# Partnerships for Inclusion
~ Nova Scotia ~

**AN EVALUATION BASED ON THE FIRST COHORT
OF CHILD CARE CENTRES**

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ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

Partnerships for Inclusion – Nova Scotia
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INTRODUCTION

Recent bilateral agreements between the Government of Canada and provincial governments, and new funding to expand and improve early learning and child care across Canada, reflect solid commitments to expand access to high quality early learning and care programs that enhance children's development and are universally inclusive. As a consequence, there is considerable interest in learning about initiatives that can provide evidence-based examples of ways to enhance program quality and improve inclusion capacity that might be expanded or adapted in other jurisdictions.

This evaluation report describes the initial offering of an innovative approach, *Partnerships for Inclusion - Nova Scotia (PFI-NS)* that combines assessment, on-site consultation, and the provision of resources and personal support to directors and lead educators (head teachers) in preschool rooms in licensed child care centres. The project was designed to achieve two goals: (1) To improve overall program quality in child care centres, with a focus on promoting change in the preschool classrooms, and (2) to enhance child care centres' inclusion capacity and inclusion quality. Evaluation procedures were used to determine both immediate and longer-term impacts of this model on a first cohort of 22 child care centres in Nova Scotia that volunteered to participate in the program.

The 10-step model utilized in *PFI-NS* is based on a successful consultation model that was developed at the University of North Carolina at Chapel Hill, and was modified based on research and experience in Canada, particularly the work of Dixie (VanRaalte) Mitchell in developing the *Keeping the Door Open*[1] project in New Brunswick, Prince Edward Island and Saskatchewan. Funding for *PFI-NS* was provided by the government of Nova Scotia through an allocation of resources received under the terms of the Federal/Provincial/Territorial *Early Childhood Development Agreement*[2]. *PFI-NS* was administered by Early Intervention Nova Scotia (*EINS*) with additional support provided by Dr. Sharon Hope Irwin, SpeciaLink: The National Centre for Child Care Inclusion. The evaluation was conducted by Professor Donna S. Lero of the University of Guelph and Dr. Sharon Hope Irwin.

The *PFI-NS* project was run over the course of a year, beginning with a start-up and training phase in November/December 2002 and extending until November of 2003. The project coordinator, Ms. Carolyn Webber, and four inclusion facilitators (quality consultants), who were selected for their knowledge and experience, worked with a director and a lead preschool educator in each centre. Inclusion facilitators worked directly with centre staff, engaging them in collaborative action planning and providing a range of resources and support to facilitate improvements. Each director, lead educator and inclusion facilitator was trained in how to administer a well-known measure of overall program quality [the *Early Childhood Environment Rating Scale-Revised* (*ECERS-R*)][3] and

inclusion facilitators were trained to administer two additional measures[4] to assess progress towards the provision of high quality inclusive care for children with special needs.

The project included a baseline assessment followed by collaborative action planning, a 6-month period of active consultation and support, and a follow-up sustainability phase. Each inclusion facilitator worked with the director and a lead preschool educator in five centres to develop collaborative action plans to improve quality following the initial assessments, and provided consultation, workshops, resources, and direct personal support to enable positive change — usually on a weekly basis for about six months. A second set of assessments was made at the end of the active consultation phase and a complete report was provided to the director and lead educator to help them see where improvements had been made. The report to the centre and the second set of scores were used to develop a second collaborative action plan to promote continued improvement through a sustainability period of 4-5 months.

Descriptive information about the centre, inclusion experiences, and staff's education and attitudes was obtained from the director and lead educator at the beginning of the project. Measures of program quality, inclusion principles and inclusion practices were obtained at Baseline, at the end of the active consultation period, and after an additional 4-5 months.

The evaluation method used to assess the short-term and longer-term impacts of *PFI-NS* in this first cohort of centres involved assessing quantitative changes in program quality (using the *ECERS-R*) and inclusion practices and principles (using the 2001 versions of the *SpeciaLink Inclusion Practices Profile* and the *SpeciaLink Inclusion Principles Scale*) at three points of time:

❖ at Baseline, before or at the very beginning of the *PFI-NS* assessment and consultation process;
❖ at the end of the active intervention / support phase — Time 2; and
❖ approximately 4-5 months after the active support phase ended (the end of the sustainability phase — Time 3).

In addition to quantitative data collected at these three points of time, semi-structured interviews were conducted with directors and lead educators at the end of the active consultation period to capture their thoughts about the project and its impacts on staff, on programming, and on the children attending the centres. These interviews and the extensive case notes provided by the facilitators and project coordinator provided rich information about the change processes that occurred, and also provided contextual information that was useful for identifying what facilitated change and what acted as impediments or barriers. While no control group data were available, this multi-method approach provides rich information about the project and its impacts, based on a variety of data sources.

A BRIEF DESCRIPTION OF THE CENTRES AT BASELINE

The 22 centres that participated in this first cycle of *PFI-NS[i]* were drawn from five regions of the province: the Halifax/South Shore region, Dartmouth/Valley, Antigonish, Truro/Northern region, and Cape Breton. While not a statistically representative sample of centres in the province, the

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[i]   Two more cycles of *PFI-NS* have been offered in Nova Scotia, and a third is underway.

centres are a fairly diverse group in a number of ways. The majority of centres (68%) are non-profit, community-based programs, including some that operate as individual, stand-alone programs and others that are affiliated with another organization or service (a college or university, a military base, a community centre). One program offered child care and early education at more than one site. Two of the centres offered only full-day care; most offered both full-time and part-time programs. Some centres were purpose-built as child care centres, but a number of others are converted homes or are located in other buildings, many of which are not wheelchair accessible, especially if the centre is on more than one level.

The number of children that centres were licensed for ranged from as few as 21 to as many as 140. Half the centres in this sample were licensed for fewer than 50 children, including six (27%) that were licensed for fewer than 40 children. By contrast, five centres (23%) were quite large, licensed to accommodate more than 100 children.

The programs in this cohort of centres offered care to children of many ages. Infants from as young as 3 months of age to school-aged children up to and including 12-year-olds were included. The majority of programs (73%) provided care to children under two years old, including seven centres (32%) that offered care to infants under one year old. Slightly more than one third (36%) of the centres offered care only to children younger than 5 years of age, while the remaining two thirds accommodated school-aged children as well.

About half of the centres in the sample (55%) were described by their director as a "regular centre," while 45% were described as integrated or with contracted spaces. Those in the latter category are more likely to have had more continuous involvement in including children with special needs, one or more staff members with at least 5 years of experience with inclusion, and to have benefited from past or current relationships with community-based professionals. About one third of the lead educators had only recently begun to work with children with special needs, however. Most directors and lead educators evidenced fairly positive attitudes towards the principle of including children with special needs in child care programs; however all agreed that doing so effectively requires appropriate funding and support.

Program Quality at Baseline

Two measures of program quality (in actuality, quality within the particular preschool room that was the focus of the project) were used — the *Early Childhood Environment Rating Scale-Revised (ECERS-R)* and the *Caregiver Interaction Scale (CIS)*[5]. At Baseline, prior to the active consultation phase, the 22 centres averaged 4.56 on the full *ECERS-R* scale. A score of 4.5 would be interpreted as indicative of a mediocre level of quality by Harms, Clifford & Cryer, the developers of this assessment procedure, and is not atypical in North American samples. Individual centre scores ranged from a low of 2.4 to a high of 5.8 out of a maximum of 7. While only one of the centres scored in the inadequate range (less than 3.0), most centres (15 or 68%) had scores in the minimal to mediocre range (3.0 - 4.9), and only six centres (27%) had scores indicative of good to very good overall quality at Baseline. Average scores on the seven *ECERS-R* subscales at Baseline indicated that the educators in these centres were generally very positive and responsive to children and encouraged positive peer interactions. The average score on the *Interaction* subscale was 5.9, and this high score was confirmed by scores obtained on the *CIS*, which reflected generally high scores on an index of teacher Sensitivity and low scores on indices of observed Harshness and

Detachment. All other *ECERS-R* subscale scores averaged between 3.6 and 4.9, reflecting mediocre levels of quality. Average scores were lowest on the *Activities* (3.6) and *Language and Reasoning* (4.3) subscales, indicating a need to enhance curriculum activities and enrich language opportunities.

Inclusion Capacity and Inclusion Quality at Baseline

As mentioned previously, approximately half the centres in this sample were described by directors as integrated or having contracted spaces, thus a history of including children with special needs. Within the sample were centres that had little or no experience with inclusion and one centre that was recognized as a leader in the province with more than 25 years of experience as an inclusive centre. Eight of the 22 centres had a formal (written) inclusion philosophy at the start of the project. Despite this diversity, directors and staff shared the desire to extend their capacity to include children with special needs fully and comfortably in their programs and evidenced fairly positive attitudes towards the inclusion of children with special needs in community-based child care programs.

At the beginning of the project, 14 of the 22 directors said their centre had become more inclusive or more effective in including children with special needs in the previous seven years as a result of having additional personnel, such as resource teachers, stronger support for inclusion amongst centre staff, and more assistance from professionals. Despite this positive statement, 18 directors reported that inclusion at their centre has been limited or frustrated in the previous seven years by inadequate funding to support inclusion, staff not being adequately trained, and/or stress caused by additional workload and time demands on centre staff. Ten directors reported having turned down children with special needs in the past 3 years — four because they already had the maximum number of children with special needs they could support with additional resources, and six for other reasons, including lack of staff for 1:1 support for children who needed it, inappropriate physical access, and lack of funding or appropriate technical support.

Fifteen lead educators commented on their current (at Baseline) or recent experiences in working with one or more children with disabilities or complex health problems. Most described themselves as moderately successful in including children with special needs in their program. Their comments emphasized both their commitment to inclusion and the need to have appropriate resources in place (funding, human resources, equipment, training and support from professionals) to support their efforts.

Sixteen of the participating 22 centres had at least one child with identified special needs enrolled in the centre at the start of the consultation phase. In most cases only one or two children with special needs were enrolled in a centre; however two programs reportedly had four or more children with special needs attending. The children with special needs had a range of conditions — the most common of which were autism, speech and language problems, global or pervasive developmental delay and cerebral palsy. The nature and extent of support provided to centres by specialists and intervention agencies varied depending on the children's and staff's needs and the availability of support in the geographic area.

Three measures related to inclusion were obtained at each data point, when appropriate. At Baseline, of the 13 classrooms that included a child with special needs, 5 were assessed as having

inadequate provisions to support inclusion, while 8 classrooms were rated as having very good or excellent provisions to support inclusion using Item 37 of the *ECERS-R*. Measures of *Inclusion Practices* and *Inclusion Principles* on a centre-wide basis also showed considerable variability (with average scores of 3.3 and 3.6, respectively, out of a maximum of 5). Based on a composite *Index of Inclusion Quality* developed by Lero in an earlier study, 2 of the 13 classrooms/centres would be classified as evidencing high inclusion quality, one would be classified as evidencing low inclusion quality, and the majority would be in the moderate range.

The *Partnerships for Inclusion - NS* interventions in this cycle were focused primarily on enhancing program quality (and, hence, inclusion capacity) in participating centres. Specific efforts to improve inclusion practices were limited to a smaller number of centres, particularly when a child with special needs was in the preschool room or would be moving to that room, or improving inclusion practices was a high priority among the staff.

IMPACTS OF *PFI-NS* INTERVENTIONS

Program Quality as Assessed by the *ECERS-R*

The data clearly show strong, positive effects of the *PFI-NS* interventions on program quality at the end of the consultation phase that were maintained over a 4-5 month sustainability period. The average *ECERS-R* score increased from 4.57 at Baseline to 5.49 at Time 2 and 5.6 at Time 3. At Baseline, five centres (22.7%) had overall *ECERS-R* scores in the minimal or inadequate range (below 4.0); including one with an average score below 3.0; only five centres (22.7%) had scores of 5.0 or above. At Time 2 and Time 3, 80% of the 21 preschool rooms for which data were available[ii] had overall *ECERS-R* scores above 5.0, the cut-off that indicates good overall quality, including 5 classrooms that exhibited very good quality with scores above 6.0. None of the rooms scored below 4.0 at Time 2 or Time 3.

Statistical comparisons revealed highly significant differences between Baseline and Time 2 on total *ECERS-R* scores and on each of the seven subscales. Prior to intervention, average scores on 5 of the 7 subscales were in the mediocre range. At Time 2, average scores on all but one subscale, *Activities*, indicated good development-enhancing practices and experiences were observed, and by Time 3, all subscales scores averaged 5.0 or better. Scores on the *Activities* and *Program Structure* subscales showed the greatest average improvement. The specific items that showed the greatest average improvement from Baseline to Time 2 were:

- Item 25, Nature and science (average change of +2.71),
- Item 34, Schedule (+2.48),
- Item 3, Furnishings for relaxation and comfort (+1.86),
- Item 7, Space for gross motor play (+1.71), and
- Item 22, Blocks (+1.62).

In addition to tests of statistical significance, 13 of the 21 participating *PFI-NS* classrooms (61.9%) demonstrated an "observable change" in program quality between Baseline and Time 2, the end of

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[ii] One centre was excluded from analysis after the Baseline period because of multiple changes in the lead educator position. *PFI-NS* consultation was provided to the centre as a whole in this instance, rather than being focused primarily on one preschool classroom, as was the case in the other centres.

the active intervention period. An observable change is defined in the literature as a change from one quality category to another (i.e., a change from inadequate to adequate care or adequate to good quality care *or* an increase of 1.0 or more on the *ECERS-R* in centres that were already evidencing good quality care).

The fact that almost all centres showed some improvement is important, as it indicates that the *PFI-NS* model has positive effects across the range of centres, including those that started off with scores indicating overall good quality. Obviously, centres that had the lowest scores on the *ECERS-R* measure at Baseline had the highest potential for improvement.

Changes Made in Classroom Arrangements and Teacher Practices Related to Measured Quality; Comments on Effects on Children's Behaviour and Experiences

Directors and lead educators' responses to semi-structured interviews and the inclusion facilitators' case notes described the changes that were made in each area measured by the *ECERS-R*, changes in staff attitudes and behaviour, and corresponding changes observed in the children.

➢ *Space and Furnishings*: Changes in this area were often made first and provided a visible way to demonstrate how classrooms could be made more comfortable and attractive for children, with better organization of materials, more defined activity centres, and with child-related displays. Creation of a quiet area with soft furnishings, a more attractive and effective room layout, purchase of and/or better access to equipment and materials to support learning, more accessible materials, and better use of child-related displays were commonly reported. Directors and educators commented that these changes enhanced children's participation and enjoyment. The development of a quiet area was seen as one change that was particularly appropriate to enhance inclusion capacity.

➢ *Personal Care Routines*: 70% of directors and 80% of lead educators reported changed snack and meal time practices that enabled children to be more involved in helping and provided more comfortable, pleasant, and extended interactions between staff and children. Other changes included greater awareness and consistency in hand washing and toileting procedures and, in some centres, increased interaction between staff and parents during arrival and departure times.

➢ *Language and Reasoning*: A majority of directors and lead educators described changes related to staff interactions with children that promoted language development through the use of open-ended questions and more extended conversations, as well as greater awareness on the part of staff about the importance of doing so. Educators also reported becoming more encouraging of children's problem solving and interactions with other children. Forty percent of directors and 35% of lead educators also described improved access to books and more time spent reading to children, as well as rotation of books to ensure more varied content, diversity, and suitability to enhance children's development at different stages.

➢ *Activities*: A majority of directors and one third of educators reported development and expansion of different activity centres. Improvements were most notable related to dramatic play, art, science and nature activities, and music and movement. Directors, educators, and inclusion facilitators commented on staff becoming more creative, and the positive benefits they saw from adopting a more child-oriented curriculum approach.

➢ *Interactions*: Fewer changes were reported related to the nature of staff-child interactions, as this was an area of strength across the centres in this sample. Nevertheless, one quarter of directors noted that staff initiated more interactions with children and observed improved peer interactions, and 45% of lead educators reported being more focused on listening to and playing with the children. Thirty-five percent of educators reported that children were more often engaged in conflict resolution, were less confrontational, and were more cooperative with each other.

➢ *Program Structure*: Approximately half of the directors and lead educators commented that, as a result of *PFI-NS*, schedules were better planned and were more flexible, allowing smoother transitions between activities. Programs were said to have become more age-appropriate, to offer more choices for children, and to allow more time for small group activities. One in five directors and lead educators commented that their program was more inclusive of all children, including children with special needs, as a result of these and other changes.

➢ *Parents and Staff*: Sixty percent of directors and 30% of lead educators reported greater support for staff, including professional development, staff breaks, and more effective and consistent evaluation procedures. One quarter of directors and 20% of lead educators reported improvements in communication with parents, and, in some cases, increased parental involvement, as well as parents commenting on the positive changes that were being made in the centre.

Changes in Staff Attitudes; Creating Reflective Practitioners

Significant changes in staff awareness and attitude occurred in addition to, and concomitant with observed changes in the classroom environment and activities, the ways educators approached curriculum planning and teacher-child interactions. Directors, educators and inclusion facilitators made numerous references to the positive effects on staff awareness, attitudes and focus that occurred as a result of the project. Processes of assessing strengths and weaknesses, collaborative action planning, engagement in discussions with the facilitators and other centre staff, learning about new curriculum approaches and alternative ways of approaching activities, participating in professional development workshops, and receiving personal, responsive support from the inclusion facilitators that enhanced motivation and provided reinforcements resulted in many positive changes. Directors reported that, by and large, staff were more positive, more actively involved in their work, and more aware of how to deliver quality care to meet children's needs. Directors also described staff as more enthusiastic, focused and reflective about quality care, more knowledgeable, and more confident and involved in their work. Directors also reported that they had also benefited from the project in being better equipped to organize and evaluate staff, and in working more effectively with staff in their centre as a team to achieve longer-term goals.

For their part, lead educators also commented on the positive impacts the project made on themselves personally and on other staff. Almost half reported an improvement in attitudes, awareness and approach; most noted that they were more confident and comfortable in their abilities to meet the needs of children and parents and worked better as a team with other centre staff. Staff described not only increased knowledge and skills, but enthusiasm, personal and professional growth, a sense of renewal, and pride in the quality of care they were providing as a result of the changes they had made. The fact that most educators and centres were able to maintain the positive changes that had been made in the sustainability period, and in some cases continued to improve

towards longer-term goals, speaks to the fact that educators and directors remained committed and involved in monitoring quality and retained responsibility for its assurance.

Impacts of *PFI-NS* on Inclusion Capacity and Effectiveness in Including Children with Special Needs

Improvements in program quality and more child-centred practices can enable children with special needs to participate in child care programs more easily. However, other changes and additional resources are required to ensure that children with special needs will benefit fully and that staff are supported in their efforts. Three quantitative measures were used to assess changes over time in inclusion capacity and effectiveness, as well as specific questions posed to directors and lead educators in the semi-structured interviews at the end of the active consultation period. Additional insight was provided in inclusion facilitators' case notes.

There is evidence to support the statement that the interventions and support provided by *PFI-NS* enhanced centres' inclusion capacity, and improved inclusion effectiveness in *some* classrooms, but a more mixed picture emerges based on the quantitative measures that are specific to inclusion for a number of reasons. First, two of the three measures of inclusion effectiveness (Item 37 from the *ECERS-R*, and the *SpeciaLink Inclusion Practices Scale*) are only appropriate when children with special needs are both enrolled and present at the time of observation. While 15 of the 22 classrooms had at least one child with special needs attending at some point during the 10-11 month period of investigation, specific children with special needs came and left centres and sometimes transferred from one room to another within a centre. Consequently, only 8 classrooms had a child with special needs enrolled at all three data points, but not necessarily the same child or children. Secondly, considerable efforts were being made in most centres related to overall quality over the 5-6 month period of active consultation. In most centres, this absorbed the bulk of time and effort. Consequently, the project focussed particularly on improvements in overall quality as a way to address primary goals and to build a foundation for enhancing inclusion capacity. Facilitators did focus on inclusion practices and effectiveness in those centres and classrooms that were already evidencing high levels of overall program quality where children with special needs were present or were expected, and where staff indicated that improvements in inclusion effectiveness was something they wanted to address.

Improvements in inclusion capacity were evident in the ways that improvements in program quality and the educators' approach to working with the children more effectively allow children with diverse abilities and needs to participate in the program. For example, while creating a quiet area benefits all children, it is particularly helpful for children with autism or ADHD who often need a place to withdraw from the stimulation of a typical early childhood classroom. Similarly, adding picture labels, changes in program scheduling that lead to increased flexibility, the use of a curriculum approach that is more child-centred and child-initiated, and the provision and use of equipment that supports varying levels of development all enable centres and classrooms to more easily accommodate children with special needs who can participate at their own level of ability. Increased capacity was also evident in the fact that two thirds of directors and lead educators reported that they and their centre had become more accepting of including children with a broader range of special needs and that *PFI-NS* had increased staff's awareness and knowledge of inclusion principles.

While average scores increased modestly over time on the *SpeciaLink Principles Scale* and *SpeciaLink Practices Profile*, differences from Baseline to Time 2 and Time 3 were not statistically significant. (A revised version of both instruments has been developed that should increase the sensitivity of these measures.)[6] Given the fact that some centres had limited experience with inclusion, while others had more consistent involvement, changes in average scores may not appropriately capture improvements in these two different groups or in individual classrooms.

Despite the lack of quantitative data, inclusion facilitators' reports and the interviews provided examples of a number of centres and classrooms that made specific changes that enhanced inclusion effectiveness. These included the consistent use of individual program plans, more time spent in a relaxed and flexible manner with individual children with special needs, and the reduction of separate pull-out times in favour of more flexible accommodation of activities for several children together, thereby enhancing peer interactions between children with special needs and other children.

At the same time, it is fair to note that directors, lead educators and inclusion facilitators noted other changes in policies, funding and access to additional training and resources that are required to ensure that centres have the resources they need to effectively include more children with special needs. In summary, it would appear that *PFI-NS'* impact on inclusion effectiveness could be strengthened by more focused efforts and planning with centre directors and staff, but that structural modifications to ensure accessibility, additional staff training and on-going support, including extra staffing and additional funding provided in a timely manner, are other important aspects that require attention.

Wider Impacts: Diffusion Effects to Other Classrooms and Other Positive Effects

One of the major additional positive effects of *PFI-NS*, mentioned by 85% of directors and lead educators, was a positive diffusion of intervention effects into other centre classrooms. Staff in other centre classrooms became interested in the changes that were occurring and often expressed interest and enthusiasm in understanding how to better meet children's needs in their rooms. Positive centre-wide effects occurred, both as a result of shared information, materials and encouragement, but also as a result of the *PFI-NS* inclusion facilitators being willing to provide professional development workshops to all staff (and in some cases to parents, as well), and sharing materials with other staff. One third of the lead educators reported that staff in other rooms adopted activity ideas and improvements, made changes in room arrangements and in the playground, changed personal care routines, and became interested in curriculum changes. In fact, one of the suggestions made by directors and educators was that *PFI-NS* should be offered on a centre-wide basis when possible.

A second wider impact that was noted was improved relationships with parents and increased parental satisfaction. Thirty percent of lead educators specifically commented that the project had resulted in more positive and frequent communication with parents and that parents were more involved and satisfied. Comments about the impacts of *PFI-NS* changes on children's behaviour have been noted above.

A third wider impact of the project described by directors, educators, and inclusion facilitators is related to enhanced community involvement and networking among ECEs both within and across centres. In several cases, *PFI-NS* inclusion facilitators arranged for staff to visit other centres or

provided professional development workshops that were open to staff from several centres in the same region. In addition, the project sometimes forged stronger connections with other community professionals, particularly in support of more effective efforts to include children with special needs. These experiences provided for both formal and informal networking and information sharing, and, in some cases, led to a stronger sense of professionalism and community building among centres and their staff.

ENABLERS AND FRUSTRATORS OF POSITIVE CHANGES

One focus of the evaluation was to identify those factors that enabled positive changes to occur and what factors limited or frustrated positive change. Interviews with the directors and lead educators provided important information in this regard, as did the inclusion facilitators' rich case notes. Enablers included:

- The capabilities, sensitivity and resourcefulness demonstrated by *PFI-NS* inclusion facilitators in gaining trust and providing the kinds of support that enabled directors and child care staff to commit to the project. Their professionalism and friendship was critical to the success of *PFI-NS* and enabled staff to feel supported and valued. Their skills and knowledge were also essential.

- Directors who provided leadership and demonstrated their support for making positive changes and following through by doing their part to address issues important to staff;

- Early childhood educators' active involvement in the process and receptiveness to change;

- Early childhood educators' increased knowledge, skills and understanding of how they can provide effective learning environments and interact with all children to enhance their learning and development; and

- In some cases, access to funding and additional resources to support centres' efforts to include children with special needs by government and community professionals.

Significant barriers or challenges included:

- High rates of staff turnover and instability. In a number of cases this was a significant impediment to making positive changes and maintaining momentum. Over the long run, the recruitment and retention of skilled, committed early childhood educators who are compensated for their efforts is a critical systemic factor that must be addressed to ensure program quality and inclusion capacity.

- Inadequate funding to make major changes to programs, including those that would improve access and facilitate the full participation of children with a variety of special needs.

- Initial resistance on the part of some staff to making changes in long-established routines and practices; disagreement among staff and lack of effective team work in a few centres;

- Lack of recognition or compensation for the additional time that was required on the part of early childhood educators to fully participate in the project; lack of resources to centres to provide paid planning time or professional development opportunities; and

- Continuing or new uncertainties about the availability and adequacy of extra support funding to support centre's efforts to include children with special needs.

LESSONS LEARNED

A number of lessons were learned from this evaluation and the process of delivering *PFI-NS* supports to this first cohort of child care programs. These lessons suggest that this type of community-based intervention can be an effective means to enhance universally inclusive, high quality developmental early learning and care programs, but that it should be part of a more systemic policy approach that addresses recruitment and retention, access to appropriate training and professional development, and specific supports for including children with special needs effectively.

Lessons Pertaining to Improvements in Program Quality

1. There is clear evidence of the project's success in effecting improvements in program quality, and in engaging staff in a process of renewal.

    Improvements included those measured by the *Early Childhood Environment Rating Scale-Revised* (*ECERS-R*) and other changes in child care environments, teacher-child interactions, and staff attitudes and behaviour described by directors, lead educators and inclusion facilitators in interviews and case notes. By the end of the consultation period, 80% of centre classrooms received ratings indicative of good or very good quality, compared to only 27% of the preschool classrooms at Baseline.

2. Improvements in program quality were sustained over time.

    Improvements on all subscales and total *ECERS-R* scores were sustained for 4-5 months beyond the period of active consultation and, in some cases, continued. Staff involved in the project maintained their commitment and were able to act on their new knowledge and the collaborative actions plans for improving quality in which they had participated.

3. There were substantial diffusion benefits — *PFI-NS* had centre-wide impacts.

    Directors, lead educators, and inclusion facilitators reported that the benefits of the consultations tended to spread to other rooms in the centres beyond the individual preschool rooms that were the initial target of the *PFI-NS* intervention. Most directors, lead educators and facilitators felt, by the end of the project, that *PFI-NS* would be more effective if introduced on a centre-wide basis.

4. Sustainable quality in child care programs requires that systemic issues be addressed — *PFI-NS* is not a panacea.

    While centres were able to improve in many areas, they still faced challenges to enhancing quality and effectively including children with special needs. Staff turnover was a particular challenge in many centres, and was the biggest impediment to making and sustaining changes over the course of the project. Other concerns are lack of funding for capital improvements and to purchase materials and equipment, and opportunities for professional development that are locally available and of high quality. Many directors and staff also identified the need to be

assured that appropriate and timely access to additional funding and staff support will be available to support their efforts to include children with special needs, along with access to on-going training and support.

Lessons Learned about the Effects of *PFI-NS* on Inclusion Capacity

1. There was evidence of positive impacts of *PFI-NS* on directors' and educators' attitudes towards inclusion, their use of individual program plans to ensure children's continuing progress in making developmental gains, and staff comfort and confidence in being able to meet children's individual needs more effectively, but no clear improvements were noted across the full sample in the adoption of inclusion principles or specific practices. (The latter may reflect differences among centres with very different levels of experience with inclusion, limited time to address these issues with the six-month intervention period, and measurement difficulties.) Nonetheless, examples were evident of specific changes made to more effectively include individual children in specific classrooms and centres.

2. Improvements in centre and classroom environments and in teacher-child interactions benefit all children and enhance inclusion capacity.

    Lead educators and inclusion facilitators reported many positive impacts of the changes they made and their greater involvement with the children on children's behaviour and enjoyment. More flexible, child-centred programming is more suitable to accommodate children at different developmental levels and/or with varied rates of learning.

3. *PFI-NS'* impact on inclusion could be strengthened by more focused efforts and planning with centre directors and staff. Additional staff training and on-going support are also required. Centres must be confident that extra staffing and appropriate resources will be available, if needed, when children with special needs are enrolled.

4. Other issues must be addressed to ensure inclusion quality: trained support staff when children with disabilities are enrolled; environmental changes; access to specialized equipment; secure, prompt and adequate funding to support centres' efforts; additional staff training; and continuing and appropriate support from professionals are all needed.

Lessons Learned about Policy, Practice and Program Issues

1. *PFI-NS* is an example of the infrastructure that is needed to support program quality and inclusion capacity.

    PFI-NS was a time-limited experimental initiative that was provided to a small number of centres. It is an example of how provincial or municipal resources can be used to provide part of the community-based infrastructure that is required to support quality enhancement and its maintenance. It is unique in providing on-site assessments and resources "in situ" in ways that can have specific, visible impacts on programs. It can also play an important role in promoting greater professionalism and mutual support across child care programs and among early childhood educators. The project also helped build capacity among the inclusion facilitators/quality consultants who are in a position to help train others to participate across the province.

2. A resource such as *PFI-NS* can be particularly important when programs are under stress or during a period of major change.

3. *PFI-NS* requires significant involvement on the part of centre staff. Staff involvement should be recognized and compensated. Costs may be a barrier to participation and to improvements. One of the drawbacks to this model is that it may require substantial investments of unpaid overtime on the part of early childhood educators. Typically child care staff are not paid for preparation time or for attending staff meetings or professional development workshops after hours or on weekends. Releasing staff to participate in project activities requires hiring replacement staff — an additional cost to programs that have little discretionary revenue. Time and lack of funds to make quality improvements were both identified by directors and lead educators as impediments or problematic aspects.

   Policy makers who wish to facilitate centres' participation and recognize staff involvement might consider a stipend or budget for participating centres. Programs that make substantial improvements can be publicly recognized and reinforced. Staff who take on a leadership role as change agents and those who participate in many professional development workshops should also be recognized, with appropriate compensation and credits that are recognized as contributions to continuing professional education.

4. The importance of voluntary participation

   Discussions with the developers of the *PFI-NS* model and related initiatives suggest the importance of voluntary, rather than compulsory, participation by child care centres. Their view is supported by the findings that staff openness and engagement are foundational for success and that staff (and director) resistance is a major impediment to making positive changes.

5. The importance of administering quality enhancement programs through mechanisms that are arms-length from government

   This issue has also been discussed by the developers of the *PFI-NS* model, including Dixie (VanRaalte) Mitchell, who has extensive experience with a related program in New Brunswick. Their strong recommendation is to ensure that all *ECERS-R* scores and observations are treated as confidential information, with no sharing of such information with licensing officials. This approach is seen as critical for developing and maintaining trust and for ensuring honest and frank discussions about necessary quality improvements (the only exception being unusual circumstances that endanger children's health and welfare).

6. *PFI-NS* and related initiatives can be a component in Program Accreditation

   A number of jurisdictions are implementing or considering implementation of accreditation processes to promote centre quality. Accreditation is a voluntary system that uses external measures and criteria as a basis for determining whether a program meets specific standards indicative of high quality. Programs may or may not have access to funding and resources to assist them to meet accreditation criteria and subsidize the expenses of applying for accreditation. In some jurisdictions, accredited centres (and home day care providers) are eligible for higher per diem rates or other additional benefits.

   It is possible to easily use the *PFI-NS* approach as a component within an accreditation system. Specifically, the model offers centres an important vehicle for making the kinds of quality

improvements that would be included in accreditation criteria. Further, *PFI-NS's* attention to inclusion practices is unique and would add additional support to this aspect in an accreditation model. In effect, participation in *PFI-NS* processes and the use of the *ECERS-R* and other objective measures could easily support an accreditation approach and provide participating centres with additional recognition and reinforcement for participating. It also works on its own, however, without orienting to an external agent for validating the quality improvements centres make when empowered and supported to do so.

Lessons Learned for Further Research

1. The importance of continuing research

    The current study was an evaluation of the first trial of a new program to enhance program quality and inclusion capacity in Nova Scotia child care programs. The small sample size and lack of a randomized control group are limiting factors in this evaluation. Multiple methods and the use of a well-known and widely used instrument to assess quality and quality improvements are strengths.

    Further offerings of this project will provide additional opportunities to confirm the very positive impacts observed to date. Variations from one cycle of centres to another can also be studied as part of an on-going project that could gauge, for example, the effects of providing *PFI-NS* on a centre-wide basis from the start. Comparisons to related programs in other jurisdictions should also be useful, particularly since they would provide the opportunity to assess how differences in program implementation affect outcomes. In particular, no studies have compared such programs using planned variations in the frequency of visits or the nature of support provided, or with or without a stipend provided to centres.

2. Maintaining the integrity and usefulness of the research process

    This evaluation has suggested the importance of ensuring research integrity and research utility. Research integrity would be enhanced by having an independent person, other than the inclusion facilitator who works with a centre, participate in assessments. A second recommendation is the importance and evident value of having an external individual collect information on changes made, and on enablers and impediments to improvements from centre staff. These interviews provided an important window on the change process and provided unique information that informed this evaluation.

3. Assessing impacts on children and parents

    Another possible extension of this research would be to examine the impacts of program improvements and more effective inclusion practices on children and parents — particularly children with disabilities. These outcomes are important to capture well, since critical policy goals encompass ensuring that early learning and child care programs are both more universally inclusive and of high quality.

4. Studying program expansion and maturity

    Further follow ups and additional cycles of the project will evidence the processes that mark expansion and program maturity. It is important to study how initiatives like this can be ramped

up and expanded without losing their uniqueness, and what lessons we can learn from the facilitators as they gain more experience with a wider range of centres. In particular, it will be important to examine how *PFI-NS* changes if it becomes an on-going program, rather than a time-limited initiative or if it changes in any other significant way.

End Notes

1   (VanRaalte), Mitchell, D.L. (2001). *Keeping the door open: Enhancing and monitoring the capacity of centres to include children with special needs*. NB: New Brunswick Association for Community Living.

2   Government of Canada (2000). *Early Childhood Development Agreement*. Reports and background documents are available at http://www.socialunion.gc.ca/menu_e.html.

3   Harms, T., Clifford, R. M., & Cryer, D. (1998). *Early Childhood Environment Rating Scale - revised edition (ECERS-R).* N.Y.: Teachers College Press, Columbia University.

4   Irwin, S.H. (2001a). *The SpeciaLink Inclusion Practices Profile*. In S. H. Irwin, D.S. Lero & K. Brophy. *Inclusion: The next generation in child care in Canada* (Appendix A). NS: Breton Books. Available from Web Site: http://www.specialinkcanada.org.

     Irwin, S.H. (2001b). *The SpeciaLink Inclusion Principles Checklist*. In S. H. Irwin, D.S. Lero & K. Brophy, *Inclusion: The Next Generation in Child Care in Canada* (Appendix B). NS: Breton Books. Available from Web Site: http://www.specialinkcanada.org.

5   Arnett, J. (1989). Caregivers in day care centers: Does training matter? *Journal of Applied Developmental Psychology 10*: 541-552.

6   Irwin, S.H. (2005). *The SpeciaLink Child Care Inclusion Scales (Revised).* Available from Web Site: http://www.specialinkcanada.org

PREFACE: AN INTRODUCTION AND GUIDE TO READING THIS REPORT

This report describes the initial offering of an innovative approach that combines assessment, on-site consultation, and the provision of resources and personal support to 22 child care centres in Nova Scotia. The project, named *Partnerships for Inclusion - Nova Scotia (PFI-NS)*, is based on the successful *Partnerships for Inclusion* model developed at the University of North Carolina, Chapel Hill by Palsha and Wesley[1] and was adapted through experiences gained in Canada through the *Keeping the Door Open* project led by Dixie (VanRaalte) Mitchell.[2] The project benefits from knowledge gained from research and practice on inclusion quality in Canadian child care centres and the leadership provided by Dr. Sharon Hope Irwin, Executive Director of SpeciaLink: The National Centre for Child Care Inclusion. Funding was provided by the government of Nova Scotia through an allocation of resources received under the terms of the Federal/Provincial/Territorial *Early Childhood Development Agreement (ECDA).*[3]

This evaluation study was designed to test the effectiveness of this model that combines training, assessment, consultation and support in order to achieve two goals: (1) To improve overall program quality in child care centres, with a focus on promoting change in the preschool classrooms, and (2) to enhance child care centres' inclusion capacity and inclusion quality.

The *Partnerships for Inclusion - Nova Scotia* project was run over the course of a year, beginning with a start-up and training phase in November/December 2002 and extending until November of 2003. The project coordinator, Ms. Carolyn Webber, and four trained "inclusion facilitators" worked with a director and a lead preschool educator in each centre that volunteered to participate. Each director, lead preschool educator and inclusion facilitator was trained in how to administer a well-known measure of overall program quality and inclusion facilitators were trained to administer two additional measures to assess progress towards the provision of high quality inclusive care for children with special needs. The inclusion facilitators worked with the director and centre teachers to develop collaborative action plans to improve quality following the initial assessments and the facilitators provided consultation, workshops, and direct personal support to enable positive change. A second set of assessments was made at the end of the active consultation phase and a complete report was provided to the director and lead educator to help them see where improvements had been made. This report and the second set of scores were used to develop a second collaborative action plan to promote continued improvement beyond the active consultation period.

The evaluation method used to assess the short-term and longer-term impacts of *PFI-NS* in this first cohort of centres involved collecting extensive data on the centres initially, and on program quality and inclusion practices at three points of time:

❖ at Baseline, before or at the very beginning of the *PFI-NS* assessment and consultation process;
❖ at the end of the active intervention / support phase; and
❖ approximately 4-5 months after the active support phase ended (the end of a sustainability phase).

In addition to quantitative data collected at these three points of time, semi-structured interviews were conducted with directors and lead educators at the end of the active consultation period to

capture their thoughts about the project and its impacts on staff, on programming, and on the children attending the centres. These interviews and the extensive case notes provided by the facilitators and project coordinator provided rich information about the change processes that occurred and also provided contextual information to assess what facilitated change and what acted as impediments or barriers. This information also contributed to the identification of lessons learned from this initial offering of the *PFI-NS* model, including ways to enhance success with future cohorts of centres in Nova Scotia and in similar programs in other jurisdictions.

This report includes seven chapters.

- Chapter 1 provides historical and contextual background on the history of inclusive child care across Canada and efforts to support inclusive child care for children with special needs in the province of Nova Scotia.
- Chapter 2 describes the development and features of the *Partnerships for Inclusion - Nova Scotia* model as utilized in this first cohort of centres and describes the role of the inclusion facilitators as change agents.
- Chapter 3 describes the methods used to conduct this evaluation and the specific measures used to assess program quality and centres' inclusion principles and practices.
- Chapter 4 provides additional descriptive information about this sample of centres, Baseline data on centre and classroom quality, and information about centres' inclusion capacity at Baseline as informed by responses to director and staff questionnaires and the scores obtained on Baseline assessments of inclusion principles and practices.
- Chapter 5 presents evidence of both short-term and longer-term improvements in program quality and inclusion capacity based on analysis of the quantitative data and director and staff responses to semi-structured interviews at the end of the consultation period.
- Chapter 6 describes the factors that promoted and impeded positive changes as described by centre directors, lead teachers and inclusion facilitators.
- Chapter 7 extracts the Lessons Learned from this first intervention cycle and provides some suggestions to improve the process and outcomes in successive offerings.

End Notes

1   Palsha, S.A. & Wesley, P.W. (1998). Improving quality in early childhood environments through on-site consultation. *Topics in Early Childhood Special Education*, 18:4, 243-253.

2   Mitchell, D.L. (VanRaalte). (2001). *Keeping the door open: Enhancing and monitoring the capacity of centres to include children with special needs*. NB: New Brunswick Association for Community Living.

3   Government of Canada (2000). *Early Childhood Development Agreement*. Reports and background documents are available at http://www.socialunion.gc.ca/menu_e.html.

CHAPTER 1: BACKGROUND TO *PARTNERSHIPS FOR INCLUSION - NOVA SCOTIA*

1.1 A SHORT HISTORY OF INCLUSIVE CHILD CARE ACROSS CANADA

It is important to understand the history of inclusive child care across Canada if we are to understand its current context in Nova Scotia and, perhaps, avoid repeating previous problems.

As we see it, the **1950s** provide the earliest benchmark for inclusive child care and can be characterized by "behaviourism, antibiotics, and *Brown versus the Board of Education*." The behaviourists proved that anyone could learn, provided tasks are broken down into their smallest units, repeated to mastery, and reinforced for success. This gave hope to parents and to staff who worked with people with intellectual challenges that their children and clients could learn more than previously expected. The availability of sophisticated antibiotics meant that children born with physical disabilities and long-term health conditions were likely to have much longer life spans than previously anticipated. Both of these advances suggested that there were other options for parents of children born with disabilities than the traditional two — take him home and care for him or institutionalize her and have another child. And, finally, the U.S. Supreme Court decision on *Brown vs. the Board of Education*[4] signaled in the strongest terms the inherent injustice of segregation. Although *Brown* was a U.S. decision and was related to racial segregation, it was to have a profound influence on other disadvantaged groups, including persons with disabilities.

The **1960s,** from the perspective of inclusive child care, focused on the first and second themes — "behaviourism" and "antibiotics," and gave rise to developmental preschools (for children with intellectual challenges) and child development centres attached to rehabilitation centres (for children with physical disabilities). Mainly driven by parent volunteers, the developmental preschools were generally part-day programs, free to eligible children, and based on huge amounts of volunteer labour for fund-raising, transportation, and assistance in the classrooms. Still, many children (including those who were blind, Deaf, autistic, with special health care needs or aggressive, and those who were "difficult to care for") were either sent to special schools or programs or were simply ineligible for enrollment in any preschool program. The issue of "integration" was minor during the 1960s, as program advisors and staff concentrated on the new techniques of task analysis, mastery learning, and positive reinforcement. Targeted preschool programs were also the societal norm in the U.S. Head Start program (for poor children) and in remedial Canadian programs for the same population.

By the **1970s,** with the advent of federal programs such as the Canada Assistance Plan, the Local Initiatives Program, and Canada Works, and dramatic increases in maternal employment, licensed child care expanded rapidly in Canada. During the same decade, a visiting scholar to the Canadian National Institute on Mental Retardation, Wolf Wolfensberger (1972)[5] was educating a generation of Canadian researchers, parents and advocates about the injustice and ineffectiveness of segregation for persons with intellectual disabilities, generalizing *Brown vs. the Board of Education* to persons with disabilities, from people of racial minoritie*s*. Although it would be many years before most Canadian Association for the Mentally Retarded (CAMR) locals (now renamed the Canadian Association for Community Living) would disband their specialized preschools or integrate them into community-based programs, another voice had taken up the

theme of *Brown*. As well, it was obvious to parents of children with disabilities that the part-time segregated preschools could not easily be transformed into full-day programs, since they usually occupied space without kitchens, playgrounds, nap rooms and the like. Thus, by the mid- or late-1970s, *some* community-based child care centres were including *some* children with special needs. Provincial policy documents from that period provide evidence of some flexibility of structuring and funding such spaces, generally in a fairly reactive, rather than proactive way. Child care curriculum development for children with special needs was generally characterized by an attempt to mimic the processes current in special education and clinical settings — namely "pull-out sessions" for skill development, hopefully followed by generalization of those new skills into the classroom settings. The Individual Program Plan (IPP) became a widely used tool for measuring and monitoring child progress.

The **1980s** saw further growth in maternal employment, as well as continuing growth of licensed child care in Canada. Obviously, mothers of children with special needs had the same needs for child care as did mothers of typically developing children. The decade saw expansion of policy initiatives around "integration" or "mainstreaming" in child care, as well as the beginnings of specialized training about "children with special needs in child care." Increasingly, community-based child care centres were voluntarily expanding their mission to include children with special needs, and they were often able to hire "special needs workers" who had previously worked in the specialized preschools and were familiar with behavioural techniques, mastery learning, and reinforcement for success. "Pull-out" or "resource time" continued to be seen as the most effective way of teaching skills to children with special needs.

1990 provides a benchmark for mainstream or integrated child care. At that time, the *In-House Resource Teacher model*[6] seemed to be the state of the art. A centre might now have an integrated license (Ontario) or contracted spaces (British Columbia) or, through more informal funding arrangements, the capacity to include a resource teacher (special needs worker, support staff) on staff, in addition to the regular ratio. The centre would then be obligated to enroll a specified number of children with special needs (usually four). Training increased for integrated child care, with resource teacher training programs in Ontario, a post-diploma special needs credential in British Columbia, and variations of these in other provinces. National, provincial, and local child care conferences increasingly included workshops and pre-conference day-long sessions on issues related to child care inclusion. The emphasis in training began to move toward embedding skill development into the natural activities of the centre and into the idea that accommodation and adaptations could make it possible for *all* children to learn within the group. Many therapists had moved from a clinical model of skill development to providing therapy that focused on functional skills in natural settings; the child care centres followed (or even preceded) this change in orientation.

By the middle of the decade, another model of child care inclusion support was expanding rapidly. Sometimes called the *Itinerant Resource Teacher model*,[7] sometimes called the *Resource Consultant model*, this model evolved as an answer to the question of how parents of children with special needs could have the same range of child care choices that other parents had. Parents of children with special needs would speak about the inconvenience of travel to the integrated child care centre across town, compared to the nearby centre all of their other children had attended. As well, with the fiscal constraints of the mid-decade, policymakers were searching for ways to serve the increasing number of children with special needs whose parents

requested enrollment by using the same dollars differently. However, it was obvious that if "the supports follow the child," a different system of inclusion support would have to be developed. The economies of scale of four children with special needs being enrolled in one setting would no longer exist — these four children might be scattered in four different settings. In addition, there was increasing pressure to include children with special needs from waiting lists. Thus, there was an evolution toward the Itinerant Resource Teacher model, providing a range of services including direct service, consultation, modeling, information, equipment loans, in-service training, and provision of contract staff when and where needed, budget permitting. In some jurisdictions, the In-house Resource Teacher model remained or expanded, generally with a focus on centres that regularly enrolled at least four children with special needs.

The Itinerant Resource Teacher or Resource Consultant model thus presumes that most community-based child care programs can include children with special needs if appropriate resource support is provided in the form of child-specific training and support to staff. The nature and duration of assistance (which may include an aide who facilitates individual children's participation) is based on the views of the resource consulting agency, with variable amounts of input from the child care staff, and is limited by the financial and human resources available to resource consulting agencies.

(It should be noted that the evolution to inclusive education followed much the same path over the same period, as did inclusive child care. The education system evolved from exclusion of children with certain levels and types of disability to specialized, self-contained schools for the handicapped, to special education classes within schools, and then to "pull-out" for academic learning, but inclusion for homeroom, gym, art, playground and lunchtime. By the mid-1990s, parents and advocates were no longer willing to see their children ride on "the handicapped bus" to a school outside of their community, regardless of the special skills of the teachers there. *Eaton versus the Brant Board of Education*,[8] a Canadian case that went to the Supreme Court, summarizes the positions very well. As with the role of the special needs worker or resource teacher in child care, the issue of the role of the educational assistant in education also remained contentious.)

By the year 2000, federal/provincial/territorial government support for child care and, specifically, for inclusive child care, seemed to be on the upswing. After the cutbacks and reorganization in the middle of the 1990s, the *National Children's Agenda* (1997)[9] seemed to signal a new interest in the well-being of Canada's children, initially focusing on children from birth through six years of age and, after substantial lobbying by families and advocacy organizations, emphasizing children with special needs. The *Early Childhood Development Agreement* (2000)[10] provided direction for the first stage of the *NCA*, with funding for pre-natal, early childhood development, and parenting services. The *National Child Benefit* (1998)[11] program paid direct dollars to low-income working parents and, in most provinces, "clawed back" equivalent dollars from parents on social assistance, using these dollars for reinvestments in a wide range of early childhood programs and services. The *Multilateral Framework on Early Learning and Child Care* (2003)[12] targeted dollars directly for regulated child care, and used the term "inclusivity" as one of its five principles. Transparency, third party monitoring and accountability are mentioned repeatedly in the documents. In 2004, "early learning and child care" became a key plank in the federal Liberal Party platform, as well as in that of the New Democratic Party. The minority government that was elected under the leadership of the

Honourable Paul Martin has continued to work to forge bilateral agreements with the provinces and territories to guide spending of 5 billion dollars on regulated child care based on the *QUAD* principles — Quality, Universally Inclusive, Accessible, Developmental as a means of developing a national system of early learning and child care.[13] The government of Nova Scotia affirmed its commitment to these principles upon signing a bilateral agreement on May 16, 2005[14] and has outlined its initial priorities in that agreement. Federal and provincial/territorial governments have also agreed to develop an accountability framework to ensure that funds are used to achieve the desired outcomes specified in these agreements.

1.2 A SHORT HISTORY OF RESOURCE SUPPORT TO CHILD CARE CENTRES IN NOVA SCOTIA TO INCLUDE CHILDREN WITH SPECIAL NEEDS

In Nova Scotia, there are no policies, legislation, or regulations that assure that parents caring for children with special needs have access to child care. It is up to the individual centre to decide whether or not a child with disabilities will be included. If the centre is agreeable, the government may (budget permitting) provide funding to any licensed non-profit or private centre to support the child with special needs. While there are general guidelines with regard to inclusion, these have had little impact on practice. Nonetheless centres, both private and non-profit, often have been willing to accept children with disabilities (Roeher Institute, 2003).[15]

Public funding of child care in Nova Scotia began in 1972 under the *Canada Assistance Plan*, in compliance with the *Day Nurseries Act* of 1967.[16] Children with exceptionalities are defined in the *Regulations of the Consolidated Daycare Act of 1978* [17] as "child(ren) who ha(ve) a mental, physical, emotional, sensory-motor or learning handicap which, if the full potential of the child is to be realized, requires early intervention to prepare the child for entry into appropriate school placements," and, under its provisions, "The Minister may license a facility to provide a day care program for exceptional children."

Segregated child care centres and preschools were set up in various regions of the province in the early 1970s. The funded "differentials" (funding per child/per day based on costs above "regular" child care or preschool costs) in those segregated centres were budget-based and significantly higher than those in community-based centres that were set on a province-wide basis.

By the mid-1970s, a number of community-based child care centres were including *some* children with some levels and types of special needs through funding from a variety of short-term grants, such as the Local Initiatives Program (LIP), Canada Works, summer student employment programs, Manpower Industrial Training Programs, and the like. Volunteers and students on practicum placements were also utilized to support the attendance of children requiring extra support. It is also clear that many day care centres and nursery schools periodically included *some* children with disabilities without additional staffing, because they felt it was the right thing to do, and that it could and should be done. (In the literature, these children are sometimes referred to as "invisible children" — not counted among those with disabilities enrolled in child care, because they are not connected either to "differential funding" or to formal consultative services.) Within this developing movement for integration, directors of community-based centres who saw enrolment of children with special needs as a *right*, not as a *privilege*, felt frustrated that differential funding could only go to segregated specialized centres, even if

children with the same level and types of disabilities were present in their programs.

When the Nova Scotia government accepted the recommendations of the 1979 *Task Force on Day Care,*[18] twelve integrated day care spaces were funded with differentials in one community-based centre as a developmental centre, and five portable integrated day care spaces were made available for use in any non-profit centre in the province. That number was increased by five further spaces under the *1983 Task Force on Day Care,*[19] which also recommended that the need for additional spaces for handicapped (sic) children be reviewed annually, and (that) the number of differentials be increased to meet any increase in need. From 1993 through 2000, 10% of any allocation of additional subsidized spaces was budgeted for children with special needs. A different funding mechanism was developed after that date, and additional differentials have been provided in a less transparent manner. In addition, the requirement that differentials be used only in non-profit centres ended in 2000, at which time the differentials became portable to any licensed child care program (whether non-profit or commercial).

In 2004, 521 supported spaces were funded for children with disabilities, of which 85 were attached to developmental centres, and 436 were portable. While this allocation provides additional parental choice, it has led to unevenness in both inclusion quality and global quality, since neither the centres themselves nor Early Childhood Development Services have the capacity to garner appropriate consultative services and appropriately trained personnel or to monitor the effectiveness of the interventions provided to children with disabilities across all the programs.

1.3   TRAINING IN SPECIAL NEEDS AND INCLUSION

In the 1970s and 1980s, most Early Childhood Education training programs in Nova Scotia included very limited offerings in special needs or in inclusion strategies. In the 1990s, all ECE training programs had begun to embed special needs into many of their courses, and usually included at least one course specific to special needs/inclusion in their regular diploma program.

In 1975, Mount St. Vincent University introduced a 2-year certificate in Child Development. By 1979 this had evolved into a four-year degree program with four specializations — Teaching Young Children; Child Care Programs; Administration and Development; and Working with Atypical Children. In 1980, Child Study students could choose specializations from: 1. Developmental Disabilities, 2. Development and Administration of Early Childhood Programs, 3. Teaching Young Children (grades primary to three), and 4. Special Education of Young Children (education program at Acadia University). An independent Department of Child Study was established in 1981, as it had previously been housed in the Education Department. In 1991, the department added a child and youth care specialization for the first time. The name of the degree was changed in 1992 to Bachelor of Applied Arts, Child and Youth Studies. In 1994, admission requirements to all B.Ed. programs were changed in Nova Scotia to require a first degree, thereby requiring Child and Youth Studies students to complete their degree prior to being admitted into a B.Ed. program and eliminating the education specialization.

Today all students in the Child and Youth Studies program are required to take core professional and academic courses that include a birth-through-adulthood emphasis, as well as courses that have content specific to youth, special needs, and early childhood. All students complete at least 500 hours of supervised practicum experiences. Students are also required to complete a special needs

placement and 2 half courses in special needs. In addition, special needs topics are embedded into all courses. In 2006, it is anticipated that new courses in communication, early intervention, child life and autism will be added to the program.

A Master's Degree in Child and Youth Studies has been offered since 1999. Core courses in contemporary social issues, developmental issues, leadership, and programming with a child and youth focus are required of all students. Thesis research is highly individualized.

The Institute for Human Services Education (formerly the Institute for Early Childhood Education and Developmental Services) offered a two-year diploma in ECE from its inception and added a 3rd year post-basic diploma program in Special Needs in 1987. This program continues, but because of lower enrollments, the Institute is considering offering it on a full-time basis only every other year. The Institute has plans to offer a customized ECE Inclusive Education certificate to a group in Halifax in 2005-2006 on a part-time basis in the evening as an alternative to the 3rd year Special Needs Diploma.

In 1986 the Kingstec branch of the Nova Scotia Community College added an optional post-diploma one-year program to follow the one-year ECE diploma program. The post-diploma program consisted of a two-part focus: working with children with special needs and managing early childhood programs. At that time, according to the instructor, she believed that theirs was the only full-time program focusing on children with special needs, with the exception of what was offered at Mount St. Vincent as part of their 4-year degree in Child Studies. She felt that there was a very strong need to offer a program for pre-service ECE students who were not pursuing a degree. She approached the principal at the time and he suggested a one-year pilot. That one-year pilot evolved into a relatively small full-time program option. Many students were very disappointed to see its discontinuation in 2000, but when the Early Childhood Studies program became a two-year program there were insufficient faculty to continue offering it. The two-year diploma program includes a 6-hour course on special needs, along with embedded material in other courses.

St. Joseph's College of Early Childhood Education opened in 1970 as St. Joseph's Early Childhood Education Training Program. The one-year diploma program included a course in special needs right from the beginning. Now called St. Joseph's College of Early Childhood Education, the college provides a two-year diploma program, and intends to introduce a post-diploma in special needs in the near future.

Periodic workshops, often facilitated by staff who had worked in segregated preschools for the handicapped and who typically had been trained in Mental Retardation (sic) or as Human Services Workers, began to appear on conference agendas in the late 1970s and early1980s, emphasizing such strategies as task analysis and mastery learning. During that period, therapists occasionally made presentations at these workshops, focusing on their professional roles. By the early 1990s, occasional conferences and presentations by inclusion advocates and experts began to replace the earlier special needs sessions, which tended to focus on pull-out or one-to-one strategies.

1.4   CONSULTATIVE SUPPORT AND IN-CENTRE SUPPORT STAFFING

No formal consultative support for community-based centres enrolling children with disabilities was available during this period. Centres seeking "differentials" for children with special needs

were required to submit individual program plans (IPPs) for each such child, and to explain how the additional funding would be used. It was assumed that expertise in IPP design and in child assessment would be accessed from disability organizations, children's treatment programs, etc. The expanding network of early intervention programs across Nova Scotia often played a role in finding child care programs for their children and in helping families and centres through a transition process. By the early 1990s, some early intervention programs, notably The Progress Centre for Early Intervention in the Halifax Regional Municipality, were playing a more formal transition and coordinating role.

In other regions of the province, some of the other early intervention programs informally provide at least transition consultation, as children leave their programs and enter child care or preschool. As early as 1978, for example, the AllKids Early Intervention Program in Cape Breton was providing consultative services, equipment, and half-day staff to centres that agreed to enroll children with special needs. And to some extent therapists, such as occupational therapists, physiotherapists, and speech and language pathologists, also perform some of these functions, but their role is generally more limited to therapy and to IPP meetings. Itinerant resource teachers from the Atlantic Provinces Special Education Authority (for children with visual and auditory disabilities) also provide on-site services and consultation at child care centres and preschools for individual children on their caseload, but their role is often limited to a focus on school readiness.

It should also be noted that *ad hoc* resource teachers have been employed in a number of the larger child care centres across Nova Scotia for at least twenty years. In centres where at least four children with disabilities are regularly enrolled, the "resource" position has tended to be filled by a staff person with both experience and training in special needs and inclusion. These centres included, but were not limited to, Children's Place in Antigonish, Pictou County Child Care Centre, Dartmouth Day Care, Colchester Community Day Care, Little People's Place in Shelburne, the Yarmouth Boys and Girls Club and Amherst Day Care. The resource coordinator at Town Daycare in Glace Bay has held that position since 1977! Until the development of a wider range of early childhood development services and programs, the career ladder for these early childhood resource teachers, as well as for other ECEs, had been was very limited. Thus, many of these staff stayed in their positions for fifteen or twenty years, keeping inclusion capacity quite high.

Unlike Ontario and British Columbia which encouraged the growth of "integrated" centres during the late 1970s and throughout the 1980s by budget-basing a resource teacher (or extra staff person) for every four "eligible" children with disabilities, the Nova Scotia government provided case-by-case differentials to child care centres that enrolled children with disabilities (except for the developmental centres, where case-by-case funding was also provided, but where a designated number of spaces was guaranteed). However these larger centres with pro-integration directors all decided, often unbeknownst to each other, to develop an in-house resource teacher model and to keep that person on staff, despite the comings and goings of different children with disabilities.

With the encouragement of Early Childhood Development Services staff and their guidelines for inclusive programs, other centres that now more regularly include children with disabilities are developing greater resource capacity — training one staff in special needs, assigning an interested ECE to the position, or hiring staff with the post-basic specialization in special needs, where possible. Thus, often the "differential" pays for a contract staff person to work as a

"regular" staff member while the ongoing resource staff does the paperwork and develops the adaptations, the modeling for others, and the extra support required by the child or children with special needs. This trend is informal and tentative, and seems to be dependent on a committed director and the on-going participation of a number of children with disabilities in their centre.

In 2002, Nova Scotia began to receive funding from the *Early Childhood Development Agreement (ECDA)*. Early Childhood Development Officers (ECDOs) with a strong background in early childhood development were hired throughout the province to address licensing and annual inspections, to consult with centres, and to assist on issues of quality and inclusive child care practices. In addition, Nova Scotia began implementation of several consultation projects designed to increase inclusion quality in child care centres and preschools. One key pilot project, *Partnerships for Inclusion* (Webber, 2003)[20] involved staff in 22 centres each year in using the *Early Childhood Environment Rating Scale - Revised* (*ECERS-R*) (Harms, Clifford & Cryer, 1998),[21] the *SpeciaLink Child Care Inclusion Practices Profile* (Irwin, 2001a)[22] and the *SpeciaLink Child Care Inclusion Principles Scale* (Irwin, 2001b)[23] as the basis for an intensive consultation process to improve the quality of care and inclusion capacity.

This report describes that initiative, the experiences of the first cohort of centres that participated, and the views of the inclusion facilitators who worked with the centres. Data are presented that illustrate the effectiveness of this approach, and lessons are extracted to identify what factors need to be considered in order to ensure that such efforts result in sustained improvements in overall program quality and inclusion capacity.

End Notes

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CHAPTER 2: BEGINNINGS: *PARTNERSHIPS FOR INCLUSION - NOVA SCOTIA (PFI-NS)*

2.1 IDENTIFYING THE PROBLEM / SEEKING A SOLUTION

Since 1978, an increasing number of child care spaces in Nova Scotia were funded with "differentials" so that they could offer support to children with special needs. Through the next decade and a half, most of these spaces were assigned to children enrolled in non-profit centres with a fair degree of experience in including children with special needs. This tended to happen mainly because of word-of-mouth suggestions among parents and also because of external agency referrals. It was considered probable that these inclusive centres were of higher quality than were many non-inclusive centres in Nova Scotia, for reasons similar to those cited by Buysee, Wesley, Bryant & Gardner (1999)[24] in "Quality of Early Childhood Programs in Inclusive and Non-inclusive Settings." However, with the new funding arrangements in 2000 through the *Early Childhood Development Agreement*, more spaces began to "follow the child with special needs" to any licensed preschool or child care centre in Nova Scotia. Unfortunately, there simply were not enough centres of demonstrated quality and inclusion commitment to accommodate all children with special needs at natural proportions. With most centres having neither full time, on-staff resource teachers in addition to ratio nor an adequate supply of ECEs with specialized education or training to prepare them to work with children with special needs, nor a formalized consultation program to the centres, Departmental staff as well as centre staff, parents, and related professionals had reason to be concerned about child care centre quality, as well as inclusion quality — especially as they were now supporting the enrolment of children with special needs in *any* licensed centre.

The problem that was identified in Nova Scotia was common throughout North America. As Palsha and Wesley (1998)[25] state:

> *A significant…barrier to implementing inclusion has been the limited availability of high-quality, community-based early childhood programs… Without careful attention to the way in which aspects of quality such as physical space, materials, and staff are used in the classroom, children with disabilities are less likely to benefit from inclusion. The quality of early care and education has been found to be highly correlated with gains in early language development, cognitive growth, and social competence; …however, a recent large-scale study reported that child care in most centres in the United States was poor to mediocre* (p. 243).

2.1.1 LOOKING AT THE RESEARCH — *PARTNERSHIPS FOR INCLUSION (NORTH CAROLINA)*

The article, "Improving Quality in Early Childhood Environments through On-Site Consultation" (Palsha & Wesley, 1998) sparked consideration about potential solutions to the quality problems that had been identified. In fact, it went back even further than the 2001 discussions in Nova Scotia. In early 1999, Dixie (VanRaalte) Mitchell and Sharon Hope Irwin had a day-long discussion about the article and its potential relevance to Canadian child care. Dixie then wrote a successful proposal to Child Care Visions, Human Resource Development Canada that led to the project, *Keeping the*

Door Open: Enhancing and Maintaining the Capacity of Centres to Include Children with Special Needs (Mitchell, 2001).[26]

2.1.2 *KEEPING THE DOOR OPEN: ENHANCING AND MAINTAINING THE CAPACITY OF CENTRES TO INCLUDE CHILDREN WITH SPECIAL NEEDS (NEW BRUNSWICK, PRINCE EDWARD ISLAND, SASKATCHEWAN)*

Across provincial borders in New Brunswick and Prince Edward Island (as well as in Saskatchewan), efforts to promote quality and inclusion capacity were being addressed through the project, *Keeping the Door Open: Enhancing and Maintaining the Capacity of Centres to Include Children with Special Needs*. Adapting the project initiated in North Carolina by Patricia Wesley and Sharon Palsha called *Partnerships for Inclusion*, Dixie (VanRaalte) Mitchell designed *Keeping the Door Open* for a Canadian context. Under the sponsorship of the New Brunswick Association for Community Living, the project ran from January 2000-December 2002, and was funded through Child Care Visions, a program then under the Employability and Social Partnerships Division of Human Resources Development Canada. At the end of the project, all three provinces — pleased with the results in raising global quality in child care centres — provided continuing funding so that additional centres could be included. These programs, now called *Measuring and Improving Kids' Environments* (*MIKE*) in PEI and *Opening the Door to Quality Childcare and Development* in New Brunswick, continue today.

Word travels quickly in Canada. Staff of the Nova Scotia Early Childhood Development Services division heard about *Keeping the Door Open* and felt that it could help address issues of global quality and inclusion capacity in Nova Scotia child care centres. A proposal for funding provided under the Early Childhood Development Agreement was written and accepted, an Advisory Committee was established, a research and evaluation team was hired (Dr. Sharon Hope Irwin of SpeciaLink and Dr. Donna S. Lero of the University of Guelph), and a program manager and four inclusion facilitators were hired. By December 2002, a 3-day facilitator training was held (with Dixie (VanRaalte) Mitchell and Dr. Sharon Hope Irwin as presenters), centres were informed of the project, and plans were in place.

2.2 GETTING STARTED: *PARTNERSHIPS FOR INCLUSION - NOVA SCOTIA (PFI-NS)*

2.2.1 Administrative and Management Structure

Partnerships for Inclusion - NS is fully funded through a grant by the Government of Nova Scotia, Department of Community Services, Early Childhood Development Services. Early Intervention Nova Scotia (*EINS*) is responsible for project supervision and administration.

RELATIONSHIP TO GOVERNMENT
Partnerships for Inclusion - NS shares with government the names of current centres involved in the project. *PFI-NS* does not share scores, goals or collaborative action plans of individual centres with government staff. Monthly progress reports and financial statements are sent to government, as well as to the direct supervising body — *Early Intervention Nova Scotia* (*EINS*). Both formal and informal contacts are maintained with the Coordinator of Special Needs Policy & Program Development, Early Childhood Development Services, Department of Community Services.

PFI-NS staff are very visible in the centres, generally there once a week, and often cross paths at the centres with Early Childhood Development Officers (ECDOs). Posted centre notices and newsletters often include articles about *PFI-NS* participation, and goals may be posted within the centre acknowledging the progress the centre is making. Thus, any move to secure anonymity of the participating centres would be challenging. There is also a sense that this is unnecessary as both *Partnerships* facilitators and ECDOs work to support centres.

Thus far, there has been a very positive, collaborative relationship between the ECDOs and the *PFI-NS* staff. ECDOs realize that *PFI-NS* works because it is voluntary and confidential; *PFI-NS* staff realize that their roles and those of the ECDOs are complementary and mutually reinforcing. If, in the future, government decides to make participation in *PFI-NS* mandatory for all centres — or even for struggling centres — this arrangement would have to change.

CONFIDENTIALITY
Centres are assured that what is learned in the centres stays within the centres (except, of course, for abuse issues that require mandatory reporting). Centres are also assured that scores and comments used for evaluation and research are confidential, and that data are only used in aggregated form.

Permission is requested to take photos, and centres are assured that such pictures, if used in workshops or training events, will not be identified by name. Permission forms must be signed by parents of all children in the centre.

Annual reports, minus direct centre attribution, are shared with the government, *EINS*, and SpeciaLink.

MANAGEMENT STRUCTURE
The *Partnerships for Inclusion - NS* manager reports to the Early Intervention Nova Scotia *(EINS)* executive committee. Monthly progress reports and statements of expenses are presented. Various sub-committees, such as Policy, Staffing, and Program are struck on an as-needed basis.

2.2.2 The Process

With the hiring of a program manager and four inclusion facilitators in December 2002, *PFI-NS* began. Its goals were to use training, assessment, consultation and support to:

> ➢ improve program quality, and
> ➢ enhance child care centres' inclusion capacity and inclusion quality.

The on-site consultation model, as outlined by Palsha and Wesley (1998) with modifications recommended by Dixie (VanRaalte) Mitchell from the *Keeping the Door Open* project, provided a template for the one-year pilot project.

Job descriptions and qualifications were circulated widely in Nova Scotia for a project manager and for inclusion facilitators who would train centre directors and lead teachers in preschool rooms in procedures for assessing program quality and then provide direct support through on-site consultations to enhance program quality and centres' capacities to include children with special needs. Emphasis was placed on front-line experience in child care centres and on familiarity with children with special needs. Staff were to be hired to cover four regions of Nova Scotia — Halifax/South Shore Region; Dartmouth/Valley Region; Antigonish Region; Truro/Northern

Region; and Cape Breton Region. Other regions of the province would be addressed in a later phase of the project, if one was funded.

Three members of the project advisory committee interviewed short-listed candidates for the project manager position. Two members of the advisory committee and the project manager interviewed candidates for the inclusion facilitator positions. *PFI-NS* was able to hire facilitators with strong backgrounds in front-line child care (three had experience as directors); and in special needs (one had twelve years experience as a centre-based resource teacher, while another had ten years experience as an inclusion support staff person in child care and as a classroom assistant in public school); one facilitator had experience in using the *ECERS-R* instrument for training in another province. Although none had certification in adult education, three of the five had extensive experience in providing workshops and informal presentations to the child care field. Three of the staff are university graduates, including one with a degree plus an ECE diploma; one staff has an ECE diploma; one has a teaching certificate plus over 400 recognized workshop and course hours in ECE.

2.3 SELECTION OF CHILD CARE CENTRES

Letters and flyers were sent to all licensed child care centres in Nova Scotia, explaining the *PFI-NS* project and seeking volunteers. Word-of-mouth recruitment by inclusion facilitators, the project manager, and Sharon Hope Irwin brought in additional interested centres.

The criteria included: geography/region; diversity in centre characteristics such as size, rural/urban location; and for-profit/non-profit auspice. Other requirements were that the centre have an appropriate age group for the *ECERS-R*; volunteering for the project; the centre was an inclusive program (if possible, having a child with special needs in the group of the lead educator, or if not, having a child with special needs enrolled in the centre); a history of inclusion in the centre; a full-day program; a minimum of one year in operation; not a developmental centre (meaning a centre that includes 33% or more children with special needs); and not providing a specialized program, such as Reggio Emilio or Montessori.

For research purposes (assessing changes in inclusion quality), criteria related to having a child with special needs in the observed classroom and having an "inclusion history" in the centre were employed. It was not possible to fully meet these criteria in all centres in the sample. Six centres (27%) had no children with special needs in the centre, and 9 (40%) had no child with special needs in the observed classroom. Even where one or two children with special needs were present in the observed classroom at the beginning of the project, in some cases the children with special needs left the classroom before the end of the year. In addition, some centres did not have a "history of inclusion" to draw upon. Using the director's experience in working with children with special needs as a proxy for "inclusion history," three programs (14%) had worked with children with special needs for two years or less.

In the final analysis, the project manager, in cooperation with inclusion facilitators and some members of the advisory committee, selected centres that met as many criteria as possible, noting that in the less densely populated areas, the total number of potential participating centres was not large. This difficulty pointed up one of the original issues cited by Early Childhood Development Services staff — the need to increase the number of centres that would be willing and able to appropriately include children with special needs.

2.4 TRAINING

***Inclusion Facilitators*:** A full 3-day session, facilitated by Dixie (VanRaalte) Mitchell with Dr. Sharon Hope Irwin, was held for all five staff, as well as for the provincial Early Childhood Development Officers (ECDOs) and interested central office staff. Two full classroom days of *PFI-NS* and *ECERS-R* training were provided, plus a day for direct centre observation so that participants could obtain adequate inter-rater reliability. A two-hour training session on the inclusion quality instruments was also provided.

Consultee and Advisory Committee Training: The 22 centre directors and 22 lead ECEs were invited to a two-day training session at the Harbourview Holiday Inn in Dartmouth on January 31-February 1, 2003 [facilitated by Dixie (VanRaalte) Mitchell with Sharon Hope Irwin]. All participants were able to attend, with the exception of one who had a medical emergency. (This was quite a feat considering that 52 people travelled from various parts of the province in the middle of winter!) Several members of the Department of Community Services attended parts of this training, a further demonstration of their support for this project. The 13-member Advisory Committee held its first meeting on January 30th, and most members stayed for the training (some of the 13 are double-counted, because they are Departmental staff or are otherwise involved in the Project). In February, Shannon Harrison, one of the inclusion facilitators, travelled to New Waterford to conduct a workshop on the use of the *ECERS-R*. This workshop was offered to meet the needs of the only lead ECE who had been unable to attend the Dartmouth training event. Twenty other staff from participating Cape Breton centres also attended this regional workshop —indicating a high level of interest in the project. The travel, staff replacement, and accommodations were provided at no cost to participants. The *PFI-NS* staff had the opportunity to reinforce their earlier *PFI-NS* and *ECERS-R* training, and to act as facilitators for small groups. Inter-rater reliability sessions were not held during the weekend training, but were scheduled between facilitator and director and facilitator and lead ECE during the Project.

2.5 OVERALL PROJECT DESIGN: 3 PHASES AND 10 STEPS

The project was conceptualized as having three phases that corresponded to points of data collection. Following training in the use of the *ECERS-R* as a measure of program quality, baseline measures were collected prior to, or at the start of an intensive period of consultation and collaborative work with the lead educator in the preschool room in the centre and with the director. During this period the inclusion facilitator worked directly with centre staff to improve program quality and inclusion capacity in on-site visits every week or two weeks. Measures were repeated at the end of the 5-month on-site consultation phase, and again, approximately 4-5 months later (the end of the sustainability period). The three phases were to take place within a 10-month period.

PFI-NS, like the earlier *Keeping the Door Open* project, was designed with 10 steps, not 8 as in the original *PFI* model. Two steps related to the sustainability period (Step 7 — "Sustainability Period" and Step 8 — "Evaluation after Sustainability") were added as distinct steps in the model. A diagram of the 10 steps that guided project activities is included in Figure 2.1.

Figure 2.1   The Partnerships for Inclusion - Nova Scotia Model

Partnerships for Inclusion
On-Site Consultation Model

(Adapted from Palsha and Wesley 1998/van Raalte and Lysack 2001)

Capacity Building

Step 1 - Establish Relationships
Facilitator presents on-site consultation model and a relationships begins between Facilitator and educator/personnel in the site.

Step 2 - Provide Training for ECERS-R Scale
Facilitator provides training on Environment Rating Scale.

Step 3 - Jointly Assess Needs
Facilitator administers Environment Rating Scale. Educator, Director and Facilitator have consensus meeting.

Step 4 - Collaborative Action Plan
Facilitator, Director and Educator develop a collaborative action plan based on the results of the environment rating scale and other needs the centre may have.

On- Site Consultation

Step 5 - On-Site Consultation
Facilitator, Educator and all other necessary personnel work together on objectives of collaborative action plan.

Step 6 - Evaluate Changes
Facilitator evaluates changes using ECERS and once again meets with centre to determine further changes needed.

Step 7 - Sustainability Period
Educators work on final objectives for a period of time without on-site visits or supports from Facilitator to gauge their ability to maintain the changes that have occurred.

Step 8 - Evaluation After Sustainability
Period of sustainability is established for maintaining changes. Facilitator and centre evaluate using ECERS-R to establish if changes have been maintained, and to what level.

Step 9 - Written Report
Facilitator writes final report detailing the changes that were effected and any barriers that opposed change being maintained.

Step 10 - Identification of Future Needs
Facilitator and centre identify any future needs that the centre may have and establish a framework for satisfying those needs. Facilitator may assist Educator with referrals elsewhere.

2.6 ROLE OF THE INCLUSION FACILITATORS

It was originally anticipated that the inclusion facilitators would visit each of their five centres on a weekly basis during the active consultation phase, staying approximately half a day in each. The project manager was assigned only two centres, because of her other responsibilities. The capacity building phase — Steps 1 through 4 — required this intensity of visitation, but needs varied during the on-site consultation phase. Project logs indicate that *PFI-NS* inclusion facilitators usually made 3 or 4 visits to each centre every month, but sometimes logged as many as 6-8 visits. These visits may have been used for observation, dropping off resources, staff meetings, parent meetings, work parties or in-house workshops.

It is important to be clear about the role and responsibilities of the inclusion facilitators, their "caseload," and the frequency and nature of their visits, both to appreciate the nature of the intervention as it was delivered to this cohort of centres and to enable appropriate comparisons to other cohorts in Nova Scotia and to similar programs in other jurisdictions. Depending on the purpose, visits varied in length from one hour to a full day, but most often lasted for a full half-day. Efforts were made to schedule the visits when the lead educator (and sometimes the director) were available and could be freed up from normal duties. Not infrequently, visits occurred at the end of the day or even on a weekend to facilitate changes in room arrangements. Facilitators often provided food during work parties or professional development workshops to support participation of staff in after-hours activities.

In retrospect, the term "inclusion facilitator" may be misleading, as much of the time was not directly focused on providing supports for including children with special needs.[iii] In reality, the major focus and the majority of time and energy was spent working collaboratively with lead preschool educators and centre directors to enable them to change current practices in order to provide more enriched, flexible, child-oriented programming in comfortable and well-organized environments. A basic assumption was that such changes would result in better quality programs, more confident and skilled early childhood practitioners, and greater capacity to include children with special needs. This premise is based on the fact that positive inclusion experiences for children with special needs and their parents require high quality programs that are staffed by committed, sensitive early childhood educators who have the training, resources and support they need to be successful in meeting the needs of all of the children in their centre.[27]

[iii] Specific supports that focused directly on inclusion practices were observed, however, when children with special needs were present in the classroom in which *PFI-NS* interventions were focused, as well as in centres that had children with special needs in other classrooms.

Inclusion facilitators played multiple roles: they were trainers during the technical assistance phase (training directors and staff in procedures for conducting and interpreting the *ECERS-R* and SpeciaLink Inclusion scales), they were models, they were coaches, and they were confidants. They were active listeners, they were workshop presenters (a major professional development role), they were resource locators, and they were librarians. They often became friends. In large part, they facilitated staff and director engagement in reflective processes and active change. (See Figure 2.2.)

Figure 2.2   Inclusion Facilitators' Multiple Roles

WHAT INCLUSION FACILITATORS DID:

- ✍ Inter-rater assessments of program quality (*ECERS–R*)
- ✍ Regular visits
- ✍ Collaborative action plans
- ✍ Discussions, Encouragement, Suggestions
- ✍ Joint problem solving
- ✍ Shared information with staff in other rooms

- ✍ Brought equipment, materials, resources, print information
- ✍ Modeled specific behaviours; Helped develop specific skills
- ✍ Mentor, Colleague for directors
- ✍ Took staff to visit other child care centres
- ✍ Workshops for staff on various topics centre wide; Regional workshops

Partnerships for Inclusion - Nova Scotia
Lero, Irwin, and Darisi

Each facilitator received $200 per centre to spend during the length of the project. This money was to be used in ways that might make the consultation process a little easier for centres. Inclusion facilitators used this money to buy pizza for a supper meeting if they wanted to meet with staff, or perhaps to take the "lead educator" to lunch if she wanted to meet with her over her lunch break. Funds were used to purchase resource books for centres. Books such as *The Inclusive Classroom* or *Designs for Living and Learning* were given to some centres after inclusion facilitators finished working with them. Money was also used to purchase inexpensive materials to be used in the centres. A trip to the local "Frenchy's" allowed facilitators to pick up items that could be added to the dramatic play area. They also used their knowledge of a centre's needs to be on the lookout for things that the centre might be in need of. (One facilitator would tell you that she spent the bulk of her money on science materials.)

There has been some discussion about whether or not funds should be given directly to the centres to spend instead of being spent at the facilitators' discretion. The facilitators recognize that *PFI* in

North Carolina gives the money directly to centres. *PFI-NS* facilitators haven't decided to change what they are doing, but there is a valid argument to be made about giving centres control of this resource. At the same time, the facilitators recognize that in doing so, they would no longer have the option to use the money for a meal to bring staff together for a meeting. Facilitators have also been able to support staff in attending PD events that they might not otherwise access by providing gas money or money for a substitute.

Facilitators worked hard to gain the trust and respect of centre directors and lead teachers in the first, capacity-building phase of the project, and to obtain buy-in and engagement. In particular, initial concerns about being evaluated and judged by an outsider had to be addressed in order to use the initial assessments effectively as a tool for collaborative action planning. Collaborative action planning is a key feature of this model. As is true of most change models, participants must take an active role in committing themselves to specific goals and activities and appreciate the value of doing so (rather than simply acting in compliance with or to please an external agent) if change is to be significant and sustained.

Because of their extensive knowledge and experience in providing high quality, inclusive child care, the inclusion facilitators were often able to anticipate what they could do or provide to help the early childhood educators make positive changes. The first areas selected for collaborative planning often were related to room arrangements or other physical changes that could be made relatively easily, such as changing traffic patterns to enable easier transitions, creating an area with soft cushions and privacy for a place for quiet activities, and organizing materials to make them more easily accessible to the children and staff. Other immediate targets were any changes required to ensure children's health and safety, as well as program aspects with particularly low scores on the *ECERS-R* measure. These early changes often produced visible results and typically were well-received by the staff, the children and their parents, providing positive reinforcement and additional impetus for making changes that required a greater investment of time and/or a willingness to learn and adopt new ways of working with the children.

In this first offering of the *PFI-NS* model, efforts were concentrated on work with the lead educator in one selected room, with the lead educator working to support buy-in and change among other ECEs in the room. One of the early learnings for all *PFI-NS* facilitators, however, was the importance of providing information and support to all staff in the centre, and sometimes to parents and board members as well. Consequently, many of the professional development presentations and workshops that the facilitators provided were open to all centre staff, and sometimes to parents and board members. Project logs confirmed that at least three of the five inclusion facilitators offered significant numbers of these presentations — 2 parent meetings each, 2 board meetings each, and 2 staff meetings each that included focused content on items from the *ECERS-R* (often related to emergent curriculum development, and to activities related to Math and Science). The other two inclusion facilitators did no board or parent meetings, and provided staff training sessions during the day at lunch time or nap time to enable more staff to attend than would otherwise be possible.

One inclusion facilitator conducted a regional *ECERS-R* training session that attracted not only the two lead educators who had missed the earlier provincial training session, but also many staff from the five centres she was working with (both staff from the target classrooms and other staff). This same facilitator provided a centre-wide *ECERS-R* training session (with assistance from another facilitator) that provided the opportunity for a lead educator from another region to attend.

It is important to note that this first offering of the *PFI-NS* model also provided learning opportunities and experiences for the *PFI-NS* inclusion facilitators. Anecdotal information revealed that over time they became an extremely effective team and that they shared resources and provided support to each other that was invaluable.

<u>End Notes</u>

24   Buysee, V., Wesley, P.W., Bryant, D. & Gardner, D. (1999). Quality of early childhood programs in inclusive and non-inclusive settings. *Exceptional Children*, *65,* (3), 301-314.

25   Palsha, S.A. & Wesley, P.W. (1998). Improving quality in early childhood environments through on-site consultation. *Topics in Early Childhood Special Education*, 18:4, 243-253.

26   Mitchell, D.L. (VanRaalte). (2001). *Keeping the door open: Enhancing and monitoring the capacity of centres to include children with special needs*. NB: New Brunswick Association for Community Living.

27   Irwin, S.H., Lero, D.S. & Brophy, K. (2000) *A matter of urgency: Including children with special needs in child care in Canada.* NS: Breton Books. Available from Web Site: http://www.specialinkcanada.org.; Irwin, S.H., Lero, D.S. & Brophy, K. (2004). *Inclusion: The next generation in child care in Canada.* NS: Breton Books. Available from Web Site: http://www.specialinkcanada.org.

CHAPTER 3: METHODS USED TO EVALUATE *PFI-NS* PROCESSES AND OUTCOMES

It is important to collect both process and outcome evaluation data about new initiatives to appreciate what impacts they have and for whom, and how outcomes can be improved by fine-tuning or revising intervention strategies. The data collected for the present study describe the first offering of *Partnerships for Inclusion* in Nova Scotia *(PFI-NS).* As such, it can be anticipated that much can be learned from examining how the process worked and what effects this method of providing assessment, consultation and supports had on centres and their staff. In particular, data were collected to learn about the extent to which this strategy has short and longer-term impacts on program quality and on centres' capacities to effectively include children with special needs.

3.1 EVALUATION DESIGN

From a scientific perspective, an experimental design that could compare centres that are randomly assigned to a group that receives *PFI-NS* support, to a control group of centres that do not, would offer a stronger test of the effects of the *PFI-NS* intervention. For a variety of reasons, however, many training and support initiatives do not use an experimental methodology. Typically, training and support is offered to a number of centres in a particular locale and measures of program functioning or staff's knowledge or skills are compared before and after training. Often there is no longer-term follow-up, and response rates vary. Attention to the contextual factors in centres or in the community or province that may affect centres at the same time, or that might facilitate or limit the capacities of the intervention to have a strong impact, is often lacking.

The evaluation method used to assess the impacts of *PFI-NS* on the first cohort of centres participating in the project involved collecting extensive data on the centres initially, and on program quality and inclusion practices at three points of time:

- ❖ at Baseline, before or at the very beginning of the *PFI-NS* assessment and consultation process;
- ❖ at the end of the active intervention / support phase; and
- ❖ approximately 4-5 months after the active support phase ended.

These three points of data collection (January-February, June, and October-November 2003 — alternatively referred to as Baseline or Time 1, Time 2, and Time 3) mark the beginning and end of the period of active intervention, followed by a sustainability phase when no active support was provided. Collecting data some time after the active support phase ends is important in order to determine whether impacts are sustained when there is no external agent visiting the centre on a regular basis and staff must follow through on initiatives themselves.

Although no control group of centres was utilized, we intend to repeat the evaluation process with successive cohorts of centres that participate in the *PFI-NS* initiative. Analyses that include data from the second and third offerings of the project will enable comparisons to be made of the effectiveness of the *PFI-NS* approach when initial training about program quality and its assessment is delivered in a more decentralized manner and to most of the staff in the participating centres, rather than only to the centre director and a selected lead educator, as was the case in this first cohort. Comparisons across successive cohorts of centres will provide a more rigorous test of the

impacts of this initiative and allow the program time to reach full maturity. Successive cohort analyses will approximate a quasi-experimental design.

Strengths of the evaluation approach are evident in the richness of the data collected and the use of well-known instruments to assess program quality and inclusion capacity. In addition, interviews were conducted with each centre director and lead educator to obtain their views of the changes that occurred in their centre/room and the factors that contributed to those changes. Reflective reports on each centre were obtained from inclusion facilitators and their observations provided a third window on the changes that occurred in the centres. Inclusion facilitators also provided invaluable insights on the factors that appeared to facilitate or limit desirable changes in the centres, leading to further improvements in successive waves of the project.

3.2 RESEARCH MEASURES

A variety of measures was used to obtain information about the centres, the participating directors and lead educators, and classroom practices. Each measure is described briefly in this section.

3.2.1 Survey Questionnaires from Centre Directors and Lead Educators

Each centre director and lead teacher who agreed to participate in the *Partnerships for Inclusion - NS (PFI-NS)* project completed survey questionnaires at Baseline. Two questionnaires were originally developed for a study to assess child care directors' and early childhood educators' attitudes and experiences related to inclusion and have been used in two earlier studies [*A Matter of Urgency* (Irwin, Lero & Brophy, 2000)[28] and *Inclusion: The Next Generation* (Irwin, Lero & Brophy, 2004).][29] The director questionnaire also contains questions about centre practices and the resources available to support inclusion.[iv] These two questionnaires, supplemented by a Centre Profile form completed by the inclusion facilitators, provided important background information about the centres, directors and lead teachers.

3.2.2 Measures of Program Quality

In order to assess program quality, two measures were utilized at Baseline, the *Early Childhood Environment Rating Scale-Revised (ECERS-R)* (Harms, Clifford & Cryer, 1998)[30] and the *Caregiver Interaction Scale (CIS)* (Arnett, 1989).[31] Inclusion facilitators were trained in the use of both scales and inter-rater reliability was established as part of training. Directors and lead educators were trained in the use and interpretation of the *ECERS-R* and efforts to improve quality relied strongly on collaborative action planning following the Baseline and Time 2 assessments. The *ECERS-R* was administered at each data point; the *CIS* was administered only as part of the Baseline assessment. Other indicators of quality (ratio and group size) were not assessed, as they are incorporated in provincial licensing requirements and presumably would not evidence much variability. Wages and working conditions of staff, the funding available to centres, and rates of staff turnover were not assessed directly, but are known to affect program quality. As will be discussed later, inclusion facilitators noted that these factors did affect the extent to which some centres were able to make and sustain positive changes in program quality and inclusion capacity.

[iv] Copies of the questionnaires are included in appendices to both of these publications, which are available at www.specialinkcanada.org

The Early Childhood Environment Rating Scale-Revised (ECERS-R)

The *ECERS-R* is the most widely used measure of program quality in North America. Trained observers made detailed ratings on 43 items that yield an overall quality score and seven subscale scores. The seven subscales comprise: (1) space and furnishings; (2) personal care routines; (3) language-reasoning; (4) activities; (5) interactions between children and staff; (6) program structure; and (7) resources and supports for parents and staff. One item specifically assesses provisions for children with disabilities; however a number of other items contain components that must be met for a score of 5 or higher if children with special needs are present. The *ECERS-R* is actually a measure of quality in the specific classroom/playroom in which observations are made. While there may be differences in quality from room to room and for children of different age groups, in practice the observational score obtained from a room is treated as a measure of program or centre quality.

Each observational item in the *ECERS-R* instrument has specific descriptors that are considered in the rating of that item; each item is scored from 1 to 7. The average score obtained across all items is used as the measure of program quality. Average *ECERS-R* scores below 3.0 are indicative of poor or inadequate quality. *ECERS-R* scores between 3.0 and 4.9 indicate minimal or mediocre quality. Scores above 5.0 indicate good quality programs that promote children's development, with scores closer to 7.0 indicating excellent overall quality.

The *ECERS-R* has been demonstrated to be a reliable and valid measure of program quality in a wide range of studies. Research on the influence of child care quality on children's development consistently confirms that children in high quality programs compared to those in low-quality care have better social skills (Peisner-Feinberg & Burchinal, 1997;[32] Vandell, 1999[33]); fewer problem behaviours (Vandell, 1999);[34] better language skills (Clarke-Stewart, 1999;[35] Peisner-Feinberg & Burchinal, 1997);[36] and higher scores on measures of school readiness.[37] Moreover, the effects of the quality of child care received by children in the preschool years has been demonstrated to affect children's subsequent language and math skills and peer relationships in Grade 2 (Peisner-Feinberg, Burchinal, Clifford, Culkin, Howes, Kagan, Yazejan, Byler, Rustici & Zelazo, 1999).[38] Research in both the U.S. and Canada indicates that centres that evidence higher levels of inclusion quality also score higher on measures of program quality (Buysee, Wesley, Bryant & Gardner, 1999;[39] Irwin, Lero & Brophy, 2004[40]). Indeed, Irwin, Lero & Brophy (2004) concluded that high program quality is an essential requirement for inclusion quality.

The Caregiver Interaction Scales

The *Caregiver Interaction Scales (CIS)* were developed to gather specific information about the affective tone of adult-child interactions in a child care room. The scales assess three specific dimensions of teacher affect. The first is teacher *Sensitivity*, indicating that an early childhood educator behaves in ways that indicates she/he is warm, attentive and engaged. A second dimension is *Harshness*, indicated when teachers are critical, threatening or punitive. The third dimension is *Detachment,* indicated by low levels of interaction with the children and limited involvement. Trained observers rated ECEs in preschool rooms on 26 items, each of which is a specific behaviour. Observers noted whether each behaviour was observed not at all, somewhat, quite a bit, or very much (scored as 1-4). High scores on the Sensitivity subscale and low scores on Harshness and Detachment are desirable. Research indicates that scores obtained on these scales predict

children's language development and attachment security (Whitebook, Howes & Phillips, 1990).[41] Higher scores on the *ECERS-R* were significantly and positively correlated with *CIS* Sensitivity ratings and negatively correlated with ratings of teacher Detachment and Harshness in the Canadian *You Bet I Care!* study (Goelman, Doherty, Lero, LaGrange & Tougas, 2000).[42]

3.2.3   Measures of Inclusion Quality / Inclusion Capacity

ECERS Item 37 – Provisions for Children with Disabilities

While other items in the *ECERS-R* include indicators that are relevant to the quality of the program and the environment for children with special needs, Item 37 focuses on inclusion specifically. It is used only if there is at least one child with special needs enrolled and present in the classroom in which observations are being made. This item is part of the subscale assessing program structure, along with three other items. Item 37 criteria relate to four dimensions of inclusion:

➢ the extent to which children's needs are formally assessed, staff have information about the assessments, staff follow through with activities and interactions recommended by professionals to meet identified developmental and social goals, and staff contribute to individual assessments and intervention plans;

➢ the degree to which modifications are made in the environment, program, and schedule to enable children with special needs to participate with other children;

➢ the degree to which parents are involved in helping to set goals for their child, information is shared between parents and staff, and parents provide feedback on how the program is working; and

➢ the extent to which children with disabilities participate with other children and are integrated into the group rather than being segregated or excluded. Efforts are also made to carry out professional interventions within the regular activities of the classroom.

These four dimensions are based on criteria that can be observed directly, as well as educators' responses to questions about specific practices. A rating of 3 or lower on Item 37 reflects a situation where assessments are either not done, or are not shared with staff in ways that would be useful to meet the needs of the child; only limited modifications in teacher-child interactions, the environment, or program activities have been made to meet the needs of children with disabilities; parents are involved minimally or to some extent in setting goals for the child, but are not extensively involved or provided with information and support; and there is limited involvement of children with disabilities with other children in on-going activities. A rating of 5 or higher indicates that staff are actively involved in programming to meet the child's needs and follow recommendations made by professionals to help children meet specific goals; modifications to activities and the environment have been made so that children with disabilities can participate fully and comfortably with other children; and parents are active partners with the staff and are respected and supported.

The SpeciaLink Inclusion Principles Scale

The *SpeciaLink Inclusion Principles Scale* (2001)[v] is based on five questions posed to the centre director and is designed to assess the extent to which a centre has adopted principles to guide decisions about enrolling children with disabilities and ensure that their needs are met, as far as possible, within the regular setting. The inclusion facilitators administered the scale at Baseline and at Time 2 and Time 3. Score values reflect the director's replies, tempered by the inclusion facilitator's own opinion if she observed instances when practice appeared to diverge from the principles espoused by directors. Each item is scored on a scale of 1 to 5 with a value of 1 indicating that principles are completely undeveloped and a value of 5 indicating that the centre has adopted principles that explicitly support full inclusion and that they are evident in observed practices.

The five items that make up the *SpeciaLink Inclusion Principles Scale* pertain to the following areas:

1.	The principle of "zero reject"	No *a priori* limits are set that would exclude children with particular levels or types of disabilities.
2.	The principle of naturally occurring proportions	The centre enrols roughly 10-20% of children with special needs, in "natural proportion" to their occurrence within the catchment area of the community.
3.	Hours of attendance	Children with special needs are not limited in their attendance to part time or four days a week, while other children may attend full time.
4.	Full participation	The centre is committed to enabling the full participation of children with special needs in the regular program; pull-out time is limited or avoided when interventions can be done in the room and involve other children. It is never assumed that any activity cannot be adapted so that every child can participate.
5.	Advocacy for inclusion and maximum feasible parent participation	The centre is committed to reducing barriers to inclusion and promoting accessible high quality child care for all children and parents in the community. It also involves families to the maximum extent feasible, providing child care, transportation, flexible meeting hours, translation, etc., as necessary. "Maximum feasible participation" does not force family participation as a requirement of enrolment, but it demonstrates that every effort is made to make families feel welcomed and valued.

The *SpeciaLink Inclusion Principles Scale* was used in the study, *Inclusion: The Next Generation* and scores were used as one component in composite Index of Inclusion Quality.

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[v]   Both the *SpeciaLink Inclusion Principles Scale* and the *SpeciaLink Inclusion Practices Profile* have recently been redesigned to include specific indicators for each item, with a new scoring system that is similar to that used in the *ECERS-R*. The 2001 version was used for the first cohort of centres in *PFI-NS*.

The SpeciaLink Inclusion Practices Profile

The *SpeciaLink Inclusion Practices Profile* is based on observations initially and then on questions posed to the centre director. It is designed to assess 11 specific practices related to inclusion and was used to assess inclusion quality at Baseline and at Time 2 and Time 3 in this study. Each item is scored on a scale of 1 to 5 with 1 indicating that only beginning efforts have been made to ensure inclusion quality, while 5 indicates an ideal setting with respect to that specific practice. The *Profile* was developed in 1991 as a synthesis of best practices in integrated child care research and literature, in a form that could serve as a checklist or benchmark in a study of high quality child care centres and was used in the study, *Inclusion: The Next Generation*. The 11 items cover practices in the following areas:

1.	The physical environment	The degree to which modifications have been made to support inclusion and enhance accessibility
2.	Equipment and materials	The extent to which adaptations have been made and special equipment and materials are available and used in ways that allow children to participate comfortably in the group and that enhance their skills and capabilities
3.	Director's role	The director is actively involved in supporting inclusion, is knowledgeable and enthusiastic
4.	Support for staff	The degree of support provided to staff through consultative assistance and flexible/reduced ratios to support them in meeting individual children's needs
5.	Staff training	The number of staff who have some training related to special needs and staff's access to continuing in-service training opportunities
6.	Therapies	The degree of provision of therapeutic intervention provided to children in the centre — and the manner in which it is provided (in a pull-out space or separate clinic and/or within the program); the extent to which staff are involved in goal setting and work collaboratively with parents and therapists
7.	Individual Program Plans	The extent to which IPPs are used to inform programming in the regular group setting, and are developed collaboratively by resource teachers or consultants, staff and parents
8.	Parents of children with special needs	The extent to which parents are involved, receive information and participate in decision making—both related to their own child, and as an advocate for other children at the centre and in the community
9.	Involvement of typically developing children	The extent of interaction between children with special needs and their peers; the extent to which social interaction is facilitated and children are accepted by others

10.	Board of directors or advisory committee	The centre's board or parent advisory committee promotes and supports inclusion as policy in the centre and as desirable in the wider community
11.	Transition to school	The degree to which the local school or school board, parents and program staff work collaboratively in transition planning and are proactive to support the child's school placement

In retrospect, it appears that there were some difficulties in using the 2001 versions of the scales, and that concentrating on the *ECERS-R* was more than sufficient in this first offering of the model. As well, the focus on inclusion principles and practices often seemed to be more appropriately applied to the centre as a whole, while much of the interventions dealt with change initially within one selected classroom. Revisions to the scales, including specific indicators and a revised scoring system that is similar to the *ECERS-R* and more experience in using them by the inclusion facilitators should enable more effective use of these measures in later cohort offerings.

3.2.4   Qualitative Data

Interviews with directors and lead educators
In order to obtain further information about how *PFI-NS* interventions and supports affected the programs involved, semi-structured telephone interviews were conducted with the participating centre directors and lead educators shortly after the active intervention period ended by a member of the research and evaluation team. Both directors and teachers were asked what specific changes they made in the classroom as a result of *PFI-NS* that relate to improved quality and about other individual and centre-wide impacts attributable to the project. They were also asked about any changes that pertain to children with special needs and/or inclusion practices that resulted from the project. Interview questions also covered whether any changes resulted from other co-occurring workshops or activities, as a check on the validity of interpreting the impacts of *PFI-NS*. Finally, participants were asked what recommendations they had for optimizing *PFI-NS* consultation if the project were to be extended to other centres. Responses to these open-ended questions were coded and summarized for analysis and provided further insight into the experiences of participating child care staff and directors.[vi]

Inclusion facilitators' reports
The project manager and inclusion facilitators kept detailed notes and observations about each centre. These notes summarized what inclusion facilitators experienced over time and the changes they observed in the centres and classroom environments. The inclusion facilitators' reports provided particular insight into the factors that, in their opinion, facilitated positive changes in program quality, as well as factors that were obstacles and barriers to positive change. The facilitators' reports also provided insight into the relational aspects embedded in this type of intervention and support project. Valuable suggestions for future offerings of the *PFI-NS* model to successive cohorts were also obtained.

In summary, data pertinent to evaluating both the <u>processes</u> involved in providing training, assessment, collaborative action planning and support to child care programs and to the <u>outcomes</u> of the project were obtained from a variety of sources, using both quantitative and qualitative

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[vi]   The interview schedules are included in Appendices A and B to this report.

approaches. Considerable information was obtained about the centres at Baseline. Repeated measures of program quality and inclusion capacity were utilized to assess both short-term and longer-term effects of *PFI-NS*. Interviews with centre directors and lead educators and detailed summaries provided by inclusion facilitators added further rich information about this first offering and suggested ways the model could be improved in the future.

<u>End Notes</u>

28   Irwin, S.H., Lero, D.S. & Brophy, K. (2000) *A matter of urgency: Including children with special needs in child care in Canada.* NS: Breton Books. Available from http://www.specialinkcanada.org.

29   Irwin, S.H., Lero, D.S. & Brophy, K. (2004). *Inclusion: The next generation in child care in Canada.* NS: Breton Books. Available from http://www.specialinkcanada.org

30   Harms, T., Clifford, R.M., & Cryer, D. (1998). *Early Childhood Environment Rating Scale - revised edition (ECERS-R).* N.Y.: Teachers College Press, Columbia University.

31   Arnett, J. (1989). Caregivers in day care centers: Does training matter? *Journal of Applied Developmental Psychology 10*: 541-552.

32   Peisner-Feinberg, E.S. & Burchinal, M.R. (1997). "Relations between preschool children's child care experiences and concurrent development: The Cost, Quality and Outcomes Study." *Merrill-Palmer Quarterly, 43*: 49-70.

33   Vandell, D.L. (1999). *Cognitive, linguistic and social consequences of early experience: Child care and social competence: NICHD study.* Paper presented at the American Association for the Advancement of Science meetings, Anaheim, CA. January 21-26.

34   *ibid.*

35   Clarke-Stewart, A. (1999). *How child care relates to children's cognitive and language development: NICHD study.* Paper presented at the American Association for the Advancement of Science meetings. Anaheim, CA. January 21-26.

36   Peisner-Feinberg, E.S. & Burchinal, M.R. (1997). "Relations between preschool children's child care experiences and concurrent development: The Cost, Quality and Outcomes Study." *Merrill-Palmer Quarterly, 43*: 49-70.

37   *ibid.*

38   Peisner-Feinberg, E.S., Burchinal, M.R., Clifford, R.M., Culkin, M.I., Howes, C., Kagan, S.L., Yazejan, N., Byler, P., Rustici, I. & Zelazo, J. (1999). *The children of the cost, quality, and outcomes study go to school: Executive Summary.* Chapel Hill: University of North Carolina at Chapel Hill, Frank Porter Graham Child Development.

39   Buysee, V., Wesley, P.W., Bryant, D. & Gardner, D, (1999). Quality of early childhood programs in inclusive and non-inclusive settings. *Exceptional Children*, *65,* (3), 301-314.

40   Irwin, S.H., Lero, D.S. & Brophy, K. (2004). *Inclusion: The next generation in child care in Canada.* NS: Breton Books. Available from Web Site: http://www.specialinkcanada.org.

41   Whitebook, M., Howes, C. & Phillips, D. (1990). *Who cares? Child care teachers and quality of care in America*. Final Report of the National Child Care Staffing Study. Oakland, CA: Child Care Employee Project.

42   Goelman, H., Doherty, G., Lero, D.S., LaGrange, A. & Tougas, J. (2000). *You Bet I Care! -- Caring and learning environments: Quality in child care centres across Canada.* ON: University of Guelph: (Centre for Families, Work and Well-Being). Available from Web Site: http://worklifecanada.ca

CHAPTER 4: A DESCRIPTION OF PARTICIPATING CENTRES AND STAFF AT BASELINE (TIME 1)

The first cohort of centres involved in *PFI-NS* consisted of 22 child care programs: 5 from the Halifax/South Shore region, 5 from the Dartmouth/Valley region, 2 from Antigonish, 5 from Truro/Northern region, and 5 from Cape Breton. All of the centres volunteered to participate and might be considered "keeners," as this was the first time the project was offered. (It is also possible that directors and staff in the participating centres may have been more confident about their baseline level of quality and inclusion capacity and more open to being assessed and supported in improvement efforts than other centres.) Directors generally saw participating in the *PFI-NS* project as a very desirable opportunity — one that could move their centre forward to make changes that they felt they were more than ready for, and as a potentially very positive support for child care staff.

A lead educator volunteered or was selected by each centre director to participate as well. It is the lead educator's room that was the focus for assessment and quality improvements.[vii] The director and lead educator participated in the original training related to the *ECERS-R* and the *PFI-NS* model in Halifax. Both had instrumental roles in encouraging other staff in their centre/room to be involved in change processes. The director and lead educators were the individuals who completed the survey questionnaires and provided information in interviews at Baseline and following the end of the active support phase.

While the 22 centres that comprised this first *PFI-NS* cohort are not statistically representative of child care programs in Nova Scotia, they are a fairly diverse group in many ways. For evaluation purposes, it is important to describe and appreciate centre and staff characteristics.

4.1 CENTRE CHARACTERISTICS

4.1.1 Centre Type and Auspice

Program directors were asked to describe their centre as a regular child care centre with no designation, or as a centre that is designated as integrated or with contracted spaces. About half of the centres in the sample (55%) were described by their director as a "regular centre," while 45% were described as integrated or with contracted spaces. The description a director provides for her/his program is important for a number of reasons. First, integrated and regular programs likely have different mandates and therefore different histories and links to community resources with respect to the inclusion of children with special needs. Secondly, the director's description of her program is indicative of the centre's identity in the community. Thirdly, identifying oneself as an integrated or inclusive centre is likely to be a significant indicator of the director's and staff's continuing commitment to inclusion.

[vii] While the *ECERS-R* assessment and *PFI-NS* consultations were focused on one preschool room in each centre, the inclusion facilitators often provided centre-wide support to improve quality. Diffusion effects are discussed in Chapter 5.

Centre directors were also asked whether their program is privately owned and operated (commercial) or non-profit. Only seven of the 22 program directors in this sample described their centre as privately operated. The majority (68%) are run as non-profit centres.

In addition, it is fair to point out that the centres in this sample included both individual stand-alone centres and centres that are affiliated with another organization: a college or university, a military base, or some other community agency. One program offered child care and early education at more than one site. Some centres were purpose-built as child care programs, but a number of others are converted homes or are located in other buildings, many of which are not wheelchair accessible, especially if the centre is on more than one level.

4.1.2   Centre Size, Enrolment, Ages of Children Served

The number of children centres were licensed for ranged from as few as 21 to as many as 140. Half the centres in this sample were licensed for fewer than 50 children, including six (27%) that were licensed for fewer than 40 children. By contrast, five centres (23%) were quite large, licensed to accommodate more than 100 children. Two centres offered only full-time care; most offered both full-time and part-time programs.

The programs in this cohort of centres offered care to children of many ages. Infants from as young as 3 months of age to school-aged children up to and including 12-year-olds were included. The majority of programs (73%) provided care to children under two years old, including seven centres (32%) that offered care to infants under one year old. Slightly more than one third (36%) of the centres offered care only to children younger than 5 years of age, while the remaining two thirds accommodated school-aged children as well.

4.2   DIRECTORS

4.2.1   Roles

When asked whether their position entailed administrative duties only or included some teaching responsibilities, 68% of directors reported performing strictly administrative duties, while 32% mentioned that teaching was also a large component of their role.

4.2.2   Experience

The centre directors in this sample are a fairly senior group, averaging 20.5 years of experience in the child care field. In fact, only one centre director had less than 10 years experience in child care, while 50% had 20 or more years experience. Two centres had recently had a director or assistant director retire. Given the age and experience profile of directors, one can project continuing change over the next decade as administrators and experienced supervisors leave the field.

4.2.3   Educational Background

The sample of directors had a range of educational backgrounds that extended from those with no completed post-secondary education to one director who had a graduate degree. The majority of directors in this sample (64%) have a college diploma in Early Childhood Education; another 27%

have a university degree, including two directors who have both a diploma and degree. One director holds a graduate degree in education.

4.2.4 Experience Working with Children with Special Needs

In all, half of the centre directors reported having more than 10 years of experience working with children with special needs. Indeed, five directors (23%) reported having 20 to 30 years experience working with children with special needs. Three directors (14%) had only recently begun working with children with special needs, having two years or less experience with inclusion.

4.2.5 Leadership for Inclusion

Previous research (Irwin, Lero & Brophy, 2004)[43] suggests that directors who are inclusion leaders play a particularly important role in articulating a strong commitment to inclusion, modelling positive and accepting behaviours, encouraging staff to be active learners, and marshalling resources to support inclusion effectiveness in their centre. We classify a director as an inclusion leader if she/he has been actively involved in advocating for more support for including children with special needs in child care programs and if she/he has provided any workshops or in-service training related to children with special needs. While the directors in this cohort were supportive of inclusion, as measured by their responses on an attitude scale and their agreement with a number of statements that articulate support for inclusive child care, they generally did not display either of the two behaviours that signify inclusion leadership. Only three directors reported having been involved in one or more advocacy activities related to inclusion since 1996 and only four directors had provided workshops or in-service training on topics related to children with special needs. In summary, two directors could be described legitimately as inclusion leaders. The majority, while supportive, had not been directly involved in efforts to ensure that their centres would be consistently and effectively involved in providing inclusive child care on a proactive basis.

4.3 FRONT-LINE STAFF

4.3.1 Number of Front-line Staff and Their Education

The number of program staff varied considerably among centres commensurate with the number and ages of children enrolled. One centre had only a single front-line ECE who worked with the director, while another centre had 20 ECEs on staff. The average centre had 10 front-line child care staff. Early childhood educators in this cohort of centres varied in terms of their educational background. The full set of centre staff included some with little or no training, a few who had pursued an ECE equivalency or were doing so at the time of the study, and others who had either an ECE diploma or more advanced training. The majority of early childhood educators employed in these centres had an ECE diploma or related post-secondary training relevant to their work.

4.4 LEAD EDUCATORS

A lead educator was identified in each centre. This educator worked intensively with the inclusion facilitator and engaged other staff in the room in the process of making positive changes. In most centres, the same person continued to fulfill this role throughout the project. However, in a number

of centres, staff turnover and/or changes in staffing patterns resulted in some discontinuity in this position. One centre, in particular, was not able to continue with the *PFI-NS* model as planned for this reason. The *PFI-NS* inclusion facilitator continued to provide support to the centre as a whole, but it was not appropriate to consider intervention as involving the same educator or the same room over time. Consequently, data from this centre is included in average Baseline scores, but analyses of change over time are based on 21 centres/classrooms, rather than 22.

4.4.1 Current Position

Of the 22 lead educators who participated, more than three quarters (77%) identified themselves as early childhood educators (ECEs), while 4 (18%) indicated their role is a combination of being an ECE and special needs worker. One lead teacher (5%) described herself as an ECE and assistant supervisor.

4.4.2 Educational Background

The lead educators in this sample had a range of educational backgrounds that extended from those with little or no post-secondary training in ECE (four teachers) to one who had a university degree. In all, an impressive 82% of the lead educators had a post-secondary diploma or degree in Early Childhood Education or a related field. The fact that this proportion of the lead teachers had completed post-secondary training in the field of Early Childhood Education is noteworthy.

4.4.3 Experience in Child Care

The average lead educator in this sample had worked in the child care field for 9 years. Approximately one third of the educators (32%) reported having 10 or more years experience in child care; another third of the lead educators in this sample had been working as an ECE for 5 to 10 years. Slightly more than a third (36%) had worked in the early childhood education and care field for fewer than 5 years, including two who had only one or two years of teaching experience.

4.4.4 Experience Working with Children with Special Needs

Exactly half of the lead educators had more than 5 years of experience working with children with special needs, including 18% who had 10 years experience or more. Slightly more than one third of this sample (36%), however, had only recently begun to work with children with special needs, and had less than 3 years experience in direct work with them.

4.5 PROGRAM QUALITY AT BASELINE

Two initial measures of program quality (in actuality, quality within the particular preschool room that was the focus of the project) were obtained. *The Early Childhood Environment Rating Scale-Revised (ECERS-R)*[44] was used to assess program quality across a number of dimensions. The Baseline *ECERS-R* assessment was also used to ensure that the lead educator and director could reliably apply the measure. Baseline observations were used specifically by the inclusion facilitator, director, and lead educator to formulate collaborative action plans to guide and prioritize quality improvements. The *ECERS-R* was used again at Time 2 and Time 3 to assess change over time. In

addition, the inclusion facilitators utilized the *Caregiver Interaction Scales* (*CIS*)[45] to assess the quality and tone of staff-child interactions. The *CIS* was used only at Baseline.

4.5.1 *ECERS-R* Baseline Scores

At Baseline, prior to the active consultation phase, the 22 centres in this first cohort of centres averaged 4.56 on the full *ECERS-R* scale. This score is comparable to the average obtained across 234 centres in seven jurisdictions in the 1998 *You Bet I Care!* study of predictors of quality in Canadian child care centres (Goelman, Doherty, Lero, LaGrange & Tougas, 2000).[46] A score of 4.5 would be interpreted as indicative of a mediocre level of quality by Harms, Clifford & Cryer, the developers of this assessment procedure. Individual centre scores ranged from a low of 2.4 to a high of 5.8 out of a maximum of 7, with a standard deviation of 0.80. Based on the criteria used by Harms et al, six of the centres (27%) had scores indicative of good to very good overall quality at Baseline. While only one of the centres scored in the inadequate range (less than 3.0), most centres (15 or 68%) scored in the minimal to mediocre range (3.0 - 4.9).

Figure 4.1   Distribution of Total *ECERS-R* Scores at Baseline
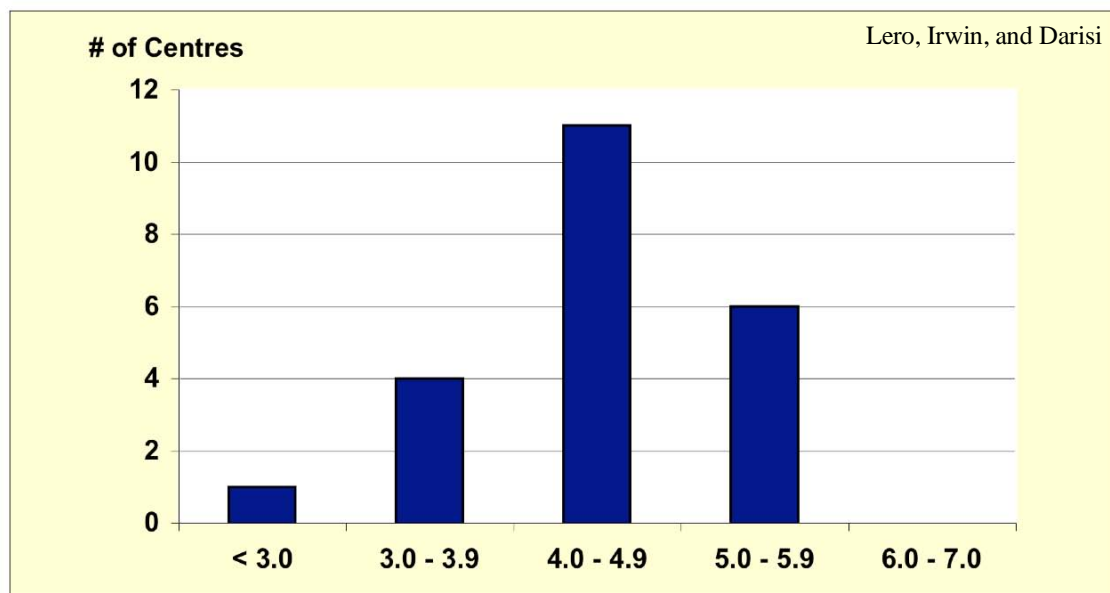
Based on 22 centres

Average scores on *ECERS-R* subscales ranged from a low of 3.6 to a high of 5.9. The two subscales with the lowest average scores were Learning Activities (3.6) and Language-Reasoning (4.3), indicating a need to enhance curriculum activities and enrich language opportunities. The Interaction subscale had the highest average score (5.9), indicating that staff in these programs were strongly involved in positive interactions with the children in their care and promoted positive peer interactions among the children.

Figure 4.2   Average *ECERS-R* Subscale Scores at Baseline

Lero, Irwin, and Darisi
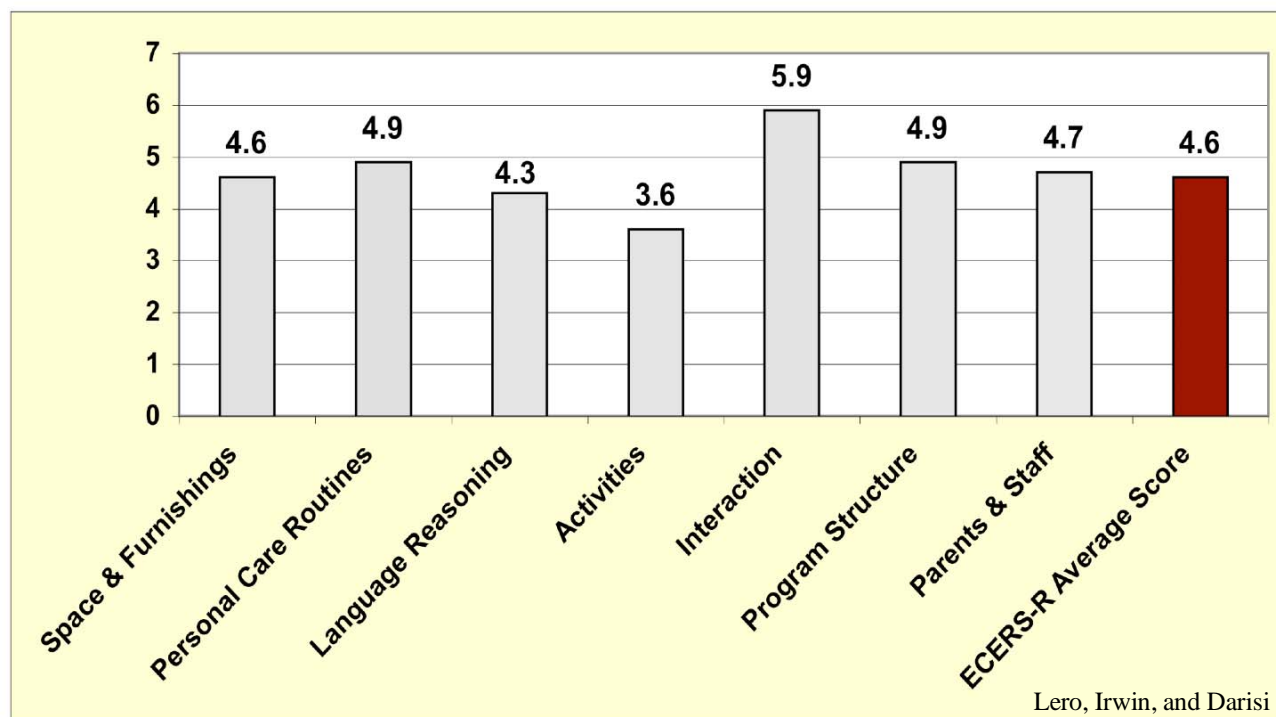
Based on 22 centres

4.5.2   Caregiver Interaction Scale Scores

The *CIS* is based on observations of the nature and quality of teacher-child interactions in a classroom with ratings based on the observed frequency of 26 specific behaviours. These behaviours, in turn, are then used to calculate three scores that summarize the frequency with which a trained observer sees: a) interactions characteristic of staff who are sensitive, warm, and engaged in interacting with the children; b) interactions that can be described as harsh, punitive or controlling; and c) teacher behaviours that suggest detachment, lack of supervision and lack of involvement in interacting with the children. Each behavioural item is scored from 1 (not observed or rarely observed) to 4 (usual, observed much of the time). High average scores are desirable for items that characterize Sensitivity and low scores are desirable on items that contribute to scores denoting Harshness and Detachment.

Observations of educators in the preschool classrooms that were the focus of this intervention project were made at Baseline by the inclusion facilitators following several hours of observing. The average scores on the three 3 *CIS* measures across all 22 programs were:

Sensitivity   3.4   Harshness   1.1   Detachment   1.3

The *CIS* scores obtained at Baseline from the *PFI-NS* centres are a close match to those obtained in the national *You Bet I Care!* Study (3.3 for Sensitivity, 1.3 for Harshness, and 1.4 for Detachment).

The scores obtained for this sample on the *CIS* are consistent with the high scores recorded on the "Interaction" subscale of the *ECERS-R,* suggesting that one of the strengths of the staff in these programs is the quality and positive tone of teacher-child interactions.

4.6   INCLUSION CAPACITY AND INDICATORS OF INCLUSION QUALITY AT BASELINE

The 22 centres that volunteered to be in the first cohort of centres to participate in the *Partnerships for Inclusion - Nova Scotia* project ranged from centres that had little or only sporadic experience in including children with disabilities to one centre that was recognized as a leader in the province with more than 25 years of experience as an inclusive centre. Similarly, directors and lead teachers varied in the amount of experience they have had with children and parents with special needs, and centres had different histories and different degrees of contact with various professionals and agencies that can support their efforts. What the centres, directors and staff had in common was the desire to extend their capacity to include children with special needs fully and comfortably in their programs.

4.6.1   Directors' and Lead Educators' Attitudes towards Inclusion

Both the directors and lead educators responded to a lengthy scale that assessed their attitudes to inclusion and their beliefs about inclusion as part of the questionnaires they completed prior to Baseline observations. As per previous Canadian studies (Irwin, Lero & Brophy, 2000; Irwin, Lero & Brophy, 2004), both the directors and lead educators were quite supportive of including children with a wide range of conditions in community-based child care programs, as long as appropriate resources were provided to support inclusion. Both groups were asked to indicate the extent to which they felt children with specific conditions should be included in community-based programs using a 5 point Likert scale where 1 = strongly disagree and 5 = strongly agree. Across 30 items describing different conditions, directors had an average score of 4.24 and lead educators had an average score of 4.16 out of 5.

There were, however, eight circumstances in which directors were more frequently uncertain or in disagreement about whether a child with that particular characteristic should be enrolled in a regular program. These items received a mean rating lower than 4.0 (equivalent to Agree) and were:

- A child who requires medical monitoring by the staff, e.g. a child with diabetes, heart problems, epilepsy, etc. (3.9),
- A child who often cannot recognize situations involving danger to him/herself (3.9),
- A child who has tested HIV positive (3.8),
- A child who has AIDS (3.7),
- A child who is at times uncontrollably aggressive (3.6),
- A child who requires catheterization if the parents are not willing or able to assist (3.5),
- A child who requires assistance with an artificial bowel or bladder if the parents are not willing or unable to assist (3.5), and
- A child who has moderate mobility difficulties if access is unsuitable (3.4).

Lead educators also expressed ambivalence under these circumstances, as well as when a child has a phobic resistance to school attendance.

Both directors and lead educators were strongly supportive of inclusion principles, as illustrated below; however both groups also expressed some uncertainty or ambivalence about whether it is better to have some child care programs accept children with special needs (with specialized resources) than try to have all child care programs be inclusive. Directors' average score on this item was 3.6 and lead educators averaged 3.3 out of 5. Previous experience in using these measures suggests that this response is an indicator of how much support is available to enable and sustain inclusive programs, as well as the amount of experience individuals have working with children with a wider range of special needs in an effective way (Irwin, Lero & Brophy, 2000; 2004).

Table 4.1 Directors' and Lead Educators' Beliefs about Inclusion (Mean Ratings)

Inclusion Statements	Directors	Lead Educators
1. Most child care programs would be willing to include children with special needs, if adequate resources were available.	4.6	4.8
2. Having children with special needs in child care benefits the non-disabled children.	4.6	4.5
3. Legislation should be passed to ensure disabled children and their parents have full access to child care programs.	4.5	4.2
4. Day care programs should accept all children, regardless of their individual needs.	3.7	3.8
5. It would be better to have some child care programs accept children with special needs (with specialized resources) than try to have all child care programs be inclusive.	3.6	3.3
6. Having children with special needs in most child care centres puts too much pressure on the staff.	3.5	3.6
7. Training for early childhood educators has provided them with a good background to support inclusion	3.1	3.5

Ratings: 1= strongly disagree, 3= uncertain, and 5= strongly agree.   Based on 22 centres

4.6.2   Directors' Reflections on Their Centre's Inclusion Capacity

Fourteen of the 22 directors reported that their centre had become more inclusive in their practices since 1996. When asked what had enabled their program to become more inclusive or more effective, 13 directors reported that additional personnel, such as resource teachers, had been instrumental in enabling their centre to become more effective at including children with special needs. Stronger support for inclusion amongst centre staff and more assistance from other professionals or services were also frequently reported by directors to have enabled inclusion. Other factors that were said to have enabled inclusion by about a third of directors were: additional training of staff, specific policy initiatives, information and support gained from networking with peers, and accumulated experience in working with children who have special needs.

When asked what, if anything has been a barrier or factor that has limited inclusion, 18 directors (82%) reported that inclusion at their centres was limited by having inadequate funding to support

inclusion. About half indicated that their staff were not adequately trained and that the stress caused by additional workload and time demands on centre staff limited their inclusion practices. Six directors noted that their staff had not been willing or committed to inclusion. Fully one half of the directors (50%) indicated that inclusion was limited by the general lack of provincial support and funding for child care programs. Other limitations to inclusion reported by directors were: no in-house resource teacher/support worker and limited support from other professionals or services.

It was further noted that 10 directors reported having turned down children with special needs in the past three years. Four directors noted that there was already the maximum number of children with special needs at their centre; four directors stated that they had turned down a child with special needs because the child required one-to-one attention; and two directors reported that the child was too aggressive. Other reasons for turning down children with special needs included: inappropriate physical access, a lack of funding, the child had complex health reasons, the staff were not willing, and that it was too difficult to meet parents' expectations.

4.6.3 Lead Educators' Reflections and Experience with Inclusion at Baseline

Most lead educators reported that, over the past 6 years, they had become more committed to inclusion, as well as more comfortable working with children who have special needs. As well, they reported that generally they were somewhat more accepting of a broader range of children being included in their program. Lead educators' comments emphasized both their commitment to inclusion and the need to have the appropriate resources in place (funding, human resources and equipment) in order to support inclusion.

Fifteen lead educators reported currently working with one or more children who have an identified disability or chronic health problem. While not currently working with children who have special needs, six additional lead educators reported having worked directly with a child with special needs in the past two years.

Lead educators with current or recent experience in working with children with special needs were asked in questionnaires how successful they felt they had been and what had been helpful and/or problematic. Overall, lead educators reported that they believed they have been moderately successful in including children with special needs in their program. In terms of their perceived level of success, lead educators' ratings on a 10-point scale (where 1 was "not at all successful" and 10 was "great!") ranged from 3 to 10. The mean rating was 7.7; however three lead educators rated their success as 5 or lower.

About half of the lead educators with experience in working with children who have special needs indicated that the most helpful resources were training and workshops, an external resource consultant, an in-centre special needs worker or resource teacher, visits from therapists, and specialized equipment or materials. As well, about half indicated that empathy and understanding from other staff and support from the parents of children with special needs contributed to their success.

When asked what they had found frustrating or problematic in their work with children who have special needs, lead educators most frequently noted issues about the program. These issues were: the lack of a support worker (7), lack of time to plan/consult (6), and lack of equipment/adequate space (4). Nine lead educators (41%) reported that their lack of knowledge and training was problematic in their work with children who have special needs. Other factors lead educators

reported were frustrating or problematic for them were: feeling pulled by the needs of the other children, feeling stressed, and the family's inability or unwillingness to follow through.

4.6.4   Enrollment of Children with Special Needs at Baseline

Information obtained by the inclusion facilitators from centre directors indicated that 16 (73%) of the participating 22 centres had at least one child with identified special needs enrolled prior to the consultation phase. In most cases, only one or two children with special needs were enrolled, however two programs reportedly had 4 or more children with special needs attending.[viii] These numbers pertain to children enrolled in the centre, not necessarily in the classroom in which the *PFI-NS* interventions were targeted. The children with special needs who were attending these programs had a range of conditions — the most common of which were autism, speech and language problems, global or pervasive developmental delay, and cerebral palsy. Of those children for whom information was available, 38% were described as having a mild disability, 38% were described as having a moderate disability, and 24% were described as having a severe disability. A few children with special needs had not yet been assessed and were on waiting lists. In addition, 13 directors reported that there were other children in their centre who, while not identified as having special needs, required additional supports or a modified curriculum (i.e., children "at risk" due to familial circumstances and children who do not speak English as a first language).

At the beginning of the project, only 8 of the 22 centres had a formal (written) inclusion philosophy. Fifteen directors said they had access to a resource teacher or specialist to support inclusion efforts. (It appears that in some centres this refers to an in-house resource teacher with specific training in inclusion hired above ratio; while in other centres, directors were speaking of program assistants who supported the inclusion of a specific child and had varying levels of education and experience.) Fifteen directors reported that their centre used individual program plans for each child with special needs. Typically, the ECE and resource teacher/specialist developed this plan. Outside consultants available to support inclusion in the past or currently included speech and language therapists, early interventionists, physiotherapists and occupational therapists, the Progress Centre and the Atlantic Provinces Special Education Authority. The nature and extent of support varies depending on children's and staff needs and the availability of support in the geographic area. Further information about the extent of these professionals' and agencies' involvement would be helpful.

4.6.5   Observations and Scores Related to Inclusion Obtained at Baseline

One or more children with special needs were enrolled in 13 of the classrooms in which lead teachers were active participants in *PFI-NS*. In these cases, the inclusion facilitator was able to make detailed observations about inclusion practices and work with the lead educator and other staff in the classroom to support the child's participation and development. In other cases, changes made to enhance program quality were seen to be useful in building the capacity to include children with special needs more effectively at a later time.

[viii]   These numbers are somewhat lower than those provided by directors on the director questionnaire (e.g. six centre directors reported that 4 or more children with special needs were enrolled on either a full or part-time basis on their questionnaires). The discrepancy may result from a tendency for inclusion facilitators to count only children with more visible disabilities or challenges for whom supported child care funding is available and from differences that arise when enrollments are reported at slightly different times.

Three measures were used to assess inclusion quality, as described in Chapter 3. The first, *ECERS-R Item 37* is a specific item that assesses provisions for children with disabilities. It was obtained only if a child with special needs was enrolled and present in the target classroom. *The SpeciaLink Inclusion Practices and Principles* measures were obtained for all centres, as they provide information that is useful for measuring inclusion capacity at the centre level.

SCORES ON ECERS-37: PROVISIONS FOR CHILDREN WITH DISABILITIES

The average score obtained for the 13 classrooms that included a child with special needs at Baseline on this multifaceted item was 4.7 out of 7, indicating mediocre quality. The average score, however, masks the fact that 5 of the 13 classrooms had scores of 1 or 2, indicating inadequate provisions for children with disabilities, while the remaining 8 classrooms were rated as 6 or 7, indicative of very good or excellent provisions. This degree of variation among the classrooms was expected. Centres that had many years of experience with children with special needs and staff with specialized training and ongoing support from external professionals and agencies were most likely to be rated 6 or 7.

SCORES ON THE SPECIALINK INCLUSION PRACTICES PROFILE

The *SpeciaLink Inclusion Practices Profile* is based on observations initially, and then on questions posed to the centre director. It is designed to assess 11 specific practices related to inclusion. Each item is scored on a scale from 1 to 5 with 1 indicating that only beginning efforts have been made to ensure inclusion quality, while 5 indicates an ideal setting with respect to that specific practice. Scores were obtained for each participating centre and reflect practices and resources in the centre as a whole.

The average score on the *SpeciaLink Inclusion Practices Profile* at Baseline was 3.3 out of a maximum of 5.0. Scores ranged from 2.1 to 4.5, with a standard deviation of 0.74. Individual item scores ranged from 2.5 to 4.6. Items that had the highest ratings (averaging above 4.0) were item 9, a rating of the extent to which interactions are facilitated among children with special needs and their typically developing peers, and item 3, indicating the extent to which the director is actively involved in supporting inclusion. Five items had average ratings below 3.0, indicating potential room for improvement. (See Table 4.2.)

Table 4.2 Average Scores on Items from the *SpeciaLink Inclusion Practices Profile* at Baseline

SpeciaLink Inclusion Practices Profile Items	Mean Rating
The degree to which modifications have been made to support inclusion and enhance accessibility	2.6
The extent to which adaptations have been made, and special equipment and materials are available and used in ways that allow children to participate comfortably in the group and that enhance their skills and capabilities	2.5
The director is actively involved in supporting inclusion, is knowledgeable and enthusiastic	4.3
The degree of support provided to staff through consultative assistance and flexible/reduced ratios to support them in meeting individual children's needs	3.5
The number of staff who have some training related to special needs and staff's access to continuing in-service training opportunities	3.3
The degree of provision of therapeutic intervention provided to children in the centre and the manner in which it is provided (in a pull-out space or separate clinic and/or within the program); the extent to which staff are involved in goal setting and work collaboratively with parents and therapists	3.2
The extent to which IPPs are used to inform programming in the regular group setting, and are developed collaboratively by resource teachers or consultants, staff and parents	2.7
The extent to which parents are involved, receive information and participate in decision making — both related to their own child, and as an advocate for other children at the centre and in the community	2.8
The extent of interaction between children with special needs and their peers; the extent to which social interaction is facilitated and children are accepted by others	4.6
The centre's board or parent advisory committee promotes and supports inclusion as policy in the centre and as desirable in the wider community	2.8
The degree to which the local school or school board, parents and program staff work collaboratively in transition planning and are proactive to support the child's school placement	3.9
Overall SpeciaLink Inclusion Practices Profile Score	3.3

Based on scores obtained from 22 centres

SCORES ON THE SPECIALINK INCLUSION PRINCIPLES SCALE

The *SpeciaLink Inclusion Principles Scale* is based on five questions posed to the centre director and is designed to assess the extent to which a centre has adopted principles to guide decisions about enrolling children with disabilities and ensure that their needs are met, as far as possible, within the regular setting. Score values reflect the director's replies, tempered by the inclusion facilitator's own opinion if she observes instances when practice appeared to diverge from the principles espoused by directors. Each item is scored on a scale from 1 to 5 with a value of 1 indicating that principles are completely undeveloped and a value of 5 indicating that the centre has adopted principles that explicitly support full inclusion and are evident in observed practices.

The average score on the *SpeciaLink Inclusion Principles Scale* at Baseline was 3.6 out of a maximum of 5.0. Scores were quite variable, ranging from 1.8 to 5.0, with a standard deviation of 1.15. Average scores on Inclusion Principles items ranged from 3.4 to 3.9, again masking the

variability among centres, since scores on most items ranged from 1 to 5, with some centres scoring consistently at either the high or low end on most items.

Table 4.3   Average Scores on Items from the *SpeciaLink Inclusion Principles Scale* at Baseline

SpeciaLink Inclusion Principles Scale **Items**	**Mean Rating**
Principle of Zero-Reject: No *a priori* limits are set that would exclude children with particular levels or types of disabilities.	3.4
Principle of Naturally Occurring Proportions: Roughly 10-20% of children with special needs, in "natural proportion" to their occurrence within the catchment area of the community are enrolled.	3.4
Principle re: Hours of Attendance: Children with special needs are not limited in their attendance to less than full-time participation.	3.8
Principle of Full Participation: The centre is committed to enabling full participation of children with special needs in the regular program and activities with accommodations as required.	3.9
Principle of Advocacy and Maximum Feasible Parent Participation: The centre is committed to reducing barriers to inclusion and promoting accessible high quality care for all children. It involves families to the maximum extent feasible and makes families feel welcomed and valued.	3.5
Overall SpeciaLink Inclusion Principles Scale Score	3.6

Based on scores obtained from 22 centres

4.6.6   Summary of Centres' Inclusion Quality at Baseline

One way to summarize the status of the participating centres at Baseline is to consider how they scored on all three measures of inclusion quality simultaneously. In our previous research (*Inclusion: The Next Generation*, Irwin, Lero & Brophy, 2004),[47] we developed an Inclusion Quality Index that effectively differentiated centres that demonstrated high, moderate and low levels of inclusion quality. Centres that demonstrated high inclusion quality in that study had scores of 7 on Item 37 of the *ECERS-R*, 4.3 or above on the *SpeciaLink Inclusion Practices Profile*, and 4.1 or above on the *SpeciaLink Inclusion Principles Scale*. Centres that had low demonstrated inclusion quality had scores of 3.9 or below on the *ECERS-R*, 3.0 or below on the *SpeciaLink Inclusion Practices Profile*, and 2.8 or below on the *SpeciaLink Inclusion Principles Scale.* Among those centres in the *PFI-NS* sample for which all three scores were available (n=13), two would qualify as evidencing high inclusion quality using this method, one would be classified as demonstrating low inclusion quality, and the majority would be in the moderate range.

When all the data available in this section are considered, one can conclude that most centres at Baseline could improve in their capacities to include children with special needs effectively. The generally positive attitudes of the directors and staff provide a good starting point. Our past research demonstrates that effective inclusion requires a mix of resources within the centre and supports provided to the centre. Of course, one always wants to ensure that the programs children are included in are of high overall quality. That is exactly why the *Partnerships for Inclusion - NS approach* focuses on improving both overall program quality and inclusion capacities.

End Notes

43   Irwin, S.H., Lero, D.S. & Brophy, K. (2004). *Inclusion: The next generation in child care in Canada.* NS: Breton Books. Available from http://www.specialinkcanada.org.

44   Harms, T., Clifford, R. M., & Cryer, D. (1998). *Early Childhood Environment Rating Scale - revised edition (ECERS-R).* N.Y.: Teachers College Press, Columbia University.

45   Arnett, J. (1989). Caregivers in day care centers: Does training matter? *Journal of Applied Developmental Psychology 10*: 541-552.

46   Goelman, H., Doherty, G., Lero, D.S., LaGrange, A. & Tougas, J. (2000). *You Bet I Care! -- Caring and learning environments: Quality in child care centres across Canada.* ON: University of Guelph: (Centre for Families, Work and Well-Being). Available from Web Site: http://worklifecanada.ca

47   Irwin, S.H., Lero, D.S. & Brophy, K. (2004). *Inclusion: The next generation in child care in Canada.* NS: Breton Books. Available from http://www.specialinkcanada.org.

CHAPTER 5:   ASSESSING THE IMMEDIATE AND LONGER-TERM EFFECTS OF *PFI-NS*

This chapter provides clear evidence of the positive effects of the *PFI-NS* model of assessment, collaborative action planning, and direct support on program quality and suggests that there were modest improvements in centre inclusion capacity as well. The data include scores obtained on repeated administrations of the *ECERS-R* measure of overall quality at three points in time: Baseline, the end of the active consultation period (Time 2), and after a sustainability period of 4-5 months (Time 3). Interviews with the director and lead preschool educator in each centre at Time 2 and inclusion facilitators' detailed case notes throughout the project provide additional information about the changes made in programs, educators' attitudes and positive involvement, and the benefits observed for children attending the programs.

5.1   IMPACTS ON MEASURED PROGRAM QUALITY

5.1.1   Improvements in *ECERS-R* Scores from Baseline to Time 2

Scores on the *ECERS-R* measure of program quality were available for 21 of the 22 centres across all three data points.[ix] The average *ECERS*-R score of these classrooms was 5.49 at Time 2 compared to 4.57 at Baseline, a difference that was highly significant statistically (p < .001). At Time 2, *ECERS-R* scores ranged from 4.21 to 6.52 out of a maximum of 7.0, with a standard deviation of .62, while Baseline scores ranged from a low of 2.71 to a high of 5.80.

At Baseline, five centres (22.7%) had overall *ECERS-R* scores in the minimal or inadequate range (below 4.0); including one with an average score below 3.0; only five centres (22.7%) had scores of 5.0 or above. At Time 2, 17 of the 21 centres (81%) had overall *ECERS-R* scores above 5.0, the cut-off that indicates good overall quality, including 5 centres that exhibited very good quality with scores above 6.0. None of the centres scored below 4.0 at Time 2 or Time 3. Figure 5.1 shows the number of individual centres at each level of quality at Baseline and Time 2, the end of the active intervention period.

In addition to tests of statistical significance, it is important to underscore what Kontos (1996)[48] and Campbell and Milbourne (2005)[49] refer to as "observable changes" in program quality — changes that result in a classroom's overall score moving from one quality category to another (i.e., a change from inadequate to adequate care or adequate to good quality care *or* when both pre-and post-test scores are in the good quality category but there is a mean score difference of at least 1 full point, such as a change from 5.25 to 6.40). Based on this criterion, 13 of the 21 participating *PFI-NS* classrooms (61.9%) demonstrated an "observable change" in program quality between Baseline and Time 2, the end of the active intervention period. (Eleven of the 13 centres changed quality categories, while two made observable improvements within the good quality range.)

In all, 7 of the 21 individual classrooms evidenced an improvement of .50 - .99 and 11 of the 21 classrooms recorded an increase of 1.0 or more on the overall *ECERS-R* score. The fact that almost all centres showed some improvement is important, as it indicates that the *PFI-NS* model has

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[ix]   One centre was not included after the Baseline assessments due to multiple changes in staff and the facilitator's decision to focus on the whole centre, rather than just one preschool room.

positive effects across the range of centres, including those that started off with scores indicating overall good quality. Obviously, centres that had the lowest scores on the *ECERS-R* measure at Baseline had the highest potential for improvement.

Figure 5.1   Distribution of Total *ECERS-R* Scores at Baseline and Time 2

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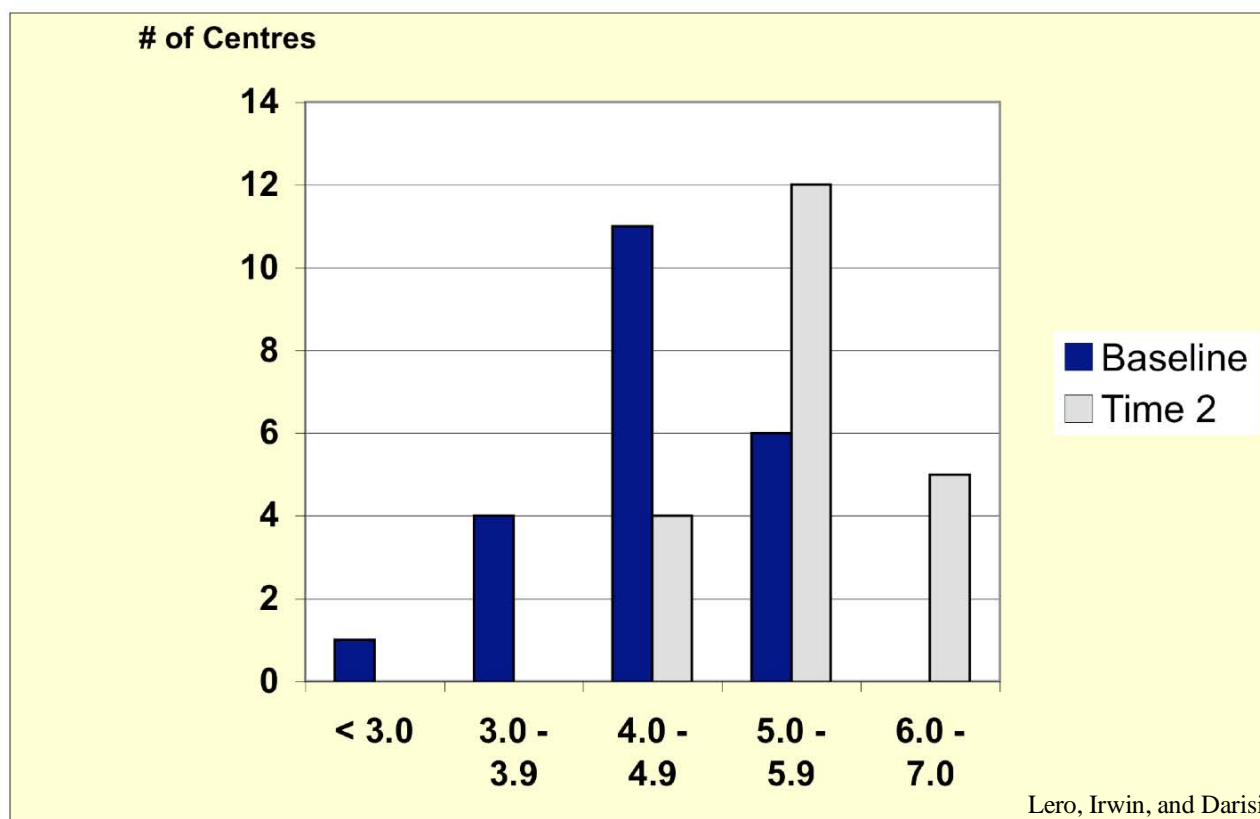
* 22 centres at Baseline; 21 centres at Time 2

Table 5.1 provides information on changes observed on the seven *ECERS-R* subscales between Baseline and Time 2. Prior to intervention, average scores on 5 of the 7 subscales were in the mediocre range and only 2 had average scores indicating good quality. At Time 2, all but one subscale average indicated that good development-enhancing practices and experiences were observed.

Table 5.1   *ECERS-R* Scores Before and After Consultation (Baseline and Time 2)

Category	Baseline Score		Time 2 Score		Comparison	
	M	Range	M	Range	Mean Difference	Significance
Total *ECERS-R* Score	4.6	2.6 - 6.0	5.5	4.2 - 6.5	.925	.000
Space and furnishings	4.6	2.2 - 7.0	5.6	3.6 - 6.5	1.041	.000
Personal care	4.9	2.5 - 6.0	5.7	3.3 - 7.0	.730	.007
Language - Reasoning	4.3	2.4 - 5.4	5.3	3.3 - 7.0	.952	.000
Activities	3.6	2.0 - 6.8	4.8	3.5 - 6.1	1.200	.000
Interactions	5.9	2.5 - 7.0	6.3	2.6 - 7.0	.390	.021
Program structure	5.0	2.8 - 6.7	6.2	4.5 - 7.0	1.190	.001
Parents and Staff	4.7	2.7 - 5.8	5.4	4.0 - 7.0	.689	.000

 Based on N = 21

Statistical comparisons of differences between Baseline and Time 2 were all significant at the .01 level, with the exception of scores on the Interaction subscale, on which centres had high average scores at Baseline, resulting in a ceiling effect. Even there, however, the overall difference in scores was statistically significant at the .05 level. (See Figure 5.2.)

Scores on the *Activities* and *Program Structure* subscales showing the greatest average improvement (+1.20 and +1.19, respectively). The specific items that showed the greatest average improvement from Baseline to Time 2 were:

- Item 25, Nature and science (average change of +2.71),
- Item 34, Schedule (+2.48),
- Item 3, Furnishings for relaxation and comfort (+1.86),
- Item 7, Space for gross motor play (+1.71), and
- Item 22, Blocks (+1.62).

5.1.2   Improvements Maintained: *ECERS-R* Scores From Time 2 to Time 3

While *PFI-NS* facilitators provided full reports to the centres following the Time 2 assessment and once again engaged the director and lead educator in collaborative action planning to encourage further improvements, facilitators did not make regular visits during the sustainability period, which covered the 4-5 month period from June to October/November. However, this may have been a time for facilitating visits to other centres, completing inter-rater reliability checks with lead educators, or providing specific professional development that couldn't be scheduled for centres during the support period.

At the end of the sustainability period, the average overall score on the *ECERS-R* was 5.60, slightly but not significantly higher than the average of 5.49 at Time 2. Scores ranged from 4.82 to 6.42, with a standard deviation of .49. Again, 80% of classrooms had scores indicative of good to very good quality and 20% scored in the mediocre range, but these scores were approaching the 5.0 cut-off that indicates good, development-enhancing learning and care.

Figure 5.2 shows scores on the *ECERS-R* subscales and overall scale at Baseline, the end of the active intervention period (Time 2), and following the 4-5 month sustainability phase (Time 3).

None of the comparisons between Time 2 and Time 3 scores were statistically significant, indicating that, on average, improvements made from Baseline to Time 2 were maintained.

Only four centres showed a slight decrease in overall *ECERS-R* scores (.25 or greater) between Time 2 and Time 3. None of these centres, however, slipped below a score of 4.8. By contrast, six centres continued to improve, with overall scores increasing by .25 or more from Time 2 to Time 3. Centres' scores most frequently declined on the *Parents and Staff* subscale (9 classrooms had slightly lower scores at Time 3); *Program Structure* (8 classrooms had lower scores at Time 3); and *Interaction* (7 classrooms had lower scores at Time 3). Specific individual items that showed the greatest declines from Time 2 to Time 3 were:

- Item 8, Gross motor equipment (average change of -0.62),
- Item 18, Informal use of language (-0.62),
- Item 34, Schedule (-0.57), and
- Item 43, Opportunities for professional growth (-0.43).

Figure 5.2   Average *ECERS*-R Scores at Baseline, Time 2 and Time 3 in *PFI-NS* Preschool Rooms

Lero, Irwin, and Darisi

	Space & Furnishing	Personal Care Routines	Language Reasoning	Activities	Interaction	Program Structure	Parents & Staff	ECERS Overall Score
Baseline	4.6	4.9	4.3	3.6	5.9	4.9	4.7	4.6
Time 2	5.6	5.7	5.3	4.8	6.3	6.2	5.4	5.5
Time 3	5.6	5.9	5.2	5.0	6.5	6.3	5.3	5.6
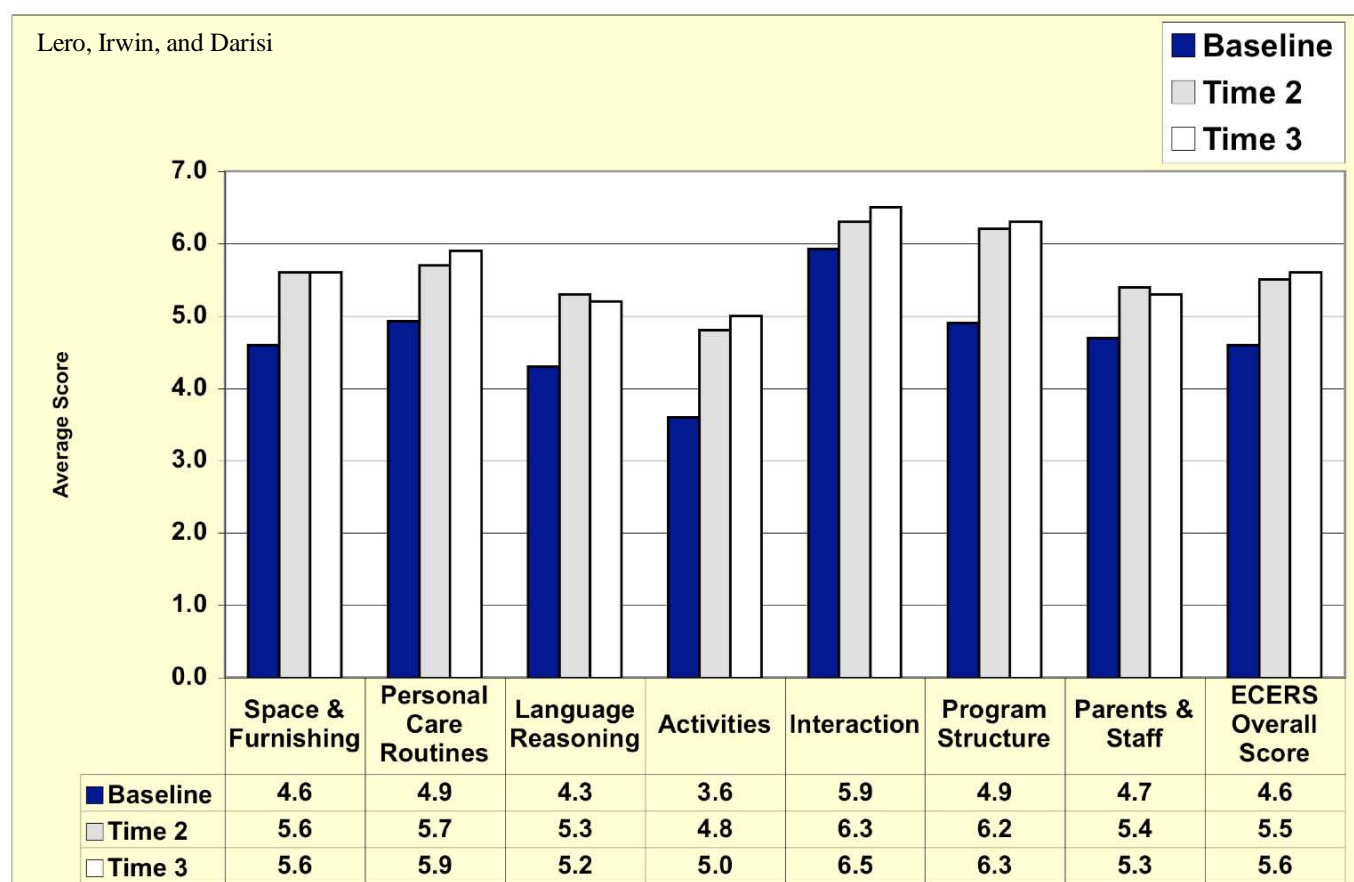
Based on 21 centres with scores available at Baseline, Time 2 and Time 3

5.2 CHANGES MADE TO ENHANCE PROGRAM QUALITY AND INCLUSION CAPACITY

At Time 2, 20 centre directors and lead educators participated in semi-structured telephone interviews to obtain their views of how the *PFI-NS* interventions and supports affected their program.[x] They were prompted to discuss changes relating to each of the *ECERS-R* subscales that were directly attributable to participation in *PFI-NS* and to provide more details about the nature of the changes that were made. In addition, the interviews provided directors and staff with an opportunity to comment on what had enabled or frustrated improvements, what benefits they felt children were deriving, and whether the changes had an impact on their capacity to include children with special needs. The following section summarizes the information obtained about changes in each aspect covered by the *ECERS-R* measure.

Space and Furnishings: 65% of the directors reported that the biggest, most visible change was rearrangement of the classroom. Directors noted that an improved layout enhanced children's participation and experience: for example, activity centres had become better defined and more accessible, quiet areas were made available, and displays were made more child-related.

All lead educators reported improvements in this area: 65% reported the development of a soft, quiet play area; 50% of educators reported changes to the classroom layout and better organization of materials through the addition of shelves and labels; 35% reported acquisition of equipment and materials; and 25% reported greater use of child-related displays.

Personal Care Routines: 70% of the directors reported changes to snack and meal times that enabled children to become more involved in helping, and commented that there was more interaction between staff and children. As well, 40% of directors reported that staff demonstrated greater awareness and consistency in personal care routines, and had, for example, made improvements to hand washing and toileting procedures.

Similarly, 80% of lead educators reported positive changes to snack and meal times. Children were said to be more involved in helping, and it was reported that staff sit and interact with children more. Some educators commented that these changes have been very successful and that the children enjoy these times. Other changes included increased interaction between staff and parents during arrival and departure times.

Language and Reasoning: 65% of directors reported changes related to staff awareness of language and reasoning development and interaction styles. They reported having observed an increased use of open-ended questions and extended conversations between the staff and the children. As well, 40% of directors reported improvements to book areas. In particular, books were said to be more accessible to children, were rotated more often, were more varied in content and reflected greater diversity, and were more suitable to children's developmental stage.

55% of lead educators also reported changes in staff interactions with children that included more open-ended questions. Educators reported having gained an increased awareness of the need to expand language and reasoning. Staff also reported that they had become more encouraging of children's problem solving and interactions with other children. Thirty-five percent of the educators reported improved access to books and more time reading to children.

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[x]   Copies of the interview schedules are included in Appendices A and B to this report.

Activities: The majority of directors reported development and expansion of different activity centres. In particular, changes most frequently noted related to the dramatic play area; art, science and nature activities; and music and movement. As well, 30% of directors commented that staff had more ideas for activities that were more creative, child-initiated and inclusive, in keeping with inclusion facilitators' encouragement of an emergent curriculum approach.

Thirty-five percent of lead educators reported improvements to dramatic play, science and nature activities, and programming. More materials were added, and some teachers said they developed more ideas for engaging the children. As well, 35% noted that art activities were more creative, and less teacher-directed; 15% reported that activities had been improved by the addition of more equipment, toys and games.

Interactions: More than half of the directors reported few changes to interactions, many noting that staff were already strong in this area. Changes that were mentioned included improved staff-child interaction and child-peer interactions. Twenty-five percent of directors noted that staff initiated more interactions with the children and were more encouraging of children's communication. As well, 25% of directors observed that the children had improved peer interactions and conflict resolution.

Forty-five percent of lead educators reported improvements to staff-child interactions in that teachers initiated more interactions, and were more focused on listening to and playing with children. Thirty-five percent reported that children more often engaged in conflict resolution, were less confrontational, and were more cooperative with each other.

Program Structure: 50% of directors commented that schedules were better planned and were more flexible, and that there were smoother transitions between activities; 20% reported that the program structure had changed in that there were more choices for children. Twenty percent of directors also reported that the program was more inclusive of all children.

Similarly, 45% of lead educators reported changes to the schedule, with greater flexibility and smoother transitions between activities. Programs were said to have become more age-appropriate, to offer more choices to children, and to allow more time for small groups. Twenty percent of lead educators also reported that their programs were more inclusive of children with special needs.

Parents and Staff: 60% of directors reported there was greater support for staff, including professional development, the addition of a staff room, breaks, and better, more consistent evaluation procedures. Twenty-five percent of directors noted that parents received more communication from the centre and have increased their involvement.

Fewer lead educators (30%) reported that changes had been made to allow for more professional development, evaluations, and staff breaks. Twenty percent noted changes were made to improve parent involvement and access to centre information. These lead educators reported that, as a consequence, there was greater communication between staff and parents.

Overall Comments about the Training and about Making Changes Relating to the *ECERS-R* included:

> *"As a director, the ECERS has helped me with long-range planning and with justifying what I am doing."*

"Our biggest surprise after an ECERS was conducted was the small things — and then once making a few minor changes, we improved our score greatly! After getting over the initial intimidation of having an 'outsider' evaluate 'your' program, the rest was easy to hear and to change and our centre greatly benefited from the experience." (Director)

"Doing the ECERS in our room has made us more aware of how your classroom is set up, and the importance of both rotation and consistency, which has a direct result on the children." (Lead Educator)

"ECERS training has given me the opportunity to learn more about what my room has to offer, but also about my own personal limits and expectations. This project gave me the challenge I needed to get out of the rut that I feared I was falling into." (Lead Educator)

While some child care professionals may have reservations about the focus on the *ECERS-R* scale and an emphasis on score improvement, these quotes indicate that the use of a quantitative tool with clear indicators of what improvements result in higher scores can be an effective means to promote quality in a range of areas. Moreover, engaging staff in setting goals, learning about emergent curriculum approaches, responding to individual staff needs, and providing both information and encouragement complemented and diffused the emphasis on scores alone.

The inclusion facilitators also noted many successes in centres' efforts to improve the quality of their environments that correspond to the directors' and lead educators' observations about the changes they made. In particular, facilitators noted improvements in program activities, and the efforts directors and educators made to improve the curriculum with well-designed and well-organized activity areas and the adoption of a more child-centered curriculum approach. Facilitators also noted the efforts made to improve room arrangements and how these enhanced children's participation.

Both the centre staff and the facilitators observed that it was easiest for directors and educators to effect change initially by purchasing new materials and equipment. Facilitators also observed that it was easier for centres to improve their scores in areas that had low scores at Baseline and was more difficult when centres started out with high scores. Nevertheless, facilitators commended the efforts centres and ECEs made to improve the quality of their programs and the successes that were evident across most centres.

Further Improvements:

While the majority of directors reported that improvements had been achieved on each of the *ECERS-R* subscales, there were some who were aware of the need for further improvements at the end of the active intervention period. In particular, 25% of directors noted that further improvements were needed in the classroom related to *Activities*, and 20% said noted that further improvements were needed in *Language and Reasoning*.

Similar to the directors, lead educators believed that there were still areas that could be improved. Specifically, 35% of lead educators reported that further improvements in *Program Structure* were needed and 20% reported that further improvements were needed in *Activities*. Collaborative action planning at the end of the intervention period provided information and encouragement to continue improvements in these and other areas.

5.3   CREATING REFLECTIVE PRACTITIONERS: IMPACTS OF *PFI-NS* ON STAFF

5.3.1   Directors' Observations

Throughout the follow-up interview, directors repeatedly mentioned having observed positive changes in staff awareness and attitudes as a result of their participation in *PFI-NS*. When asked directly about effects on the staff, almost all reported that they had observed positive effects (see Figure 5.3). They noted that educators were more positive, more actively involved in their work, and more aware of how to deliver quality care to meet children's needs. Directors reported that a major effect on staff was a change in their attitudes and focus. Staff were said to be more enthusiastic, focused, and reflective about quality care. Thirty-five percent of directors reported staff had improved their skills and knowledge. Staff were also said to be more confident and involved in their work.

More than half of the directors discussed improvements to management-related issues. They reported that they and their staff had become more effective in working together as a team and that more attention was being given to professional development. Staff meetings were said to be more productive and valuable. As well, some mentioned that they, as directors, were better equipped to organize and evaluate staff.

Figure 5.3   Directors' Comments on the Effects of *PFI-NS* on Staff
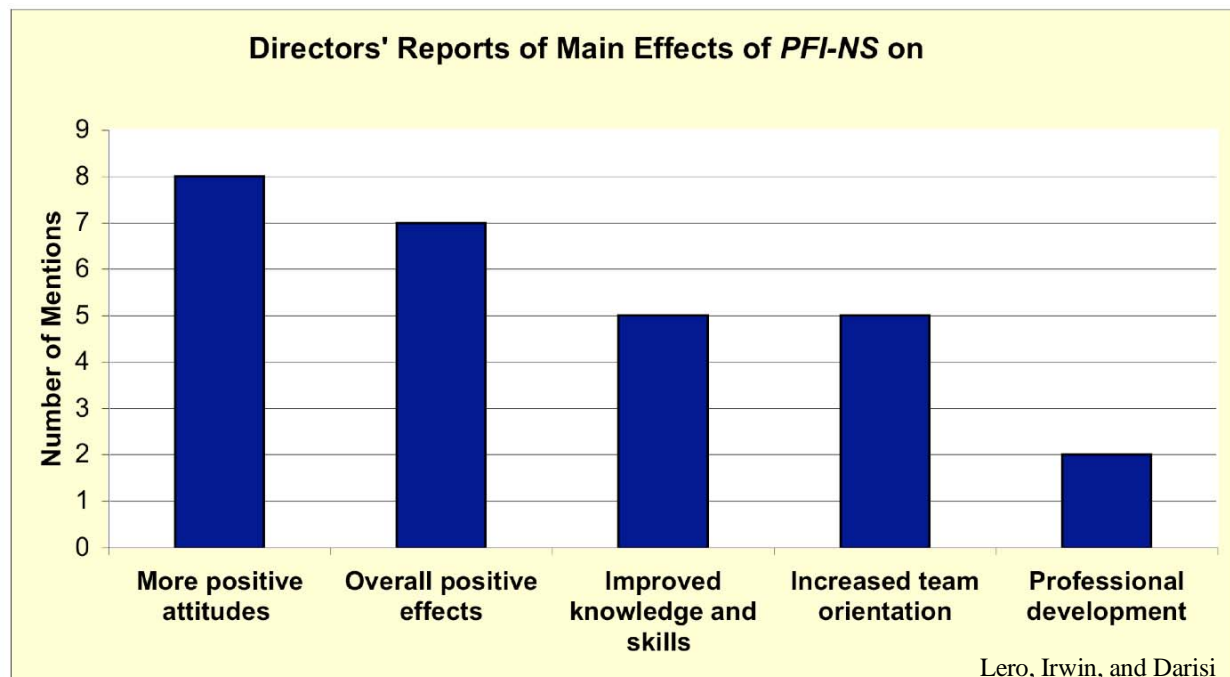
N = 20 directors

Directors' comments about the impacts of *PFI-NS* on staff included:

> *"It has challenged them; they are more aware of what quality means. They can now define activities such as science and math more accurately and understand what materials they need and how to use them."*

> *"I think that the staff are more conscious of how they are doing with their job, making sure that they've looked at it to see what kind of program they have. It's much better."*

> *"Staff that have been here for a long time, they are realizing that they don't know it all. The ECERS training helped them want to improve and change with the times."*

> *"Our program seemed blocked and ECERS came at the right time. … PFI really helped [staff] to see why I wanted things done differently."*

5.3.2 Lead Educators' Observations

Lead educators also reported that PFI-NS had a positive impact on themselves individually and on other classroom staff (see Figure 5.4). Almost half reported an improvement in staff attitudes, awareness and approach. They noted that they and other educators in their classrooms were more confident and comfortable in their abilities to meet the needs of children and parents. Some said that they had become more enthusiastic about their work and more attentive to the children. Some lead educators also reported that there was an improvement in working together as a team. Other positive effects on staff included an increase in knowledge and skills, and the feeling that they could do a better job providing quality care.

Lead educators made the following comments:

> *"I'm growing as a professional and a team leader."*

> *"When I finished school, I was full of ideas, but couldn't make changes on my own. PFI has been a good eye-opener and a good reinforcer. Staff meetings are held as a result of PFI and are valuable."*

Importantly, changes in staff attitudes and behaviour were seen to have a positive impact on children's experiences. Some educators saw themselves as listening to and interacting more with the children. As well, many believed that they were better able to respond to children's needs.

They said:

> *"The project has definitely helped the children. We are always listening to them, watching them. We talk about what we can do now, how can we extend this. … I feel the children are more empowered and have better self-esteem."*

> *"My practice has changed. I now plan from the children's interests. I am more on the floor with them, talking to them and listening."*

Figure 5.4   Lead Educators' Comments on the Effects of *PFI-NS* on Staff

Lead Educators' Reports of Effects of *PFI-NS* on
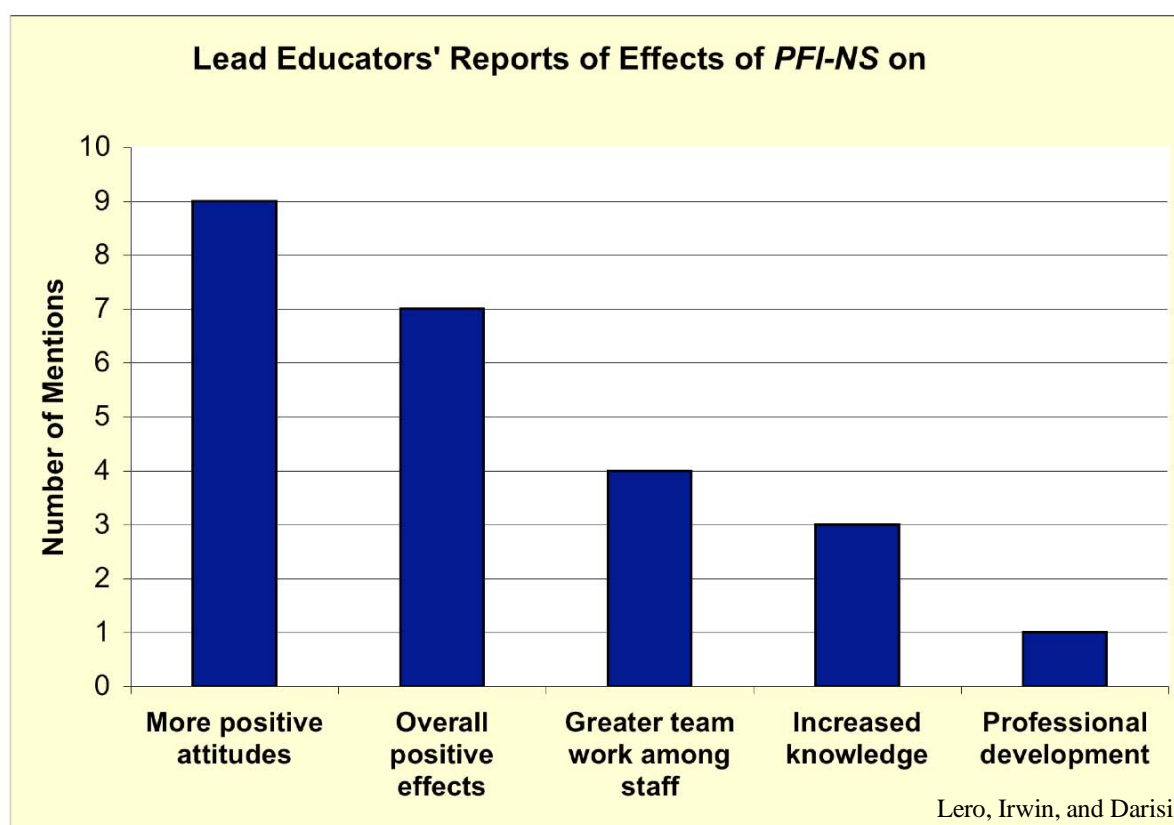
N = 20

5.4   CHANGES TO INCLUSION CAPACITY AND INCLUSION QUALITY

Improvements in program quality and more child-centred practices can enable children with special needs to participate in child care programs more easily. However, other changes and resources are required to ensure that children with special needs will benefit fully and that staff are supported in their efforts. This section of the report provides a mixed picture of improvements in inclusion effectiveness that was more effectively captured in interviews with directors and lead educators and in the inclusion facilitators' case summaries than in changes in the quantitative measures used for this cycle of *PFI-NS*. It appears that some centres/classrooms with limited experience became more willing to include children with special needs, while other centres/educators with more experience improved their effectiveness in working with the children in a planned and effective manner.

Not all centres had children with special needs in their program over the duration of the project, and sometimes children with special needs were enrolled in the centre, but not in the preschool room that was the target of *PFI-NS* interventions. In all, 15 of the classrooms had at least one child with special needs attending during the 10-11 month period when *ECERS-R* observations were made; however only 8 rooms had a child with special needs at all three data points. Furthermore, facilitators' records show that if there were children with special needs in the participating classroom, they were often not present for each observation, that they started the program after the beginning of the project or that they left the program before project completion. As well, facilitators

occasionally attributed improvement in scores to the absence of a child with special needs at one of the observations or a decrease in scores to the presence of a child with special needs at one of the observations.[xi]

5.4.1 *ECERS-R* Item 37 — Provision for Children with Disabilities

Figure 5.5 shows the number of classrooms at each level on Item 37 of the *ECERS-R* measure at Baseline, the end of the active intervention period (Time 2), and after the sustainability period. These scores do not pertain to the same classrooms/centres across the three periods, however.

At Baseline, the average score for 13 preschool classrooms on Item 37 was 4.7, with 5 classrooms scoring in the inadequate range (1 or 2) and 8 classrooms scoring in the very good range (6 or 7). At Time 2, the average score for 13 classrooms was 5.8. Eight classrooms had scores on Item 37 at Time 3, the end of the sustainability period. The average score for these classrooms was 6.0. No preschool room was assessed as having inadequate provisions for children with special needs at Time 2 or Time 3.

Figure 5.5   Distribution of Classrooms on *ECERS-R* Item 37 Scores Across Each Phase of *PFI-NS*
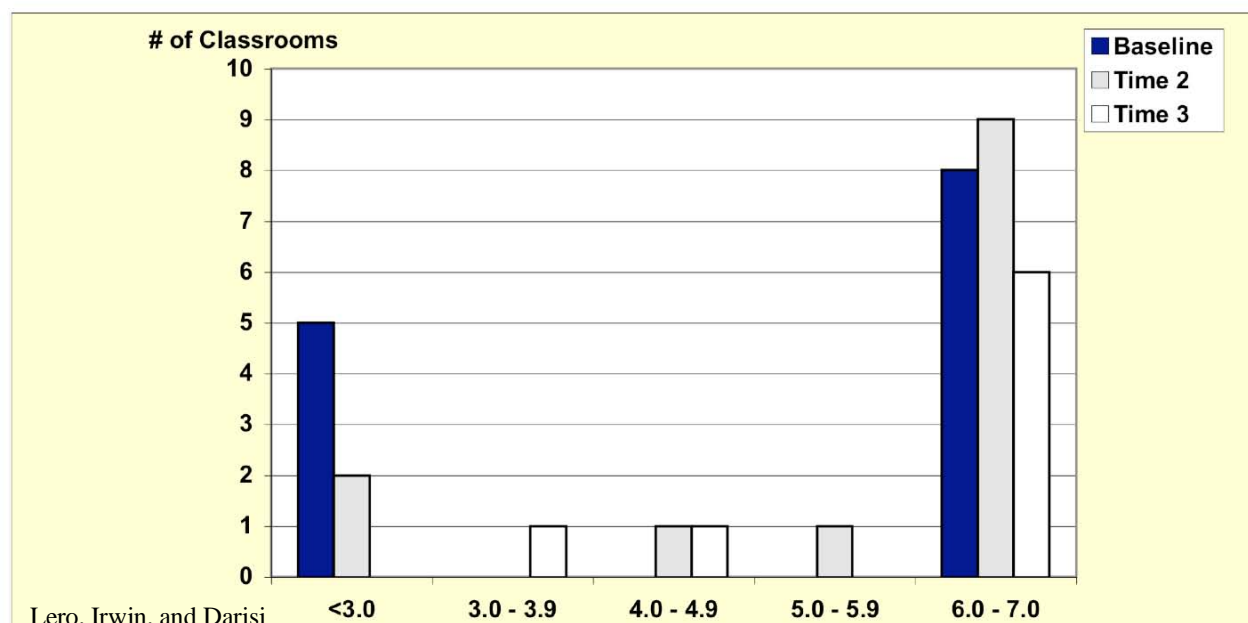
13 classrooms at Time 1, 13 classrooms at Time 2, 8 classrooms at Time 3
• Scores do not pertain to the same centres/classrooms across data points.

Scores on *ECERS-R* Item 37 were available for 12 preschool rooms at both Baseline and Time 2. One classroom showed a decline, 5 rooms had the same score at both points, and 6 classrooms had

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[xi]   These effects can occur because certain items or indicators on the *ECERS-R* are scored only if a child with special needs is present when observations are made.

higher scores at the end of the intervention period. Between Time 2 and Time 3, 4 classrooms maintained their score and two improved their score on this item; however, two classrooms had lower scores at Time 3 than at Time 2. These results suggest that improving and maintaining inclusion quality across time requires additional focus in the project, especially as children with special needs come and go, with varying levels of support from government, resource consultants, and specialized professionals.

5.4.2 Scores on the *SpeciaLink Inclusion Practices Profile*

The average score on the *SpeciaLink Inclusion Practices Profile* was 3.3 out of a maximum of 5.0 at Baseline, 3.4 at Time 2 and 3.6 at Time 3. Scores ranged from 2.1 to 4.6 at Baseline. As shown in Table 5.2, improvements on this measure were modest and not statistically significant for the sample as a whole. For the majority of centres, scores changed less than 0.50 from the Baseline assessment.

Table 5.2   Average Scores on Items from the *SpeciaLink Inclusion Practices Profile* at Baseline, Time 2, and Time 3

SpeciaLink Inclusion Practices Profile Items	Baseline	Time 2	Time 3
The degree to which modifications have been made to support inclusion and enhance accessibility	2.6	2.6	2.7
The extent to which adaptations have been made, and special equipment and materials are available and used in ways that allow children to participate comfortably in the group and that enhance their skills and capabilities	2.5	2.8	**3.4***
The director is actively involved in supporting inclusion, is knowledgeable and enthusiastic	4.3	4.2	4.5
The degree of support provided to staff through consultative assistance and flexible/reduced ratios to support them in meeting individual children's needs	3.5	3.8	4.1
The number of staff who have some training related to special needs and staff's access to continuing in-service training opportunities	3.3	3.3	3.3
The degree of provision of therapeutic intervention provided to children in the centre and the manner in which it is provided (in a pull-out space or separate clinic and/or within the program); the extent to which staff are involved in goal setting and work collaboratively with parents and therapists	3.1	3.3	3.5
The extent to which IPPs are used to inform programming in the regular group setting, and are developed collaboratively by resource teachers or consultants, staff and parents	2.7	**3.4***	3.3
The extent to which parents are involved, receive information and participate in decision making — both related to their own child, and as an advocate for other children at the centre and in the community	2.8	3.0	**3.6***
The extent of interaction between children with special needs and their peers; the extent to which social interaction is facilitated and children are accepted by others	4.6	4.7	5.0
The centre's board or parent advisory committee promotes and supports inclusion as policy in the centre and as desirable in the wider community	2.8	2.7	**3.3***
The degree to which the local school or school board, parents and program staff work collaboratively in transition planning and are proactive to support the child's school placement	3.9	4.1	3.6

*While not statistically significant, these scores are higher than their previous scores by .50 or more.

5.4.3 Scores on the *SpeciaLink Inclusion Principles Scale*

The *SpeciaLink Inclusion Principles Scale* was completed for all 22 centres at Baseline and for 21 centres at Times 2 and 3. The average score was 3.6 (out of a maximum of 5.0) at Baseline, 4.0 at the end of the active consultation phase, and 3.9 at the end of the sustainability period. At Time 2, 13 classrooms had higher scores on the *SpeciaLink Inclusion Principles Scale* than at Baseline (on average +0.62 higher), 5 centres maintained their scores, and 3 had lower scores. The difference in average scores across time on this measure was not statistically significant, however.

Table 5.3 Average Scores on Items from the *SpeciaLink Inclusion Principles Scale* at Baseline, the End of the Active Support Phase (Time 2) and the End of the Sustainability Period (Time 3)

SpeciaLink Inclusion Principles Scale Items	Baseline	Time 2	Time 3
The principle of zero reject	3.4	4.0	3.8
The principle of naturally occurring proportions	3.4	4.0	3.6
Hours of attendance	3.8	4.2	4.1
Full participation	3.9	4.0	4.2
Advocacy for inclusion and maximum feasible parent participation	3.5	4.0	3.7

N = 22 at Baseline and 21 at Time 2 and Time 3

5.4.4 Changes Made to Support Inclusion: Directors' and Lead Educators' Reports

Based on the interviews conducted at Time 2, about two thirds of the directors and lead educators said that they and their centre had become more accepting of including a broader range of children with special needs. (Twenty percent of directors commented their centre had always been inclusive of all children, as did 35% of lead educators.)

Twelve directors and 12 lead educators (60%) reported that increased staff awareness and knowledge of inclusion principles supported greater inclusion. They believed that *PFI-NS* training contributed to staff becoming more willing, confident, and comfortable in working with children who have special needs. As a result of increased skills and more accepting attitudes, staff were observed to have increased their time and interaction with children who have special needs, to put greater effort into communication, and to avoid singling out children with special needs. (See Figure 5.6)

Seven directors discussed program changes, such as the use of individual program plans (IPPs), reflective of more effective inclusion. They reported having implemented IPPs, or using a new format for IPPs, and getting more staff input into IPP development. Two lead educators reported program changes had been made to support inclusion. In particular, individual program plans were used and programming offered children greater freedom to choose activities.

Six directors reported that they had increased their ability to locate and use external resources, which allowed greater acceptance of children with special needs. Changes made to the layout and organization of space helped to create a more accessible classroom environment. A few (3) directors indicated that participation in *PFI-NS* was a catalyst for change in that it raised awareness of the

limitations of the centre and the need for growth. As well, increased access to funding helped some centres become more accepting of children with special needs.

Figure 5.6   Reported Changes that Support Greater Inclusion
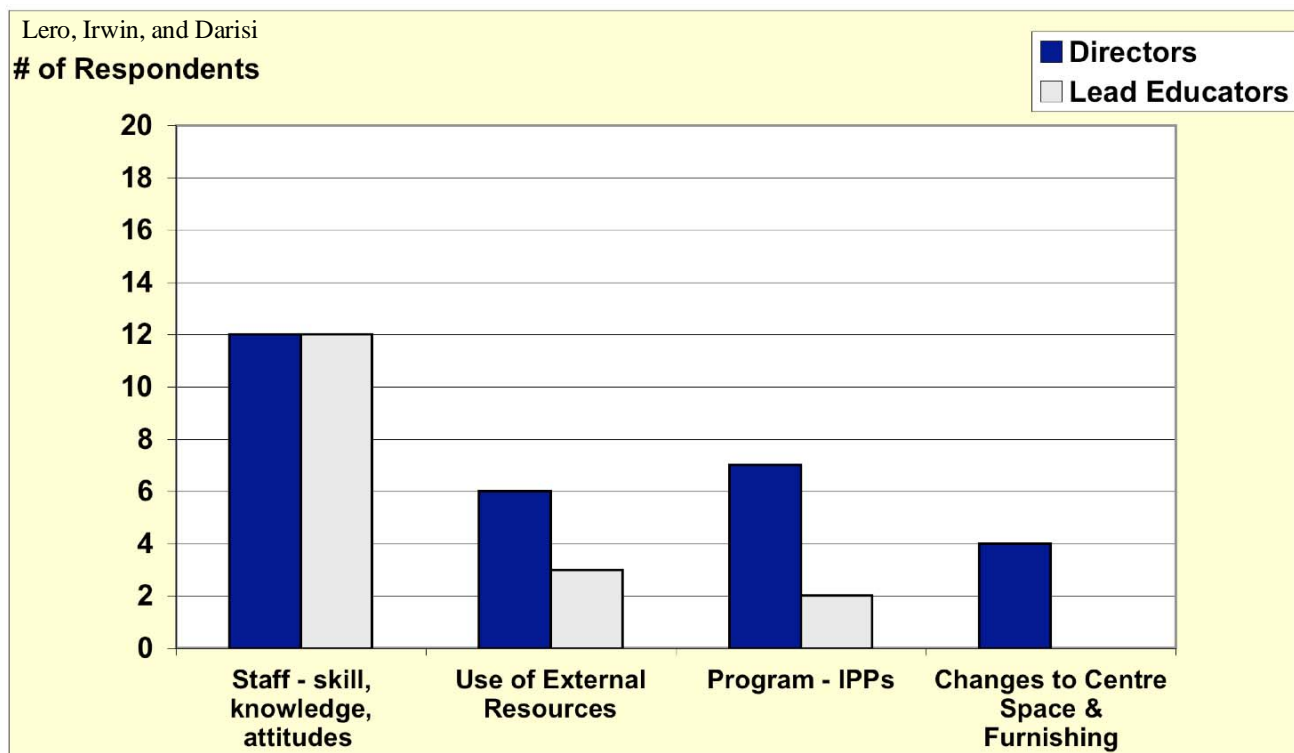
Based on interviews with 20 directors and 20 lead educators

Comments about the impact of *PFI-NS* on inclusion included:

> *"There is a difference in the philosophy of the administration, a willingness of staff to attempt to help children with special needs and to incorporate them into the classroom structure."* (Director)

> *"We always integrated them the best we could. Now we are more aware of the resources that are available to us. We are doing more with IPPs, with meeting with the child's support staff. We are more aware; it's been very good."* (Director)

> *"I'm more confident and better prepared."* (Lead Educator)

> *"Experience with children with special needs and meeting with the physiotherapist and OT have opened my eyes about how to help children. I'm not timid anymore."* (Lead Educator)

"We just got a child with special needs two months ago…[The classroom is] relaxed, comfortable, he's really included. He even does his speech therapy with the whole class." (Lead Educator)

"An IPP for our children with special needs — I'm excited about this. It's just starting and is amazing to me, who never knew what an IPP was." (Lead Educator)

"There is more understanding of their situation and how we can help them and their parents. I'm more involved with them, feeling more confident that I can help." (Lead Educator)

5.4.5 Changes Made to Support Inclusion: Facilitators' Observations

Centres ranged in their experience of including children with special needs, from those centres that had little or only sporadic prior experience including children with disabilities to one centre that was recognized as a leader in the province with more than 25 years as an inclusive centre. Facilitators' comments regarding centres' histories of including children with special needs reflect this range of experience. Facilitators commended those centres with successful and fully inclusive practices at project Baseline. For example, one facilitator commented:

"Inclusion of children with special needs was not an issue at this centre. They will accept all children regardless of their level of needs and will find the resources and supports. … Children with special needs are fully integrated into the classrooms and, in some cases, have aides to help them succeed in the class. There is a strong commitment to inclusion at this centre. The director has many connections within the community."

However, inclusion facilitators also recorded concerns regarding some centres' practices and policies. During initial observations, facilitators noted that while some centres did have a history of including children with special needs, these centres did not have fully inclusive practices. Their concerns included:

➢ The inaccessibility of older, two-story buildings -- In one case, a child with special needs was placed with younger children because the floor with the age-appropriate classroom was inaccessible to the child's wheelchair;

➢ The policy of one centre that limited enrolment to children who are mobile because of the Board of Directors' concern about liability in case of injury;

➢ The demands on staff with multiple responsibilities, such as resource teachers and special needs program coordinators who also take on other responsibilities, such as being a substitute for other staff or having supervisory responsibilities. It was noted that such additional demands make it difficult to give full attention to the role of working with children who have special needs.

➢ Staff anxiety and inexperience in working with children who have special needs;

➢ Children with special needs who are pulled out of the classroom to work with a resource teacher. This was a frequent concern at centres that accepted children with special needs, yet were not fully inclusive.

Inclusion facilitators commented:

> *"Staff try, but they are not always aware of the particular needs. They intervene in interactions with other children and engage in pull-outs."*

> *"Taking part in more workshops focussing on inclusion could help prepare [staff] and reduce their anxiety about their abilities in this direction."*

> *"It must also be noted that integrating children with special needs holds its own set of challenges. … When a centre agrees to include a child with identified special needs into their program, they make certain commitments…[and] many of the staff have little training or experience with regards to the specific needs of the children with whom they work."*

Over the course of the intervention, facilitators made recommendations on how centres could improve in their inclusion of children with special needs. In each case, although centres did not always achieve the goal of full inclusion, facilitators observed that a number of centres overcame some of their particular barriers and challenges and improved their practices over time. Similar to directors' and educators' reports of changes they had made to become more inclusive, facilitators noted:

➢ fewer pull-outs... In centres where this was a concern, staff were able to achieve greater success including children with special needs in activities and interactions with other children;

➢ greater effort at including children with their peer groups;

➢ greater confidence among some staff—training and workshops provided staff with knowledge and skills that helped them to develop more confidence in working with children who have special needs;

➢ better communication with parents;

➢ better use of external resources; and

➢ room rearrangements and additions.

Their comments about the process of centres becoming more inclusive included:

"The staff became more aware of issues concerning child care and inclusion. While the centre had a history of inclusion, they are now moving into developing their own ideas and principles rather than following an example set by someone else. The children in the room who are part of the special needs program at the centre are now receiving more specific programming and goals and objectives are set. Parents are now more involved in the decision-making process."

> *"Throughout the process, inclusion was at the forefront of discussion. As a result of many conversations, the centre was able to become more involved with an Early Intervention worker visiting the centre and staff were able to develop strong*

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xiii   This centre was not dropped from the project per se. The *PFI-NS* inclusion facilitator decided to work with all staff in the centre, rather than focusing on just the one preschool room. However, *ECERS-R* and other scores from this centre's preschool room were not included in the Time 2 and Time 3 data, as it represented a substantial departure from the model that was being tested in cycle 1 centres.

connections with the parents of children with special needs. All of these changes allowed the centre to include all stakeholders in decision making. The centre staff also became more confident in talking with parents if they had a concern about their child and made them aware of resources."

5.5 OTHER POSITIVE IMPACTS OF *PFI-NS*

In addition to effects on program quality and inclusion quality in the target classrooms, directos, lead educators and inclusion facilitators noted other positive impacts of the *Partnerships for Inclusion - NS* project. Figures 5.7 and 5.8 summarize the responses provided in interviews with directors and lead educators, respectively.

Figure 5.7   **Directors' Observations of Other Positive Impacts of *PFI-NS***

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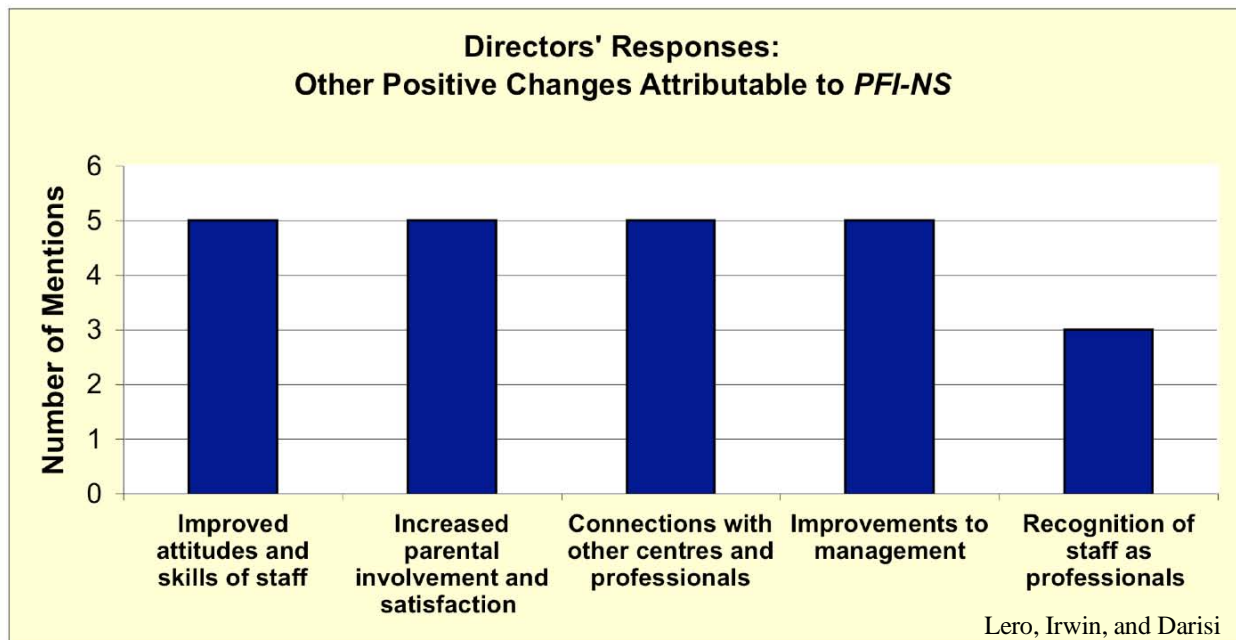
N = 20

Figure 5.8   Lead Educators' Observations of Other Positive Impacts of *PFI-NS*

**Lead Educators' Responses:
Other Positive Changes Attributable to *PFI-NS***

Number of Mentions (y-axis: 0 to 8)

- Improved attitudes and skills of staff: 7
- Increased parental involvement and satisfaction: 6
- Connections with other centres and professionals: 5
- Overall positive changes: 3
- Professional recognition of staff: 1

Lero, Irwin, and Darisi
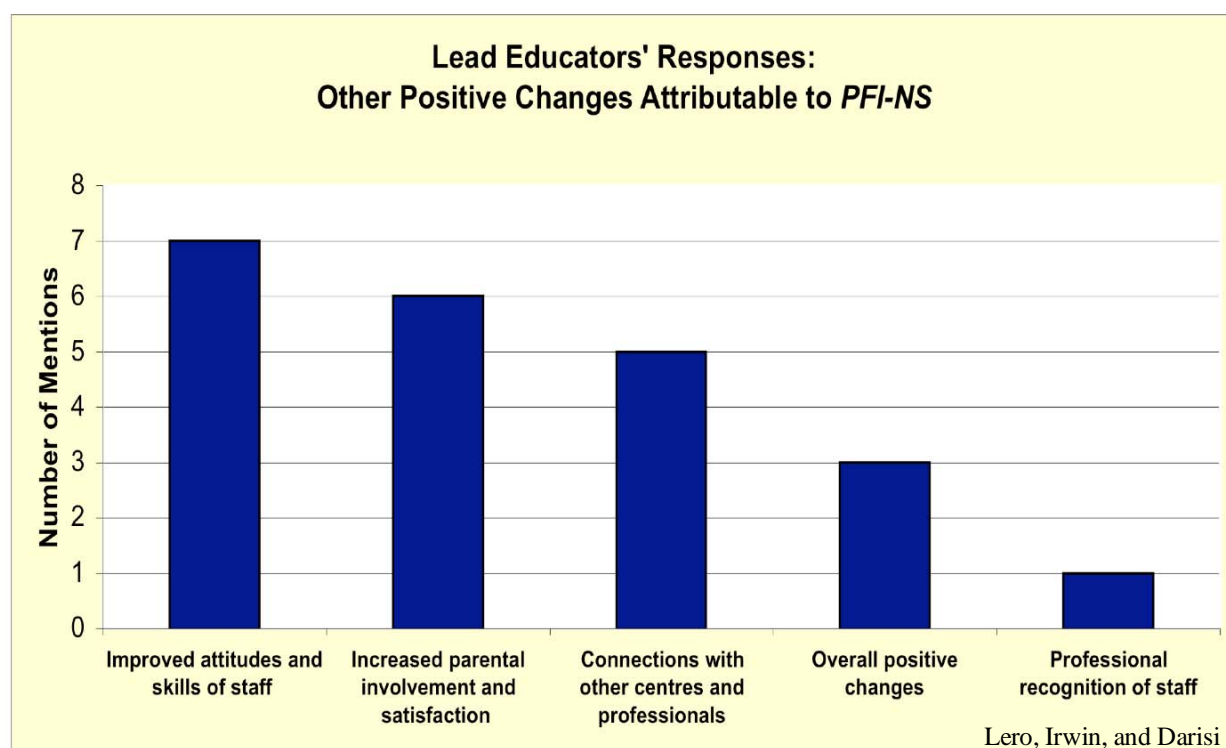
N = 20

5.5.1   Diffusion Effects: Positive Impacts in Other Centre Rooms

One of the major additional positive effects of the program, mentioned by 85% of directors and lead educators, was a positive diffusion of intervention effects into other centre classrooms as a result of the *PFI-NS* consultations that initially focused only on one preschool room. Directors reported that staff in the other centre rooms have an increased desire and enthusiasm for professional development, as well as an increased understanding of how to better meet children's needs. While in many centres these results were achieved as a consequence of the inclusion facilitators generously sharing information and including other teachers in workshops, in other centres staff followed the lead of the educator in the participating classroom and implemented changes in their own rooms.

In particular, about a third of lead educators noted that other staff adopted activity ideas and improvements to activity centres, and made changes to the layout in their rooms. Diffusion effects were noted in personal care routines, such as greater participation of children during meals and snacks. Directors also reported layout changes in other rooms and in playgrounds, and the sharing of activity and program ideas. In some cases other rooms were observed to have benefited from the acquisition of materials and equipment.

Comments about diffusion effects included:

> *"The spillover effect has been strong, especially in our three-year old room…. They want ECERS, which we can do." (Director)*

> *"I've seen room changes, based on materials and information from the [project facilitator]. They wanted the same positive effects in terms of children's behaviour that they observed in the project room. Supplies that were bought to flesh out the lead classroom have also been purchased for other classrooms." (Director)*

> *"I plan to continue to evaluate other programs within the centre using ECERS." (Director)*

> *"Staff from other classrooms ask us for help. The work in our room has overflowed into the other classrooms." (Lead Educator)*

> *"To sum it up, I loved this program; it is the best thing we've ever done. We want to change some of the other rooms around now." (Lead Educator)*

PFI-NS facilitators also recognized diffusion effects to other classrooms. They were asked by centre staff not directly involved in the project to evaluate their classrooms and work with them to help set goals. In many cases, the entire centre adopted the *ECERS-R* as a guide for quality.

5.5.2 Perceived Impacts of *PFI-NS* on Children's Experiences

The directors and lead educators were asked to comment on any changes they noticed in the children that they felt were attributable to the influence of the *PFI-NS* project. Lead educators, in particular, commented on improvements in children's experiences and behaviour. Several educators specifically commented that their participation in *PFI-NS* had helped them to develop greater skills and awareness, which had a positive impact on children's play and interaction. They observed that children were happier and more satisfied, with some educators noting that children were more cooperative and better behaved. As well, they believed that improvements made to play areas and interest centres also contributed to an improvement in children's experiences.

Educators commented:

> *"We really have done quite a bit. [The inclusion facilitator] showed us how to put more emphasis on what the children want and really changed the classroom around, making it more kid-friendly."*

> *"The good part was the children, their attitude…You can see it on their faces. I am so much better at role modeling."*

> *"Staff have noticed it makes an incredible difference — children love the extended conversations."*

> *"The children have really started to behave; the day is more relaxed."*

Lead educators also observed that *PFI-NS* had positive results for children with special needs. They reported that staff had become better able to include children and give them opportunities to participate, and that they and other staff in their classrooms were interacting and communicating more with children with special needs. Four lead educators reported that they were making more of an effort to involve children with special needs in activities, and were planning activities that were more appropriate and inclusive of all children.

Several lead educators reported that children with special needs had benefited from being more involved; for example, by participating in meal preparation and by having greater interaction with other children. They also noted that other children have become more accepting, noting that their peers were communicating more with the children with special needs and involving them more often in play.

5.5.3 Improved Relationships with Parents

Thirty percent of lead educators noted that there had been an increase in communication with parents. Parents were said to be more involved and satisfied. A few directors also noted greater parent involvement. Resources were shared more frequently with parents, and parents reportedly have provided positive feedback about the improvements they have seen in the centre. Comments included:

> *"Parents have made comments about how fabulous our programming is." (Director)*

> *"Parental awareness has increased, and they trust us." (Lead Educator)*

> *"Many parents have commented on the things in the classroom....They also enjoy seeing the children's comments posted on the paper." (Lead Educator)*

5.5.4 Community Involvement and Networking

One quarter of the directors and lead educators reported that increased involvement with other child care centres and a greater connection with external professionals were additional positive effects of their participation in the *PFI-NS* project. Lead educators reported that they had benefited from increased peer networking and learning from other centres.

Directors' comments included:

> *"Staff have gone out to see other centres. There is growing openness and camaraderie."*

> *"The networking was a huge bonus to me, and getting to know directors in the area, especially as a new director; sharing battle stories."*

> *"Meeting other staff in other centres has been valuable. At different workshops, everyone seemed so friendly and open to sharing ideas. ...We're all in this together."*

5.6 SUMMARY

The results reported in this chapter demonstrate that there is clear evidence that the *PFI-NS* model of assessment, collaborative action planning, and direct support had positive impacts on participating centres, staff, and ultimately, the children enrolled in these programs. The results, based on observations of the centres by the facilitators, interviews with participating staff and directors, and scores on successive *ECERS-R* assessments, indicate that program quality was enhanced to a significant degree, and that in most centres improvements were maintained or continued during the sustainability period. In addition, *PFI-NS* resulted in the renewal and active engagement of centre staff who became more reflective practitioners through the process. Staff also described how the changes they made in the program, in activities, and in their methods of interacting with the children resulted in children's enjoyment, improvements in children's behaviour, and a more relaxed and positive tone as activities became more child-centered, and as staff improved their skills.

While the original focus of the project was directed to promoting change in a specific classroom within each centre, positive diffusion effects to other centre classrooms were common and added to the observed benefits.

There were fewer measurable gains observed in inclusion quality and inclusion practices based on the *SpeciaLink Inclusion Scales* used in this study. In general, it seems that much of the energy was directed to improving overall quality and inclusion capacity. Nonetheless, qualitative feedback from inclusion facilitators, directors and lead educators suggests that some centres did become more inclusive and effective in promoting development and positive peer interactions among children with special needs. Many centres that had children with special needs enrolled made improvements to their programs, and facilitators noted their efforts. In addition, directors and lead educators in centres that did not have children with special needs during the project reported that they had become more willing to accept children with special needs in their program and believed that they were more capable of meeting their needs as a result of program changes and changes in the ways they interacted with the children in their centre that occurred as a result of their participation in *PFI-NS*.

End Notes

48   Kontos, S., Howes, C. & Galinsky, E. (1996). Does training make a difference to quality in family child care? *Early Childhood Research Quarterly, 11,* 427-445.

49   Campbell, P.H. & Milbourne, S.A. (2005). Improving the quality of infant-toddler care through professional development. *Topics in Early Childhood Special Education. 25,* 3-13.

CHAPTER 6:   FACTORS THAT LIMIT AND ENABLE IMPROVEMENTS IN PROGRAM QUALITY AND INCLUSION CAPACITY

6.1   CHALLENGES AND IMPEDIMENTS TO CHANGES IN PROGRAM QUALITY

Two sources of information were used to identify what factors facilitated positive changes in program quality and inclusion capacity and what acted as impediments or challenges. Directors and lead educators were asked to comment directly on these matters in the telephone interviews that were conducted after Time 2 assessments. In addition, the researcher read all of the reflective case notes provided by the inclusion facilitators and project coordinator, paying special attention to entries that provided information on these matters or that described circumstances that were very successful or were frustrating for the centres and the project staff. These case notes were particularly important for identifying "external" issues, such as turnover among staff, as an important factor affecting the rate of improvement in some centres.

Figures 6.1 and 6.2 illustrate how directors and lead educators responded when asked what impacts of *PFI-NS* were unhelpful or problematic. Fifteen percent of directors did not identify any challenges or problems, noting that changes had been positive overall; the same was true of 30% of the lead educators. Both groups identified common concerns: resistance to change, additional time and workload, and different perspectives among staff or between the director and staff that needed to be resolved. Directors also commented on the need for additional funding to support desired changes, especially major structural changes to improve the facilities.

6.1.1   Staff Resistance to Change

Seven directors (35%) and 10 lead teachers (50%) noted that staff resistance or difficulties in adjusting to change was a challenge or problematic aspect — a point also noted by inclusion facilitators. While centres voluntarily participated in the *PFI-NS* project, not all lead educators or other staff were initially enthusiastic. Some staff were perceived to be set in their ways, finding it difficult to adopt new practices. Two directors noted that differences between staff in their commitment to the project and in their teaching styles were also barriers to implementing change.

Fifty percent of lead educators reported that making the changes the inclusion facilitator was encouraging them to make was problematic for them. They noted that the speed of change was too fast and that staff were asked to make significant changes to their practices.

Figure 6.1   Directors' Views of Challenges to Implementing Changes in *PFI-NS*

Directors' Views: Challenges, Problematic Aspects
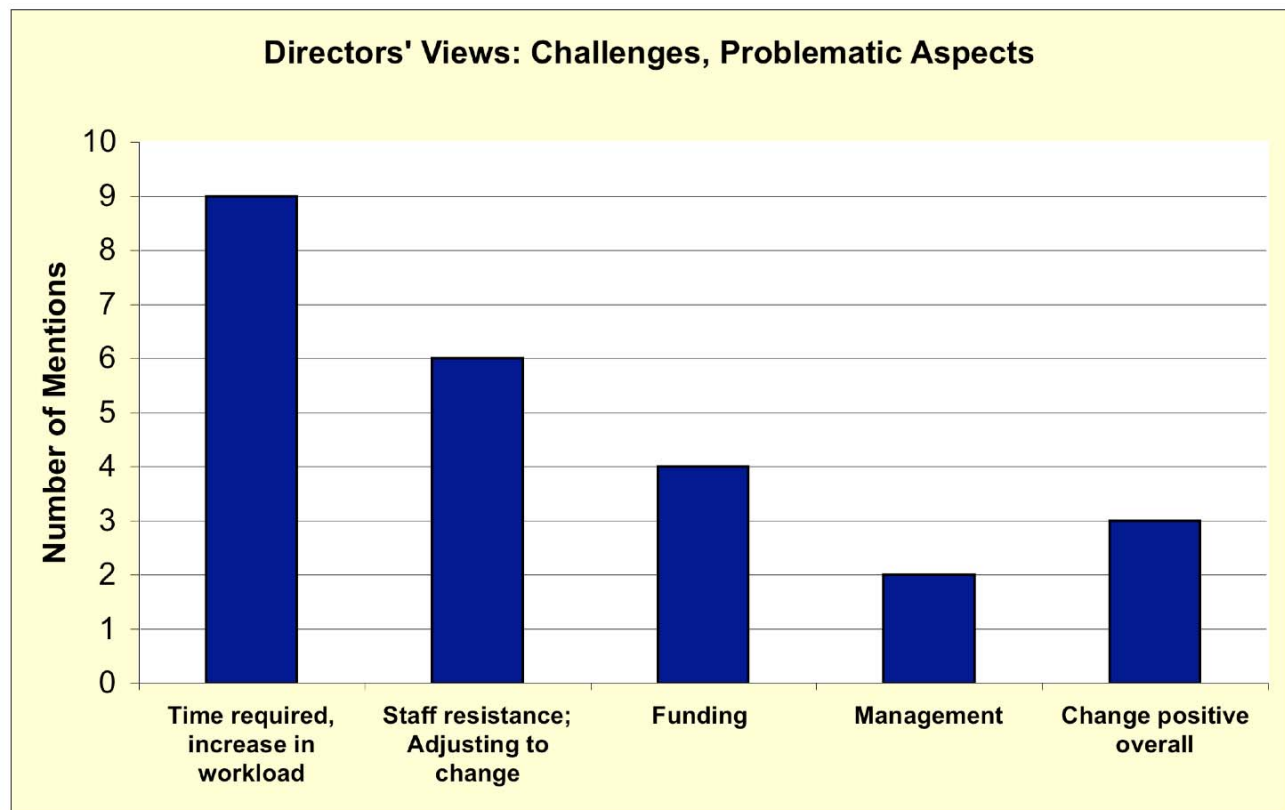
N = 20

Specific challenges were described as follows:

> *"Just getting the staff to change. Some staff have been here for 25 years; they like the way we do things now. Some of it didn't work; we had to change some things back...Had to deal with staff friction." (Director)*

> *"I sometimes found it very hard that not everybody was willing to put in 100%." (Lead Educator)*

> *"Some of the staff have had a hard time with the changes, [such as] changing craft to art was a big change, as was getting the children involved in serving themselves at meals and snacks, and changing room arrangements." (Lead Educator)*

Facilitators also commented on the negative impacts of staff resistance or inertia, noting that these impeded the process of effecting change within centres. Resistance was usually noted towards particular *ECERS-R* items requiring change, not towards inclusion. For example, facilitators' records show that they frequently encountered resistance to their suggestions for

making art less "cookie-cutter" and for encouraging children's active participation in serving food during snack and mealtimes.

Figure 6.2   Educators' Views of Challenges to Implementing Changes in *PFI-NS*
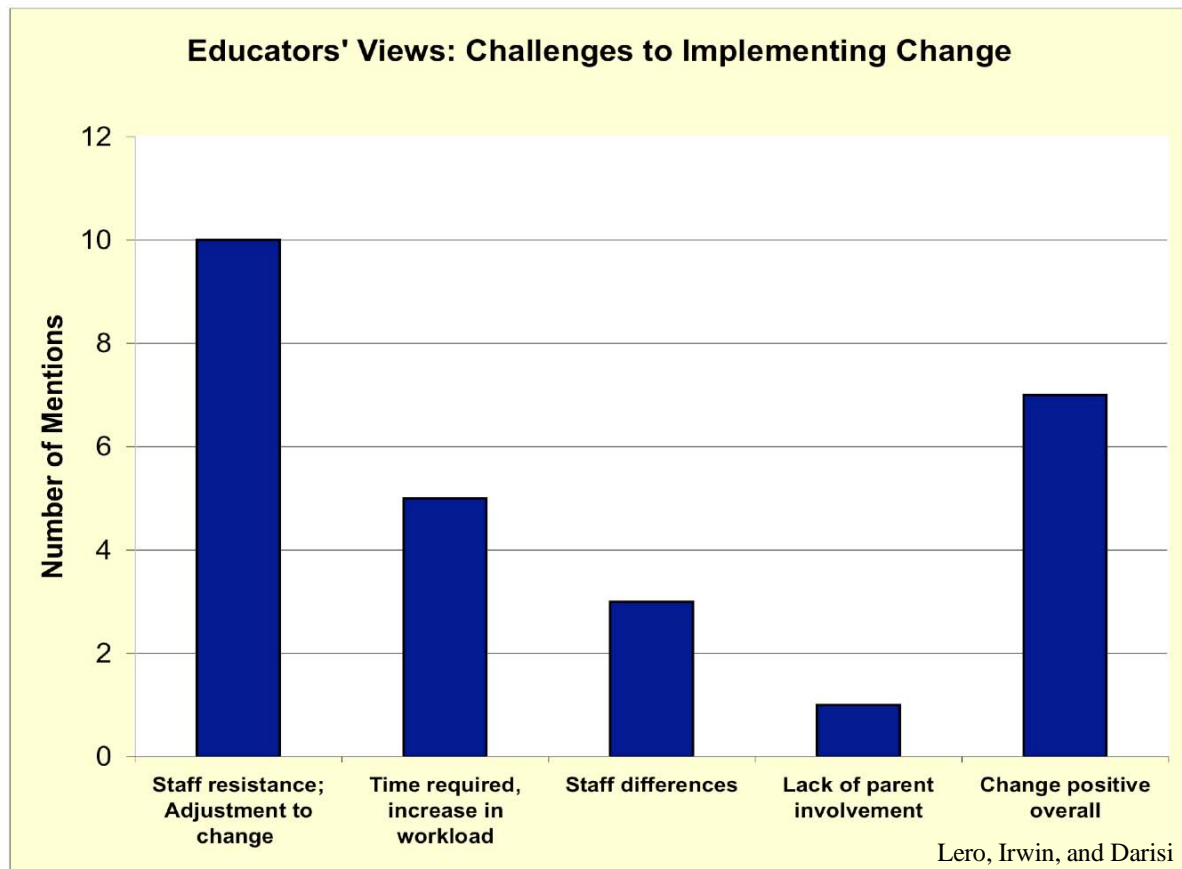
N = 20

Facilitators' comments included:

> *"Doing the project [in this centre] was very difficult. This group of teachers is very much 'stuck' in their old ways and change is very hard for them."*

> *"One of my educators did not manage to get past her insecurities….She was more comfortable with the status quo and so found reasons to support her opinions."*

> *"They do not want to try open-ended questions. This staff liked routine and doing their routines believe that they are safe, and this is one place they have some power and control."*

> *"Each week I brought in resources about child-centered art and each week she avoided the topic. … She received her training many years ago and is quite rigid in her beliefs about how the children need to get ready for school. Finally, we had to agree to disagree."*

In some cases, facilitators recorded that staff who were initially wary of the project and of being evaluated were able to respond more positively once they better understood the project objectives and the *ECERS-R*. Facilitators also noted that in centres where the director was controlling, where staff had only marginally agreed to participate, or where staff were committed to routine and control, change was more difficult and at times appeared to be haphazard or half-hearted.

6.1.2   Demands of *PFI-NS* Participation

TIME

When asked about aspects of *PFI-NS* that may have been unhelpful, 45% of directors discussed the time required by the project. They also reported that the increase in paperwork and workload took time away from other priorities. Similarly, 25% of lead educators noted that *PFI-NS* required a significant time commitment. They mentioned that they felt the increase in workload and that they seemed busier.

Time demands included time involved on the part of the director and lead educator in the initial *ECERS-R* training and in responding to questionnaires; time for meeting with the inclusion facilitator and for participating in staff meetings, workshops and professional development, Time 2 and Time 3 assessments and collaborative action planning meetings; and participation in research interviews. Initially, each director and lead educator was asked to keep an on-going journal, but this requirement was dropped in most cases. Time was also required to change room arrangements, organize materials, and prepare new and different learning activities. Sometimes meetings or workshops that involved a number of ECEs were scheduled at the end of the day and occasionally took place on a Saturday.

Directors' comments included:

> *"There is so much paperwork to do. I'd rather be in the trenches modeling what I want done."*

> *"Writing in the journal has been difficult. The nature of my job makes it difficult for me to take the time [to do that]."*

> *"It's really a good program, but there is just not enough time to do everything."*

It should be noted that most early childhood educators in child care programs do not have paid planning time and do not receive additional pay for attending staff meetings. In all likelihood, however rewarding their efforts were, those child care practitioners who put considerable effort and time into making changes, attending meetings and workshops, and developing new learning activities and plans for the children did so on unpaid overtime.

OTHER DEMANDS ON STAFF

Some directors and lead educators also reported difficulty in finding replacement staff when *PFI-NS* training sessions or meetings were scheduled. Two directors reported they experienced tension with their staff over recommended changes and found it difficult to empower them to act on their own.

Lead preschool room educators experienced the greatest demands on their time and energy in that they typically spent more time with the inclusion facilitator and had greater responsibility for supporting change among the other teachers in their room.

FUNDING AND PHYSICAL CONSTRAINTS

Twenty percent of directors reported that funding constraints and the financial strain of making improvements, such as purchasing new materials or furnishings, were challenges to their ability to implement change. A few thought that *PFI-NS* created expectations for change that funding limitations prevented them from making. Some directors noted that change was constrained by the space in which they operated and that they would have to move or significantly renovate, both of which would be cost prohibitive. Facilitators, too, noted that some centres' ability to accomplish further improvement was limited by their available resources, including centres that operated in restrictively small spaces. Facilitators and staff often worked together to find ways to achieve what they could with what they had. Facilitators did use approximately $200 per centre on materials, books and food for workshops and staff meetings after hours, but there was no other funding source available to the centres for purchases or improvements. A few directors were able to allocate some funds to support initial or high priority changes that were not too costly.

> *"Some centres really could not afford to make some of the recommended or desired changes, but most tried to find a way to achieve at least some of them or are still committed to realizing these goals eventually." (Inclusion Facilitator)*

6.1.3   Recruitment and Retention of Skilled Staff

Perhaps one, if not the most difficult, challenge encountered in a number of centres was the issue of staff turnover. Half of the directors noted that staff recruitment and retention was an on-going challenge that negatively affects quality. They reported that staff were underpaid and that there was a high turnover rate among staff. Directors also commented on the difficulties they experienced in finding and keeping trained staff, particularly substitute and special needs teachers. As well, half of the lead educators reported challenges to the recruitment and retention of staff. Similar to the directors, they too noted staff being underpaid, high turnover rates, and difficulty in finding and keeping trained staff.

Facilitators certainly noted the negative impacts of staff turnover. In fact, one of the original 22 centres experienced three staff changes in the position of lead educator in the preschool room within the first months of the project.[xiii] Instability among lead educators and other staff in target classrooms occurred sometimes as a result of illness or a staff member deciding to return to school, but more often occurred as a result of staff leaving for better paying, less demanding jobs. Changes in staff made it difficult to implement the goals and strategies of the project in some centres, especially since new staff (particularly new lead educators) who came in after the project had started needed to be trained in the *ECERS-R* and oriented to the project. Turnover often slowed down the momentum of the project and diminished enthusiasm. This was particularly evident when facilitators thought that success was, in part, dependent on the motivation of a single staff member (usually the lead educator), and expressed concern that changes would not be maintained when that staff member left the centre.

One facilitator noted that during the intervention period:

> *"It seemed that each time a staff member changed, the process either slowed down or had to start over. With these changes in staff, it was difficult for the lead educator to implement the goals we had set out. She found she was always trying to teach new staff about the process. ...She was getting really frustrated and about two months into the intervention period, I noticed a real slowdown in the momentum and enthusiasm."*

On the other hand, when staff members were resistant to change or not working well together as a team, changes in staffing could have positive effects. The same facilitator later commented that:

> *"The centre hired a recent graduate from an ECE program and they transferred a staff member from another location. This had a tremendous impact on the progress as the new staff were good and took on projects with enthusiasm.... The changes in staffing made a big impact on interactions. This new group was more engaged with the children."*

6.2 CHALLENGES AND BARRIERS THAT LIMIT INCLUSION

Both directors and lead educators indicated that greater inclusion capacity was limited by a number of factors — including physical facilities and the lack of specialized equipment, difficulties in securing funding to support inclusion and retain valued and experienced staff, and limited staff knowledge and confidence in meeting the needs of children with disabilities, especially without compromising the quality of education and care provided to other children.

Six directors and three lead educators expressed concerns about the need to expand or renovate their facilities and purchase specialized equipment to be more accommodating. Directors were particularly concerned about the lack of funds to make such improvements since financial aid was needed to support additional staff and resource specialists, in addition to improving the facilities. A few directors expressed concerns about funding freezes, funding being reclaimed, and changes to funding for different diagnoses.

Indeed, inclusion facilitators saw heroic attempts to include children with significant special needs despite the significant barrier of not having secure funding for support staff. Long waiting lists to establish the eligibility of children for extra funding, long waiting lists for special differential funding, and then long waiting lists for the actual dollars all created seemingly needless anxiety. Moreover, centres that historically employed resource teachers on an *ad hoc* basis by including at least four children with special needs all or most of the time were increasingly anxious about their continuing capacity to be inclusive.

Directors and lead educators also indicated that staff skills and attitudes could limit greater inclusion. A few directors were concerned that staff attitudes needed to be more positive towards inclusion and that staff needed additional training. They believed that their staff would not continue to make the same effort without continuing support from the inclusion facilitator. Four lead educators reported that staff needed on-going, specialized training, and that they needed additional staff in the centre to successfully include children with special needs.

Other concerns regarded the lack of support from parents and the demands on staff time. There was the belief that staff would require greater support and the concern that it would be challenging for

teachers to balance the needs of, and find time for, all children with greater inclusion. Figure 6.3 summarizes perceived challenges and barriers to inclusion as reported by directors and lead educators.

Figure 6.3   Perceived Challenges and Barriers that Limit Inclusion

Lero, Irwin, and Darisi
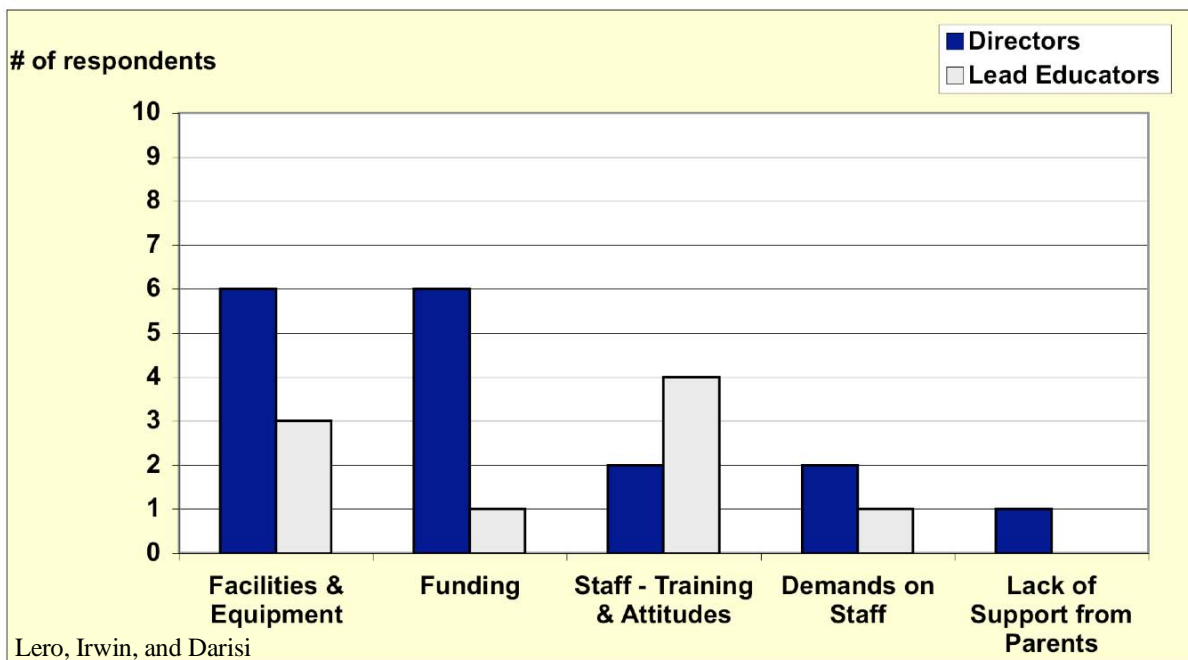
N = 20 directors and 20 lead educators

6.3   FACTORS THAT ENABLED SUCCESS IN MAKING POSITIVE CHANGES

Chapter 5 provided evidence of the many positive impacts of the *PFI-NS* project on aspects of overall program quality, staff attitudes and engagement, and changes in some centres that reflected greater teamwork and awareness of how to provide all children with more stimulating, child-centered learning and care. The director and lead educator interviews and inclusion facilitators' case notes helped identify some of the important factors that promoted or enabled these positive changes.

6.3.1   Inclusion Facilitators' Effectiveness in Engaging Staff and Creating Reflective Practitioners

The *PFI-NS* inclusion facilitators clearly played a critically important role in effecting change among centre staff. They acted as mentors and sounding boards, and offered support to directors and staff. They provided resources to directors and educators, responding to the specific needs and challenges in each centre. They worked closely with directors and educators to develop strategies for implementing change and provided workshops that met the needs of the centre. Facilitators provided detailed feedback and interpretation of *ECERS-R* scores, helping staff to see beyond the

numbers to gain an understanding of why and how the components of each subscale were important. In centres where directors and educators were enthusiastic and ready for change, facilitators helped them to focus their goals and priorities. In centres where there were greater difficulties or resistance, facilitators helped to bring staff on board where possible, providing encouragement and motivation. When centres encountered challenges or limitations, facilitators helped staff to brainstorm and problem solve, supporting different ideas and arrangements until staff could find something that worked for them.

Comments included:

> *"It wouldn't have been successful if it wasn't for the role of the facilitator. She was our guide; she gave us encouragement. She often visited us. She would hear what was going on, what we were interested in or talking about and come back with resources to help us.…It is nice having someone who says, 'You can reflect'; 'It's okay'; 'You're doing a great job', or 'Why don't you…"* (Lead Educator)

> *"If it wasn't for these meetings with [the facilitator], some of these things would never get discussed."* (Lead Educator)

> *"I thought the inclusion facilitator's support was most helpful. She brought in resources and all the support she offered — including the conversations we had."* (Director)

> *"We have been actively involved in assisting these centres, not just telling them what to do and waiting for them to do it."* (Inclusion Facilitator)

6.3.2   Staff Receptiveness

Just as it was noted that staff resistance to evaluation and change could hinder success, staff willingness and openness facilitated positive change. Inclusion facilitators noted that *PFI-NS* was most successful in centres where staff had volunteered or, at least, had agreed with the director to participate in the project. The advice from directors and lead educators to future participants of *PFI-NS* was to be open and willing to change.

Changes in staff attitudes, awareness, and practices were among the positive impacts of *PFI-NS* noted by directors, lead educators and inclusion facilitators. These changes then facilitated improvements in other areas, such as incorporating new activities in the centre, improving extended teacher-child interactions, and generally enabling children to have a more positive, enriching experience. As well, directors and lead educators reported that greater inclusion capacity was related to improvements in staff skills, knowledge, and understanding.

6.3.3   The Use of the *ECERS-R* as a Tool

While being subject to an assessment on the *ECERS-R* was intimidating for many centres and a few staff disagreed with some items or expectations embedded in the items, most very much appreciated the value of using a well-known assessment tool to identify areas in which they were already strong, and particularly to provide specific benchmarks for improvements as a basis for collaborative action planning. Seeing scores improve was reinforcing for all. Importantly, however, the *ECERS-R* provided an important vehicle to talk about why certain practices are

important for children's development and led to richer, fuller discussions about educators' roles, the nature of learning activities, and program goals.

> *"As a director, ECERS has helped me with long-range planning and with justifying what I am doing."*

> *"Our program seemed blocked and ECERS came at the right time….PFI really helped staff to see why I wanted things done differently."*

6.3.4 Director's Involvement and Leadership

Several staff commented that their director's support for the project was a critical factor that permitted and encouraged positive changes. Examples included those instances where directors provided funds for limited purchases to make immediate and visible improvements in furnishings, books and materials. Perhaps as important was directors who actively supported staff in collaborative action planning and worked with them to make desired improvements.

6.3.5 Additional External Resources

As reported in Chapter 5, improvements in program quality were widespread, while improvements related to inclusion principles and practices were uneven. Centres that evidenced significant improvements in this area had made this a priority. In several cases, access to funding or to additional external resources (specialists or early intervention support) enabled staff to develop additional skills and become more accepting of including children with a broader range of disabilities.

6.4 SUMMARY

In summary, the factors that enabled and limited positive changes in program quality and inclusion capacity reflected both sides of the same underlying aspects within centres. Enablers included:

- The capabilities, sensitivity and resourcefulness demonstrated by *PFI-NS* inclusion facilitators in gaining trust and providing the kinds of support that enabled directors and child care staff to commit to the project. Their professionalism and friendship was critical to the success of *PFI-NS* and enabled staff to feel supported and valued. Their skills and knowledge were also essential.

- Directors who provided leadership and demonstrated their support for making positive changes and following through by doing their part to address issues important to staff;

- Early childhood educators' active involvement in the process and receptiveness to change;

- Early childhood educators' increased knowledge, skills and understanding of what is important and valuable and how they can better apply that knowledge to curriculum development, activity planning, and ways of interacting with all children to enhance their learning and development; and

- In some cases, access to funding and additional resources were critical enablers and demonstrated that centres' efforts to include children with special needs would be supported by government and community professionals.

Significant barriers or challenges included:

- High rates of staff turnover and instability. In a number of cases this was a significant impediment to making positive changes and maintaining momentum. Over the long run, the recruitment and retention of skilled, committed early childhood educators who are compensated for their efforts is a critical systemic factor that must be addressed to ensure program quality and inclusion capacity.

- Inadequate funding to make major changes to programs, including those that would improve access and facilitate the full participation of children with a variety of special needs.

- Initial resistance on the part of some staff to making changes in long-established routines and practices.

- Disagreement among staff and lack of effective team work in a few centres.

- Lack of recognition or compensation for the additional time that was required on the part of early childhood educators to fully participate in the project; lack of resources to centres to provide paid planning time or professional development opportunities.

- Continuing or new uncertainties about the availability and adequacy of extra support funding to support centre's efforts to include children with special needs.

Despite these barriers, there were many positive impacts noted in this first cycle of the *PFI-NS* model.

CHAPTER 7: LESSONS LEARNED AND RECOMMENDATIONS FOR IMPROVING AND EXTENDING THE *PFI-NS* APPROACH

Recent bilateral agreements between the Government of Canada and provincial governments and new funding to expand and improve early learning and child care across Canada reflect solid commitments to expand access to high quality early learning and care programs that enhance children's development and are universally inclusive. As a consequence, there is considerable interest in learning about initiatives such as *PFI-NS* that can provide evidence-based examples of ways to enhance program quality and improve inclusion capacity and inclusion effectiveness that might be expanded or adapted in other jurisdictions. Indeed, as this report is being written, "sister" initiatives are under way in New Brunswick and Prince Edward Island and are in the development stage in Newfoundland and Labrador. Other jurisdictions have undertaken somewhat different approaches to quality assurance and enhancement (e.g., accreditation in Alberta and the U.S., a pilot project sponsored by Community Living Manitoba, and peer-administered approaches such as "Raising the Bar" in Southwestern Ontario). In each case, there is much that can be learned and shared, and research should be done to inform researchers, practitioners and policy makers to ensure that optimal investments are made to improve and sustain inclusive quality care.

This evaluation was conducted on the first cohort of 22 centres that participated in the *Partnerships for Inclusion - Nova Scotia* project. *PFI-NS* utilized an approach that has been used for some time in North Carolina and was adapted by Dixie (Van Raalte) Mitchell for the *Keeping the Door Open* project in New Brunswick, Prince Edward Island and Saskatchewan. In Nova Scotia further adaptations were made that emphasized the importance of training centre directors and lead educators in preschool rooms on the *ECERS-R* method of assessing program quality. In each of these projects, the major focus is not on inclusion per se, but on using an on-site consultation model that emphasizes sound early childhood practices in order to improve and reinforce overall program quality as a basis for providing stimulating and responsive learning and care for all children — those with and without disabilities.

"Inclusion facilitators" (quality consultants), who were selected for their knowledge and experience, worked directly with centre staff, engaging them in collaborative action planning and providing a range of resources and support to facilitate improvements. Each facilitator[xiv] worked intensively with five centres, often providing professional development workshops for all centre staff and bringing in a range of resource materials to support positive changes. The project included a baseline assessment followed by collaborative action planning, a 6-month period of active consultation and support, and a follow-up sustainability phase. Measures of program quality, inclusion principles and inclusion practices were obtained at baseline, at the end of the active consultation period, and after an additional 4-5 months. Supplementary information was obtained at the end of the consultation period from directors and lead educators in semi-structured interviews and from detailed case notes kept by the project coordinator and the inclusion facilitators.

This evaluation report provides ample evidence that the *PFI-NS* approach to on-site assessment, consultation and support is an effective way to increase program quality in preschool classrooms in child care programs and contributes to improving centres' inclusion capacity. Improvements include those measured by the *Early Childhood Environment Rating Scale-Revised* (*ECERS-R*) and other

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[xiv]   The project coordinator worked with two centres, given her other responsibilities for overall project management.

changes in child care environments, teacher-child interactions, and staff attitudes and behaviour described by directors, lead educators and inclusion facilitators in interviews and case notes. Directors, lead educators, and inclusion facilitators reported that the effects of the consultations tended to spread to other rooms in the centres and also commented on the positive impacts of quality improvements for children.

7.1 LESSONS LEARNED ABOUT THE EFFECTS OF *PFI-NS* ON PROGRAM QUALITY:

1. There is clear evidence of the project's success in effecting improvements in program quality, and in engaging staff in a process of renewal.

Facilitators' observations, *ECERS-R* scores, and directors' and lead educators' feedback all reflect substantial improvements in program quality. *ECERS-R* scores were significantly higher at both the end of the consultation phase and at the end of the sustainability period compared to baseline scores. Average *ECERS-R* scores for all centres increased from 4.6 at baseline to 5.5 at the end of the consultation period and 5.6 at the end of the sustainability period. At the end of the consultation and support phase, and at the end of the sustainability period, 80% of centres received ratings indicative of good or very good quality, compared to only 27% of centres at baseline. Moreover, centres that originally scored below 4.0 on the ECERS-R measure all obtained scores that indicated substantial improvement. Sixty-one percent of participating centres demonstrated an "observable change" in program quality by the end of the active intervention period (i.e., scores evidenced a move from one quality category to another or an increase of 1.0 or more on the *ECERS-R* in centres that were already evidencing good quality care). Significant improvements were observed on each subscale of the *ECERS-R* instrument. It is important to note that substantial improvements were observed in almost all centres, including those centres that were providing good, developmentally appropriate care at the beginning of the project. Centres that had the lowest scores made the greatest measurable gains.

Facilitators commented on directors' and educators' efforts to improve their programs and environments. As well, directors and educators themselves commented on the changes they had made in their centres and how these had improved children's experiences. Changes were most notable in room arrangements, specific learning activities (such as science, art and music), children's more active participation at snack time, extended teacher-child conversations, and scheduling to enable greater flexibility and smoother transitions. Many programs became more child-centered and adapted curricula that capitalize on children's interests and experiences.

Changes in staff attitudes and awareness were impacts of *PFI-NS* that were frequently commented upon by directors, lead educators, and facilitators. It was repeatedly noted that staff had become more reflective in their practices, and many reported having discovered a renewed sense of excitement and commitment to quality.

2. Improvements in classroom quality were sustained over time.

The sustainability period was the time to assess centres' ongoing commitment to change without the weekly support of the facilitator. Overall, improvements to centre scores were not only maintained but, in many cases, continued. Consequently, it can be concluded that the *PFI-NS* project was able

to produce impacts that required ongoing commitment and maintenance on the part of centre staff and their directors for a period of at least 4-5 months. This suggests that staff involved in the project developed the skills to be reflective practitioners, and were able to act on their new knowledge and the collaborative action plans that had been developed with the facilitators.

3. There were substantial diffusion benefits – *PFI-NS* had centre-wide impacts.

This cycle of *PFI-NS* was initially directed to staff in one selected preschool room in each centre; however, over 85% of directors and lead educators reported that *PFI-NS* had impacts in the centre beyond the participating classroom. *ECERS-R* was frequently employed centre-wide, and facilitators were able to contribute to improvements in other rooms, particularly by including all centre staff in professional development workshops and responding to some of their specific needs. A primary recommendation of directors and lead educators was that in the future all staff be trained in *ECERS-R* and that *PFI*-NS be offered on a centre-wide basis.

4. Sustainable quality and inclusion capacity in child care programs.

While centres were able to improve many areas of their program, they still faced challenges and barriers to enhancing quality and effectively including children with disabilities. Staff turnover was a particular challenge in many centres, and was the biggest impediment to making and sustaining positive changes over the course of the project, substantially slowing progress in a number of centres. Lack of funding for capital improvements and to purchase materials and equipment were other impediments, as is the need for some staff to acquire additional knowledge and skills, particularly related to inclusion. One facilitator expressed frustration in the lack of consistency between what is known to be best practices and licensing requirements. While she advocated for best practices, one centre was able to resist a particular change in their playground because it was not required by licensing. This instance points out the difference between a focus on best practices compared to a traditional focus on compliance with minimum standards. An additional concern that was documented by the inclusion facilitators and commented on by directors relates to the nature of funding available specifically to support centres' inclusion efforts. Directors commented on the degree of uncertainty they experience about criteria for extra support funding, long waiting lists to determine eligibility, and extended periods before funding is provided. These factors add additional stress and anxiety and can jeopardize directors' capacities to retain those staff who are most knowledgeable and experienced with inclusion (i.e., staff who have previously been funded on the basis of the centre's enrolling at least four children with special needs on a regular basis).

7.2 LESSONS LEARNED ABOUT THE EFFECTS OF *PFI-NS* ON INCLUSION CAPACITY:

1. There is evidence of positive impacts of *PFI-NS* on:
  ➢ **Directors' and educators' attitudes towards inclusion,**
  ➢ **The use of individual program plans to ensure children's continuing progress in making developmental gains, and**

> **Staff comfort and confidence in being able to meet children's individual needs more effectively.**

While directors' and educators' attitudes at Baseline were generally favourable towards inclusion, directors, lead educators, and facilitators all commented on an improvement in staff confidence and awareness of the importance of including children with special needs in their classrooms. Over the course of the project, facilitators were able to make recommendations that improved inclusion practices in a number of centres that regularly include children with special needs.

2. Improvements in centre and classroom environments and in teacher-child interactions benefit all children and enhance inclusion capacity.

Lead educators reported positive impacts that affect all children's experiences. Change in staff's attitudes and behaviours and adoption of more child-centred programming had a positive impact on their interactions with the children. Child care staff listened to and engaged the children more, and children were able to engage in more child-initiated activities. As a result, educators observed improvements in children's behaviour. Interactions between children with special needs and their typically developing peers were observed to have improved.

Three specific examples where "best practice" in the *ECERS-R* has led to better inclusion quality are the following:

> Adding a private space benefits all children, and specifically benefits children with autism who often need a place to withdraw from the stimulation of a typical early childhood classroom. Many centres hadn't thought to address this need until they participated in *Partnerships for Inclusion - Nova Scotia*.

> Adding picture labels benefits all children to become more independent, but is particularly supportive for children with communication delays.

> Providing equipment that supports varying levels of development allows children with developmental delays to participate at their own level of ability.

3. *PFI-NS'* impact on inclusion could be strengthened by more focused efforts and planning with centre directors and staff. Additional staff training and on-going support are also required. Centres must be confident that extra staffing and appropriate resources will be available, if needed, when children with special needs are enrolled.

Positive effects of the *PFI-NS* intervention were more uneven across centres with respect to inclusion, and scores on the quantitative measures of inclusion practices and inclusion principles used with this first cohort of centres did not evidence statistically significant improvements. Some centres were already effective in including children with special needs at Baseline, while others had only irregular and limited experience with inclusion. Moreover, children with special needs were sometimes enrolled in rooms other than the preschool room that was the focus of this study or moved between rooms or in and out of programs. While the project seems to have improved centres' inclusion capacity, more focused attention and additional staff training and specific resources appear to be required to ensure and maintain inclusion quality. Further refinements to the measures used in this project have been undertaken and the new versions will be used with later cohorts.[50]

4. **Other issues must be addressed to ensure inclusion quality: trained support staff when children with disabilities are enrolled; environmental changes; access to specialized equipment; secure, prompt and adequate funding to support centres' efforts; additional staff training; and continuing and appropriate support from specialists are all needed.**

Research on inclusion quality in Canadian child care programs has demonstrated that a variety of factors must be addressed to enhance and maintain inclusion quality. Among them are environmental changes to enable centres to be more accessible, access to specialized equipment and materials, staff training and ongoing support, additional staffing beyond ratio as necessary, and access to support from specialists and parents.

The Supported Child Care (SCC) funding system appears to be a significant concern in that:
➢ Wait lists are a huge issue for centres in their ability to include children with special needs. While a centre may have a space for a child, waiting to learn if SCC funding is available for that child can mean that the space is lost to someone else on the wait list. An expedited process is required.
➢ SCC funding does not come close to providing the necessary funds to provide appropriate supports for many children with special needs.
➢ The most skilled in–centre "resource teachers" are funded in an unstable manner, rather than as part of core funding in centres that regularly and effectively include a number of children with special needs. This is not an effective way of utilizing their skills.

7.3   LESSONS LEARNED: POLICY, PRACTICE AND PROGRAM ISSUES

1. *PFI-NS* **is an example of the infrastructure that is needed to support program quality and inclusion capacity.**

The *PFI-NS* project was a time-limited experimental initiative that was provided to a small number of child care centres. An important lesson from the project is the critical need for on-going community-based resources to support quality enhancement and its maintenance. Under usual circumstances, some staff might attend professional development workshops or take courses, but currently there is no means to ensure or support centre-wide engagement in quality enhancement initiatives — and none that provide on-site assessments and resources "in situ" in ways that can have specific and visible impacts on programs.

In addition to promoting change in individual centres, the *PFI-NS* project also has the capacity to encourage the development of networking across centres and greater professionalism and mutual support among child care programs and early childhood educators. The project is also building capacity among the inclusion facilitators/consultants, who have learned a great deal through this first offering of the project and who are in a position to provide support to each other and training to other experienced individuals to become inclusion facilitators/quality consultants in other parts of the province.

2. **A resource such as *PFI-NS* can be particularly important when programs are under stress or during a period of major change.**

Several centres in the project were observed to suffer from repeated instances of staff turnover for a number of reasons. A few experienced a move to a new location or other major stressors. *PFI-NS's* on-going support and focus on quality was an important resource for these centres during these times. Many provinces are currently embarking on a period of significant system change. In such times, it is useful to consider how to support community-based programs and ensure on-going stability and a focus on quality.

3. ***PFI-NS* requires significant involvement on the part of centre staff. Staff involvement should be recognized and compensated. Costs may be a barrier to participation and to improvements.**

One of the drawbacks to this model is that it may require substantial investments of unpaid overtime on the part of early childhood educators. Typically child care staff are not paid for preparation time or for attending staff meetings or professional development workshops after hours or on weekends. Releasing staff to participate in project activities requires hiring replacement staff — an additional cost to programs that have little discretionary revenue. The North Carolina model on which *PFI-NS* is based provides each participating centre with $200 to support quality improvements within the centre; *PFI-NS* adopted this approach by budgeting a like amount for purchases and food to support staff attendance at meetings and professional development workshops and considered it highly beneficial. However, $200 per centre is virtually symbolic, compared to the unpaid time and resources expended by the centres and centre staff. Both time and lack of funds to make quality improvements were identified by directors and lead educators as impediments or problematic aspects.

Policy makers who wish to facilitate centres' participation and recognize staff involvement might consider a stipend or budget for participating centres. Programs that make substantial improvements can be publicly recognized and reinforced. Staff who take on a leadership role as change agents and those who participate in many professional development workshops should also be rewarded, with appropriate compensation and credits that are recognized as contributions to continuing professional education.

4. **The importance of voluntary participation**

Discussions with the developers of the *PFI-NS* model and related initiatives suggest the importance of voluntary, rather than compulsory, participation by child care centres. Their view is supported by the findings that staff openness and engagement are foundational for success and that staff (and director) resistance is a major impediment to making positive changes. Voluntary participation is far more likely to result in positive outcomes to a process geared to making personal and program changes. The likelihood of voluntary participation by other centres would be expected as word spreads about the positive experiences centres in this first cohort had with the *PFI-NS* project. Providing some financial support to centres to facilitate their participation and enable them to make recommended changes would increase the likelihood of participation as well.

5. **The importance of administering quality enhancement programs through mechanisms that are arms-length from government**

This issue has also been discussed by the developers of the *PFI-NS* model, including Dixie (VanRaalte) Mitchell, who has extensive experience with a related program in New Brunswick. Their strong recommendation is to ensure that all *ECERS-R* scores and observations are treated as confidential information, with no sharing of such information with licensing officials. This approach is seen as critical for developing and maintaining trust and for ensuring honest and frank discussions about necessary quality improvements (the only exception being unusual circumstances that endanger children's health and welfare).

6. *PFI-NS* **and related initiatives as a component in program accreditation**

One of the approaches some jurisdictions are taking to promote high quality is centre accreditation. Accreditation is a voluntary system that uses external measures and criteria as a basis for determining whether a program meets specific standards indicative of high quality. Usually an external accrediting body is established and is responsible for providing independent assessments to those programs that apply to become accredited. The National Association for the Education of Young Children (NAEYC) accreditation model is perhaps the most well-known example. Programs may or may not have access to funding and resources to assist them to meet accreditation criteria and subsidize the expenses of applying for accreditation. Accredited programs use their status to attract parents and may qualify for higher per diem rates from local governments. Alberta has been developing such a system, and other Canadian jurisdictions may do so as well.

It is possible to easily use the *PFI-NS* approach as a component within an accreditation system. Specifically, the model offers centres an important vehicle for making the kinds of quality improvements that would be included in accreditation criteria. Further, *PFI-NS's* attention to inclusion practices is unique and would add additional support to this aspect in an accreditation model. In effect, participation in *PFI-NS* processes and the use of the *ECERS-R* and other objective measures could easily support an accreditation approach and provide participating centres with additional recognition and reinforcement for participating. It also works on its own, however, without orienting to an external agent for validating the quality improvements centres make when empowered and supported to do so.

7.4   LESSONS LEARNED: SUGGESTIONS FOR FURTHER RESEARCH

1. **The importance of continuing research**

The current study was an evaluation of the first trial of a new program to enhance program quality and inclusion capacity in Nova Scotia child care programs. The small sample size and lack of a randomized control group are limiting factors in this evaluation. Multiple methods and the use of a well-known and widely used instrument to assess quality and quality improvements are strengths.

Further offerings of this project will provide additional opportunities to confirm the very positive impacts observed to date. Variations from one cycle of centres to another can also be studied as part of an on-going project that can gauge, for example, the effects of providing *PFI-NS* on a centre-

wide basis from the start. Comparisons to related programs in other jurisdictions should also be useful, particularly since they would provide the opportunity to assess how differences in program implementation affect outcomes. In particular, no studies have compared such programs using planned variations in the frequency of visits or the nature of support provided or with or without a stipend provided to centres.

2. Maintaining the integrity and usefulness of the research process

This evaluation has suggested the importance of ensuring research integrity and research utility. Research integrity would be enhanced by having an independent person, other than the inclusion facilitator who works with a centre, participate in assessments. This method has been used in North Carolina and avoids the difficulty of having the same person who is providing encouragement to staff also do objective assessments. While *PFI-NS* inclusion facilitators made every effort to be objective and professional, it can be difficult to be objective when one is so intimately involved in coaching and encouraging staff and program directors.

A second recommendation is the importance and evident value of having an external individual collect information on changes made, and on enablers and impediments to improvements from centre staff. These interviews provided an important window on the change process and provided unique information that informed this evaluation.

3. Assessing impacts on children and parents

Another possible extension of this research would be to examine the impacts of program improvements and more effective inclusion practices on children and parents — particularly children with disabilities. Information from the interviews suggested that children benefited considerably from the changes made to activities, the curriculum, scheduling, and teacher-child interactions, and that some parents were also impressed with the changes that were introduced. Specific changes in inclusion practices were not captured as well in the current study, but field notes contributed by the inclusion facilitators suggested that there were some significant changes in how well individual children with disabilities were accommodated in specific centres — in a number of cases leading to more positive interchanges between children with special needs and more typically developing children. These outcomes are important to capture well, since critical policy goals encompass ensuring that early learning and child care programs are both more universally inclusive and of high quality.

4. Studying program expansion and maturity

Further follow ups and additional cycles of the project will evidence the processes that mark expansion and program maturity. It is important to study how initiatives like this can be ramped up and expanded without losing their uniqueness and what lessons we can learn from the facilitators as they gain more experience with a wider range of centres. In particular, it will be important to examine how *PFI-NS* changes if it becomes an on-going program, rather than a time-limited initiative or if it changes in any other significant way.

End Notes

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APPENDIX A: INTERVIEW SCHEDULE FOR DIRECTORS

PARTNERSHIPS FOR INCLUSION FOLLOW-UP QUESTIONNAIRE
(Administered at time of 2nd *ECERS-R* review)

Centre ID _____   Centre Name _____
Date of Interview   _____
Person Interviewed   _____

1. What has changed in your centre (main changes), in the past 6 months, directly as a result of *PFI-NS*?
    Please comment on changes in any of the following: (the 7 subscales)
    a. Space and furnishings
    b. Personal care routines
    c. Language and reasoning
    d. Activities offered to the children
    e. Teacher-Child Interactions
    f. Program structure
    g. Parents and staff

2. Were there any other changes, of a positive nature, that you feel are directly attributable to *Partnerships for Inclusion*? (e.g., peer networking; public perception, connections with related professionals).

3. Were there any other changes, related to *PFI* that you think have not been helpful (have been difficult for you), for your centre, or for you as a director? (increased workload, increased demands for financial expenditures – staff time, new equipment, friction between staff or between you and staff).

4. If *PFI-NS* were to be done in other centres, what recommendations would you make to optimize the intervention?
    • For project staff?
    • For other directors?
    • For other staff?

5. What do you think have been the main effects of *PFI* on your staff?

6. What (if anything) has changed in your centre, in the past 6 months, as a result of other training /consultative interventions or events? (such as Building Blocks, Speech and Language project, Autism Initiative).

7. Do you know of any "diffusion effects" from *PFI* — that is, effects in other classrooms or centres that are not part for the project but that are making changes using the *ECERS-R*?

8. Are there any other changes that have affected quality both positively and negatively? (e.g., special needs assistants, turn-over, equipment, sustainability grants).

9. Please comment on changes specific to inclusion ………
    • Number of children with special needs now, in the entire centre _____
    • Types of special needs _____
    • Are you / your staff more accepting of a broader range of children with special needs than before? _____If yes, what allowed you to do this?

- What are you doing with the children with special needs that you didn't do until recently? (e.g., IPPs, closer involvement with professionals, social facilitation).

10. Do you have any lingering concerns about your centre's capacity to be successful with inclusion and continue to grow? Please explain

APPENDIX B: INTERVIEW SCHEDULE FOR LEAD EDUCATORS

PARTNERSHIPS FOR INCLUSION FOLLOW-UP QUESTIONNAIRE
(Administered at time of 2nd *ECERS-R* review)

Centre ID _____   Centre Name _____

Date of Interview   _____

Person Interviewed   _____

1. What has changed in your classroom (main changes), in the past 6 months, directly as a result of *PFI-NS*?
      Please comment on changes in any of the following: (the 7 subscales)
      a. Space and furnishings
      b. Personal care routines
      c. Language and reasoning
      d. Activities offered to the children
      e. Teacher-Child Interactions
      f. Program structure
      g. Parents and staff

2. Were there any other changes, of a positive nature, that you feel are directly attributable to *Partnerships for Inclusion*? (e.g., peer networking; public perception, connections with related professionals).

3. Were there any other changes, related to *PFI* that you think have not been helpful (have been difficult for you), for your classroom, or for you as a lead teacher? (increased workload, increased demands for financial expenditures – staff time, new equipment, friction between staff or between you and staff).

4. If *PFI-NS* were to be done in other centres, what recommendations would you make to optimize the intervention?
      • For project staff?
      • For other directors?
      • For other staff?

5. What do you think have been the main effects of *PFI* on your staff?

6. What has changed in your classroom, in the past 6 months, as a result of other training/consultative interventions or events? (such as, Building Blocks, Speech and Language project, Autism Initiative)

7. Do you know of any "diffusion effects" from *PFI* — that is, effects in other classrooms or centres that are not part for the project but that are making changes using the *ECERS-R*?

8. Are there any other changes that have affected quality in your classroom both positively and negatively? (e.g., special needs assistants, turn-over, equipment, sustainability grants).

9. Has *PFI* had any effects on children with special needs? What changes specific to inclusion (if any) have occurred during *PFI* intervention period?
      • Number of children with special needs in your classroom ___
      • Types of special needs ___

- Accepting of a broader range of children with special needs?
- If yes, what allowed you to do this?

10. What are you doing with the children with special needs that you didn't do until recently? (e.g., IPPs, closer involvement with professionals, social facilitation)

11. Do you have any lingering concerns about your classroom's capacity to be successful with inclusion and continue to grow? If yes, please explain.