Envision: The Manitoba Journal of Child Welfare

Volume 4, Number 2, October 2005

Parenting Youth Support Needs: Implications for Stakeholders[1]

D. Noreen Ek
School of Health Studies, Brandon University

In Canada approximately 45 teens under the age of 19 become pregnant each week (Manitoba Health, 1993, as cited by Gfellner & Jolly, 1998). In 1994, the teenage pregnancy rate for Manitoba was 64 per 1,000 (Canadian Institute of Child Health, 2000). Predominantly, they will keep their babies and become young parents. A number of young parents will subsequently give birth to a second child within a one or two year period. The additional birth puts further stress on the young parent through the disruption of child care and living arrangements, causing further delay in returning to education and/or gaining employability until children enter school (Williams & Sadler, 2001).

Young parents face an uphill struggle in regards to parenting, education and acquiring financial security for themselves and their children. Analysis based on 6,074 teens found educational and financial outcomes varied significantly depending on the occurrence of non-marital adolescent pregnancy, the resolution of non-marital adolescent pregnancy and the age at which pregnancy occurs (Robbins & Streetman, 1994). Outcomes in terms of education attainment and employment appear to be more positive for teen parents when there is provision of school-based child care centers (Crean, 2001), or where income incentives are given for school attendance (Wood, Bloom, Fellerath, & Long, 1995) and where there are teen living welfare programs in existence (Clinton, 1996; Collins, Lane, & Stevens, 2003).

While prevention of pregnancy in youth is desired, the youth who does become pregnant experiences distress and has significant need for support and education. The earlier this support is provided, the more positive should be the outcomes (Honig & Morin, 2001). Public health and Child and Family Services of Western Manitoba have been providing supportive services, including an educational prenatal group designed to meet the needs of young parents in the Brandon area since the early 1970s. This program gradually evolved into the Special Delivery Club (SDC), active since 1992. Over 300 pregnant and parenting youth have been involved in the program over the last five years. This study was designed to follow up with as many of these parents as possible and to involve them in a process of program evaluation to gain insight into their perceptions of the SDC program, schooling, housing, current lifestyle practices and to evaluate their children's temperaments and atypical behavior patterns.

[1] This project was funded by Brandon University Community Outreach and by Health Canada: Centre of Excellence for Child and Youth Centred Prairie Communities. This was a collaborative project between Child and Family Services of Western Manitoba, Brandon Regional Health Authority and Brandon University, School of Health Studies.

The SDC program offers eight sessions to participants that are briefly described below in Table 1. This study was designed to provide young parents with the opportunity to provide feedback regarding prenatal programming and to gain insight into their perceptions related to parenthood, schooling and provide an assessment of their child's functioning.

Table 1: Session Content

1-self-care during pregnancy, fetal growth and development, exercises for labor	2-nutrition, weight gain, safe exercises, healthy lifestyle choices, breathing exercises	3-legislation for single parents, community resources and parenting issues to think about	4- stages of labor and labor positions
5-newborn characteristics, caring and safety for baby	6- benefits of breastfeeding, benefits to mother and child and the "how to's" of breastfeeding	7-tour of the hospital and videos of the birthing experience	8-budgeting skills

Beyond identifying the perceived impact of the SDC program, this study also sought to determine what factors were perceived as facilitators and/or obstacles in returning to school, accessing services and/or accessing daycare and housing.

Method

This descriptive study involved interviews of past participants of the SDC program. Variables measured included impact ratings, educational attainment, repeat childbirth rates, employment status, issues related to schooling and housing/daycare availability, service utilization, lifestyle practices and measures (self-report questionnaires) of parental attitude and child temperament and atypical behavior.

Sample

While there were 308 young parents registered in the program, not all continued in the program. Some were from non-local areas (Winnipeg, Churchill, and Saskatchewan, n = 115), and some had lost their babies through miscarriage and stillbirth or other unknown causes of infant death (n = 11). This left 182 participants that we could attempt to reach. With the potential for name change through marriage we were significantly challenged in reaching many participants. Forty-two participants were contacted and two declined participation, leaving us with a sample of forty parents who had been involved with the ***SDC*** program.

Assessment Tools

Temperament and Atypical Behavior Scale (TABS) (Bagnato, Neisworth, Salvia, & Hunt, 1999). This parent-completed questionnaire has four dimensions where children's behavior is rated on detachment, hypersensitivity/hyperactivity, under-reactive and deregulated features TABS scores are useful in meeting criteria for early intervention

program eligibility and for mental health behavioral support. The authors indicate that a temperament regulatory index (TRI) of 5 (percentile 23 and standard score of 91) is sufficient to consider a child at risk and a TRI of 8 (percentile 11 and standard score of 78) is sufficient to consider a child to demonstrate severe atypical behavioral dysfunction. TABS scores have been utilized as a screening tool in early intervention programs and as an indicator for mental health behavioral support and have been recommended for use to justify a diagnosis of temperament/regulatory disorder (Bagnato, et al., 1999). Normative information is available for children not-at-risk, children with disabilities, by age and by gender.

The Index of Parent Attitudes (IPA) (Hudson, 1997). The IPA is a 25-item questionnaire designed to measure the extent, severity or magnitude of parent-child relationship problems as reported/evaluated by a parent (Corcoran & Fischer, 2000). There are two primary scores. A score below the first cutoff score of 30 (+ or – 5) indicates the absence of any clinically significant problem. A score above the second cutoff score of 70 indicates the client is experiencing severe stress with a clear possibility that some type of violence may occur in response to the problems being experienced by the client (Corcoran & Fischer, 2000). As young parents face multiple stressors, it was felt that this measure may prove useful in providing a measure of that stress, in particular as it relates to parent-child relationship difficulties.

Procedure and Analysis

Participants were seen in small groups for focus group discussions. If scheduling was difficult or if they preferred not to meet in a group, a phone interview was conducted. Whether seen in-person or over the phone, participants received the same questions. In the case of the latter, surveys/questionnaires were mailed, with a prepaid return envelope. This involved three individuals and all questionnaires were returned. Data, which was both qualitative and quantitative, were analyzed using descriptive statistics and more advanced statistical analysis where possible.

Results

Sample Characteristics

Year Attending Special Delivery Club. Using the date of birth of their child, participants were fairly equally distributed across each year from 1998 to 2002 in terms of when they attended the SDC Program. One participant had her baby in 2003, though attended the program in 2002.

Table 2: Year of involvement with SDC program based on the birth date of the child

	1998	1999	2000	2001	2002	2003
DOB	8	6	9	6	10	1

Age of Mother. The average age of participants in this study was 18.48 with an age range of 15-24. Only 27 participants responded to this question. There was one 24-year-old that had been included in the SDC program due to need level. Eight participants were between the ages of 15-17, with 14 participants between the ages of 18-20 and five participants between the ages of 21-24.

Number of Children. A number of participants had more than one child (n = 15, 35%). The table below indicates the length of time between first and second born children and for three participants, between second and third born children. For this group of parents 37% of them had given birth to a second child within 1 or 2 years. Of these, 20% had had a third child within one to two years of their second born (see Table 3 below). Number of children was correlated with scores on the IPA and the TABS regulatory index score ($r = .37$, $p = .01$ and $r = .34$, $p = .03$ respectively).

Table 3: Frequency related to years between births of second and third born

Years Between Births	First and Second Child	Second and Third Child
1	6	1
2	4	2
3	1	--
4	4	--

Marital Status. Predominantly, the participants were in supportive relationships (total = 55%), with 26% married and 29% in common law relationships. Lone parents accounted for 42% of participants of these, 75% had one child, 12% had two children and another 12% had three children.

Education Attainment. In the final sample, 20% of participants had completed grade 12 however, 45% had less than grade 12. Some had gone on to University or College (12%) and the remainder did not respond to this question (9%).

Employment/Occupation and Source of Income. For the most part, the participants were employed in labour roles (40%) some were employed in areas that had a potential for career growth (20%), and a small proportion were students at the post-secondary level (15%). Over half of the respondents (55%) indicated their income came directly from their job and 25% indicated their husbands provided support. Some were receiving support from employment insurance (12%) and from social assistance (.05%). Student loans were being received by some participants (.05%).

Impact Ratings. Each session was ranked on a likert scale (0-5). A rank of 5 was very positive impact with 0 representing no impact. Session two, which covered nutritional information for the mother, healthy lifestyle choices, safe exercises and

breathing exercises, received the highest ranking of 4.4 out of 5. The lowest ranked session pertained to legislation for single parents, community resources and parenting issues, 3.7 out of 5. All other sessions (see Table 1 above for descriptors) were ranked between 3.8 and 4.2.

Focus Groups

Focus groups and/or telephone interviews (n = 3) resulted in a rich database of information, which was qualitative in nature. As a number of focus groups were conducted, results were initially grouped according to question and then analyzed for thematic content to provide summaries. Comments selected are a representative sample.

Positive Support. The information provided by the SDC was viewed positively with reduction in anxiety being noted by participants. Preparing one for birth and delivery was achieved with the proviso offered by one participant that "nothing can really prepare you".

Program Improvement. Comments focused on providing more information regarding atypical births; of not talking to participants like they were in grade school; delaying the weigh-in until later in the session ("not what you want to do as soon as you arrive"). Breastfeeding encouragement was viewed negatively, with many participants wanting the program as well as post-natal follow-up nurses to "quit pushing breastfeeding at me". Older participants noted they didn't like being grouped with younger participants who "didn't want to be pregnant and for sure didn't want their baby." Additionally, some participants had partners who objected to the partner being excluded as it "made me feel I was going to lose him."

Negative Attitudes of Nurses, Teachers and Society at Large. Participants felt a clear negative attitude from nurses during birth and delivery ("they wouldn't listen to me, I had to get my Mom to come help me"; from their teachers ("like I am never going to finish school - I am a failure" and from people in general ("just staring at me because I am young and have a child").

Schooling Challenges. Significant discussion of the need for schools to have daycares occurred in most focus groups held. Daycare availability is poor and additionally, some require that the child be "potty-trained by age two" which was a major obstacle for participants. As daycares are often not conveniently located to schools, this posed related transportation difficulties for parenting youth and caused some to give up on the idea of returning to school.

Housing and Daycare Challenges. Being connected with a service seems helpful (i.e., "I had a family member involved with Manitoba Housing so I got in really quick"), but others were not so lucky and had to wait. Numerous participants noted the waiting was problematic for housing and that once one did get into a place, Manitoba Housing was very slow on repairs, despite in one case medical letters being written about mould in the house that was exacerbating her child's asthmatic condition. Location of housing was problematic (near open railway tracks), and participants noted many homes

had dryers but no washers. The alternative to dealing with Manitoba Housing appeared to be "dealing with slum landlords: those that would take kids, that were dirty, windows wouldn't open, houses in bad shape". Family and services (public health and Child and Family Services) were helpful in providing assistance in accessing reasonable housing.

In terms of daycare challenges, the groups were fairly consistent in calling for more daycares and for daycares in school (i.e., "you can't breastfeed if the child can't be near you"). Affordability of daycare was also noted (i.e., "if you are not 18 you don't get help from the government and if you are in school, not working, you don't have the money"). Age of child was also problematic, with youth parents reporting being told that the child had to be two years of age and potty-trained, (yet public health tells them not to potty-train until age three). Rides were seen as essential ("rides to drop the child off at daycare if the daycares aren't in school"). Participants noted that "childcare in school would definitely help some youth go back to school".

Perceptions of Parenthood. Parents were asked what they liked the best and the least about parenting and how having a baby and keeping the baby changed their lives. The best things about parenting included watching their child grow and learn, hugs and kisses, companionship and the experiencing of the many 'firsts' the child achieves. In terms of the least-liked aspects of parenting, these included not having help from a significant other, working at a job and at home, feeling that the acting-out behavior they see in their child is caused by them not being at home, feeling like they are doing it alone (even if married), the cluttered home, struggles with potty-training and behavior. Raising two or more children by themselves was challenging; transportation, daycare accessibility and affordability another challenge. In terms of how babies changed their lives, this question evoked reactions around change of lifestyle (less freedom, change in friends, not always a bad thing), loss of friends (you find out who your friends are), growing up (faster, you have to plan re: going on outings or going out period, nothing is spontaneous).

Sources of Support. In terms of who supported them, most frequently the young parents noted family and public health. Friends received mixed responses as many youth parents noted "my friends stopped coming by" or "my friends changed". In terms of accessing support from school guidance counsellors, this was very much under-utilized in this sample. Teachers as well received mixed review as some participants perceived clearly negative attitudes and lack of understanding and/or assistance vs. some whose teachers had made a point of encouraging them.

Service Utilization. Supports available in the community, which include health services, school division supportive services and Child and Family Services (CFS), offer a wide range of varied and complementary programs. Public health was accessed by 62% of participants, pediatricians by 45%, health programs by 40% and Healthy Baby programming and the Baby First program were utilized by 38% of participants. The latter two programs were designed for at-risk situations. CFS offers voluntary and prescribed programs. In the community-based voluntary program, which is open to anyone from the community, only 15% of participants indicated they had attended this program. Workshops offered by the voluntary community-based program were attended

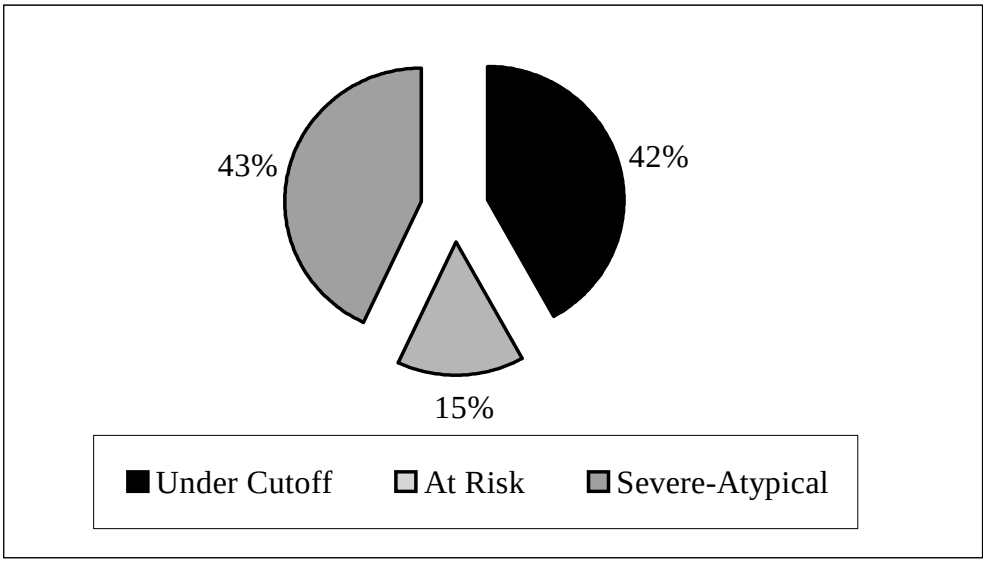
by 20% of participants in this study. Support groups were attended by 18%, while skill-building groups were attended minimally (.05%). CFS prescribed contact was attended by 20% of the participants in this study with 10% of these receiving counselling and family aid and 13% receiving a family support worker. The number of participants who indicated they had utilized available school counsellors, teachers or other school personnel was low (1%).

Lifestyle. Within the survey, questions related to lifestyle practices were administered which indicated difficulties with weight control and exercise. A large number of participants considered themselves overweight (67% desired weight loss). This combined with a large percentage of individuals who felt too tired, lacked the energy to engage in activity, or lacked transportation to get to gyms or activities. While 60% of participants indicated they were smokers prior to pregnancy, some had quit during or after the pregnancy. There was a 10% reduction in the number of participants who smoked during pregnancy to after pregnancy. Current drug and alcohol use was at 2% and 13% respectively.

Temperament and Atypical Behavior and Parenting Attitudes

Based on the ratings the mothers provided, 43% of the children met the severe-atypical cutoff, which would be associated with the need for supportive mental health programming. A further 15% of the children would be considered at risk for needing such support (see Figure 1 below). Scores on the TABS regulatory index score were correlated with number of children ($r = .34$, $p = .03$) and the Index of Parental Attitude (IPA)($r = .38$, $p = .01$).

Figure 1: TABS: Percent of Children Rated as Under The Cutoff, At Risk, and Severe-Atypical



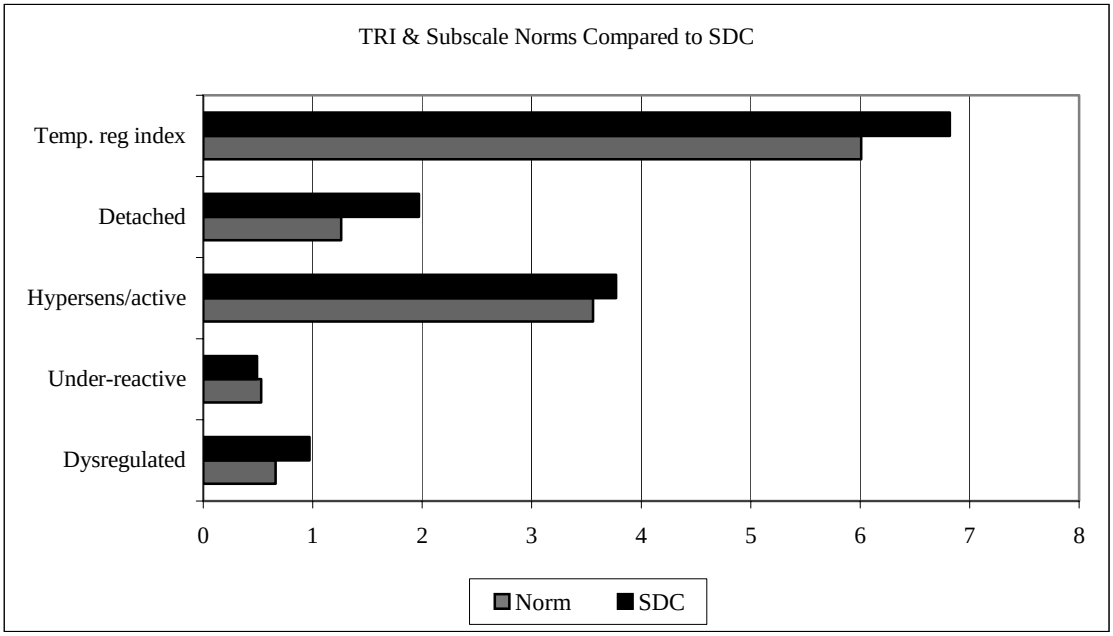
Where Parents Need Help. On the TABS, parents indicate problem areas; however, they also can indicate whether they feel they need help with a particular problem. The following areas were endorsed by the parents as areas in which they needed help with their children, based on the four dimensions of the TABS rating scale:

Table 4: Where parents felt they needed help with child management

Detached	Hyper-sensitive/ active	Under-reactive	Dysregulated
Incongruent emotions; resists eye contact; never starts on own to play with others; tunes out; disturbed by too much light, noise; overexcited in crowds; wanders around without purpose.	Anger and bossiness, throws & breaks things, doesn't sit still.	Doesn't pay attention to sights and sounds; doesn't react to own name; isn't upset when toy is taken away.	Often frightened by dreams or the night time; can't comfort self when upset; doesn't have a sleep schedule; too often needs help falling asleep

Comparison to Norms. Figure 2 below presents the data related to the SDC parent ratings of their child compared to norms for boys and girls (combined). On all dimensions with the exception of under-reactive, the group of children involved in this study was beyond the normative levels established (Bagnato, et al., 1999). As parents were not asked (in error) to identify the gender of their child in order to compare, the norms established for boys and girls were combined.

Figure 2: SDC Parent ratings of their child: compared to norms for boys and girls (combined)



Index of Parental Attitudes (Hudson, 1997). Thirty-nine participants completed this rating scale, with all but one scoring under the first cutoff score (30 + or – 5) and one exceeding it with a score of 35.30. Scores on the IPA were correlated with number of children ($r = .37$, $p = .01$), and the hyperactivity scale on the TABS ($r = .60$, $p = .000$) and dysregulation on the TABS ($r = .34$, $p = .03$). The IPA is particularly sensitive to parents experiencing multiple stressors and measures in particular the likelihood that a parent may respond to that stress in a manner that places the child at risk for maltreatment.

Discussion

Implications for the SDC Program: Impact ratings were generally positive however, data credibility is somewhat limited due to the length intervening between time of participation in the program and ratings of impact. As a result, a key recommendation to the SDC program was to build in an ongoing evaluative process such that data collection is more immediate and hence more valuable. This being said, the participants did have a number of comments related to program improvement (i.e., defer the dreaded 'weigh-in' to later in the session, not as soon as you walk in; include, as opposed to exclude, boyfriends/partners; attend to differences in needs of the younger versus older teen; and provide more assistance with needs beyond the infancy period). The objection to breastfeeding pressure was also a key point made not just of the SDC program but also in relation to public health nurse post-delivery follow-up. Programming which attends to the developmental stage of the youth parent may be needed to change attitudes in this area. Negative attitudes perceived by participants involving nurses, teachers and society in general were problematic for participants, suggesting a need for greater sensitivity to be directed to interactions involving young parents.

While the SDC program focus was on assisting through birth and delivery through support and education, it is clear from the results that the program and other community supports available to young parents (CFS, public health) are not impacting the delay of a second child. It is disconcerting that our young parents are having a second child within two years of the first, which is consistent with the literature (Williams & Sadler, 2001). This not only multiplies the stress the young parent is under but appears avoidable. When young parents are provided with more support with a focus on self-efficacy and their return to education has been facilitated, the occurrence of a second child has been reduced by 50% (Griffin, 1998).

A large percentage of youth parents in this study were lone parent females with multiple children which has implications for ongoing support needs. Lone parent families have the highest level of confirmed child maltreatment rates based on the Canadian Incident Study (Trocmé, et al., 2001). Additionally, growing up without a father has been implicated as a significant predictor of future teen pregnancy (Nowak, 2003). There is thus concern both immediately (risk for child maltreatment and lack of potential support from the father) and in terms of the future (regarding future rates of teen pregnancy). Male youth parents were not interviewed during this study and thus their involvement in the child(ren)'s lives was not evaluated.

The high level of at-risk (15%) and severe/atypical behavior (43%) children found in this study is support for initiatives targeting early years intervention. This study indicates that such support needs to offer strategies for dealing with challenging children

in combination with being prepared to deal with complex lives impacted by poverty, educational challenges and lone parenthood. This study clearly indicates there is need for mental health intervention to help parents cope with the challenging behavior that their children are displaying. Baby First, now known as Families First, is an option for families, however, this is a voluntary program that a parent/family must be screened into. Comprehensive prevention and early intervention efforts with high-risk children is recommended and research is indicating that every risk factor we can reduce matters (Appleyard, Egeland, van Dulmen, & Stroufe, 2005).

The psychosocial support needs of young parents and their children require a comprehensive approach as difficulties are encountered socially/emotionally (i.e., maternal potential for depression, child emotional/behavioral challenges, social isolation), physically (i.e., housing, daycare, transportation, engagement in physically active lives), mentally (i.e., continued education, employment), and spiritually (i.e., supportive relationships and engagement). Evidence supports the role of nursing in home visiting programs as opposed to paraprofessionals (MacMillan, 2000). The role of nurses/paraprofessionals with youth parents has not been a focus of selective attention.

Implications for Stakeholders

Clearly a number of obstacles lie in the path of youth parents, most particularly as they try to access child care, housing and make attempts to return to school. Collaborative efforts across multiple stakeholders (income security, housing authorities, schools, public health, and mental health services) are required to address the complex needs of our young parents to ensure healthy transitioning to adulthood and the preparedness of their children for school entry and for healthy child development in general. Reducing the obstacles that young parents perceive as they attempt to negotiate varied systems of income security, school divisions, and daycares (to name but a few) requires sensitivity of professionals employed in these areas such that they can provide advocacy for youth parents who clearly feel stigmatized within these systems. Collectively, community agencies and programs need to lobby for daycares within schools, or at least near schools such that youth parents can more easily address their educational needs.

Professional educational needs of nurses as well as social workers may benefit from a greater curriculum focus on the impact of pregnancy on youth, monitoring of parenting challenges for youth parents, and the role of supportive relationships in mediating some of the stressors that youth parents face. Greater attention to assessing developmental needs of the youth parent would also be implicated. As well, a focus on how their attitudes, which often reflect white, middle class values, influence their interactions with young parents. In one study, a professional's attitude was found to reflected the perspective that "children in care beget children in care" and subsequent interactions were biased towards greater assistance provision to those young parents perceived as having a greater potential to raise themselves out of 'working class backgrounds' (Rutman, Strega, Callahan, & Dominelli, 2002). Society cannot afford such biasing to seep into early intervention/prevention programs and policies, especially as they pertain to youth parents.

Limitations of the study

This study is compromised by the failure to attend to potential differences in support needs that may exist between the youth parent that is 13-16 versus the youth parent that is 17-19. It is critical that we begin to differentiate the youth parenthood experiences with due consideration for the developmental stage of the young parent (Coleman & Dennison, 1998). Retroactive recall of sessions held some time back is also problematic, however, more immediate evaluation is being built in. There was also no attempt to determine ethnic background in this study so cultural factors are not possible to determine.

References

Appleyard, K., Egeland, B., van Dulmen, M. H. M., & Stroufe, L. A. (2005). When more is not better: The role of cumulative risk in child behavior outcomes. *Journal of Child Psychology and Psychiatry, 46*(3), 238-245.

Bagnato, S. J., Neisworth, J. T., Salvia, J., & Hunt, F. (1999). *Temperament and atypical behavior scale: Assessment tool*. Baltimore, MD: Paul H. Brookes Publishing Co.

Canadian Institute of Child Health (2000). *The health of Canada's children*: *A CICH profile*, 3rd Edition. Ottawa, ON: Canadian Institute of Child Health.

Clinton, W. J. (1996). Memorandum on the welfare initiative for teen parents. *Weekly Compilation of Presidential documents*, *32*(20), 842-844.

Coleman, J., & Dennison, C. (1998). Teenage parenthood. *Children and Society, 12*, 306-314.

Collins, M. E., Lane, T. S., & Stevens, J. W. (2003). Teen living programs for young mothers receiving welfare: An analysis of implementation and issues in service delivery. *Families in Society*, *84*(1), 31-39.

Corcoran, K., & Fischer, J. (2000). *Measures for clinical practice: A sourcebook*. Third Edition, V. 1. NY: The Free Press.

Crean, H. (2001). School-based child care for children of teen parents: Evaluation of an urban program designed to keep young mothers in school. *Evaluation and Program Planning, 24*(3), 267-275.

Gfellner, B., & Jolly, G. (1998). Teen mother's needs, resources and supports. *Unpublished Report*.

Griffin, N. (1998). Cultivating self-efficacy in adolescent mothers: A collaborative approach. *Professional School Counseling*, *1*(4), 48-53.

Honig, A. S., & Morin, C. (2001). When should programs for teen parents and babies begin? Longitudinal evaluation of a teen parents and babies program. *Journal of Primary Prevention, 21*(4), 447-454.

Hudson W. W. (1997). *The WALMYR assessment scales scoring manual*. Tallahassee, FL: WALMYR Publishing Co.

MacMillan, H. (2000). Preventative health care, 2000 update: Prevention of child maltreatment. *Canadian Medical Association Journal*, *163*(11), 1451-1459.

Manitoba Health (1993). *Teen pregnancy in Manitoba*. Women's Health Branch.

Nowak, R. (2003). Absent fathers linked to teenage pregnancies. *New Scientist, 178*(2395), 13-14.

Robbins, C., & Streetman, L. (1994). Resolution of non-marital adolescent pregnancy and the transition to adulthood: Educational attainment and financial well-being. *Policy Studies Review, 13*(1-2), 141-156.

Rutman, D., Strega, S., Callahan, M., & Dominelli, L. (2002). Undeserving mothers? Practitioners' experiences working with young mothers in/from care. *Child and Family Social Work, 7*(3), 149-160.

Trocmé, N., MacLaurin, B., Fallon, B., Daciuk, J., Billingsley, D., Tourigny, M., Mayer, M., Wright, J., Barter, K., Burford, G., Hornick, J., Sullivan, R., & McKenzie, B., (2001). *The Canadian incident study of reported child abuse and neglect: Final report*. Ottawa, ON: Minister of Public Works and Government Services Canada.

Williams, E. G., & Sadler, L. S. (2001). Effects of an urban high school based child care center on self selected adolescent parents. *Journal of School Health, 71*(2), 47-53.

Wood, R. G., Bloom, D., Fellerath, V., & Long, D. (1995). Encouraging school enrollment and attendance among teen parents on welfare: Early impacts of Ohio's LEAP program. *Children and Youth Services Review, 17*(1-2), 277-307.

About the Author

Employed in mental health for 27 years and in the academic world since 1997, Dr. Ek has focused her interests on children and their early years. She has been involved in studies related to youth mentoring, youth firesetting, parenting youth, and Aboriginal Head Start. She has been involved with the former Centre of Excellence for Child and Youth Centred Prairie Communities and now with the Centre of Excellence for Child Welfare. The latter supported the evaluation of the Families First program in Manitoba. She is involved with Brandon's Early Years Committee and with Healthy Child Manitoba.