explain the quantitative findings.

#### **Study Objective 4**

Study objective 4 focused on evaluating the extent to which parents' and service providers' perspectives on community supports strengths and needs differed. The differences between parents and service providers' perspectives were

not examined in any of the community level NA published in the literature. Some researchers included the perspectives of various stakeholders, but they did not distinguish between perspectives (Bloomfield et al., 2005; CATCH, 2007; J. Law et al., 2009). In so much as there were obvious differences between the perspectives of parents and service providers on the community support needs of parents with young children; they did also share some of the same issues or concerns. As discussed in the previous section, Phase 2 results highlighted clear differences in priorities among parents and service providers, but there were also issues that the two groups agreed on. When considering service providers 15 highest priorities (NI score of 50 or above), four of the parents top six issues (NI score of 50 or above) were included: child care (Casual, centre-based and family-based) and housing a variety of programs and services for parents with young children in one building.

Interestingly, none of the parents' highest priorities focused on enhancing parenting skills or the parent-child relationship, they were all about parent supports that focused on children and location of services. Service providers, however, included supports focused on parents, parents and children, and children alone among their highest priorities for community supports, but they also had many more issues of high priority compared to parents. Overall, service providers were less satisfied with supports that they felt were very important for parents.

When initially embarking on the NA with the Coalition, there was some resistance to asking parents their perspectives on community supports. Some service providers felt that parents did not know what they needed, and service providers should be making the decisions about programs and services given their

expertise and knowledge of the issues. While this was not necessarily the prevailing attitude among service providers, it did highlight for the student researcher that not all service providers felt they should be collaborating with parents in the development of community supports for parents with young children. Despite scepticism from some service providers, parents were invited to participate in the NA process. Axford (2010) also suggested that relying on parents to identify community concerns or felt need may not result in the identification of programs and services that are needed to achieve healthy child development. However, the results of this study would suggest otherwise. All of the parents' highest priorities on the Concerns Report Survey had a strong or emerging evidence base that supported their contribution to promoting and enhancing child development.

When asked to consider community support needs, it can be difficult to consider experiences and needs beyond one's context. Service providers indicated during the interviews and focus groups that they tended to focus more on the needs of the families that they typically worked with and not necessarily on the needs of the broader community of parents or those that did not access their programs and services. They also indicated that it was difficult to know the perspectives of these parents as they were not interacting with them. Roche et al. (2005) indicated that professionals bring their own lens to early childhood issues that may limit their ability to see the full spectrum of need. For example, these lenses may only focus on one aspect of potential needs such as social services, health services, early childhood education, or a particular population, limiting the possibilities for community supports. In the same way that parents also view early childhood issues through

their own lenses based on their knowledge of themselves, their child, their family circumstances, their strengths, needs, and values, which is why it is also important to consider the perspectives of various parents.

While the establishment of the Parent Child Coalition in this community helped to bring together the perspectives of service providers from various sectors, parents had not yet been invited to participate in the Coalition. The differences that emerged between the two groups were important to highlight for service providers that potential service recipients do not always share the same perspectives of need. Service planners need to consider that planning and implementing services based on the perspectives of service providers alone can create barriers to engagement, if service recipients do not perceive a community support will address or meet their needs.

In an attempt to reconcile the different perspectives of parents and service providers identified in the Concerns Report Survey, members of the parent child coalition invited the student researcher to present the NA findings at three separate community meetings for various community service providers. Each of these meetings was tied to a strategic planning session and provided an opportunity for the groups to discuss the NA findings in relation to their understanding of the needs of the community. The notion of proportionate universalism (Marmot et al., 2008) was proposed to service providers for their consideration of the continuum of services that could be offered to the community.

Having open discussions with service providers about the differences in perspectives provided opportunities for reflection and discussions on ways to

involve parents in the program planning process moving forward. The information was presented with both views suggesting that there is no one right view or set of opinions that matters more – the perspectives are different and come from different places of knowing, understanding, and experiencing the issues; both need to be valued. Integration of the differing perspectives is not easy; however encouraging ongoing dialogue between service providers and parents as the community works with the information from the NA to discuss actions and develop solutions to address the needs of the community can promote better understanding among the groups. Pinnock and Garnett (2002) suggested that

Any attempts to engage service users, the wider community and service providers in discussions are unlikely to reveal a single ‘truth’ about needs or how they may best be met. Indeed, they may reveal conflicting perspectives. Whilst there are no easy solutions to how differences might be reconciled, sustained participation is likely to promote better understanding between different interest groups and could lead to the development of new solutions.” (p.84)

Focusing on shared areas of concern is also important when attempting to reconcile the priorities of the two groups.

Y. Lee, Altschuld and White (2007) indicated that attempting to understand the reasons for the differences between stakeholders could be done through additional interviews with stakeholders following the quantitative phase. For the purposes of this study, some of the reasons for the differences were identified in the initial qualitative phase and assisted with the interpretation of the different needs.

However, this process does not make the perspectives the same, it only highlights why they differ.

Some researchers have suggested that where community residents and service providers differ in their perspectives about community issues, the community members' views should be given priority (Jordan, Dowswell, Harrison, Lilford, & Mort, 1998; Williams & Yanoshik, 2001). The theoretical underpinnings of the CRM are strongly rooted in community development and empowerment theory (Ludwig-Beymer et al., 1996; Schriner & Fawcett, 1988a,b), both of which are about giving the community a voice in establishing community priorities and setting the community's agenda for change. Given this emphasis, communities that engage in using the CRM to establish the community's needs and strengths related to community supports for parents with young children should also understand the reasons for using this process. Coalitions that seek to empower parents and wish to engage them in the decision making process should consider using this approach.

For the purpose of this study, two Need Indexes were calculated to evaluate the extent to which parents and service providers' perspectives on community supports may have differed. Typically, in the CRM a single Need Index score is calculated meaning that not all perspectives are weighted equally. The stakeholders with the greatest number of participants will have the strongest voice in generating the community issues and priorities, which needs to be considered when interpreting the findings and developing action plans from the CRM. For example, there were more middle and higher income parents than lower income parents who responded to the survey suggesting that the concerns identified may more strongly

reflect their views. The issues of greatest importance to subpopulations, such as lower income families, may not be reflected among the top priorities given proportionally this group was smaller. Though, logistic regression of the variables associated with parents' greatest perceived needs did not indicate that income was a factor. The intent of the NA was not to focus on the needs of any particular sub-population of parents in the community, but to focus on the community supports needs of parents in the community as a whole.

Moving into Phase 3 of the CRM, the Coalition decided to use the typical approach and calculate a single Need Index based on the responses of parents and service providers to the Concerns Report Surveys. Given the much higher number of parents who responded, this meant the single community Need Index placed more emphasis on the perspectives of parents. During the course of the NA, there had been a shift in the value placed on parents' perspectives; whereas, at the outset there had been some resistance to including parents perspectives in the establishment of priorities for community supports. The student researcher would like to think the NA process had contributed to this shift.

Another possible approach to determining priorities would be to consider the issues that were of mutual concern to both parents and service providers and had a Need Index Score greater than 50. Incorporating the concerns of both stakeholders groups could lead to better outcomes. Peters et al. (2004) reported positive parent and child outcomes when they engaged parents in decision-making and leadership activities to strengthen community cohesion and foster local capacity. Melhuish et al. (2007) found that more parent empowerment in programs was related to greater

positive outcomes for parents and children. Involving parents in the planning and delivery of services, parent representation, and mutual respect between parents and service providers supported parent empowerment and better outcomes for parents and children.

The ongoing involvement of parents and service providers in developing the actions and solutions to address the identified concerns can help with the continued reconciliation of the two stakeholder groups' views. Determining if including parents as partners in the process of establishing community support needs for parents with young children will enhance outcomes for parents and children remains to be seen and warrants further research. However, the Coalition's approach going forward appears to be one of involving parents in the process of seeking solutions and planning actions to implement community supports and resources.

Community supports for parents are generally preventative services that rely on parents actively seeking them out to meet a particular need (Katz et al., 2007; Whittaker & Cowley, 2012). However, the perceived lack of appeal and inability of programs to address parents' needs deterred participation in community supports for some of the parents who responded to our survey. Other researchers have also found that important factors preventing parents from accessing community supports relate to the lack of congruence between parents' perception of their needs and the inability of available programs and services to meet those needs (S. S. Lee, August, Bloomquist, Mathy, & Realmuto, 2006; MacNeill, 2009; Whittaker & Cowley, 2012). Berlin, Brooks-Gunn, McCaron and McCormick (1998) found that parents'

active engagement in the program led to better outcomes for parents and children. They suggested that active engagement and involvement of parents should be a goal of support programs. Consulting with parents in the development of community supports can help to ensure supports are relevant for parents and do not only reflect service providers perceptions of the needs of parents (Katz et al., 2007; S. S. Lee et al., 2006; Moran et al., 2004; Rogers & Moore, 2003).

Engaging parents in the NA process to assist in the shaping of programs and services for the benefit of their children can be a vital aspect in the development of community supports that address the needs of parents with young children. While the entire CRM process is not yet complete with this community, the CRM has demonstrated its potential in helping to identify parent perceived community support needs. It also highlighted for service providers that what they perceived parents in the community needed may not be what parents perceived they needed.

Each perspective contributes important information to the NA process in the identification of community support needs for parents with young children; both perspectives need to be valued. These perspectives need to be considered in conjunction with the existing community data, programs and services, the research evidence, and current government policy. As well, the aim of the Coalition is to support positive parenting, improve children's nutrition and physical health, promote literacy and learning, and build community capacity. Therefore, the identified concerns need to be considered in relation to these four pillars for the Coalition to be involved in taking action.

## **Study Objective 5**

Study objective 5 was to evaluate the extent to which parents' perspectives of needs differed based on child and family characteristics. A limited number of studies have examined factors that influenced parents' perceived need for community supports. Very few of the risk factors discussed in the literature that are often used to identify families' needing targeted community supports were associated with parent perceived need in this study. The factors most frequently associated with parent perceived needs were: difficulty finding out what was available, use of a community support, age of the youngest child, and mother's employment status. Not surprisingly, parents who felt it was difficult to find out what community supports were available and those who had not used a particular community support were more likely to indicate the community support was a need. Knowledge of availability was significantly associated with child care centres, programs in community school, and preschool programs. These findings were also important for the NA indicating that more should be done to let parents know about the community supports that were available to engage parents in the existing programs and services. As well, determining where gaps remained based on existing community supports and parent and service providers' identified needs were also considered.

Mothers' employment status was only associated with child care centres not family-based child care or casual child care, with mother's employed full time more likely to perceive centre-based child care as a need. The student researcher would also have expected that mother's employment status would be associated with family-based child care given they offer the same service as centre-based child care

and also have limited availability in the community. Casual child care would not necessarily meet the needs of mother's employed full-time, but the student researcher thought that it may meet the needs of mothers employed part-time or stay at home mothers who do not require full-time care. It is also possible that the definition of casual child care was not clear to all parents and including a definition may have been helpful.

Not surprisingly, the age of the youngest child was also associated with child care centres and family-based child care. Mother's with young children are more likely to not yet have secured a child care space. Once a parent has a child care space, she may be more inclined to no longer perceive it as a need even though she may also have struggled at some point to find child care. However, in the interviews and focus groups, many parents also spoke about the difficulty finding child care when their preschoolers were transitioning to school as this often required a different child care arrangement, and preferably one situated at their child's school.

Mother's employment status was also associated with offering community supports in the same building, with mother's that were employed full-time being more likely to perceive this issue as a need. Again, this finding was not surprising, given the limited time available to mothers employed full-time to fulfill their parenting roles and responsibilities. Providing community supports in one location would require less travel time, less hassle, and could help alleviate parent stress (Corter & Pelletier, 2010; Corter & Peters, 2010).

The student researcher was surprised that income was not associated with any of the parent perceived needs, particularly given the emphasis on targeted

community supports for lower income families. McConnell et al. (2012) found that decreased parent need satisfaction was associated with low income, unemployment, parent with English as a second language, parent with a disability or chronic health condition, and parent of a child with a disability or chronic health condition. All of these factors, with the exception of parent with English as a second language, were considered in the current study. However, none of these factors were associated with parent identified needs. The lack of a relationship with income could be explained in a few ways. The top six concerns that parents identified were not those typically identified as targeted programs and services. These community supports are to some extent universal in that they are “equally” available to all parents, despite the limited availability of many of these programs within the community. Community supports that may typically be considered targeted programs such as the home visitor programs and programs that provide transportation which were not priorities may have been more strongly associated with family income.

In addition, key differences between the two studies could explain the different findings. McConnell et al. (2012) only surveyed parents who had participated in programs and services and asked parents to indicate the extent to which these programs and services had addressed their needs. The present study surveyed all parents in the community whether or not they had participated in community supports and asked them to identify their perceived needs.

At best the factors included in the logistic regression models in the current study explained only 16.8% of the variance in parent perceived need indicating that other factors were at play, or that parents shared these perceived needs regarding

community supports for parents with young children regardless of their different characteristics. Other authors exploring parent and child factors associated with parent perceived need were also only able to explain a small percentage of the variance (McConnell et al., 2012; Kesselring et al., 2012).

The student researcher thought that a lack of social support and increased parent stress would be associated with parent perceived need given the emphasis on these variables in the literature. As well, the reliance on social supports and their importance to parenting were discussed in the interviews and focus groups with parents and service providers, and while not labelled as “stress”, being overwhelmed by parenting responsibilities was also discussed. Based on the few questions that were asked about supports in the survey, parents in our study reported feeling supported in their parent role. There were also a few questions about stress on the parent survey, but they had mixed results in that parents agreed with some statements more than others. The responses to the survey questions on supports and stress were combined into two scores, one for supports and one for stress, to determine their associations with perceived need. Neither was associated with parents’ highest priorities or needs.

McConnell et al. (2012) found that need satisfaction was associated with parent stress and social support, along with child difficulties, family functioning and parent-child interactions. McConnell et al. used a social support measure that included 8 items, and a parent stress measure that included 36 items, unlike in the current study, both were well-validated tools. Family functioning, parent-child interaction, and child difficulties were not measured in the current study and

warrant further examination in relation to parent perceived needs in future studies. Other factors examined by Kesselring et al. (2012) such as neighbourhood levels of cohesion and trust may also influence parent perceived need for community supports and warrant further consideration in future studies. However, the possibility that parents who share similar characteristics do not share similar perceptions of need is also a possibility, given the uniqueness of each family's situation.

### **Strengths and Limitations of Each Method of Data Collection and the CRM.**

#### **Document review of existing data and community supports.**

There are several strengths and limitations of relying on existing data for establishing community support needs of parents with young children. The strengths of these data were that they are gathered on a representative population sample, meaning the data were valid and reliable for application to the community or group that is represented. Another strength of the existing data are that they are made publicly available to various stakeholders for use in their program planning and development at no cost to the agency, other than the staff time needed to gather and summarize the existing information.

As the most recent EDI or census data were not available at the time of completing this study, any changes to the school readiness of children since 2008/09 or to the socioeconomic conditions of the community since 2006 were not known. The analysis of the EDI data collected over the past three years showed no trends in any of the outcomes; therefore, we would not expect to see any significant differences. The EDI 2012/13 findings would be the most current and would

indicate if the existing community supports for parents with young children had made a difference to the school readiness of kindergarten children. Finding ways to get the EDI data into the hands of communities sooner is also important moving forward. As well, since the 2006 Census data, the community has continued to expand and the housing market prices have doubled in most neighbourhoods. The impact of these changes on the socioeconomic make-up of the community is not known. The 2011 census data had not yet been released in a community profile at the time of completing this study. Continuing to provide communities with profiles based on the Census data would be important for planning community supports. Not having the most recent data readily available to the community presents a disadvantage for program planning and development.

While using existing data to plan and develop community programs and services is strongly emphasized, stakeholders do not always know what data are available, where to find the data they are looking for, or what to do with the data when they find it. Making the information available and presuming that stakeholders will know what to do with the information or be able to make sense of it in relation to their community supports for parents with young children is not a fair assumption. The student researcher became aware of this issue when embarking on the document review. Service providers were asked about key documents they used in their program planning and development. The response was often they were not sure and would refer the researcher to their supervisor/manager.

When the findings from the document review were presented to service providers, many were not aware of all the data that were available at a community level and indicated that having it all summarized in one document was very helpful. No one had considered it all together to that point. Many of the parent child coalition members reviewed data specific to their area of practice (i.e., health, education, social services) and did not consider all the community data that may relate to families and children. Many service providers had reviewed the EDI results when the Coalition organized a community event to discuss the communities EDI findings in conjunction with the NA. The Coalition had not brought community service providers together around existing data prior to this event.

Even when data exist that could be very useful to the development of community supports for parents and young children, the community stakeholders still need to be engaged in using the information for this purpose. Preparing a summary of the information for the Coalition was iterative and required dedicated time for reviewing the information, some knowledge of where to locate the data, and how to interpret the findings. A first step in the NA process for many coalitions would be to ensure that communities know where to find the existing data, and how to interpret and use it for program development. For many coalitions, this step in the process could be a challenge.

As well, translating data into community needs and strengths is not always apparent or straightforward. For example, the indicators do not always suggest the point at which a particular rate or proportion might be a problem for the community, even if it is not statistically different from the city or the province.

Specific supports should be put in place to assist with this process if communities are expected to take action based on the existing data. Once communities are able to use and interpret the existing data, they could gather additional information that would also assist in identifying community needs and strengths. They would likely require support and capacity building in this regard as well. Coalitions would also have to decide the extent to which they wished to involve the community in the process and hear different perspectives. Deciphering the information that was specific to families with young children was also challenging as most of the data were not presented or analyzed specific to this population. There were no existing data on the quality or use of child care, early learning experiences, recreational programs, parenting programs, or parent-child programs at a community level.

Given the emphasis on engaging and empowering stakeholders as part of the NA process, the reliance on existing data alone to determine community needs would limit the community's knowledge of the NA process and their involvement in contributing to the solutions or participating in efforts to address the concerns. As Marti-Costa and Serrano-Garcia (1983) proposed combining information from existing data with other techniques that seek to mobilize the community and raise awareness of the concerns or issues is important. Others have also recommended the use of existing data, along with data from service providers and service users, as principal sources of information for the NA (Pinnock & Garnett, 2002; Utting, 2009).

### **Interviews and focus groups.**

The use of interviews and focus groups with parents and services providers to reflect on values and issues of importance to the community also had many

strengths and limitations. In keeping with the purpose of an exploratory sequential mixed methods research design, these methods assisted in the generation of issues for the survey to determine the community's priorities. This is the primary purpose of the qualitative phase of the CRM, and was implemented as such for this study. The data were analyzed with the focus of generating issues that would be relevant at a community level, not specific to sub-populations. If the community wished to know more about a particular sub-population(s) as part of their NA, larger samples of each of the subpopulations would be needed to ensure data saturation for each subgroup, making the data collection process much more lengthy and resource intensive.

The strength of the qualitative research was that it was especially responsive to the local situation, conditions, and stakeholders' perspectives. For example, parents spoke of their personal experiences with trying to access services or looking for services that were not available. The difficulty in navigating the community supports with little guidance and the need for more supports in certain areas. They also spoke about the supports that had been very helpful to them in certain circumstances or at different points as parents. Service providers also spoke about the families that they worked with and the challenges that they experienced in providing community supports. Parents and service providers shared their knowledge of the conditions of the existing community supports and the issues that they felt were needs or gaps based on their experiences. The qualitative data allowed for a greater understanding and description of parents and service

providers personal experiences with community supports for parents of young children.

The interviews and focus groups allowed for the identification of contextual and setting factors specific to community supports being offered for parents with young children. The student researcher was able to gain a better understanding of some of the challenges associated with the delivery of community supports and the barriers to participation for some families. As well, the student researcher gained a better sense of the focus of existing community supports and the groups of parents that were targeted. The richness of the data allowed for the exploration of a limited number of cases to describe complex phenomena, community supports for parents with young children. Interviews and focus groups also gave community stakeholders an opportunity to engage in the NA process. A great deal was learned from parents and service providers about their perspectives on gaps and concerns related to community supports.

Some of the limitations of the qualitative methods were that it took more time to collect and analyze the data compared to the quantitative research or the document review. As well, the Coalition members were not familiar with qualitative methods and data analysis, which required that the student researcher take the lead on this aspect of the NA. The Coalition members were interested in hearing about the data collection and results; however, the student researcher was primarily responsible for this phase. Other Coalitions wishing to use the CRM would need to have support for collecting and analyzing the qualitative data, if they were not familiar with this approach.

Another challenge of the qualitative methods was that the results could be more easily influenced by the researcher's personal biases and idiosyncrasies. The student researcher had to continually reflect on her biases and assumptions throughout the research process and particularly while analyzing and interpreting the findings. Interpretation of the findings in conjunction with the NA team helped to ensure that the student researcher considered her biases, assumptions, and beliefs. In addition, the quantitative findings extended the knowledge produced from the qualitative findings. For this reason, several authors have suggested that relying solely on qualitative data was not sufficient for identifying community needs (Axford, 2010; Pinnock & Garnett, 2002; Ward & Rose, 2002).

As outlined earlier, many of the issues identified in the interviews and focus groups were not identified in the existing data, in the same way that many of the issues identified in the existing data were not identified in the interviews and focus groups. The information gathered from the interviews and focus groups often supplemented or complemented the existing data providing additional information that could be used to identify parents and service providers perceived needs. Virtually none of the information was duplicative or contradictory to the existing data as it was meant to offer a different perspective and clarify some of the issues the existing data may not have been able to do..

### **Concerns Report Survey.**

The Concerns report survey like the other methods also had many strengths and limitations. A strength is that the community stakeholders were involved in the development of the items included on the survey to reflect their potential needs.

Psychometric testing was not completed to establish the reliability and validity of the survey instrument, as this is not a part of the CRM process. Use of a random sample of parents for the survey was also a strength of this method. Despite the low parent response rate, the survey respondents were fairly representative of the parents in the community based on the available data for comparison. Lower income families were, however, not as well represented, which can be a limitation of using surveys with this population (Dillman et al., 2002; Mohadjer & Choudhry, 2002). A range of service providers participated in the survey, but there were far fewer service providers compared to parents, though not unlike the ratios in the community.

Use of a web-based survey limited responses to parents and service providers who had access to the Internet. However, parents and service providers were given the option to mail their responses to the student researcher. Sending the survey to all parents regardless of their level of participation in community supports was also a strength of this method. The potential respondents were not limited to those parents who were already engaged with a particular community support, but they did have to be registered with Manitoba Health.

The Concerns Report Survey relies on a discrepancy score that is calculated based on two scales – importance and satisfaction. While this method is central to the CRM as it allows for the calculation of the Need Index Score, it can also be problematic. A Need Index Score was generated for parents and service providers that prioritized each groups perceived needs and strengths. The Need Index Score is an important feature of the Concerns Report Survey as it allowed for the

identification of stakeholder priorities. The student researcher chose to include a not applicable option on the satisfaction scale as not all parents or service providers may have been able to identify with a particular community support. Those who indicated not applicable were not eliminated from the analysis in accordance with Y. Lee et al. (2007) as this would decrease the number of responses available for analysis. Whereas others have indicated not removing the not applicable responses could introduce bias into the resulting Need Index (Thomas, as cited in Y. Lee et al., 2007). However, there is no consensus on the best approach.

Another issue with the some of the responses on the survey related to the questions on parent attitudes toward parenting. Many of the statements were susceptible to socially desirable answers, which could limit the interpretation of the findings. The use of validated measures for this construct may have provided a better understanding of the influence of parent attitudes on parent perceived needs.

For the purpose of this study, the student researcher developed two separate Need Indexes to determine if parents and service providers shared the same concerns. The differing views of parents and service providers were highlighted in this way. Typically, only one Need Index is generated for all community stakeholders. As mentioned earlier, the Coalition decided that they wanted the priorities to be based more so on the parents views as they felt that their views were lacking in the Coalitions activities, program planning, and development. Generating the combined Need Index in this way was a decision of the Coalition; however others considering use of this methodology should be aware of the way that the Need Index is typically calculated. Given the discrepancies between the two groups,

one potential approach would be to identify the issues that both groups felt were a priority and begin with these issues. This approach would identify areas of overlap or consensus between the two groups and could potentially lead to more positive outcomes.

When using mixed methods approaches, as in this study, researchers must draw on the strengths and recognize the limitations of both qualitative and quantitative methods to increase the breadth and depth of understanding of the issues. The use of several methods facilitated a more comprehensive understanding of the issues related to community supports for parents in this community than either method on its own allowed. Considering all of the information together in conjunction with knowledge of existing programs and services, the research evidence, and government policy informed decisions about the community's priorities and needs related to community supports for parents with young children.

### **Concerns Report Method.**

The CRM has many strengths. The framework and five phases of the CRM are easy to follow. The calculation of the NI does not require any special software or statistical consultation. The generation of a NI score for establishing community priorities allows for the involvement of many community stakeholders in the establishment of community needs/concerns.

Use of the CRM process identified felt need, normative need, and to a lesser extent expressed and comparative need related to community supports for parents with young children. Each perspective of need contributes valuable information for planners or policy makers, which adds to the depth and breadth of understanding of

need. However, no perception of need is sufficient on its own (Bradshaw, 1978; Axford, 2010).

Through the use of existing data, we were able to compare community indicators with municipal and provincial indicators to establish normative need. The literature and the evidence to support different approaches, programs, and services, along with the service provider survey were also important in establishing normative need. The interviews, focus groups, and parent surveys identified felt need. Expressed need such as use of programs and services and waitlists were identified through the interviews and focus groups with parents and service providers and the parent survey, but this information was not available for the various community supports being offered in the community. This type of data would have been helpful for the NA process. Comparative need was more difficult to determine as the types of community supports offered in similar communities are not summarized or available without more extensive data gathering, which were not within the scope of this study. Nevertheless, basing estimates of need on existing service provision for similar populations assumes that the existing level of service in the reference population is the appropriate type and amount.

The CRM has a strong participatory theoretical perspective that is in keeping with the mandate of the Coalitions and seeks to empower stakeholders through the NA process. As discussed earlier, the use of multiple sources of data and involvement of multiple stakeholders in the NA provided more detailed and in-depth information about the community. Other Coalitions may choose to use other NA approaches but should strongly consider these aspects and the rigour of the

approach being taken to ensure the most meaningful results for the community. Using the CRM allowed for the identification of community issues and concerns that were not otherwise apparent to the Coalition and not readily available in the existing data. While not all of the issues raised in the NA were under the purview of the Parent Child Coalition, the information generated was shared beyond the Coalition with other partners, agencies, organizations who have a vested interest in the findings and also support parents with young children.

While important information about the community support needs and strengths were gathered using the CRM, there were also some challenges using this methodology with the Parent Child Coalition. The intention of the methodology is to engage, build capacity, and empower stakeholders throughout the process. Given the coalition consists of volunteers with one part-time paid staff, the coordinator, engaging Coalition members in the process proved difficult at times. The Coalition was receptive to hearing about progress and results of the data collection process were discussed and reviewed on an ongoing basis; however, they relied on the student researcher to gather the data and complete the analysis in consultation with the team monthly. The student researcher was fully invested in ensuring the completion of the study given she was relying on the data for her doctoral work. This reliance also created inner turmoil for the student researcher around relinquishing control of the research process to the community. The community was as a result less engaged in the process than was ideal for evaluating the use of the CRM with the Coalition.

The readiness of the Coalition to engage in the NA process was also perhaps less than ideal. The student had approached the Coalition with the idea of conducting the NA and the commitment and capacity for working through the various stages of the process varied throughout. The Coalition chair and coordinator were important supporters of the NA and provided access to stakeholders and credibility to the process. Both, the chair and coordinator left their positions in the middle of NA process creating loss of momentum for the Coalition and the NA. It took several months before a new chair was appointed and a coordinator was hired, both of whom had not been active members of the Coalition to that point. Changes in staff and committee membership, along with the nature of the Parent Child Coalition, which tended to be an information-sharing forum rather than an action-based coalition, made using a participatory approach more challenging at times. Many of these challenges have been discussed in the literature on conducting participatory research (e.g., Israel et al., 1998; Minkler & Baden, 2008; Turnbull et al., 1998).

The Coalition decided to no longer meet monthly and started to meet quarterly. This decision was taken during a strategic planning session of the Coalition. However, the Coalition remained committed to working with the information and using the findings to inform funding and development of community supports. Planning for Phase 3 of the CRM required more active involvement of the coalition in using the results to effect community change. Hence, a small sub-committee of Coalition members continued to meet around the NA and planning of a community forum to develop action plans related to the NA results.

This sub-committee met more often than the larger Parent Child Coalition. The development of this sub-committee was a shift from an information-sharing to an action-oriented group with a focus on community mobilization that was not present prior to completing the NA process.

Berger (2013) in a review of the literature on sustainability and effectiveness of coalitions suggested that coalitions have several core features that include among others - community mobilization. The goal of coalitions is being a catalyst for change in their community. Other Coalitions wishing to use the CRM would need to be receptive to the use of a participatory process that serves to mobilize the community with the goal of creating change. As well, Coalitions would need to be committed to the time and capacity building required to complete the various phases and involve the community in the process.

Funds would need to be secured to conduct the interviews/focus groups and surveys if the Coalition members were not prepared to assist with the data collection. The student researcher facilitated the interviews and focus groups, hired a transcriptionist to transcribe the data, completed the submission to Manitoba Health to distribute the surveys, and analyzed all of the qualitative and quantitative data in consultation with the NA team. The Parent Child Coalition and a grant the student researcher received from the Manitoba Health Research Council for her PhD research funded the NA.

Phases 1 and 2 of the CRM were completed over the course of two years. One year was needed to obtain the necessary approvals to conduct the study, to complete the qualitative data collection and analysis and use this information to

develop a concerns report survey. The approval processes required to conduct phase two also added to the time needed to complete the study. Following receipt of all the necessary approvals another six months was needed to complete the quantitative data collection and analysis. Reconciling the data gathered using various methods also added to the length of the study as did other factors discussed previously (e.g., staff turnover). Throughout this time, the student researcher in conjunction with the NA team reviewed several documents that were included in the document review.

Members of the Coalition would need to be prepared to participate in the qualitative and quantitative data collection and analysis. Coalitions should also be committed to not only completing phases 1 and 2 but the remaining phases of the CRM that involve community forums and the development of action planning committees to implement the changes sought. It would be advisable that Coalitions partner with a researcher, in keeping with PAR, to conduct the CRM. The researcher would be responsible for assisting in building Coalition members' capacity to conduct research. If the Coalition is ready and willing to engage in the process, the CRM offers a detailed framework that Coalitions can follow and implement with their stakeholders.

The survey costs were the greatest expense due to the number of mail outs through Manitoba Health. Coalitions could use other methods to distribute the survey that are less costly but may have to rely on a convenience sample rather than a random sample of parents. Given the low response rate through Manitoba Health, which could be considered a limitation of the current study, other methods to

ensure a representative community sample based on knowledge of the community characteristics could be contemplated. Other researchers have used a convenience sample to gather their survey data in the CRM and taken the opportunity to engage with the community while completing the data collection in various community locations (Balcazar et al., 2009; Fawcett et al., 1988; Ludwig Beymer et al., 1996; Suarez Balcazar et al., 2005). This method would also be time consuming and resource intensive.

Many of the parents' top priorities were beyond the Coalitions direct influence and required a systemic change in policy in relation to community supports for parents with young children. For example, concerns related to child care are not unique to this community, and Coalitions alone lack the authority to alter the funding constraints to allow for quality universal child care. However, the findings raise important issues that can be shared with a broader audience who has the authority and power to create change at a policy level and can mobilize the community around developing solutions to assist in addressing these issues. The community can also choose to take action at the local level to address this issue through seeking additional funding for new spaces and child care centres.

Finally, the CRM does not offer ways to integrate existing community data into the final decision-making process around priorities for action. The items generated from the survey are meant to be the areas of focus. This is a limitation of the methodology that could present a challenge for other Coalitions given the importance of using existing community data in the planning of programs and services. The approach taken in this study involved examining the findings in

relation to the existing data to determine the extent to which the results from the different methods complemented, supplemented, differed or conflicted with one another. In keeping with the purpose of mixed methods research, the strengths of each method were combined to increase breadth and depth of understanding facilitating a more comprehensive understanding than either method allowed on its own. Each method was intended to build on the other to provide additional information that each method could not have provided alone. Decisions needed to be made based on a careful consideration of all the information together.

### **Study Limitations**

This study had several limitations. While a random sample was generated, the low response rate could have biased the sample. Dillman's method recommends at least two reminders to increase the response rate; however, Manitoba Health completed the mail out and allowed for only one reminder. Very little information is available on the difference between respondents and non-respondents as limited existing data permitted comparisons between the survey sample and all parents with young children (0 to 6 years old) that reside in the community of interest. Area level income quintiles (Manitoba Centre for Health Policy, 2013) were used to generate the sample, which are not the same as self-reported family income. However, a comparison of the quintiles with survey respondent self-reported family income before taxes showed that low-income families were not as well represented as middle and higher income families. In addition, very few fathers responded to the survey. The exclusion of parent survey participants whose responses were "neutral" as opposed to "strength" or "need" in the logistic regression analysis may also have

biased the results and raised the question of whether future researchers should eliminate the neutral option.

The use of a web-based survey may have limited parent participation as not all families have access to the Internet and many families who do not have access are more likely to be from low-income households (Statistics Canada, 2013). The student researcher offered to send all participants a paper survey with return postage if this was the respondents preference; however all participants chose to respond via the web. The web-based survey may also have limited service provider participation as not all service providers have access to the Internet in the workplace, assuming many respondents completed the survey at work versus at home.

The generation of a random sample of service providers was extremely difficult without the availability of a master list of service providers in the community of interest. Therefore, a convenience sample was used making the results from this survey non-generalizable. Nonetheless, a broad range of service providers from varying professional backgrounds and many with several years of experience responded to the survey.

As well, the student researcher made a decision not to analyze parent perceived need in association with neighbourhood clusters (North and South), but rather to consider individual income of families given the variation in income across neighbourhoods. However, including neighbourhood clusters in the analysis may have provided additional information about factors associated with parent

perceived needs in this community. Geography within the community should be considered in future analysis.

Items used to determine parent support, attitudes, and stress were not validated measures of the constructs and may have contributed to the lack of a significant association with the outcome variables. Validated measures such as those used by McConnell et al. (2012) would increase the time to complete the survey; however they would provide more accurate information related to parent stress, attitudes, and social support.

The student researcher is a resident of the community of interest, middle class, an older first time mother, and a parent with two young children who has accessed programs and services in the community. While every effort was made to bracket and reflect on personal biases and perspectives throughout the study, not unlike other qualitative studies, it is possible that the student researcher's own experiences influenced the qualitative data collection and analysis.

## **Chapter 6: Conclusion**

The CRM is an example of a participatory approach to NA that uses a systematic mixed methods process for setting agendas for community change from the perspective of community members who share a common issue. The process and outcomes are intended to keep an organization's agenda from only reflecting the interests of service providers. The methodology has a clear grounding in theories of empowerment, self-help, and community development (Ludwig-Beymer et al., 1996; Schriner & Fawcett, 1988a). Despite only examining the first two phases of the CRM, this study adds to the body of literature on the use of the CRM in the context of identifying the community supports needs of parents with young children.

The use of existing data as part of the NA process provided important information about the community. Differences in socioeconomic status between the neighbourhood clusters (North and South) and the individual neighbourhoods within the clusters were apparent. This information considered in conjunction with the existing community supports indicated that many programs and services were targeted to the neighbourhoods with the most vulnerable families. As well, the existing data highlighted community strengths related to maternal and child health indicators in comparison to the city and the province. The data also identified neighbourhoods in the North and South of the community with a large percentage of vulnerable children or children not ready on the EDI. The findings from the existing data considered all together suggested that proportionate universalism (Marmot et al., 2008) should inform the approach to service delivery in this community, but the

existing data did not outline what proportionate universalism should entail. Given the wide range of potential community supports that could be delivered using this approach, additional information was gathered from parents and service providers. This information would assist in determining parents and service providers' perceived community support needs for parents with young children in this community and could contribute to decisions related to the use of proportionate universalism in offering community supports for parents moving forward.

Based on the experiences from this study, understanding the existing community data were an important first step in the NA process. Prior to completing any additional data collection, the community should concentrate on understanding the existing community information and determining based on these findings any supplementary information that could be gathered to identify community support needs. The capacity of Coalitions to gather and interpret all of the relevant information should also be a primary focus prior to engaging in more data collection.

Interviews and focus groups with parents and service providers conducted in Phase 1 of the CRM offered additional insights into issues of importance related to community support needs of parents with young children. The information gleaned from the interviews and focus groups was helpful in creating a community Concerns Report Survey, which is the intended purpose of this phase of the CRM. The findings did not indicate the extent to which the issues were a priority for the community. The quantitative findings helped to extend the initial exploratory qualitative findings and establish parent and service provider priorities. Hence, relying solely

on qualitative data for identifying community needs were not sufficient. The qualitative findings also extended our understanding of the quantitative results.

Typically, the responses to the Concerns Report Survey are used to calculate only one Need Index that includes the perspectives of all stakeholders to identify community concerns. However, for the purpose of this study separate Need Indices were calculated for parents and service providers. The Need Indices that were generated suggested that the two stakeholder groups did not always share the same perspectives related to community supports for parents with young children. Based on their responses to the Concerns Report Survey, service providers tended to be less satisfied with community supports that they felt were very important for parents. As a result, their Need Indices were much higher overall with fifteen items with a score of 50 or greater, while parents only had six.

Parents' perceived community support needs based on their Need Index scores of 50 or greater were child care centre, family child care, casual child care, preschool programs, housing programs and services in one building, and community supports for parents with young children offered in community schools. Service providers perceived community support needs were much more varied and included: developmental screening, parenting workshops, programs for fathers, parent programs that offered child care, doctors for children, casual child care, transportation to programs, programs that assist with the transition to parenthood, informal get-togethers with neighbours, nutrition for young children, child care centres, housing programs and services in one building, family child care, and a

parent hotline. Shared areas of concern were: child care and housing programs and services in one building.

The survey findings suggested that parents and service providers' perspectives may come from different places of knowing, understanding, and experiencing the issues, but both need to be valued. Focusing on the areas of shared concern among parents and service providers offers a starting point for engaging both stakeholders groups in the planning and delivery of community supports for parents. Many of the community support needs that parents identified had a strong or emerging evidence base that supported their contribution to promoting and enhancing child development, the goal of community supports for parents with young children. In addition, previous research has demonstrated that engaging parents in decision-making related to the planning and delivery of community supports and leadership activities led to better outcomes for parents and children (Peters et al., 2004). Parent representation and mutual respect between parents and service providers supported parent empowerment and also resulted in better outcomes (Melhuish et al., 2007). Further research examining whether involving parents in the decision-making process results in better outcomes for parents and children is warranted.

Knowing that parents and service providers may not always share the same perspectives highlights the importance of seeking parents' views in identifying community support needs, if the intent of the community supports is to address the needs of parents with young children. Service providers need to consider that planning and implementing services based on the perspectives of service providers

alone can limit engagement in community supports, if parents do not perceive the community supports will address or meet their needs. Without parent engagement, community supports cannot achieve their goals.

The intent of the NA was not to focus on the needs of any particular sub-population of parents in the community, but on the needs of all parents at a community level. This meant that the perspectives of sub-populations may not have been as well reflected among the priorities generated on the Need Index as stakeholders with the greatest representation will have the strongest voice in generating community issues and priorities. However, this notion assumes that subpopulations share the same perspectives on community support needs. When using the CRM, and interpreting the community findings, this needs to be considered. The CRM could, however, also be used with subpopulations of parents if that was the focus of the NA.

Based on the literature review, this study examined child, parent, and family characteristics that may be associated with parents' perceived needs. The presence of certain child, parent, and family characteristics are often used to identify families at risk and subsequently to encourage their involvement in targeted community supports. Knowing if certain parents are more likely to perceive a community support as a need could be helpful in identifying parents who feel their needs are not being met. However, in this study many of these factors were not related to the top six parent perceived community support needs calculated based on parents' responses to the Concerns Report Survey. Despite differences among child, parent

and/or family characteristics, many parents shared the same perceived needs for community supports.

Of the factors that were associated with parents perceived community support needs, parents who felt it was difficult to find out what community supports were available and who had not used a particular community support were more likely to perceive a community support was a need. These findings were important for the NA indicating that more should be done to let parents know about the community supports that were available to engage parents in the existing programs and services. Mothers who were employed full time and parents with younger children were more likely to perceive a community support was a need. Other factors that were not considered in this study warrant further examination in subsequent studies such as parenting style, neighbourhood cohesion and trust. In addition, social supports and parent stress should be explored with valid and reliable measures of these constructs. Finally, the idea that parents who share similar characteristics do not share similar perspectives of need is also a possibility, given the uniqueness of each family's situation.

Each of the methods used in this study - document review of existing data and community supports, interviews, focus groups, and Concerns Report Survey - has strengths and limitations that need to be considered when identifying community support needs of parents with young children. In keeping with the purpose of mixed methods research, the strengths of each method were combined to increase breadth and depth of understanding facilitating a more comprehensive understanding of community supports for parents with young children than either method allowed

on its own. Generally when using the CRM, the priorities generated from the Concerns Report Survey would inform the community's actions. However, the approach taken in this study involved examining the findings from the CRM in relation to the existing data, policies, and research evidence. Decisions needed to be made based on a careful consideration of all the information together.

The participatory nature of the CRM is both a strength and a challenge in the context of Parent Child Coalitions. Coalitions wanting to use this approach would need to be aware of the time, resources, commitment, knowledge, and capacity needed to complete the process. As well, Coalitions would need to be committed to involving parents in the decision-making process. Coalitions seeking to engage parents and service providers in a NA process should consider using the CRM to identify community support needs and priorities.

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## **Appendix A: Synthesis of Evidence on Specific Support Programs for Parents of Young Children**

Within many of the child-health partnerships and other community-based programs, the most common approaches to the provision of parent community supports included: parent education and training, home visiting, parent-child programs, early learning opportunities, and child care services (Jayaratne et al., 2010), all of which are offered to some extent in the community of interest. The effectiveness of each approach will be discussed in further detail.

### **Parent education/training.**

Research on parent education/training suggests that the quality of parenting matters, is open to change (Goodnow, 2006), and may be the single most important factor in a child's life (Tremblay et al., 2008). In the past 40 years, hundreds of studies focusing on parent training and education have appeared in the literature. Study designs have ranged from case descriptions to randomized controlled trials of which the methodological sophistication of many has been quite high, and more recently to systematic reviews and meta-analyses. These programs and services provide information and education on several different topics (e.g., child development, parenting self-efficacy, discipline), are delivered in a variety of settings (e.g., home, clinic, community), use various techniques to engage parents and teach relevant content (e.g., group discussion, role play, homework), have varying intensities (e.g., bi-weekly, weekly, monthly) and provide services to different types of families (e.g., children with behaviour problems, low-income, teen mothers) and parents with children of varying ages (e.g., newborn to adolescents).

The following section will discuss the effectiveness of parent education/training programs.

The meta-analyses reviewed reported positive small to moderate effects of parent training/education on child behaviours (de Graaf, Speetjens, Smit, de Wolff, & Tavecchio, 2008; Kaminski, Valle, Filene, & Boyle, 2008; Layzer et al., 2001; Lundahl, Risser, & Lovejoy, 2006; Menting, Castro, & Matthys, 2013; Nowak & Heinrichs, 2008; R. Thomas & Zimmer-Gembeck, 2007), particularly on children with more severe behavioural problems (de Graaf et al., 2008; Lundahl et al., 2006; Menting et al., 2013). Not surprisingly, children with less severe behaviour problems had smaller effect sizes as they had less room for change (de Graaf et al., 2008; Lundahl et al., 2006; Menting et al., 2013); however in a preventive framework even small improvements or no decline can be important to child and family well-being. Many of the studies reported behavioural programs had greater positive changes in behaviour for younger children five years of age or less in comparison to older children (Lundahl et al., 2006; Moran et al., 2004; Nowak & Heinrichs, 2008).

Improvement in parenting behaviour is thought to be the most important factor in changing child behaviour (McMahon, 2006), yet, fewer studies focused on the effect of parent-training programs on parent behaviours. Kaminski et al. (2008) reported that the mean effect size was larger for parents than children, and for parenting knowledge, attitudes, or self-efficacy than for parenting behaviours and skills. Others found moderate effect sizes for improved parent behaviour (Lundahl

et al., 2006; Nowak & Heinrichs, 2008), parental perceptions (Lundahl et al., 2006), and parental well-being (Nowak & Heinrichs, 2008).

Overall, the effect of group-based parent education/training programs on children's outcomes was mixed (J. Law, et al., 2009). Group-based parent support programs have been reported to produce significant results immediately following the intervention, and less pronounced results at one-year follow-up (Barlow et al., 2010). Lundahl et al. (2006) and Nowak and Heinrichs (2008) reported that families participating in group sessions experienced less pronounced positive changes in children's behaviour than parents receiving individual sessions. However, long-term data was limited beyond one year for most studies, and parents most likely to participate in group sessions are those whose children have less severe behavioural problems (de Graaf et al., 2008; Lundahl et al., 2006; Menting et al., 2013).

Parent outcomes for group-based parent training revealed that parental emotional and mental health demonstrated positive short-term improvements (Barlow et al., 2012; Moran & Ghate, 2004; Shulruf, 2005). These findings suggest that having supports to deal with parenting challenges makes a difference; however, sustaining the effect without the supports present is more difficult. Programs that provided anger management for parents reported mixed results with only half demonstrating positive improvements in parents' stress and anger management (Shulruf, 2005). Kane, Wood and Barlow (2007), in a meta-synthesis of four qualitative studies, reported that parents who participated in group-based parent education/training found that support from other parents in the group along with the new knowledge and skills gained helped them to cope. Parents felt less isolated

and more confident in dealing with their child's behaviour. Overall, findings on the effectiveness of different types of group programs along with the mechanisms that bring about improvements in parental psychosocial functioning were inconclusive (Barlow et al., 2012).

Researchers have reported that children and parents from single parent families and financially disadvantaged families did not benefit to the same extent, as did children and parents from non-disadvantaged families (Layzer et al., 2001; Lundahl et al., 2006; Moran & Ghate, 2004). Lundahl et al. (2006) indicated that individual parent training was more effective for financially disadvantaged families than group training in relation to child and parent behaviours suggesting that interventions should be individually tailored for these families. Menting et al. (2013), in their meta-analyses, found that none of the family characteristics proved to be predictors of group parent-training program effectiveness. The analyses conducted to date on parent demographic factors are inconclusive and warrant more research. However, the type of program and approach used with different families should be considered.

Some researchers found that self-directed parent training programs have similar effects on children and parents as face-to-face parent training programs (de Graaf et al., 2008; Lundahl et al., 2006; Nowak & Heinrichs, 2006; Thomas & Zimmer-Gembeck, 2006). Nowak and Heinrichs (2008) found that self-directed programs yielded small effect sizes directly after the program on parenting, parental well-being, and parents' relationship quality with the latter two outcomes yielding higher effect sizes than parents receiving individual and group sessions (Nowak &

Heinrichs, 2008). The use of mass media to share public announcements about positive parenting had no improvement on parenting behaviours (Thomas & Zimmer-Gembeck, 2007). The favourable results for self-administered programs on child problems and parenting require further investigation in subsequent trials.

Programs focusing on parents' attitudes rather than behaviours did not typically improve parenting skills (Moran & Ghate, 2004) and programs focused on problem solving reported smaller effect sizes on parenting behaviour and skills (Kaminski et al., 2008). The number of sessions that parents attended (Menting et al., 2013; Nowak & Heinrichs, 2008; Shulruf, 2005), the level of family distress (Nowak & Heinrichs, 2008), and the use of well-trained staff (Moran & Ghate, 2004) were also positively related to program effects. Fidelity of the intervention is an important aspect when implementing evidence-based programs to ensure they are being offered in the way that they were intended (J. Law et al., 2009). However, very few studies discussed the fidelity of the intervention.

Moran and Ghate (2004) reported promising results for programs offering social supports to parents. These included: befriending programs, services that offered specific information and advice on accessing support from agencies in the local area, and services that work with parents to develop their skills in seeking help. Layzer et al. (2001), in a meta-analysis of over 665 quantitative studies, found that programs providing parents with opportunities for peer support had larger effects on children's cognitive outcomes. Kane et al. (2007) suggested that in order to address parents' needs and promote parent-child well-being, parents needed opportunities for peer support.

Providing parents with additional services such as mental health services, case management, educational assistance, as part of the parent education and training, were associated with smaller parent effect sizes (Kaminski et al., 2008; Lundahl et al., 2006). Researchers proposed that the focus on other objectives might distract service providers' and parents' from the development of new parenting behaviours and skills.

Including children in their own therapy, separate from parent training, did not enhance outcomes (Kaminski et al., 2008; Lundahl et al., 2006). Programs that provided parents with the opportunity to practice new skills with their own children during sessions had significantly larger effect sizes for parent (Kaminski et al., 2008) and child (Kaminski et al., 2008; Thomas & Zimmer-Gembeck, 2006) outcomes. Results on the use of modelling, homework, and other types of role-playing were mixed with some indicating they were not predictive of parenting skills/behaviours (Kaminski et al., 2008), and others suggesting they were (J. Law et al., 2009; Moran & Ghate, 2004). However, they all agreed that interactive methods of teaching that were practically-focused rather than didactic approaches or talk-based styles were more effective.

Programs based on parent empowerment models were more effective at the end of the program and over time in demonstrating improvements in emotional and behavioural adjustment of toddlers (J. Law et al., 2009). Layzer et al. (2001) found that the types of program features most consistently related to effect size focused on developing parents' skills related to self-confidence, self-empowerment, family management, and parenting. Programs that focused on parent development and

improved economic self-sufficiency as a primary goal also had a moderate effect size on parent behaviour.

The overall methodological rigour of the studies was strong with many using RCTs, systematic reviews, or meta-analyses but the findings were mixed. While parent education/training demonstrated positive effects on child and parent outcomes immediately following the programs, all of the authors reported the lack of long-term follow-up was a limitation of the existing research. Hence, more long-term evaluation needs to occur to determine program effectiveness over time. The durability of programs remains to be established across several studies.

Understanding the interaction between participant characteristics and program features is important to maximize the likelihood of success for parent education/training. One approach does not fit all families and young children. A variety of approaches are needed to address the diverse needs of parents and young children. While the evidence from many programs is promising, more research is needed to determine the components that are most beneficial for particular populations and the context in which these programs are most successful.

### **Home visiting.**

A vast body of literature focused on home visiting. Home visiting is a type of service delivery model that can be used to provide a range of interventions (Zercher & Spiker, 2004). Parent education and training is often a part of home visiting programs, therefore separating the results attributable to each approach is difficult. Home visiting programs can vary considerably in terms of the goals, clients, intensity of services, and activities (Gomby, 2005; Moran & Ghate, 2005; Olds, 2006;

Zercher & Spiker, 2004). As well, the qualifications of service providers can differ across programs with some being credentialed or certified professionals, others being paraprofessionals or volunteers (Gomby, 2005; Layzer et al., 2001; Moran & Ghate, 2005; Olds, 2006; Zercher & Spiker, 2004). They do, however, share some common elements: they provide structured services in a home setting, usually by a trained service provider, with the aim of altering knowledge, beliefs and/or behaviours of caregivers, providing parenting support, and enhancing child development (Zercher & Spiker, 2004). Home visiting is considered an important strategy for supporting parents with young children as it allows for the provision of services for hard to reach families that can be tailored to meet individual family needs, and if effective, the programs can also benefit future siblings.

Home visiting programs demonstrated the highest efficacy for families at greatest risk (Boivin & Hertzman, 2012; Gomby, 2005; Olds, 2006). In addition, parents who perceived that their child needed the services (e.g., low birth weight, special needs, behavioural problems) tended to benefit more as well (Gomby, 2005). Boivin and Hertzman (2012) reported that while many home visiting programs exist, most have not been shown to reduce child maltreatment when evaluated using an RCT, with the exception of the Nurse-Family Partnership (NFP).

Olds (2006), in a review of the RCTs specific the NFP program, reported that mothers' who participated in the program tended to have: more positive prenatal health behaviours, better pregnancy and birth outcomes, more sensitive competent care of the child, better child neurodevelopmental outcomes (in one of three trials),

more positive early maternal life course, and better child adolescent functioning at 15 years of age (in one of three trials).

Most married women and those from higher socioeconomic households managed the care of their children without the assistance of a nurse home visitor; the majority of these children did not experience major future problems such as substance abuse, welfare dependence, and crime (Olds, 2006). The program was able to avert many of these issues for children from low-income families with single mothers. The cost savings were only attributable to the benefits accrued for these families, and the long-term study was only completed at one site. Olds (2006) challenged the idea that home visitation programs be made available universally, as it would be wasteful and lead to a reduction of services for those families who needed them most.

Gomby (2005) in an extensive review of the literature, including 13 meta-analyses and 11 literature reviews, on home visiting programs stated that the positive results from the NFP program, which demonstrated long-term benefits for children and parents, had led to the wide spread adoption and expansion of home visiting programs internationally. Despite the results from the NFP, few long-term studies on home visiting programs exist.

Most evaluations of home visiting programs are short-term occurring at the end of the program or shortly after and results vary considerably. On the whole, programs produced benefits that were modest in magnitude and tended to produce better outcomes related to parenting. Positive child development outcomes and improvements in the course of mother's lives were also not observed consistently

across programs (Gomby, 2005; Moran & Ghate, 2004). Layzer et al. (2001) found that programs that used home visiting as the principal intervention had weaker effects on children's cognitive outcomes. Home visiting programs offered in conjunction with centre-based early childhood education appeared to produce larger and more enduring results than home visiting alone, particularly for children's cognitive development or school achievement outcomes (Doherty, 2007; Gomby, 2005; Olds et al., 2007).

Like other support programs and services for parents with young children, family engagement was an important aspect of home visiting programs. In many instances, families did not participate in the program as intended. Some programs reported attrition rates as high as 50%. High attrition rates mean that the benefits of home visiting may be overstated. Of those families who did remain in the program, many received only half of the program visits. Families did not always follow the recommendation of their home visitors or complete the homework assigned between visits (Gomby, 2005).

Programs that used professional staff rather than paraprofessionals to help parents to be effective adults were more effective in producing positive outcomes for parents (Boivin & Hertzman, 2012; Gomby, 2005; Layzer et al., 2001; Olds et al., 2007). However, simply using nurses as home visitors was insufficient to affect important maternal and child outcomes (Olds et al., 2007). A well-designed intervention program with well-trained staff that focused on at-risk populations during pregnancy and infancy had the most potential to affect important outcomes in the lives of vulnerable children and families.

Manitoba offers the Families First/Baby First home visiting program that provides supports to families with children from prenatal to five years old living in at risk conditions (Healthy Child Manitoba, 2010). Paraprofessionals are primarily responsible for delivering the home visiting program. A recent evaluation of the program revealed several positive effects for participating families (Healthy Child Manitoba, 2010). The largest effect sizes were on increased positive parenting (0.80), the mother's self-acceptance (0.79) and sense of environmental mastery (0.76), and increased social support (0.65). Moderate effect sizes were found for decreased hostile parenting (0.53), the mother's sense of her purpose in life (0.49) and increased neighbourhood cohesion (0.42).

Unfortunately, no differences were found between program and comparison groups for delayed child development, reading sessions with children, mother's overall psychological well-being, mother's positive relationships or personal growth and autonomy, maternal depression, neighbourhood safety, use of community services, and participation in voluntary organizations. The effect sizes of many of the outcomes were much larger than other programs that used paraprofessionals. The report did recommend that continued efforts should be placed on ensuring program quality and improving the engagement and retention of families in the program.

### **Early learning experiences.**

Reynolds and Temple (2005) referred to early childhood learning as one of the most important priorities in the new century. Early learning experiences establish a critical foundation for children's academic success, health and general well-being

(Anderson et al., 2003; Canadian Council on Learning, 2008), and begin in the earliest days of a child's life (McCain et al., 2007). Cognitive developmental science and neurological research report that children learn certain things at particular ages, in a certain sequence (McCain et al., 2007; Shonkoff & Phillips, 2000). Brain sensitivity to development of emotional control, peer social skills, language and numeracy reach their highest levels between one year and three years of age, but begin in the womb. For many children, the opportunities for early learning experiences occur both in and out of the home environment; however the quality of the interactions in both settings is what matters most for children's outcomes (Canadian Council on Learning, 2008; McCain et al., 2007; Shonkoff & Phillips, 2000).

***Parent-child focused activities/programs.***

Olmsted and Montie (2001) found that when parent participation in children's program results in positive effects on children's cognitive development. Furthermore, the number of activities in which parents participated in preschool and kindergarten was significantly associated with higher reading achievement, with lower rates of grade retention at age 14, and with fewer years in special education (Miedel & Reynolds, 1999). Parent participation with their children in activities such as arts and crafts is associated with children's literacy development (Nord, Lennon, Liu, & Chandler, 1999). Parent engagement in reading and other activities with their children also promotes their academic and social development.

The longitudinal Effective Provision of Preschool Education (EPPE) project in the United Kingdom also showed that parental involvement in reading at home

strongly supported cognitive and language gains (Siraj-Blatchford, Sylva, Muttock, Gilden, & Bell, 2002; Sylva, Taggart, & Siraj-Blatchford, 2003). Encouraging and training parents to perform specific reading tasks with their children results in positive effects on children's language and pre-literacy skills (Olmsted & Montie, 2001). Practices associated with parent responsibility for learning such as providing a place for educational activities, asking a child about school, and reading to a child are related to children's motivation to learn, attention, task persistence, and receptive vocabulary and to fewer conduct problems (Fantuzzo, McWayne, & Perry, 2004).

Parent support and involvement in early literacy has a greater effect than social class: what parents do is more important than who they are. Some French research also suggests that parent involvement in preschool activities with their children promotes more complex cognitive interactions and helps mediate the effects of lower socioeconomic status (Tijus, Santolini, & Danis, 1997). Parental involvement can act as a valuable source of familial social capital that operates to reduce the harmful effects of economic disadvantage in childhood (Hango, 2007). Children who live in families with positive family functioning, whose parents are supportive and nurturing, who read to them and use more complex language, and who create a stimulating home environment, have better cognitive and social/emotional skills (Weiss, Caspe, & Lopez, 2006). However, Hart and Risley (Hart & Risley, 1999) found that four year old children from families with higher socioeconomic status had larger vocabularies than children of low income parents.

Researchers reported that children's educational outcomes improved following intensive two-generational programs (Layzer et al., 2001; Moran & Ghate, 2004; Shulruf, 2005). However, Doherty (2007) examined the effect of several two-generation programs on child outcomes. The programs that had the greatest gains in child development outcomes had the most direct programming for children. She concluded that the development of vulnerable children is best enhanced through participation in child focused centre-based group programs than two-generational programs. However, this depends on the availability of quality child focused group programs that need to be of a sufficient duration and frequency to impact child outcomes. In addition, not focusing on building parents' capacity does not recognize the importance that parents have on their child's development throughout their life and on potential future generations.

***Early Childhood Education and Care.***

Studies have shown that investing in early childhood education can help meet long-held objectives, such as improving school performance, workforce quality, and economic development (Heckman, Grunewald, & Reynolds, 2006). Reynolds and Temple (2008) summarized evidence on the effects and cost-effectiveness of early childhood education programs for preschool children, particularly children from lower socioeconomic families. Nineteen reviews synthesized hundreds of studies. Included interventions contained centre-based early education or preschool. Reynolds and Temple (2008) reported that there is substantial evidence supporting preschool programs, mostly for vulnerable children. These programs reported positive impact on cognitive skills, school achievement, social and emotional

development as well as educational attainment, employment, and later social behaviour. The extent of the effects suggested positive economic returns.

Three of the most widely cited programs from the research reviews were the High Scope/Perry Preschool Program, the Chicago Child-Parent Centers, and the Carolina Abecedarian Project. Each of the programs provided high-quality educational experiences to vulnerable children in group settings that included small class sizes, a focus on language and cognitive skills, and well-trained and paid teachers (Temple & Reynolds, 2007). The teacher to child ratio varied in all of the programs as did the teacher's level of training. In addition, they all offered some degree of parent support: including home visit or parent education/training (Shaw, 2006).

All three of the programs have strong evidence of enduring effects resulting in extensive cost benefit analysis. The programs costs were significantly different from one another, the cost-benefit of each program far surpassed the initial investment (Reynolds & Temple, 2008). The effects of the programs were large and occurred 17 to 25 years following participation in the preschool programs (Reynolds & Temple, 2008). Children who participated in the programs also had a significantly lower rate of special education programs and higher rates of high school completion. Only the Perry Preschool Program had significant group differences in employment and earnings, but this finding may be due to the higher age at follow-up assessment. Both, the Perry Preschool Program and the Child Parent Centers Program demonstrated significant program effects on crime. Furthermore, all three programs

demonstrated considerable cost savings into adulthood for education, justice, and health, and increased financial well-being (Reynolds & Temple, 2008).

Less research has been done on middle-income families or more diverse populations. However, the short-term effects of state-funded preschool programs that included more diverse populations by income, race and ethnicity, provided some promising results (Barnett et al., 2005; Reynolds & Temple, 2008). Universal prekindergarten programs that served children from all socio-economic backgrounds had the strongest effect size (0.58) (Gormley & Gayer, 2005). Most research has only studied the short-term effects, recent studies showed benefits following kindergarten and later for state funded programs (Frede, Barnett, Esposito, & Figueras, 2007; Malofeeva, Daniel-Echols, & Xiang, 2007). The economic benefits of universal preschool education at age 4 for one year had an estimated return of \$2.62 per dollar invested (Karoly & Bigelow, 2005). Effect sizes and economic returns are generally smaller for state funded universal programs compared to intensive targeted programs, the reach of the state programs was greater.

Many provinces have implemented junior kindergarten and full day kindergarten programs; however research on the effectiveness of these programs is mixed. Recent findings from Manitoba data suggested that full day kindergarten offered very few long term benefits in numeracy/reading (Grade 3), school engagement/math (Grade 7), reading/writing (grade 8) and overall school performance (grade 9) (personal communication, M. Brownell, March 27, 2014). Pelletier et al. (2014) reported no significant difference between children who had

participated in full day junior and senior kindergarten and those in half-day programs when it came to knowing the alphabet, numeracy and writing in grade 1. However, they did score significantly higher on vocabulary, self-regulation, and engagement in play-based activities.

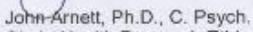
Another important context that provides Canadian children with exposure to early learning experiences is the child care setting. The Canadian Council on Learning (2008) reported that child care arrangements, to varying degrees, influence children's physical, social, emotional, language and cognitive development, and set the stage for learning in the school years. Relationships with care providers in an educational setting can provide protective factors against the stress associated with various risk factors (Japel, 2008). Sustained, quality child care may provide the most benefit to children from low-income families (Ahnert & Lamb, 2004; Cote et al., 2007). Research findings suggested that children from low-income families receiving quality child care had vocabulary scores comparable to children from higher income families and higher than children from low-income families that did not receive child care (HRSDC, 2003). The quality of early child care is determined by the ratio of children to provider, the level of training, the physical environment in which the care is provided, the relationship between the child and care provider, and the types of stimulation and activities offered, all of which can influence child development (Canadian Council on Learning, 2008; McCartney, 2007). The importance of child care quality cannot be overstated (McCartney, 2007).

Furthermore, a growing body of evidence supports the development of comprehensive family centres, "Early Years Centres" or the "hub model", an

emerging model being implemented in various jurisdictions in Canada and elsewhere (Cleveland & Colley, 2013; Corter & Pelletier, 2010). The Toronto First Duty is an integrated early childhood service delivery model that incorporates regulated child care, kindergarten and family support services into a single, accessible program, located in primary schools and coordinated with early intervention and family health services (Toronto First Duty, 2008). These models provide timely, seamless access to programs and services that offer support to parents with young children (McCain et al., 2011). However, not everyone agrees this is the best way forward. The Canadian Organization of Family Resource Programs (FRP) (2011) suggested building an integrated system through partnerships and keeping family resource programs in the community outside of the school where mandates, experience, and practices have demonstrated success. As the primary users of these services, knowing what families feel would work best should also be considered.

A credible and growing body of evidence shows that every new dollar spent in the early childhood years on quality learning, development, parenting and care programs has the largest economic return to society of any new investment, even after discounting for inflation over the years and decades it takes for children to grow up (Heckman et al., 2006; Trefler, 2009). Economists are finding that the most cost effective human capital interventions are for young children.

## Appendix B: Ethics Certificates

 <p>UNIVERSITY OF MANITOBA</p>	<p>BANNATYNE CAMPUS Research Ethics Boards</p>	<p>P126-770 Bannatyne Avenue Winnipeg, Manitoba Canada R3E 0W3 Tel: (204) 789-3255 Fax: (204) 789-3414</p>
<b>APPROVAL FORM</b>		
<p>Principal Investigator: Ms. L. Leclair Supervisor: Dr. M. Finlayson</p>		<p>Ethics Reference Number: H2011:023 Date of REB Meeting: January 24, 2011 Date of Approval: February 7, 2011 Date of Expiry: January 24, 2012</p>
<p>Protocol Title: Community supports for parents of young children: A needs assessment</p>		
<p>The following is/are approved for use:</p>		
<ul style="list-style-type: none"><li>• Protocol, Version 1 dated January 4, 2011</li><li>• Parent Participant Information and Consent Form, Version dated January 28, 2011</li><li>• Service Provider Participant Information and Consent Form, Version dated January 28, 2011</li><li>• Appendices:<ul style="list-style-type: none"><li>◦ B – Service Provider Recruitment Letter, Version dated January 4, 2011</li><li>◦ C – Service Provider Introductory Letter, Version dated January 4, 2011</li><li>◦ E – Service Provider Information Form, Version dated January 28, 2011</li><li>◦ F – Service Provider Interview Guide, Version dated January 4, 2011</li><li>◦ G – Parent Letter of Invitation, Version dated January 4, 2011</li><li>◦ H – Parent Recruitment Poster, Version submitted January 28, 2011</li><li>◦ I – Parent Introductory Letter, Version dated January 28, 2011</li><li>◦ K – Patient Information Form, Version dated January 28, 2011</li><li>◦ L – Parent Focus Group Guide, Version dated January 4, 2011</li></ul></li></ul>		
<p>The above was approved by Dr. John Arnett, Ph.D., C. Psych., Chair, Health Research Ethics Board, Bannatyne Campus, University of Manitoba on behalf of the committee per your letter dated January 28, 2011. The Research Ethics Board is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement, and the applicable laws and regulations of Manitoba. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Division 5 of the <i>Food and Drug Regulations of Canada</i>.</p>		
<p><b>This approval is valid for one year from the date of the REB meeting at which the study was reviewed.</b> A study status report must be submitted annually and must accompany your request for re-approval. Any significant changes of the protocol and informed consent form should be reported to the Chair for consideration in advance of implementation of such changes. The REB must be notified regarding discontinuation or study closure.</p>		
<p>This approval is for the ethics of human use only. For the logistics of performing the study, approval must be sought from the relevant institution, if required.</p>		
<p>Sincerely yours,</p>		
<p> John Arnett, Ph.D., C. Psych. Chair, Health Research Ethics Board Bannatyne Campus</p>		
<p>Please quote the above Ethics Reference Number on all correspondence. Inquiries should be directed to the REB Secretary Telephone: (204) 789-3255 / Fax: (204) 789-3414</p>		
<p><a href="http://www.umitoba.ca/medicine/ethics">www.umitoba.ca/medicine/ethics</a></p>		



UNIVERSITY  
OF MANITOBA

BANNATYNE CAMPUS  
Research Ethics Boards

APPROVAL FORM

P126 - 770 Bannatyne Avenue  
Winnipeg, Manitoba  
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Tel: (204) 789-3255  
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Principal Investigator: Ms. L. Leclair

Ethics Reference Number: H2011:318  
Date of Approval: January 16, 2012

Protocol Title: Community supports for parents of young children: A needs assessment - Phase 2  
(Linked to H2011:023)

The following is/are approved for use:

- Protocol Amendment, Version dated January 10, 2012
- Parent Advance Introductory Letter, Version dated January 10, 2012
- Parent Invitation Letter, Version dated January 10, 2012
- Parent Consent Letter, Version dated January 10, 2012
- Parent Concerns Report Survey, Version dated January 10, 2012
- Parent Follow-up Postcard Version dated January 10, 2012
- Service Provider/Director Introductory E-mail/Letter Version dated January 10, 2012
- Service Provider Consent Letter, Version dated January 10, 2012
- Service Provider Information Form, Version dated January 10, 2012
- Service Provider Concerns Report Survey, Version dated January 10, 2012
- Service Provider Reminder E-mail/Letter, Version dated January 10, 2012

The above was approved by Dr. John Arnett, Ph.D., C. Psych, Chair, Health Research Ethics Board, Bannatyne Campus, University of Manitoba on behalf of the committee per your submission dated January 10, 2012. The Research Ethics Board is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement, and the applicable laws and regulations of Manitoba. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Division 5 of the *Food and Drug Regulations of Canada*.

A study status report must be submitted annually and must accompany your request for re-approval. Any significant changes of the protocol and informed consent form should be reported to the Chair for consideration in advance of implementation of such changes. The REB must be notified regarding discontinuation or study closure.

This approval is for the ethics of human use only. For the logistics of performing the study, approval must be sought from the relevant institution, if required.

Sincerely yours,

*John Arnett*, Ph.D. C. Psych.  
Chair, Health Research Ethics Board  
Bannatyne Campus

Please quote the above Ethics Reference Number on all correspondence.  
Inquiries should be directed to the REB Secretary Telephone: (204) 789-3255 / Fax: (204) 789-3414

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## Appendix C: Summary of Community Data for Service Providers

### ST. VITAL COMMUNITY DATA: SUMMARY FOR SERVICE PROVIDERS



### What do we know about Families and Young Children in St. Vital?

Prepared by Leanne Leclair, PhD (Candidate), Community Health Sciences, University of Manitoba

A variety of public documents provide information on St. Vital and its residents. The following summary provides an overview of the information collected from publicly available documents. The summary creates a profile of families with young children living in St. Vital. The information included in this summary was obtained primarily from the Winnipeg Regional Health Authority (WRHA) Community Health Assessment Report (2009), the Manitoba Centre for Health Policy (MCHP) reports - *Manitoba Child Health Atlas Update* (2008), *How are Manitoba's Children Doing* (2012) and *Perinatal Services and Outcomes in Manitoba* (2012) and Healthy Child Manitoba's - the *Early Development Instrument - St. Vital Report* (2008/09).

#### What do we know generally about socioeconomic conditions in St. Vital?

Indicators	St. Vital				Winnipeg				Manitoba			
	North		South									
Total Population (2010)	65,287		697,274		1,230,270							
	26,734		38,533									
High School Completion (2005/06)	88.4%		78.7%		77.7%							
Highest level of education attained (25 to 64 yrs, 2006)	<H.S.	H.S.	Trades	other	univ	<H.S.	H.S.	Trades	other	univ	<H.S.	H.S.
	11%	26%	10%	22%	31%	15%	26%	10%	19%	30%	20%	25%
Economic Families Living Below Low Income Cut-Offs(LICO)(2006)	11%		15%		12%							
Median Household Income (2006)	\$55,363		\$50,182		\$47,875							
Unemployment Rate (2006)	4.5%		5%		8.5%							
Housing Affordability (2006) (spending 30% or more of income on shelter)	Tenants	Owners	Tenants	Owners	Tenants	Owners						
	39%	11%	37%	12%	35%	11%						
Use of physicians (2005/06)	86%		84.5%		82.6%							
Annual rate of ambulatory visits (2005/06)	5.4 per year		5.2 per year		4.9 per year							

H.S = High School; Univ=University

The information contained in this table was obtained from the WRHA Community Health Assessment Report (2009). The WRHA obtained the data from the Census and administrative data.

### What do we know about families with young children living in St. Vital?

Indicators	St. Vital		Winnipeg		Manitoba	
Newborns born to families with financial difficulties (2003-2006)	10.5%		19.5%			
Children living in families receiving income assistance (0-17 yrs) (per 100) (2004/05-2005/06)	South 5.3% <sup>t</sup>	North 18.2% <sup>t</sup>	16.6%		13.2%	
Families who screened positive on Families First Screen (2003-2006)		15.4%		24.0%		
Lone-Parent Families (2006)	Male 18%	Female 82%	Male 17%	Female 83%	Male 19%	Female 81%

The information contained in this table was obtained from the MCHP report *Manitoba Child Health Atlas Update* (2008) and the *WRHA Community Health Assessment Report* (2010). The WRHA obtained the data from the Families First screening process. Public Health nurses collected information from almost all families with newborns to determine if a family required any additional community supports.

### What do we know about community and social services available to families and young children living in St. Vital?

Indicators	St. Vital		Winnipeg		Manitoba	
Crude rate of child care spaces (0-12 yrs) (per 1000) (2006)	572.5		572.5		551	
	South 223	North 297				
Prevalence of Children in Care (0-17 yrs) (2001/02-2003/04)	1.5% <sup>t</sup>		3.3%		3.3%	
	0.7%	2.2%				
Prevalence of Children in Families Receiving services from CFS (0-17 yrs) (2001/02-2003/04)	8.2%		12.9%		11.5%	
	6%	13.5% <sup>t</sup>				
Percent of Children in Families Receiving Income Assistance (0-17 yrs) (per 100) (2004/05-2005/06)			21.6%		13.2%	
	5.3% <sup>t</sup>	18.2% <sup>t</sup>				

<sup>t</sup> statistically different from Manitoba average

The information contained in this table was obtained from the MCHP *Manitoba Child Health Atlas Update* (2008).

### What do we know about mothers giving birth in St. Vital?

Indicators	St. Vital	Winnipeg
Women giving birth with <High School Education (2007/2008-2008/2009)	6.4% <sup>t</sup>	15.8%
Women giving birth who are lone parents (2007/08-2008/09)	6.7% <sup>t</sup>	13.3%
Women who were socially isolated during postpartum (culture, language, or geography) (2007/08-2008/09)	3.3%	4.2%
Women giving birth who received income assistance (2007/08-2008/09)	9.1% <sup>t</sup>	17.7%
Women who received healthy baby prenatal benefit (2006/07-2007/08)	17.4% <sup>t</sup>	26.6%
Women who participated in Healthy Baby community support program (2006/07-2007/08)	9.8% <sup>t</sup>	11.6%
Live births to teen mothers aged 19 and younger (2001/02-2008/09)	2.7% <sup>t</sup>	6.7%
Live births to women age 35 and older (2007/08-2008/09)	19.9% <sup>t</sup>	16.7%
Live births to women age 35 and older for the first time (2005/06-2008/09)	5.9% <sup>t</sup>	4.4%
Maternal Alcohol Consumption during pregnancy (2007/08-2008/09)	10.0% <sup>t</sup>	13.1%
Maternal Smoking during pregnancy (2007/08-2008/09)	11.5% <sup>t</sup>	18.0%
Maternal illicit drug use during pregnancy (2007/08-2008/09)	1.8% <sup>t</sup>	4.5%
Late initiation of prenatal care (2007/08-2008/09)	16.6% <sup>t</sup>	23.1%
Inadequate prenatal care using R-GINDEX (2007/08-2008/09)	4.1% <sup>t</sup>	7.7%
Prenatal psychological distress (2007/08-2008/09)	9.0%	8.4%
Breastfeeding initiation (2007/08-2008/09)	89.0%	82.5%
Postpartum psychological distress (2007/08-2008/09)	14.9%	14.3%

<sup>t</sup> Statistically different from Winnipeg rate

The information contained in this table was obtained from the Manitoba Centre for Health Policy Report entitled *Perinatal Services and Outcomes in Manitoba*

**What do we know about births in St. Vital?**

Indicators	St. Vital	Winnipeg	Manitoba
Preterm <37 weeks (2005/06-2008/09)	7.2%	8.1%	7.2%
Caesarean Section (2007/08-2008/09)	20.3%	19.9%	19.8%
Vaginal Birth after Caesarean Section (2007/08-2008/09)	35.5%	31.4%	30.5%

**What do we know about fetal and newborn health in St. Vital?**

Indicators	St. Vital	Winnipeg	Manitoba
Infant mortality rate (under 1 yr per 1000) (2001/02-2008/09)	1.8 <sup>t</sup>	4.7	5.2
Crude stillbirth rate (per 1000 births) (2004/05-2008/09)	7.2	5.4	6.0

<sup>t</sup> Statistically different from Winnipeg rateThe information contained in this table was obtained from the MCHP report *Perinatal Services and Outcomes in Manitoba (2012)*.**What do we know about health care utilization of children living in St. Vital?**

Indicators	St. Vital	Winnipeg	Manitoba
Childhood immunization rates (1 yr) (2003-2005)	89.5% <sup>t</sup>	85.8%	82.5%
Childhood immunization rates (2 yrs) (2002-2004)	79.2% <sup>t</sup>	73.0%	69.6%
Injury hospitalizations (0-19 yrs) (per 10,000) (2001-2006)	27 <sup>t</sup>	33.2	57.8
Hospital episode rates (0-19 yrs) (per 1000) (2005/06)	20.9 <sup>t</sup>	28	38.9
Rate of Infants aged <1 year with at least one hospitalization for lower respiratory tract infection (per 1000) (2003/04-2005/06)	11.2 <sup>t</sup>	20.2	40.2
Tonsillectomy and Adenoidectomy rates (0-14 yrs) (per 1000) (2001/02-2005/06)	4.7	4.4	4.7
Hospital-based dental extraction rates (0-5 yrs) (per 1000) (2001/02-2005/06)	3.8 <sup>t</sup>	6.8	14.2
Annual physician visit rates (0-19 yrs) (2005/06)	3.65	3.6	3.3
50% of visits to same physician (0-19 years) (2004/05-2005/06)	60% <sup>t</sup>	62.1%	56.2%

<sup>t</sup> statistically different from Manitoba averageThe information contained in this table was obtained from the MCHP *Manitoba Child Health Atlas Update (2008)*.**What do we know about prescription use among children living in St. Vital?**

Indicators (2005/06) (per 1000)	St. Vital	Winnipeg	Manitoba
Children with at least one prescription (0-19 yrs)	573.3	572.5	551
Children with at least one antibiotic prescription (0-19 yrs)	404.6	402.8	389.9
Children with at least one psychostimulant (5-19 yrs)	35.5 <sup>t</sup>	32.2	26.8
Children with at least one narcotic analgesic (0-19 yrs)	38.5 <sup>t</sup>	28.3	27.8

The information contained in this table was obtained from the MCHP *Manitoba Child Health Atlas Update (2008)*.**What do we know about the prevalence of childhood chronic conditions in St. Vital?**

Indicators	St. Vital	Winnipeg	Manitoba
Asthma (5-19 years) (2004/05-2005/06)	15.1%	16.4%	13.9%
Diabetes (5-19 yrs) (2003/04-2005/06)	0.32%	0.36%	0.41%
Attention-deficit hyperactivity disorder (5-19 yrs) (2005/06)	4.2% <sup>t</sup>	3.9%	3.2%
Autism Spectrum disorder (5-9 yrs) (2001/02-2005/06)	1.12%	0.98%	0.88%

The information contained in this table was obtained from the MCHP *Manitoba Child Health Atlas Update (2008)*.

### What do we know about readiness for school of Kindergarten children living in St. Vital?

The Early Development Instrument (EDI) is a population-based measure used to determine readiness for school of kindergarten children at a community level. The EDI consists of five general domains of child development and 15 sub-domains. Community EDI results can, along with other sources of information, help inform the types of community programs and services made available to support families with young children.

In St. Vital, the average score for girls on all EDI domains is significantly higher than the average score for boys. The same is true for children older than 5.6 years of age at the time of EDI collection; the average score for older children is significantly higher than the average score for younger children on all EDI domains. Similar differences have been found among language groups: English as an Additional Language (EAL) or French as an Additional Language (FAL). Children without EAL/FAL tend to have significantly higher average scores on the EDI domains compared to children with EAL/FAL, as do non-aboriginal children compared to aboriginal children living in St. Vital. However, it is important to note that socio-economic status, and not Aboriginal identity, determined the lower EDI scores for Aboriginal children.

**Summary of EDI results for St. Vital (2008/09)**

Indicator	St. Vital	Manitoba Baseline (2005/06)
<b>Average scores on EDI Domains (10 is best possible score)</b>		
Physical Health & Well-being	8.65	8.75
Social Competence	8.27	8.32
Emotional Maturity	7.76	7.94
Language Skills and Thinking	8.21	8.11
Communication Skills and General Knowledge	7.57	7.57

The information contained in this table was obtained from the Healthy Child Manitoba St. Vital EDI Community Report (2008/09).

Indicator	St. Vital	Manitoba Baseline (2005/06)
<b>Proportion of children Very Ready (top 30<sup>th</sup> percentile) on EDI Domains</b>		
Physical Health & Well-being	26.9	32.1
Social Competence	34.4	33.9
Emotional Maturity	25.0	28.2
Language Skills and Thinking	24.9	30.0 (significantly lower)†
Communication Skills and General Knowledge	33.3	33.9
One or more domains	62.8	62.4
Two or more domains	42.3	43.3

† Based on three year trend of data collection

The information contained in this table was obtained from the Healthy Child Manitoba St. Vital EDI Community Report (2008/09).

Indicator	St. Vital	Manitoba Baseline (2005/06)
<b>Proportion of children Not Ready (bottom 10<sup>th</sup> percentile) on EDI Domains</b>		
Physical Health & Well-being	10.5	11.3
Social Competence	10.3	8.7 (significantly higher)†
Emotional Maturity	13.6	11.9
Language Skills and Thinking	8.7	12.5
Communication Skills and General Knowledge	11.7	11.2
One or more domains	28.4	28.6
Two or more domains	14.7	14.4

† Based on three year trend of data collection

The information contained in this table was obtained from the Healthy Child Manitoba St. Vital EDI Community Report (2008/09).

Indicator	St. Vital	Manitoba Baseline (2005/06)
<b>Proportion of children Not Ready on EDI Sub-Domains</b>		
<b>Physical Health &amp; Well-being</b>		
Physical readiness for school day	8.1	9.9 (significantly lower)†
Physical Independence	10.5	10.0
Gross and fine motor skills	39.5	31.3 (significantly higher)†
<b>Social Competence</b>		
Overall social competence	9.8	9.2
Responsibility and respect	6.8	4.4 (significantly higher)†
Approaches to learning	9.2	8.0 (significantly higher)†
Readiness to explore new things	4.1	3.1
<b>Emotional Maturity</b>		
Prosocial and helping behaviour	41.9	36.9
Anxious and fearful behaviour	5.1	2.4 (significantly higher)†
Aggressive behaviour	9.8	7.8 (significantly higher)†
Hyperactivity and Inattention	15.0	14.0
<b>Language and Thinking Skills</b>		
Basic literacy	11.5	15.1
Interest and Memory	13.9	15.1
Complex literacy	24.8	21.8 (significantly higher)†
Basic numeracy	14.5	20.5 (significantly lower)†
<b>Communication skills and General Knowledge</b>		
Communication skills and General Knowledge	38.9	39.1 (significantly lower)†
<b>Multiple Challenge Index</b>		
Challenges in 9 or more sub-domains	4.7	5.3

† Based on three year trend of data collection

School Readiness by Neighbourhood			
Neighbourhoods with large % of children Not Ready (reflects a need in that area of development)		Neighbourhoods with large % of children Very Ready (reflects a strength in that area of development)	
<b>Physical Health &amp; Well-being</b>			
Norberry	Worthington	Glenwood	Vista
Lavallee	Minnetonka		Norberry
<b>Social Competence</b>			
Varennes	Meadowood	Glenwood	Dakota Crossing
Alpine Place	Minnetonka	Victoria Crescent	Vista
Lavallee	River Park South	Meadowood	St. Vital Perimeter South
Pulberry			
<b>Emotional Maturity</b>			
Varennes	Pulberry	St. George	Meadowood
Lavallee	River Park South	Victoria Crescent	Vista
<b>Language Skills and Thinking</b>			
Alpine Place	Lavallee	Victoria Crescent	Vista
		Pulberry	St. Vital Perimeter South
<b>Communication Skills and General Knowledge</b>			
Alpine Place	Minnetonka	Glenwood	Victoria Crescent
Worthington	River Park south	St. George	Pulberry
		Norberry	

The information contained in these tables was obtained from the Healthy Child Manitoba St. Vital EDI Community Report (2008/09)

## Appendix D: Service Provider Recruitment Letter



Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

April 26, 2011

Dear Service Provider,

You are invited to participate in a research study entitled *Community Supports for Parents of Young Children: A Needs Assessment*. Researchers from the Department of Community Health Sciences at the University of Manitoba, in partnership with the St. Vital Parent Child Coalition, are conducting a needs assessment to determine the community support needs of parents of young children and the current strengths and gaps in community supports in the St. Vital community area.

We are seeking service providers offering programs and service in the St. Vital area to young children newborn to 6 years of age and their parents to participate in an interview. The interview will take approximately 45 minutes of your time. As part of the interview, you will be asked about: the programs and services that you offer young children and their parents; the barriers and facilitators to accessing community programs and services; and community programs and services that you feel young children and their parents need that are not currently available. Participating in this study will provide you with an opportunity to share your thoughts on community programs and services for parents and young children.

You have been selected to participate in this study because of your current position and the information that we believe you can provide to the research study. If you are interested in participating in the study, please contact the student researcher, Leanne Leclair at (204)977-5631 or [leclairl@cc.umanitoba.ca](mailto:leclairl@cc.umanitoba.ca).

Sincerely,

Leanne Leclair  
Principal Investigator  
PhD Candidate  
Department of Community Health Sciences  
University of Manitoba

## Appendix E: Parent Recruitment Letter



Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

May 5, 2011

Dear Parent,

You are invited to participate in a research study entitled *Community Supports for Parents of Young Children: A Needs Assessment*. Researchers from the Department of Community Health Sciences at the University of Manitoba, in partnership with the St. Vital Parent Child Coalition, are conducting a needs assessment to determine the community support needs of parents of young children and the current strengths and gaps in community supports in the St. Vital Community Area.

We are looking for parents of young children newborn to 5 years of age living in the St. Vital community area to participate in a focus group/interview. As part of the focus group/interview, you will be asked about: community supports that have helped you or that would have helped you as a parent of a young child; access to community programs and services; and community programs and services that you feel parents of young children need that are not currently available. A gift card will be provided to all participants as a token of appreciation for their time.

If you are interested in learning more about this opportunity and/or would like to participate, please contact the student researcher, Leanne Leclair at 977-5631 or [leclair@cc.umanitoba.ca](mailto:leclair@cc.umanitoba.ca).

Sincerely,

Leanne Leclair  
Principal Investigator  
PhD Candidate  
Department of Community Health Sciences  
University of Manitoba

## Appendix F: Parent Recruitment Poster and Advertisement



We are looking for parents of young children **newborn to 5 years of age** living in St. Vital to participate in a focus group.

*You are invited to participate in a research study focusing on ...*

# COMMUNITY SUPPORTS FOR PARENTS OF YOUNG CHILDREN

Researchers from the Department of Community Health Sciences at the University of Manitoba, in partnership with the St. Vital Parent Child Coalition, are conducting a needs assessment. We want to hear from parents of young children in St. Vital about their experiences with programs and services offered to parents and children.

Participating in this study will only require 1½ to 2 hours of your time. As part of the focus group, you will be asked about: programs and services that have helped you or that would have helped you as a parent of a young child; the barriers and facilitators to accessing community programs and services; and community programs and services that you feel parents of young children need that are not currently available.

*A gift card will be provided to all participants as a token of appreciation for their time.*

If you are interested in learning more about this opportunity and/or would like to participate,

**PLEASE CONTACT:** Principal investigator:  
Leanne Leclair at **977-5631** or [leclair@cc.umanitoba.ca](mailto:leclair@cc.umanitoba.ca)



UNIVERSITY  
OF MANITOBA



## Appendix G: Service Provider Informed Consent



UNIVERSITY  
OF MANITOBA

Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

### SERVICE PROVIDER PARTICIPANT INFORMATION AND CONSENT FORM Interviews

#### Title of Study: Community Supports for Parents of Young Children: A Needs Assessment

**Principal Investigator:** Leanne Leclair  
University of Manitoba  
School of Medical Rehabilitation  
Department of Occupational Therapy  
R215-771 McDermot Ave  
Winnipeg, Manitoba R3E 0T6  
(204) 977-5631

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the principal investigator. You may take your time to make your decision about participating in this study, and you may discuss it with your friends or family before you make your decision. This consent form may contain words that you do not understand. Please ask the principal investigator to explain any words or information that you do not clearly understand.

#### Purpose of Study

The primary purpose of this research study is to determine the community support needs of parents of young children through a community needs assessment. The St. Vital Parent Child Coalition is partnering with the principal investigator to conduct this needs assessment. This research study is part of the principal investigator's doctoral research.

A community needs assessment is a process that involves collecting information about the needs of a community and sharing this information with those who can use it to make decisions about programs and services.

This consent form relates to Phase 1 of the needs assessment. This phase consists of identifying the values and issues of importance to parents and service providers living in the community.

A total of 34-44 participants will participate in this phase of the study.

#### Study procedures

To complete Phase 1, the principal investigator will use four approaches: a review of key documents, interviews with service providers, interviews/focus groups with parents, and observations and field notes during the study.

Interviews will be conducted with service providers working with young children and their families in the community. Demographic information will be collected from service providers using a service provider information form. The principal investigator will conduct the interviews at a time and location of the participants' choosing. Interviews will take approximately 45-60 minutes to complete. Interviews/focus groups will be audiotaped and transcribed verbatim. The investigator will assign codes to identify participants when transcribing interview data to further increase anonymity and confidentiality. The principal investigator will mail each participant a summary of

the major points from the interview transcript and ask them to ensure the information included is accurate and complete. These interviews will provide information on service providers' perspectives of the strengths and gaps in community supports for parents of young children.

In addition, the principal investigator will conduct interviews/focus groups with parents of young children in the community. The interviews will take approximately 45 minutes to complete. The focus groups will take approximately 1 ½ hours to complete. If possible, participants will be divided into focus groups according to the age of their child: newborn to 2 years and 3 years to 5 years. Interviews and focus groups will be audiotaped and transcribed into written form. The investigators will not include any names when transcribing interview or focus group data to further increase anonymity and confidentiality.

The information gathered in Phase 1 of the needs assessment will be used to develop a Concerns Report Survey for Phase 2 of the study. The survey will be mailed to a random sample of parents living in the community and a sample of service providers working in the community.

**If you take part in this study, you will have the following procedures:**

You will be asked to complete a service provider information form and participate in an interview at a time that is convenient for yourself and the principal investigator. The interview will last approximately 45-60 minutes. As part of the interview, you will be asked about: the programs and services that you offer parents of young children; the barriers and facilitators to accessing community programs and services; and community programs and services that you feel parents of young children need that are not currently available. You will be sent a summary of the major points from the interview via mail and asked to review the information included for accuracy and completeness. You will be asked to respond with confirmation within two weeks of receiving the summary.

A subsequent phase of this study involves an interview/focus group to review the information collected in each phase of the needs assessment to determine service providers perspectives about the utility of the information gathered. You will be contacted at that time to determine your interest in participating in this phase of the study. However, you are under no obligation to participate in this phase of the study. You can stop participating at any time.

You will receive a summary of the final research report at the end of the study via e-mail or regular mail.

**Risks and Discomforts**

There are no known risks to participating in this study.

**Benefits**

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit parents with young children in your community in the future.

**Costs**

All the procedures, which will be performed as part of this study, are provided at no cost to you.

**Payment for participation**

You will receive no payment for participating in this study.

**Confidentiality**

Information gathered in this research study may be published or presented in public forums; however, your name and other identifying information will not be used or revealed. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. All study related documents will bear only your assigned study number. Your

personal information may be disclosed if required by law. The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area and only those persons identified will have access to these records. Audio recordings of the interviews and all other data collected from the study will be destroyed five years after completion of the study. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

### **Voluntary Participation/Withdrawal from the Study**

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time.

### **Questions**

You are free to ask any questions that you may have about your rights as a research participant. If any questions come up during or after the study contact the study coordinator: Leanne Leclair at 977-5631.

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

### **Statement of Consent**

I have read this consent form. I have had the opportunity to discuss this research study with Leanne Leclair. I have had my questions answered by her in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member), I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to be contacted for future follow-up in relation to this study,  
Yes  No

Participant Signature\_\_\_\_\_ Date\_\_\_\_\_  
(day/month/year)

Participant printed name\_\_\_\_\_

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed name\_\_\_\_\_ Date\_\_\_\_\_  
(day/month/year)

Signature\_\_\_\_\_

Role in the study\_\_\_\_\_

## Appendix H: Parent Informed Consent – Interviews



Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

### PARENT PARTICIPANT INFORMATION AND CONSENT FORM Interview

#### Title of Study: Community Supports for Parents of Young Children: A Needs Assessment

**Principal Investigator:** Leanne Leclair  
University of Manitoba  
School of Medical Rehabilitation  
Department of Occupational Therapy  
R215-771 McDermot Ave  
Winnipeg, Manitoba R3E 0T6  
(204) 977-5631

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the principal investigator. You may take your time to make your decision about participating in this study, and you may discuss it with your friends or family before you make your decision. This consent form may contain words that you do not understand. Please ask the principal investigator to explain any words or information that you do not clearly understand.

#### Purpose of Study

The primary purpose of this research study is to determine the community support needs of parents of young children through a community needs assessment. The St. Vital Parent Child Coalition is partnering with the principal investigator to conduct this needs assessment. This research study is part of the principal investigators doctoral research.

A community needs assessment is a process that involves collecting information about the needs of a community and sharing this information with those who can use it to make decisions about programs and services.

This consent form relates to Phase 1 of the needs assessment. This phase consists of identifying the values and issues of importance to parents and service providers living in the community.

A total of 34-44 participants will participate in this phase of the study.

#### Study procedures

To complete Phase 1, the principal investigator will use four approaches: a review of key documents, interviews with service providers, interviews/focus groups with parents, and observations and field notes during the study.

Interviews will be conducted with service providers working with young children and their families in the community. In addition, the principal investigator will conduct interviews/focus groups with parents of young children in the community. As well, demographic information will be collected from parents using a parent information form. The interviews/focus groups will be held in a private, safe community setting that can be easily accessed by the participants. Some interviews may be conducted over the phone, if arranging a suitable time and place to meet in person is not possible.

If possible, participants will be divided into focus groups according to the age of their child: newborn to 2 years and 3 years to 5 years. Interviews/focus groups will be audiotaped and

transcribed into written form. The investigators will not include any names when transcribing interviews/focus groups to further increase anonymity and confidentiality. The principal investigator will mail each participant a summary of the major points from the interview/focus group transcript and ask them to ensure the information included is accurate and complete. Members will be asked to respond with confirmation within two weeks of receiving the summary. A fifteen-dollar gift card will be provided to participants for their time. They will also be reimbursed for parking or bus fare, if applicable. Food and beverage will be provided during the interview/focus group. The interviews/focus groups will provide information on parents' perspectives of the strengths and gaps in community supports for parents of young children.

The information gathered in Phase 1 of the needs assessment will be used to develop a Concerns Report Survey for Phase 2 of the study. The survey will be mailed to a random sample of parents living in the community and a sample of service providers working in the community.

**If you take part in this study, you will have the following procedures:**

You will be asked to complete a parent information form and participate in an interview in person or over the phone at a time that is convenient for you and the principal investigator. The interview will last approximately 45 minutes. As part of the interview, you will be asked about: community supports that have helped you or that would have helped you as a parent of a young child; the barriers and facilitators to accessing community programs and services; and community programs and services that you feel parents of young children need that are not currently available. You will be sent a summary of the major points from the interview via mail and asked to review the information included for accuracy and completeness. You will be asked to respond with confirmation within two weeks of receiving the summary.

A subsequent phase of this study involves a focus group to review the information collected in each phase of the needs assessment to determine parents perspectives about the utility of the information gathered. You will be contacted at that time to determine your interest in participating in this phase of the study. However, you are under no obligation to participate in this phase of the study. You can stop participating at any time.

You will receive a summary of the final research report at the end of the study via e-mail or regular mail.

**Risks and Discomforts**

There are no known risks to participating in this study.

**Benefits**

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit parents with young children in your community in the future.

**Costs**

All the procedures, which will be performed as part of this study, are provided at no cost to you.

**Payment for participation**

You will be given a \$15 gift card for participating in the study. Reimbursement for bus fare and/or parking will be provided when attending the focus group.

**Confidentiality**

Information gathered in this research study may be published or presented in public forums; however, your name and other identifying information will not be used or revealed. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. All study related documents will bear only your assigned study number. Your personal information may be disclosed if required by law. The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area and only those persons identified will have access to these records. Audio recordings of the interviews and all other data collected from the study will be destroyed five years after completion of the study. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

#### **Voluntary Participation/Withdrawal from the Study**

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from this study will not affect your ability to participate in community programs and services in any way.

#### **Questions**

You are free to ask any questions that you may have about your rights as a research participant. If any questions come up during or after the study contact the study coordinator: Leanne Leclair at 977-5631. For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389. Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

#### **Statement of Consent**

I have read this consent form. I have had the opportunity to discuss this research study with Leanne Leclair. I have had my questions answered by her in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member), I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to be contacted for future follow-up in relation to this study,

Yes  No

Participant Signature\_\_\_\_\_ Date\_\_\_\_\_  
(day/month/year)

Participant printed name\_\_\_\_\_

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed name\_\_\_\_\_ Date\_\_\_\_\_  
(day/month/year)

Signature\_\_\_\_\_

Role in the study\_\_\_\_\_

## Appendix I: Parent Informed Consent – Focus Groups



Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

### PARENT PARTICIPANT INFORMATION AND CONSENT FORM Focus Group

#### Title of Study: Community Supports for Parents of Young Children: A Needs Assessment

**Principal Investigator:** Leanne Leclair  
University of Manitoba  
School of Medical Rehabilitation  
Department of Occupational Therapy  
R215-771 McDermot Ave  
Winnipeg, Manitoba R3E 0T6  
(204) 977-5631

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the principal investigator. You may take your time to make your decision about participating in this study, and you may discuss it with your friends or family before you make your decision. This consent form may contain words that you do not understand. Please ask the principal investigator to explain any words or information that you do not clearly understand.

#### Purpose of Study

The primary purpose of this research study is to determine the community support needs of parents of young children through a community needs assessment. The St. Vital Parent Child Coalition is partnering with the principal investigator to conduct this needs assessment. This research study is part of the principal investigator's doctoral research.

A community needs assessment is a process that involves collecting information about the needs of a community and sharing this information with those who can use it to make decisions about programs and services.

This consent form relates to Phase 1 of the needs assessment. This phase consists of identifying the values and issues of importance to parents and service providers living in the community.

A total of 34-44 participants will participate in this phase of the study.

#### Study procedures

To complete Phase 1, the principal investigator will use four approaches: a review of key documents, interviews with service providers, interviews/focus groups with parents, and observations and field notes during the study.

Interviews will be conducted with service providers working with young children and their families in the community. In addition, the principal investigator will conduct interviews/four focus groups with parents of young children in the community. As well, demographic information will be collected from parents using a parent information form. The interviews/focus groups will be held in a private, safe community setting that can be easily accessed by the participants. Some interviews may be conducted over the phone, if arranging a suitable time and place to meet in person is not possible.

If possible, participants will be divided into focus groups according to the age of their child: newborn to 2 years and 3 years to 5 years. Interviews/focus groups will be audiotaped and

transcribed into written form. The investigators will not include any names when transcribing interviews/focus groups to further increase anonymity and confidentiality. The principal investigator will mail each participant a summary of the major points from the interview/focus group transcript and ask them to ensure the information included is accurate and complete. Members will be asked to respond with confirmation within two weeks of receiving the summary. A fifteen-dollar gift card will be provided to participants for their time. They will also be reimbursed for parking or bus fare, if applicable. Food and beverage will be provided during the interview/focus group. The interviews/focus groups will provide information on parents' perspectives of the strengths and gaps in community supports for parents of young children.

The information gathered in Phase 1 of the needs assessment will be used to develop a Concerns Report Survey for Phase 2 of the study. The survey will be mailed to a random sample of parents living in the community and a sample of service providers working in the community.

**If you take part in this study, you will have the following procedures:**

You will be asked to complete a parent information form and participate in a focus group at a time that is convenient for all participants and the principal investigator. The focus group will last approximately 1 ½ hours. As part of the focus group, you will be asked about: community supports that have helped you or that would have helped you as a parent of a young child; the barriers and facilitators to accessing community programs and services; and community programs and services that you feel parents of young children need that are not currently available. You will be sent a summary of the major points from the focus group via mail and asked to review the information included for accuracy and completeness. You will be asked to respond with confirmation within two weeks of receiving the summary.

A subsequent phase of this study involves another focus group to review the information collected in each phase of the needs assessment to determine parents perspectives about the utility of the information gathered. You will be contacted at that time to determine your interest in participating in this phase of the study. However, you are under no obligation to participate in this phase of the study. You can stop participating at any time.

You will receive a summary of the final research report at the end of the study via e-mail or regular mail.

**Risks and Discomforts**

There are no known risks to participating in this study.

**Benefits**

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit parents with young children in your community in the future.

**Costs**

All the procedures, which will be performed as part of this study, are provided at no cost to you.

**Payment for participation**

You will be given a \$15 gift card for participating in the study. Reimbursement for bus fare and/or parking will be provided when attending the focus group.

**Confidentiality**

Information gathered in this research study may be published or presented in public forums; however, your name and other identifying information will not be used or revealed. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed due to the nature of the focus group. All study related documents will bear only your assigned study number. Everything that is said in the focus group is to be held in confidence and not to be repeated out of the focus group. Your personal information may be disclosed if required by law. The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area and only those persons identified will have access to these records. Audio recordings of the focus groups and all other data collected from the study will be destroyed five years after completion of the study. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

#### **Voluntary Participation/Withdrawal from the Study**

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from this study will not affect your ability to participate in community programs and services in any way.

#### **Questions**

You are free to ask any questions that you may have about your rights as a research participant. If any questions come up during or after the study contact the study coordinator: Leanne Leclair at 977-5631. For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389. Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

#### **Statement of Consent**

I have read this consent form. I have had the opportunity to discuss this research study with Leanne Leclair. I have had my questions answered by her in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member), I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to be contacted for future follow-up in relation to this study,

Yes  No

Participant Signature\_\_\_\_\_

Date\_\_\_\_\_

(day/month/year)

Participant printed name\_\_\_\_\_

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed name\_\_\_\_\_

Date\_\_\_\_\_

(day/month/year)

Signature\_\_\_\_\_

Role in the study\_\_\_\_\_

## **Appendix J: Service Provider Information Form**

**Before completing this form, please be sure to complete the Parent Participant Information and Consent Form.**

The information in this form is being gathered to describe some of the characteristics of the service providers that participated in the study. This page will be removed from the form when received, and a code number will be assigned, so that your identity is kept separate and confidential from the information you provide on the attached questionnaires.

Please print:

Your name: \_\_\_\_\_

Your address: \_\_\_\_\_

Your telephone number: \_\_\_\_\_

Check here if you would like a summary of the study findings after completion of the study?

Please tell us a little about yourself				
Your current employment/position: _____				
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Your Age	<input type="checkbox"/> 18-25 years <input type="checkbox"/> 26-30 years <input type="checkbox"/> 31-35 years	<input type="checkbox"/> 36-40 years <input type="checkbox"/> 41-45 years <input type="checkbox"/> 46-50 years	<input type="checkbox"/> 51-55 years <input type="checkbox"/> 56-60 years <input type="checkbox"/> 61-65 years <input type="checkbox"/> 65+ years	
Your education and training	<input type="checkbox"/> High School Diploma <input type="checkbox"/> College degree or diploma Please specify: <input type="checkbox"/> Bachelor's Degree Please specify: <input type="checkbox"/> Master's Degree Please specify: <input type="checkbox"/> Other Please specify:			
Years of experience in current position:				
<input type="checkbox"/> < 1 year <input type="checkbox"/> 1-5 years <input type="checkbox"/> 6-10 years <input type="checkbox"/> 11-15 years <input type="checkbox"/> 16+ years				
Years of experience working with families and young children:				
<input type="checkbox"/> < 1 year <input type="checkbox"/> 1-5 years <input type="checkbox"/> 6-10 years <input type="checkbox"/> 11-15 years <input type="checkbox"/> 16+ years				

THANK YOU!

## **Appendix K: Parent Socio-Demographic Information Form**

**Before completing this form, please be sure to complete the Parent Participant Information and Consent Form.**

The information in this form is being gathered to describe some of the characteristics of the parents that participated in the study. This page will be removed from the form when received, and a code number will be assigned, so that your identity is kept separate and confidential from the information you provide on the attached questionnaires.

Please print:

Your name: \_\_\_\_\_

Your address: \_\_\_\_\_

Your telephone number: \_\_\_\_\_

Check here if you would like a summary of the study findings after completion of the study?

Please tell us a little about your child(ren)

Number of Children: \_\_\_\_\_

Age of child(ren)      Gender of Child(ren) Male = 1, Female = 2

\_\_\_\_\_

- Male  Female  
 Male  Female  
 Male  Female  
 Male  Female

Does your child(ren) have a severe physical limitation (i.e., cannot use arms or legs functionally)?

No       Yes, Specify \_\_\_\_\_

Does your child(ren) have a severe sensory loss (i.e., visual or auditory impairment)?

No       Yes, Specify \_\_\_\_\_

Does your child(ren) have a serious health problem (requiring ongoing medical care)?

No       Yes, Specify \_\_\_\_\_

Please tell us a little about you and your family

Do you have a severe physical limitation (i.e., cannot use arms or legs functionally)?

No       Yes, Specify \_\_\_\_\_

Do you have a severe sensory loss (i.e., visual or auditory impairment)?

No       Yes, Specify \_\_\_\_\_

Do you have a serious health problem (requiring ongoing medical care)?

No       Yes, Specify \_\_\_\_\_

Your relationship to the child

- |   |  |
|---|--|
| <input type="checkbox"/> Mother               | <input type="checkbox"/> Father        |
| <input type="checkbox"/> Foster mother        | <input type="checkbox"/> Foster father |
| <input type="checkbox"/> Other, Specify _____ |  |

Your age

- |                                   |                                  |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Under 20 | <input type="checkbox"/> 30-39   |
| <input type="checkbox"/> 21-29    | <input type="checkbox"/> Over 40 |

Your gross family income

- |   |   |
|---|---|
| <input type="checkbox"/> Less than \$10,000 | <input type="checkbox"/> \$60,000-69,999    |
| <input type="checkbox"/> \$10,000-19,999    | <input type="checkbox"/> \$70,000-79,999    |
| <input type="checkbox"/> \$20,000-29,999    | <input type="checkbox"/> \$80,000-89,999    |
| <input type="checkbox"/> \$30,000-39,999    | <input type="checkbox"/> \$90,000-99,999    |
| <input type="checkbox"/> \$40,000-49,999    | <input type="checkbox"/> \$100,000 and over |
| <input type="checkbox"/> \$50,000-59,999    |   |

Your highest level of education	<input type="checkbox"/> Less than High School <input type="checkbox"/> High School Diploma <input type="checkbox"/> Apprenticeship or Trades certificate or diploma <input type="checkbox"/> College or non-university degree or diploma <input type="checkbox"/> University certificate or diploma below bachelor level <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> University certificate or diploma above bachelor level <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate
Your employment status	<input type="checkbox"/> Employed full-time (35 hours or more a week) <input type="checkbox"/> Employed part-time <input type="checkbox"/> Unemployed Please specify: (e.g., student, retired, stay at home parent, seeking employment)
Your marital status	<input type="checkbox"/> Married or Common-law <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Your primary language spoken in the home	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other, specify
Your place of birth	<input type="checkbox"/> Canada <input type="checkbox"/> Other, specify
Your use of community programs and services aimed at parents and young children (newborn to six years of age) now and in the past.	Please check all that apply <input type="checkbox"/> day care <input type="checkbox"/> preschool/nursery school <input type="checkbox"/> parenting program, Name <input type="checkbox"/> postnatal program, Name <input type="checkbox"/> family centre activities, Name <input type="checkbox"/> public library programs, Name <input type="checkbox"/> leisure guide programs, Name <input type="checkbox"/> YM-YWCA programs, Name <input type="checkbox"/> Families First program <input type="checkbox"/> Healthy Baby <input type="checkbox"/> Other, Specify

**THANK YOU!**

## **Appendix L: Service Provider Initial Interview Guide**

1. Please tell me about your involvement in community support programs and services for parents and young children (0-5 years).
2. Please tell me about the programs and services that you offer parents and/or young children.
3. Based on your experiences with children and parents, what do you perceive are your programs strengths or the communities strengths in supporting families?
4. What additional supports/programs/services do you feel parents need that are not currently available?
5. What are the barriers to accessing services?
6. What are the facilitators to accessing services?
7. What do you see are the current challenges related to developing programs and services that meet the needs of parents?
8. Is there anything else that you would like to add?

## **Appendix M: Parent Initial Interview/Focus Group Guide**

### **Welcome**

Good afternoon/evening and welcome. Thanks for taking the time to join our discussion this afternoon/evening on community supports for parents of young children. My name is Leanne Leclair and I am the principal investigator of this study which is being conducted in partnership with the St. Vital Parent Child Coalition. I am also a parent of two young children and a resident of St. Vital.

### **Overview of the Topic**

The Coalition and I are interested in knowing more about parents' experiences with community supports, programs and services offered in St. Vital to parents of young children. This information will help with the development of a survey that will be sent to parents in St. Vital to help us in determining the strengths and gaps in community supports for parents.

As parents of young children living in St. Vital, we want to hear about your experiences with programs and services.

### **Ground Rules**

There are no right or wrong answers. We expect that you will have different experiences and points of view. Please feel free to share your point of view even if it differs from what others have said.

I am recording the session because I don't want to miss any of your comments. NO names will be included in any reports. Your comments are confidential.

There are name tags to help me remember names, but they can also help you. Don't feel like you have to respond to me all the time. If you want to follow up on something that someone has said, you want to agree, or disagree, or give an example, feel free to do that. Feel free to have a conversation with one another about these questions. I am here to ask questions, listen and make sure everyone has a chance to share. I am interested in hearing from each of you. So if you aren't saying much I may call on you to make sure all of you have a chance to share your ideas.

If you have a cell phone or pager can you please put it on vibrate, and if you need to answer please step out to do so. Feel free to get up and get more refreshments if you would like.

### **Opening question**

Let's begin. Let's find out more about each other by going around the table one at a time. Tell us your name and the age of your children.

1. What have you found easy as a parent and why?

Prompt: Were certain periods of parenting easier?

2. What have you found difficult, and why?

Prompt: Were certain periods of parenting more difficult?

3. What programs/services/supports have you accessed as a parent of a young child? At what point? How did it help you as a parent?

Prompt: Have you sought out particular supports that assisted you with a particular issue?

4. Based on your experiences with programs in the community, what do you perceive are the communities strengths in supporting families?
5. What support/programs/services would have been useful? At what point?  
Prompt: Have you sought out particular supports that were not available or that you wished were available for a particular issue but were not able to find?  
What did you do in that case?
6. Have you experienced any barriers to accessing services?
7. What has facilitated your access to programs and services?
8. What do you see are the current challenges related to developing programs and services that meet the needs of parents?
9. Is there anything else that you would like to add?

## **Appendix N: Service Provider Concerns Report Survey**

Thank you for agreeing to participate in this survey. We truly appreciate your time and cooperation.

The following information is being gathered to describe some of the characteristics of the service providers that participated in the study.

Please tell us a little about yourself	
Your current employment/position: _____	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Age	Specify: _____
Your education and training	<input type="checkbox"/> High School Diploma <input type="checkbox"/> College degree or diploma Please specify: <input type="checkbox"/> Bachelor's Degree Please specify: <input type="checkbox"/> Master's Degree Please specify: <input type="checkbox"/> Other Please specify:
Years of experience in current position:	
<input type="checkbox"/> < 1 year <input type="checkbox"/> 1-5 years <input type="checkbox"/> 6-10 years <input type="checkbox"/> 11-15 years <input type="checkbox"/> 16+ years	
Years of experience working with families and young children:	
<input type="checkbox"/> < 1 year <input type="checkbox"/> 1-5 years <input type="checkbox"/> 6-10 years <input type="checkbox"/> 11-15 years <input type="checkbox"/> 16+ years	

Please read and answer each question to the best of your ability. To be truly helpful, your candid and honest answers are needed.

Communities differ in the kinds of resources and programs that are available to help parents of young children (newborn to six years of age).

- As a service provider, ***how important do you think it is*** to have the following resources or programs for parents and young children in St. Vital.

Please use the 10-point scale below, where 1 means *not at all important* and 10 means *very important*.

Resource or Program	Not at all important										Very Important	
	1	2	3	4	5	6	7	8	9	10		
A doctor for young children	<input type="checkbox"/>											
A drop-in medical clinic	<input type="checkbox"/>											
Prenatal childbirth preparation classes	<input type="checkbox"/>											
Breastfeeding, lactation support programs	<input type="checkbox"/>											
Programs that offer supports to parents in the first few months after baby's birth	<input type="checkbox"/>											
Parent-child programs such as Parent & Tot or Baby & Me classes that focus on promoting healthy child development	<input type="checkbox"/>											
Parent-child early literacy programs	<input type="checkbox"/>											
Parent & Tot or Baby & Me fitness classes	<input type="checkbox"/>											
Programs to help new parents with the transition into being a parent/parenthood	<input type="checkbox"/>											
Parenting classes or general parenting improvement sessions	<input type="checkbox"/>											
Programs on nutrition for young children	<input type="checkbox"/>											
Programs that provide transportation to the program	<input type="checkbox"/>											
Parent programs that offer child care so that parents can attend	<input type="checkbox"/>											
Summer programs for parents and young children	<input type="checkbox"/>											
Programs for fathers of young children	<input type="checkbox"/>											
Public Health Nurse support programs	<input type="checkbox"/>											
Home visitor support programs (e.g., Families First)	<input type="checkbox"/>											
Workshops or programs to learn about handling parenting challenges such as getting your child to sleep through the night, tantrums, etc.	<input type="checkbox"/>											
Parent hotline available 24 hours a day where parents can call for advice about parenting issues/concerns	<input type="checkbox"/>											
Instructional swim, skating or exercise programs for children	<input type="checkbox"/>											
Organized sports leagues for children (i.e., soccer, hockey, tball, etc.)	<input type="checkbox"/>											
Instructional creative arts classes for children (i.e., dance, painting, music or drama)	<input type="checkbox"/>											
Organized playgroups	<input type="checkbox"/>											
Drop-in programs for parents with young children	<input type="checkbox"/>											
Programs that assist parents with the transition back to work after maternity/parental leave	<input type="checkbox"/>											
Public places where you can take young children to play and meet other families that share similar values.	<input type="checkbox"/>											
Centres such as Family Resource Centres, YMCAs, community centres, etc.	<input type="checkbox"/>											
Playgrounds	<input type="checkbox"/>											
Libraries	<input type="checkbox"/>											
Arenas and community / recreation centres	<input type="checkbox"/>											
Programs in my community school	<input type="checkbox"/>											

Resource or Program	Very Important									
	Not at all important									
	1	2	3	4	5	6	7	8	9	10
Regular informal get-togethers with neighbours	<input type="checkbox"/>									
Internet chat groups or online forums	<input type="checkbox"/>									
A private or publicly funded preschool for 3 or 4 year olds	<input type="checkbox"/>									
Family child care / daycare provider	<input type="checkbox"/>									
Child care / daycare centres	<input type="checkbox"/>									
Casual child care	<input type="checkbox"/>									

2. As a service provider, ***how satisfied are you*** with the following resources or programs for parents and young children in St. Vital.

Please use the 10-point scale below, where 1 means *not at all satisfied* and 10 means *very satisfied*.

Resource or Program	Very Satisfied									
	Not at all satisfied									
	1	2	3	4	5	6	7	8	9	10
A doctor for young children	<input type="checkbox"/>									
A drop-in medical clinic	<input type="checkbox"/>									
Prenatal childbirth preparation classes	<input type="checkbox"/>									
Breastfeeding, lactation support programs	<input type="checkbox"/>									
Programs that offer supports to parents in the first few months after baby's birth	<input type="checkbox"/>									
Parent-child programs such as Parent & Tot or Baby & Me classes that focus on promoting healthy child development	<input type="checkbox"/>									
Parent-child early literacy programs	<input type="checkbox"/>									
Parent & Tot or Baby & Me fitness classes	<input type="checkbox"/>									
Programs to help new parents with the transition into being a parent/parenthood	<input type="checkbox"/>									
Parenting classes or general parenting improvement sessions	<input type="checkbox"/>									
Programs on nutrition for young children	<input type="checkbox"/>									
Programs that provide transportation to the program	<input type="checkbox"/>									
Parent programs that offer child care so that parents can attend	<input type="checkbox"/>									
Summer programs for parents and young children	<input type="checkbox"/>									
Programs for fathers of young children	<input type="checkbox"/>									
Public Health Nurse support programs	<input type="checkbox"/>									
Home visitor support programs (e.g., Families First)	<input type="checkbox"/>									
Workshops or programs to learn about handling parenting challenges such as getting your child to sleep through the night, tantrums, etc.	<input type="checkbox"/>									
Parent hotline available 24 hours a day where parents can call for advice about parenting issues/concerns	<input type="checkbox"/>									
Instructional swim, skating or exercise programs for children	<input type="checkbox"/>									
Organized sports leagues for children (i.e., soccer, hockey, tball, etc.)	<input type="checkbox"/>									
Instructional creative arts classes for children (i.e., dance, painting, music or drama)	<input type="checkbox"/>									
Organized playgroups	<input type="checkbox"/>									
Drop-in programs for parents with young children	<input type="checkbox"/>									
Programs that assist parents with the transition back to work after maternity/parental leave	<input type="checkbox"/>									
Public places where you can take young children to play and meet other families that share similar values.	<input type="checkbox"/>									
Centres such as Family Resource Centres, YMCAs, community centres, etc.	<input type="checkbox"/>									

Resource or Program	Very Satisfied									
	Not at all satisfied		Satisfied							
	1	2	3	4	5	6	7	8	9	10
Playgrounds	<input type="checkbox"/>									
Libraries	<input type="checkbox"/>									
Arenas and community / recreation centres	<input type="checkbox"/>									
Programs in my community school	<input type="checkbox"/>									
Regular informal get-togethers with neighbours	<input type="checkbox"/>									
Internet chat groups or online forums	<input type="checkbox"/>									
A private or publicly funded preschool for 3 or 4 year olds	<input type="checkbox"/>									
Family child care / daycare provider	<input type="checkbox"/>									
Child care / daycare centres	<input type="checkbox"/>									
Casual child care	<input type="checkbox"/>									

**3. Which of the following resources or programs are you involved in or do you offer/provide to parents and young children (newborn to six years of age)?**

**(Check ALL that apply)**

A doctor for young children	
A drop-in medical clinic	
Prenatal childbirth preparation classes	
Breastfeeding, lactation support programs	
Programs that offer supports to parents in the first few months after a baby's birth	
Parent-child programs such as Parent & Tot or Baby & Me classes that focus on promoting child development	
Parent-child early literacy programs	
Parent & Tot or Baby & Me fitness classes	
Programs to help new parents with the transition into being a parent/parenthood	
Parenting classes or general parenting improvement sessions	
Programs on nutrition for young children	
Programs that provide transportation to the program	
Parent programs that offer child care so that parents can attend	
Summer programs for parents and young children	
Programs for fathers of young children	
Public Health Nurse support programs	
Home visitor support programs (e.g., Families First)	
Parent hotline available 24 hours a day where parents can call for advice about parenting issues/concerns	
Instructional swim, skating or exercise programs for children	
Organized sports leagues for children (i.e., soccer, hockey, tball, etc.)	
Instructional creative arts classes for children (i.e., dance, painting, music or drama)	
Organized playgroups	
Drop-in programs for parents with young children	
Programs that assist parents with the transition back to work after maternity/parental leave	
Public places where you can take young children to play and meet other families that share similar values.	
Centres such as Family Resource Centres, YMCAs, community centres, etc.	
Playgrounds	
Libraries	
Arenas and community / recreation centres	
Programs in my community school	

Regular informal get-togethers with neighbours	
Internet chat groups or online forums	
A private or publicly funded preschool for 3 or 4 year olds	
Family child care / daycare provider	
Child care / daycare centre	
Casual child care	
None of the above	

Thank you!

## Appendix O: Parent Concerns Report Survey

Thank you for agreeing to participate in this invitation only survey. We truly appreciate your time and cooperation.

Please read and answer each question to the best of your ability. To be truly helpful, your candid and honest answers are needed. We ask that the parent who is primarily responsible for taking care of your child(ren) please respond to this survey.

<b>Please tell us a little about your child(ren).</b>			
How many children do you have? Please include any children currently away at school or temporarily living away from home. _____			
Age of child Youngest _____ yrs _____ mths Child #2 _____ yrs _____ mths Child #3 _____ yrs _____ mths Child #4 _____ yrs _____ mths Child #5 _____ yrs _____ mths Child #6 _____ yrs _____ mths Child #7 _____ yrs _____ mths Child #8 _____ yrs _____ mths Child #9 _____ yrs _____ mths Child #10 _____ yrs _____ mths	Gender of Child <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Female		
Does your child have a disability (e.g., cannot use arms or legs, visual or hearing impairment)? Youngest <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #2 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #3 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #4 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #5 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #6 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #7 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #8 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #9 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #10 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____			
Does your child have a serious health problem requiring ongoing medical care (e.g., heart condition)? Youngest <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #2 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #3 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #4 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #5 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #6 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #7 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #8 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #9 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____ Child #10 <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify _____			

Does your child have a mental health condition (e.g., autism, Asperger's, anxiety disorder)?		
Youngest	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
Child #2	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
Child #3	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
Child #4	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
Child #5	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
Child #6	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
Child #7	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
Child #8	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
Child #9	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
Child #10	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____
<b>Please tell us a little about you and your family</b>		
Do you have a disability (e.g., cannot use arms or legs, visual or hearing impairment)?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____	
Do you have a serious health problem requiring ongoing medical care (e.g., heart disease, cancer)?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____	
Do you have a mental health condition (e.g., depression, anxiety disorder)		
<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify _____	

10. Your relationship to the child(ren) newborn to six years of age	<input type="checkbox"/> Mother <input type="checkbox"/> Foster mother <input type="checkbox"/> Step mother <input type="checkbox"/> Father <input type="checkbox"/> Foster father <input type="checkbox"/> Step father <input type="checkbox"/> Other, Specify _____
11. Your age	
12. Your age when you had your first child	
13. Your marital status	<input type="checkbox"/> Single, never married <input type="checkbox"/> Married <input type="checkbox"/> Common-law <input type="checkbox"/> Separated or Divorced <input type="checkbox"/> Widowed
14. Your current employment status	Please check all that apply: <input type="checkbox"/> Employed full-time (35 hours or more a week) <input type="checkbox"/> Employed part-time <input type="checkbox"/> Short term disability <input type="checkbox"/> Long term disability <input type="checkbox"/> Unemployed Please specify: (e.g., student, retired, stay at home parent, seeking employment)
15. Are you presently on maternity/parental leave?	<input type="checkbox"/> No <input type="checkbox"/> Yes
16. If married or common law, your spouse's current employment status	Please check all that apply: <input type="checkbox"/> Employed full-time (35 hours or more a week) <input type="checkbox"/> Employed part-time <input type="checkbox"/> Short term disability <input type="checkbox"/> Long term disability <input type="checkbox"/> Unemployed Please specify: (e.g., student, retired, stay at home parent, seeking employment)
17. Is your spouse or partner, presently on maternity/parental leave?	<input type="checkbox"/> No <input type="checkbox"/> Yes

**Communities differ in the kinds of resources and programs that are available to help parents of young children (newborn to six years of age).**

18. As a parent, how important is it to have the following resources or programs in St. Vital.  
 Please use the 10-point scale below, where 1 means not at all important and 10 means very important.

Resource or Program	Not at all important Very important									
	1	2	3	4	5	6	7	8	9	10
A doctor for young children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A drop-in medical clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal childbirth preparation classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breastfeeding, lactation support programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs that offer supports to parents in the first few months after baby's birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent-child programs such as Parent & Tot or Baby & Me classes that focus on promoting healthy child development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent-child early literacy programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Tot or Baby & Me fitness classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs to help new parents with the transition into being a parent/parenthood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting classes or general parenting improvement sessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs on nutrition for young children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs that provide transportation to the program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent programs that offer child care so that parents can attend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer programs for parents and young children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs for fathers of young children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public Health Nurse support programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home visitor support programs (e.g., Families First)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workshops or programs to learn about handling parenting challenges such as getting your child to sleep through the night, tantrums, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent hotline available 24 hours a day where parents can call for advice about parenting issues/concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instructional swim, skating or exercise programs for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organized sports leagues for children (i.e., soccer, hockey, tball, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instructional creative arts classes for children (i.e., dance, painting, music or drama)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organized playgroups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drop-in programs for parents with young children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs that assist parents with the transition back to work after maternity/parental leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public places where you can take young children to play and meet other families that share similar values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Centres such as Family Resource Centres, YMCAs, community centres, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playgrounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Libraries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arenas and community / recreation centres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs in my community school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular informal get-togethers with neighbours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internet chat groups or online forums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A private or publicly funded preschool for 3 or 4 year olds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family child care / daycare provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child care / daycare centres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Resource or Program	Not at all important Very important									
	1	2	3	4	5	6	7	8	9	10
Casual child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. As a parent, how satisfied are you with the following resources or programs in St. Vital. Please use the 10-point scale below, where 1 means *not at all satisfied* and 10 means *very satisfied*.

Resource or Program		Very satisfied
	Not at all satisfied 1 2 3 4 5 6 7 8 9 10	
A doctor for young children	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
A drop-in medical clinic	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Prenatal childbirth preparation classes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Breastfeeding, lactation support programs	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Programs that offer supports to parents in the first few months after baby's birth	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Parent-child programs such as Parent & Tot or Baby & Me classes that focus on promoting healthy child development	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Parent-child early literacy programs	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Parent & Tot or Baby & Me fitness classes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Programs to help new parents with the transition into being a parent/parenthood	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Parenting classes or general parenting improvement sessions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Programs on nutrition for young children	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Programs that provide transportation to the program	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Parent programs that offer child care so that parents can attend	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Summer programs for parents and young children	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Programs for fathers of young children	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Public Health Nurse support programs	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Home visitor support programs (e.g., Families First)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Workshops or programs to learn about handling parenting challenges such as getting your child to sleep through the night, tantrums, etc.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Parent hotline available 24 hours a day where parents can call for advice about parenting issues/concerns	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Instructional swim, skating or exercise programs for children	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Organized sports leagues for children (i.e., soccer, hockey, tball, etc.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Instructional creative arts classes for children (i.e., dance, painting, music or drama)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Organized playgroups	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Drop-in programs for parents with young children	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Programs that assist parents with the transition back to work after maternity/parental leave	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Public places where you can take young children to play and meet other families that share similar values.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Centres such as Family Resource Centres, YMCAs, community centres, etc.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Playgrounds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Libraries	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arenas and community / recreation centres	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Programs in my community school	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Regular informal get-togethers with neighbours	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Internet chat groups or online forums	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
A private or publicly funded preschool for 3 or 4 year olds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Resource or Program	Not at all satisfied									Very satisfied	
	1	2	3	4	5	6	7	8	9	10	
Family child care / daycare provider	<input type="checkbox"/>										
Child care / daycare centres	<input type="checkbox"/>										
Casual child care	<input type="checkbox"/>										

20. Which of the following resources or programs have you used in the past year?

(Check ALL that apply)

A doctor for your child(ren)	
A drop-in medical clinic	
Prenatal childbirth preparation classes	
Breastfeeding, lactation support programs	
Programs that offer supports to parents in the first few months after a baby's birth	
Parent-child programs such as Parent & Tot or Baby & Me classes that focus on promoting child development	
Parent-child early literacy programs	
Parent & Tot or Baby & Me fitness classes	
Programs to help new parents with the transition into being a parent/parenthood	
Parenting classes or general parenting improvement sessions	
Programs on nutrition for young children	
Programs that provide transportation to the program	
Parent programs that offer child care so that parents can attend	
Summer programs for parents and young children	
Programs for fathers of young children	
Public Health Nurse support programs	
Home visitor support programs (e.g., Families First)	
Parent hotline available 24 hours a day where parents can call for advice about parenting issues/concerns	
Instructional swim, skating or exercise programs for children	
Organized sports leagues for children (i.e., soccer, hockey, tball, etc.)	
Instructional creative arts classes for children (i.e., dance, painting, music or drama)	
Organized playgroups	
Drop-in programs for parents with young children	
Programs that assist parents with the transition back to work after maternity/parental leave	
Public places where you can take young children to play and meet other families that share similar values.	
Centres such as Family Resource Centres, YMCAs, community centres, etc.	
Playgrounds	
Libraries	
Arenas and community / recreation centres	
Programs in my community school	
Regular informal get-togethers with neighbours	
Internet chat groups or online forums	
A private or publicly funded preschool for 3 or 4 year olds	
Family child care / daycare provider	
Child care / daycare centre	
Casual child care	
None of the above	

There are many reasons why parents find it difficult to take part in programs and activities offered by their community.

21. Thinking of your participation in local programs and activities, please indicate the extent to which you agree or disagree with each of the following statements as potential barriers to program participation.

Resource or Program	Agree Completely									
	1	2	3	4	5	6	7	8	9	10
a) I seldom have time to take part in local programs and activities	<input type="checkbox"/>									
b) I seldom have the energy to get involved in my community	<input type="checkbox"/>									
c) When I go to a program or activity in my community, I get too much unwanted advice about parenting	<input type="checkbox"/>									
d) I feel too much pressure to be the perfect parent when I go to programs and activities in my community	<input type="checkbox"/>									
e) I don't share the same values as those who attend the activities and programs in my community	<input type="checkbox"/>									
f) I don't feel safe in our community to go out with my child(ren)	<input type="checkbox"/>									
g) I get nervous when people I don't know are friendly with me or my children	<input type="checkbox"/>									
h) If I take part in a program or activity, I'll be asked to help others in return and I don't have the time or energy to do this	<input type="checkbox"/>									
i) It is difficult to find out what programs or activities are available in my community	<input type="checkbox"/>									
j) The programs and activities that I would consider attending in my community are too hard to get to	<input type="checkbox"/>									
k) The registration process is too difficult for the activities and programs I would consider attending in my community	<input type="checkbox"/>									
l) I have not found very many programs and activities in my community that are appealing	<input type="checkbox"/>									
m) I find the people running most of the programs and activities in my community unfriendly/unwelcoming	<input type="checkbox"/>									
n) I'd like to get more involved in programs and activities in my community, but I don't know how	<input type="checkbox"/>									
o) Too many of the local programs and activities that I want are disorderly and poorly organized	<input type="checkbox"/>									
p) Too many of the local programs that I want are over organized and rigid	<input type="checkbox"/>									
q) The local programs offered are too expensive	<input type="checkbox"/>									
r) Most of the local programs and activities for parents and children are not set up for Dads	<input type="checkbox"/>									
s) When I attend local programs and activities I feel like most people think Dads don't know what they are doing with young children	<input type="checkbox"/>									
t) Dads really aren't welcomed at many of the local	<input type="checkbox"/>									

Resource or Program	Disagree Completely										Agree Completely	
	1	2	3	4	5	6	7	8	9	10		
programs and activities												
u) Many of the programs that I want to attend have waiting lists.	<input type="checkbox"/>											
v) The programs and activities that I would consider attending in my community are offered at inconvenient times	<input type="checkbox"/>											
22. What would be your preferred time for programming? Please select one response.	<input type="checkbox"/> Weekday mornings <input type="checkbox"/> Weekday evenings <input type="checkbox"/> Weekday afternoons <input type="checkbox"/> Weekends											
23. Do you have any close family and friends who have infants and young children, similar in age to your children?	<input type="checkbox"/> No <input type="checkbox"/> Yes											
24. If yes, to question 23, how often do you get together?	<input type="checkbox"/> More than once a week <input type="checkbox"/> Weekly <input type="checkbox"/> Every other week						<input type="checkbox"/> Monthly <input type="checkbox"/> Every other month <input type="checkbox"/> Every six months or more					

Now thinking specifically about your relationship with your parents, to what extent to you agree or disagree with the following statements.

Please use the 10-point scale below, where 1 means *disagree completely* and 10 means *agree completely*.

25. My parents have been very helpful to me as a parent	Disagree Completely	1	2	3	4	5	6	7	8	9	10	Agree Completely	N/A
		<input type="checkbox"/>		<input type="checkbox"/>									

Now thinking specifically about your relationship with your friends and family (excluding Your parents), to what extent to you agree or disagree with the following statement?

26. All things considered, my family and friends have been very helpful to me as a parent.	Disagree Completely	1	2	3	4	5	6	7	8	9	10	Agree Completely	N/A
		<input type="checkbox"/>		<input type="checkbox"/>									

#### Now we'd like to understand your general attitudes towards parenting.

Below are some statements about children and parenting. Please indicate the extent to which you agree or disagree with each statement using the 10-point scale below, where 1 means *you disagree completely* and 10 means *you agree completely*.

	Disagree Completely	1	2	3	4	5	6	7	8	9	10	Agree Completely	
27. Before our first child, I felt very prepared for parenthood.		<input type="checkbox"/>		<input type="checkbox"/>									
28. After our first child, I felt confident in my ability to be a good parent		<input type="checkbox"/>		<input type="checkbox"/>									
29. After our first child, I felt unsure about what to do a lot of the time		<input type="checkbox"/>		<input type="checkbox"/>									
30. I find it hard to understand my child's feelings & needs		<input type="checkbox"/>		<input type="checkbox"/>									
31. I don't know how to handle difficult situations with my child		<input type="checkbox"/>		<input type="checkbox"/>									
32. Being a parent is the most important thing I can do		<input type="checkbox"/>		<input type="checkbox"/>									

	Disagree Completely	1	2	3	4	5	6	7	8	9	Agree Completely
33. I enjoy being a parent most of the time	<input type="checkbox"/>										
34. When I first became a parent, I felt I received enough <b>emotional</b> support	<input type="checkbox"/>										
35. When I first became a parent, I felt I received enough <b>practical</b> support	<input type="checkbox"/>										

Thinking of yourself as a parent, to what extent do you agree or disagree with the following statements? Please use the 10-point scale below, where 1 means *disagree completely* and 10 means *agree completely*

	Disagree Completely	1	2	3	4	5	6	7	8	9	Agree Completely
36. I work hard to care for my family but I never seem to make any progress	<input type="checkbox"/>										
37. I feel that I make a lot of mistakes in caring for my children	<input type="checkbox"/>										
38. I often feel overwhelmed by all that I have to accomplish in a day	<input type="checkbox"/>										
39. The demands of my family often interfere with my work on the job	<input type="checkbox"/>										
40. The demands of my job often interfere with my family life	<input type="checkbox"/>										
41. At the end of the day I often feel I have not accomplished what I set out to do	<input type="checkbox"/>										
42. I feel I'm constantly under stress trying to accomplish more than I can handle	<input type="checkbox"/>										
43. I often feel under stress when I don't have enough time	<input type="checkbox"/>										

Children develop in four main ways: physically, emotionally, socially and intellectually. Below are examples of what we mean by each term.

#### Physical development:

- an infant or young child's ability to sit up, crawl, walk, jump and be healthy.

#### Emotional development:

- the way an infant or young child expresses moods and feelings like contentment, happiness, sadness & fear

#### Social development:

- the way an infant or young child acts towards the people around him, like his or her family, friends or strangers

#### Intellectual development:

- an infant or young child's ability to think, explore and be curious

With these four types of child development in mind, please answer the following questions....

Where an infant or young child is concerned....	Physical Development	Emotional Development	Social Development	Intellectual Development
44. Which type of development do you feel you have the <b>MOST</b> information & knowledge about? ( <b>Check ONE type of development ONLY</b> )				

<b>Where an infant or young child is concerned....</b>	Physical Development	Emotional Development	Social Development	Intellectual Development
<b>45.</b> Which type of development do you feel you have the <b>LEAST</b> information & knowledge about? ( <b>Check ONE type of development ONLY</b> )				
<b>46.</b> Which type of development do you feel you have the <b>MOST</b> amount of influence on as a parent? ( <b>Check ONE type of development ONLY</b> )				
<b>47.</b> Which type of development do you feel you have the <b>LEAST</b> amount of influence on as a parent? ( <b>Check ONE type of development ONLY</b> )				

48. How often do you turn to the following sources for information or advice about child development or parenting?

Sources of Information	Very regularly	Fairly regularly	Once in a while	Hardly Ever	Never	N/A
a) Mother	<input type="checkbox"/>					
b) Mother in-law	<input type="checkbox"/>					
c) Father	<input type="checkbox"/>					
d) Father in-law	<input type="checkbox"/>					
e) Spouse / partner	<input type="checkbox"/>					
f) Other relatives (e.g., grandparents, siblings)	<input type="checkbox"/>					
g) Friends	<input type="checkbox"/>					
h) Neighbours	<input type="checkbox"/>					
i) Child care provider	<input type="checkbox"/>					
j) Your child's doctor	<input type="checkbox"/>					
k) Your God / religion	<input type="checkbox"/>					
l) Books or magazines	<input type="checkbox"/>					
m) The Internet	<input type="checkbox"/>					
n) Info lines (e.g., HealthLinks)	<input type="checkbox"/>					
o) Television programs	<input type="checkbox"/>					

Sources of Information	Very regularly	Fairly regularly	Once in a while	Hardly Ever	Never	N/A
p) Community parenting programs	<input type="checkbox"/>					

49. Each week do you have someone else, besides your spouse / partner who takes care of your child(ren)?

Yes  No   
[IF 'Yes']

50. How many **hours per week** do the following individuals spend looking after each child in your household?

(Please enter your best estimate to the nearest hour in the spaces below. For 'none' please enter a value of 0).

	Youngest Child	Child #2	Child #3	Child #4	Child #5	Child #6	Child #7	Child #8	Child #9
Child's grandparent or other family member									
Non-family member who lives with you or comes to your home									
Non-family member who offers licensed child care in their home									
Licensed Child care Centre									
A private or publicly funded preschool for 3, or 4 year olds									
<b>Total</b>									

Finally, a few more questions about you and your family.

52. Your highest level of education	<input type="checkbox"/> Less than High School <input type="checkbox"/> High School Diploma <input type="checkbox"/> Apprenticeship or Trades certificate or diploma <input type="checkbox"/> College or non-university degree or diploma <input type="checkbox"/> University certificate or diploma below bachelor level <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> University certificate or diploma above bachelor level <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate	
53. If married or common law, your spouse's highest level of education	<input type="checkbox"/> Less than High School <input type="checkbox"/> High School Diploma <input type="checkbox"/> Apprenticeship or Trades certificate or diploma <input type="checkbox"/> College or non-university degree or diploma <input type="checkbox"/> University certificate or diploma below bachelor level <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> University certificate or diploma above bachelor level	
54. Primary language spoken in the home	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other specify _____	
55. Your place of birth	<input type="checkbox"/> Canada <input type="checkbox"/> Other, specify _____	
56. If married, your spouse's place of birth	<input type="checkbox"/> Canada <input type="checkbox"/> Other, specify _____	
57. Your parents' place of birth	Mother <input type="checkbox"/> Canada Mother <input type="checkbox"/> Other, specify _____ Father <input type="checkbox"/> Canada Father <input type="checkbox"/> Other, specify _____	
58. Your total family income before taxes	<input type="checkbox"/> Less than \$25,000 <input type="checkbox"/> \$25,000- \$39,999 <input type="checkbox"/> \$40,000-59,999 <input type="checkbox"/> \$60,000-74,999	<input type="checkbox"/> \$75,000-99,999 <input type="checkbox"/> \$100,000- \$149,999 <input type="checkbox"/> \$150,000 and over

THANK YOU!

## Appendix P: Parent Advance Introductory Letter



Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

March 30, 2012

Dear Parent,

You are invited to participate in an online survey. The survey is part of a research study entitled ***Community Supports for Parents of Young Children: A Needs Assessment***. The purpose of this research study is to:

1. Determine the kind of programs and services that parents of young children would like to have available in St. Vital, and
2. Determine what programs and services are doing well and where more could be done for parents and young children in St. Vital.

The project is being done with the St. Vital Parent Child Coalition, a community coalition supported by Healthy Child Manitoba.

A community needs assessment is a process that involves collecting information about the needs of a community and sharing this information with those who can use it to make decisions about programs and services.

As part of our needs assessment, we are asking parents to do an online survey. The survey takes approximately 10 to 15 minutes to complete. Your response will help us better understand what the community is doing well and where more could be done in St. Vital to support parents and young children.

In a week, you will get a letter in the mail. The letter will include a web link to the online survey. Please take a few minutes to respond to the survey. We want to hear from you. Your input will help us enhance the community-based programs and services that support parents and young children in St. Vital.

Thank you,

Leanne Leclair  
PhD Candidate  
University of Manitoba

## Appendix Q: Manitoba Health Introductory Letter



Health

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**Health Information Management  
300 Carlton Street  
Winnipeg, MB R3B 3M9**

**DATE**

Dear Recipient:

**RE: Community Supports for Parents of Young Children: A Needs Assessment**

This letter is being sent to you to tell you about a study entitled *Community Supports for Parents of Young Children: A Needs Assessment*. The study is being undertaken by Leanne Leclair, a doctoral student at the University of Manitoba in collaboration with the St. Vital Parent Child Coalition. A more detailed description of the study and an invitation to participate in the study is attached.

This study has been approved by the Health Research Ethics Board at the University of Manitoba and by the Health Information Privacy Committee to comply with The Personal Health Information Act of Manitoba.

Manitoba Health has agreed to send out this letter to potential study participants, on behalf of the researcher, to ensure your privacy is protected. ***The researcher has no knowledge of who has received this letter. No information about you, not even your name, has been shared with the researcher.*** They will not know who you are unless you choose to provide them with your name, telephone number and agree to be contacted for follow-up as part of this study.

It is your choice to participate in this study. Your medical care will not be affected in any way by your decision. If you have any questions about why you received this letter, please contact the Health Information Privacy Coordinator at (204)786-7204. If you have specific questions about the study or consent process, please contact the researcher directly at (204) 977-5631. You do not need to reveal your identity to them in order to obtain further information.

Sincerely,

XXXXXXX

Executive Director, Health Information Management



## Appendix R: Parent Invitation Letter



Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

April 5, 2012

Dear Parent,

About one week ago, you were sent a letter inviting you to participate in an online survey. The survey is part of a research study entitled *Community Supports for Parents of Young Children: A Needs Assessment*. The purpose of this research study is to:

1. Determine the kind of programs and services that parents of young children would like to have available in St. Vital, and
2. Determine what programs and services are doing well and where more could be done for parents and young children in St. Vital.

The needs assessment is being done with the St. Vital Parent Child Coalition, a community coalition supported by Healthy Child Manitoba and is part of my doctoral research. A community needs assessment is a process that involves collecting information about the needs of a community and sharing this information with those who can use it to make decisions about programs and services.

As part of our needs assessment, we are asking parents to do an online survey. The survey takes approximately 15 minutes to complete. Your responses will help us better understand what the community is doing well and where more could be done in St. Vital to support parents and young children. The survey asks a few questions about yourself, your family and your use of programs and services for parents and young children (ages newborn to six years of age).

To complete the survey, go to: <https://www.surveymonkey.com/s/parentsurveystvital>

If you would like a paper copy of the survey, please contact me at 977-5631 or Leanne\_Leclair@umanitoba.ca.

Please take a few minutes to respond to the survey. We want to hear from you. Your input will help us enhance the community-based programs and services that support parents and young children in St. Vital.

Sincerely,

Leanne Leclair  
PhD Candidate  
Principal Investigator  
University of Manitoba

## Appendix S: Parent Reminder Letter



Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

Dear Parent,

Two weeks ago, you were sent a letter inviting you to participate in a survey. The survey is part of a research study entitled ***Community Supports for Parents of Young Children: A Needs Assessment.*** This survey is being done in partnership with the St. Vital Parent Child Coalition, a community coalition supported by Healthy Child Manitoba. Completing the survey will take approximately 20 minutes to finish. Your responses will help us better understand what the community is doing well and where more could be done in St. Vital to support parents and young children. You will be asked to provide some information about your family and the types of programs and services that you feel are important for parents and young children.

As I do not know the names of individuals who have completed the survey, this postcard has gone to everyone who was invited to participate in the survey. If you have already completed the survey, thank you! If you have not yet had a chance, we would really like to hear from you. You can find the survey at: <https://www.surveymonkey.com/s/parentsurveystvital> If you would like a paper copy of the survey, please contact me at 977-5631 or Leanne\_Leclair@umanitoba.ca.

Thank you in advance for taking time out of your busy schedules to help us enhance the community-based programs and services that support parents and young children in St. Vital.

Sincerely,

Leanne Leclair  
PhD Candidate  
Principal Investigator  
University of Manitoba

## Appendix T: Service Provider Introductory Letter



Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

March 30, 2012

Dear Director/Service Provider/Teacher,

You are invited to participate in a survey for a research study entitled ***Community Supports for Parents of Young Children: A Needs Assessment***. The primary purpose of this research study is to determine the community support needs of parents of young children and the current strengths and gaps in community programs and services for parents and young children in the St. Vital Community Area. The project is being done in partnership with the St. Vital Parent Child Coalition, a community coalition supported by Healthy Child Manitoba.

To gain a better understanding of the community support needs of parents of young children and the current strengths and gaps in community-based programs and services for parents and young children in the St. Vital Community Area, you are invited to complete a survey. The survey will take approximately 10 minutes to complete. As a participant in the survey, you will be asked to answer a few questions about yourself, your education and training, and your experience working with parents and young children newborn to six years of age. You will also be asked about the types of programs and services that you feel are important for parents and young children.

To complete the survey, click on: <https://www.surveymonkey.com/s/serviceprovidersurveystvital>  
If you would like a paper copy of the survey, please contact me at 977-5631 or  
Leanne\_Leclair@umanitoba.ca.

We ask that you please take a few minutes to share this e-mail with other staff in your organization and to provide us with your valuable input, which will be used to strengthen the community-based programs and services that support parents and young children living in St. Vital.

Thank you,

Leanne Leclair  
PhD Candidate  
Principal Investigator  
University of Manitoba

## Appendix U: Service Provider Reminder Letter



Faculty of Medicine  
Department of Community Health Sciences  
750 Bannatyne Avenue  
Winnipeg, Manitoba  
Canada R3E 0W3  
Fax (204) 789-3905

Date

Dear Service Provider,

Two weeks ago, you received an e-mail/ a letter inviting you to participate in a survey for a research study entitled *Community Supports for Parents of Young Children: A Needs Assessment*. This survey is being done in partnership with the St. Vital Parent Child Coalition and will take approximately 10 minutes to complete. The survey can be found at:

<https://www.surveymonkey.com/s/serviceprovidersurveystvital>

The responses will be used to gain a better understanding of parents' support needs related to community-based programs and services for parents and young children. You will be asked to respond to a few questions about yourself and the types of programs and services that you feel are important for parents and young children. We want to hear from you.

This e-mail/letter has gone to everyone who was sent an invitation to participate in the survey. Since no personal information is retained with the surveys for reasons of confidentiality, we are unable to identify whether or not you have already completed the survey. If you have already completed the survey, thank you! If you have not yet had a chance to complete the survey, please take a few minutes to provide us with your valuable input, which will be used to strengthen the community-based programs and services that support parents and young children.

Thank you,

Leanne Leclair  
PhD Candidate  
Principal Investigator  
University of Manitoba