Inclusion Quality

Children with Disabilities in Early Learning and Child Care in Canada

Sharon Hope Irwin

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for Child Care Inclusion

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SpeciaLink is The National Centre for Early Childhood Inclusion, a non-profit organization dedicated to the equitable inclusion of children with disabilities in child care and other community programs. Responding in the late 1970s to parents of children with disabilities and to local advocates and professionals, SpeciaLink has become the national force for inclusion of young children with disabilities. Since 1990, with support from the Government of Canada, SpeciaLink provides research and resources to assist parents, ELCC programs, training institutions, advocates, consultants and researchers to improve the quality and quantity of inclusive child care across Canada.

ABOUT THE AUTHORS

Sharon Hope Irwin, the Executive Director and Senior Researcher for SpeciaLink: The National Centre for Early Childhood Inclusion, has spent most of her professional career in the non-profit sector, with a focus on including children with disabilities in child care and other community programs. After working as a frontline child care director in a pioneering inclusive child care centre for 15 years, she founded SpeciaLink and has conducted research on early childhood inclusion for the past 30 years, and facilitated numerous workshops and conference presentations in all provinces and two territories and several other countries, on issues related to disability, inclusion and child care. For the past 20 years, her work has focused on the development and dissemination of an instrument to measure inclusion in child care — *The SpeciaLink Early Childhood Inclusion Quality Scale*. As part of this work, she has consulted with government officials in all provinces, as well as with researchers, trainers, agency heads, directors and early childhood educators. She has trained over 3000 related professionals in the use of the SpeciaLink tool.

Sharon holds a doctorate in education and an honorary doctorate of laws in social policy from the University of Winnipeg, as well as an appointment to the Order of Nova Scotia.

Donna S. Lero, Ph.D. is University Professor Emerita at the University of Guelph, where she taught in the Department of Family Relations and Applied Nutrition for over four decades. Donna's interdisciplinary background in the social sciences is evident in her many publications on child care policies and programs, parental leave, the integration of work and family responsibilities, and caregiving. In 1998, she co-founded the University's Centre for Families, Work and Well-being where she led a program of research on public policies, workplace practices and community supports. Donna held the inaugural endowed Jarislowsky Chair in Families and Work in the Centre from 2003-2016.

Donna and Sharon have been conducting research together on child care inclusion since 1995. Their joint publications include *Inclusion: The Next Generation in Child Care in Canada* (*2004*); *A Matter of Urgency: Including Children with Special Needs in Child Care in Canada* (*2000*) and *In Our Way: Child Care Barriers to Full Workforce Participation Experienced by Parents of Children with Special Needs* — and *Potential Remedies* (*1997*).

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Executive Summary

This research study is one component in a larger project designed to improve inclusion quality in early learning and child care programs across Canada. The specific objectives of the study were:

- To assess levels of program quality and inclusion quality in a sample of inclusive programs;
- To examine whether there are gaps in the quality of programs available for children with disabilities by comparing scores on program quality and inclusion quality across the sample and within individual centres;
- To examine the relationship between program quality and inclusion quality — specifically whether high program quality is a necessary and/or sufficient condition for inclusion quality and whether there is a program quality threshold that is required for high inclusion quality;
- To learn what factors affect the quality of children's learning and caring environments for children with disabilities by profiling those centres that evidence high and low inclusion quality;
- To consider what centre directors identify as strengths, specific challenges, and actions that can be taken to improve inclusion quality; and
- To inform policy, research, and practice to improve and sustain high program quality and high inclusion quality for all children.

Our research, supported by Employment and Social Development Canada's [ESDC] Early Learning and Child Care [ELCC] Innovation Program, 2019, is based on a purposive, voluntary sample of 67 inclusive child care centres located in five provinces. We note that almost all of the programs have a long history of inclusion and that many were connected to a range of inclusion support services and professional resources. As such, as a group, they likely evidenced higher program quality and inclusion quality than might be obtained in a random sample of Canadian programs. Information about the centres, their inclusion history and current practices was obtained from centre directors who completed a centre questionnaire. Assessments of program quality and inclusion quality were obtained by trained observers who administered the Early Childhood Environment Rating Scale-Revised (ECERS-R) and the SpeciaLink Early Childhood Inclusion Quality Scale (SpeciaLink Inclusion Scale).

A PROFILE OF PROGRAM QUALITY AND INCLUSION QUALITY IN INCLUSIVE CENTRES

Overall Program Quality

- Somewhat more than half of the centres (54%) had *ECERS-R* scores that ranged from 3.0–4.99, with most scoring in the 4.0–4.99 range, in-

dicative of mediocre program quality, while 46% had scores above 5.0, in the good to excellent range. The average score on the *ECERS-R* was 4.9.

- In general, centres had higher scores on the social and structural aspects of program quality with higher scores on staff-child interactions, program structure, and provisions for staff and parent-staff relationships. In many centres, scores indicated room for improvement in the provision of stimulating learning activities — both structured and unstructured — and in personal care routines.

- There were significant differences in average program quality scores across regions. A higher proportion of centres had scores indicative of good to excellent program quality in Ontario and British Columbia.

Inclusion Quality

- Scores on the *SpeciaLink Early Childhood Inclusion Quality Scale* covered the full range from inadequate to excellent. More than one in five centres (22%) had an average score below 3.0, indicating poor inclusion quality, while almost as many (21%) had scores indicating good or excellent inclusion quality. The average score on the *SpeciaLink Inclusion Scale* was just under 4.0 and the majority of centres clustered in the minimal to moderate range.

- Average scores on the *Inclusion Principles* subscale were significantly higher than on the *Inclusion Practices* subscale (average scores were 4.3 and 3.8, respectively). Fifteen centres had scores in the inadequate range on one or the other measure, however almost 45% of centres had scores in the good to excellent range for *Inclusion Principles*, indicating a strong commitment to full inclusion.

- Items with the lowest average scores on the *Inclusion Practices* subscale indicate substantial room for improvement. These include: Support from a Board of Directors or Parent Advisory Board, Equipment and Materials, the Physical Environment, Staff Training, and Director's Active Involvement as an Inclusion Leader in the Centre and in the Community.

- Differences in *SpeciaLink Inclusion Scale* scores were evident when the provinces were compared, although most had average scores in the moderate range. A notable outlier is Nova Scotia, which had much lower inclusion quality scores than the other provinces.

Scores on Both Program Quality and Inclusion Quality

- When scores on the two quality measures are considered together, we find that less than one fifth of the sampled centres (18%) had scores in the good to excellent range on both the program quality and inclusion quality measures.

- The majority of centres (60%) had scores on one or both measures in the minimal to mediocre range.

IS THERE A GAP BETWEEN PROGRAM QUALITY AND INCLUSION QUALITY?

Children with disabilities deserve to participate in early childhood settings that offer a high quality program to all children, but also can meet their unique needs. Evidence of a gap between overall program quality and inclusion quality was clearly evident, both for the sample as a whole and within individual centres.

- On the *SpeciaLink Inclusion Scale* the average score was almost a full point lower than the average score obtained on the *ECERS-R* measure of overall program quality (3.96 compared to 4.93). This difference is both meaningful and statistically significant.

- While no centre had an *ECERS-R* score indicative of inadequate program quality, 15 centres (22%) had a score below 3.0 (inadequate inclusion quality) on the *SpeciaLink Inclusion Scale*.

- In addition, while 31 centres (46%) had scores indicative of good or excellent program quality, less than half that number (14 centres — 21%) attained scores in the good-to-excellent range for inclusion quality.

- Average program quality scores were higher than average inclusion quality scores in every province. The difference was statistically significant in New Brunswick, Ontario, and, most dramatically among centres in Nova Scotia.

- The gap between program quality and inclusion quality was also evident when scores were compared in individual centres. The average within-centre PQ-IQ gap was almost a full point. Fully half the centres evidenced a PQ-IQ gap of one point or more and 14 centres had a gap in scores that exceeded two full points.

HIGH PROGRAM QUALITY IS A NECESSARY, BUT NOT SUFFICIENT CONDITION, TO ENSURE HIGH INCLUSION QUALITY

We found that high inclusion quality does not occur in the absence of high program quality, however high program quality on its own does not ensure high inclusion quality. In summary, good overall program quality is a platform that is required for good to excellent inclusion quality.

- Twelve of the 14 centres that had scores > 5 on the *SpeciaLink Inclusion Scale* also had scores > 5 on the *ECERS-R* measure of program quality. A threshold of 4.5 or above on the *ECERS-R* seemed to be the minimum score required to support high inclusion quality.

- A high score on program quality on its own is not sufficient to ensure high inclusion quality. Nineteen centres had *ECERS* scores that indicated good overall program quality, but had *SpeciaLink Inclusion Scale* scores reflecting inadequate, minimal or mediocre inclusion quality.

A Mix of In-Centre Resources and Resources and Supports Provided to Centres Is Required for Centres to be Successful in Including Children with Disabilities and Sustaining Their Capacity to Do So.

- On a scale of 1-10, most directors rated their centre's current inclusive practice as 8, although scores ranged from 4 to 10. Directors' ratings reflected their views of the resources available to them, and to what they perceive as their centre's strengths and challenges in providing quality inclusive care and education.

- Centres varied in terms of the number of resources available to support inclusion and the specific resources they used. Resource-rich centres were able to benefit from a variety of specialists, community agencies and government funding. Resource-poor centres were more limited and some experienced long wait lists for child assessments, consultation and support.

- Where available, inclusion coordinators/resource consultants provided information, access to resources, role modeling and support for all staff. Typically, these consultants worked mostly with educators in preschool rooms. Several directors noted the importance of additional training and support for staff who work with infants/toddlers and school-age children.

- Most directors identified early childhood educators' commitment to inclusion, knowledge and training, and capacity to work well together as an effective team — both within the centre and with professionals and parents as key strengths. These factors were also reflected in the centre's philosophy and positive inclusion culture. A smaller proportion of directors (19%) referred to access to therapies and services, funding for extra staff, and resources and equipment as centre strengths that contribute to inclusive practice.

- Similarly, 79% of directors identified as key challenges the need for more training and support for staff, as well as broader staffing issues in finding and maintaining qualified staff as major difficulties. More than half of the directors (52%) commented on the lack of funding to support inclusion as a significant challenge and 21% identified lack of access to specialists/therapists and a long wait list for support, services and assessments as significant challenges to inclusion.

The Findings from This Study and From Our Prior Research Confirm That High Quality, Inclusive Child Care Requires Informed Policies; Funding; Collaboration with Therapists, Early Intervention and Inclusion Support Programs; and Ongoing Training, Mentorship and Support for Child Care Directors and Front-Line Staff.

Our recommendations address each of these areas. We note that there are excellent examples of high quality inclusive child care in most provinces; however it is essential that policy makers address *both* the wider issues that affect child care accessibility and quality *and* specific aspects related to inclusion (training and support, access to funding and resources) in order for all children to be able to benefit from quality ELCC programs that support their development and well-being and enable their participation in their community and in Canadian society.

RECOMMENDATIONS

INCLUSION QUALITY IN EARLY LEARNING AND CHILD CARE IN CANADA

Over the past several decades there has been a strong convergence of developments in public policy and legislation, practice, and public support that makes us cautiously optimistic about the future of inclusive child care for children with disabilities in Canada. However, there is a long way to go before children with disabilities have the same opportunities to attend quality child care as do other children, with accommodations and adaptations that meet their unique needs.

Federal commitments to develop a system of high quality, affordable, accessible, inclusive child care programs across Canada have been made before. The current pandemic has made visible how critical child care programs are as an essential support to families, children, communities and the economy (Employment and Social Development Canada's [ESDC] Early Learning and Child Care [ELCC] Innovation Program, 2019). The most recent Speech from the Throne (Trudeau, J., 2000) again identified child care as an essential program that must be supported and expanded. Attention to the needs of children with disabilities must not be an afterthought in policy planning, workforce strategies and funding.

From the early 1970s, under the *Canada Assistance Plan* (*CAP*), most provinces saw some children with disabilities included in community-based child care centres. In the 1980s and 1990s, under strong parental and disability organizational advocacy, provinces began to encourage integration or mainstreaming, and many specialized centres either closed or developed into integrated centres. By the end of the 1990s, more children with disabilities attended mainstream child care. But attendance was not a right; it was a privilege. With a persuasive parent, a particularly adorable child, perhaps a centre director who was committed to inclusion — some children with disabilities were included. But children had to earn their right to enroll and stay in many centres.

Until 2005, when Foundations: A National Early Learning and Child Care Program of the federal government was introduced, no F/T/P agreement had specified "inclusion of children with disabilities" in any of its principles. The Foundations Program, under Minister Ken Dryden, stated that "Early learning and child care should be inclusive of, and responsive to, the needs of children with differing abilities; Aboriginal (i.e., Indian, Inuit and Métis) children; and children in various cultural and linguistic circumstances…." Inclusion became one of the QUAD principles, the others being Quality, Accessibility, and Developmentally Appropriate. Unfortunately, this agreement only lasted two years until the Harper government was elected and closed those doors.

From 2005 to 2017, despite the lack of federal funding or leadership, provinces reported increasing inclusion of children with disabilities; post-secondary ECE training programs reported the addition of courses and specializations regarding children with disabilities; and inclusion

became a regular topic at child care conferences. Moreover, popular media presentations of children with visible disabilities in typical settings had increased public acceptance of the concept of inclusion.

While these developments were positive, it remained to be seen whether Canadian governments (and the public in general) would develop and support effective policies and program approaches to ensure that high quality, affordable, accessible, inclusive child care for all children would become a sustainable reality. Families with children with disabilities were often still marginalized from community-based child care.

Thus, the Liberal government's Multilateral Early Learning and Child Care Framework (ESDC'S ELCC Innovation Program Framework, 2017) and its accompanying funding commitments was a positive step forward. In the F/T/P agreements that were signed for a 3-year period, to be followed by renewal for the next seven years, "children with differing abilities" were specifically included as a vulnerable group, to be addressed in the provincial Action Plans and progress reports. Several of the first year Progress Reports specifically describe progress in their plans for increasing the number of children with disabilities included and increasing centres' inclusion quality.

Now that work is being done for the 2022-2025 period and beyond, governments have the opportunity, when negotiating the bi-lateral agreements, to develop and strengthen policies, programs, and initiatives to improve the situation of children with disabilities.

The authors of this report are strongly supportive of the child care agenda proposed by Child Care Now (formerly the Child Care Advocacy Association of Canada) which addresses the significant deficiencies in current policies and provision that affect most families who need affordable, high quality child care in their communities. In addition, there are other elements that are necessary to ensure high quality, inclusive child care that require additional attention from the federal/provincial/territorial governments as listed below.

Based on our research findings in this report and three decades of research, advocacy, and support for child care programs, we make the following recommendations:

FOR EMPLOYMENT AND SOCIAL DEVELOPMENT CANADA

We recommend the following changes and expansions to the *Multilateral Early Learning and Child Care Framework* and to further policy development related to early learning and child care, as well as to the bilateral agreements developed with provincial and territorial governments pursuant to the Framework:

1. Change the phrases "differing abilities" and "varying abilities" to "children with disabilities." People in the disability community usually refer to themselves, their children and their clients as "persons with disabilities" as does the UN Convention on the Rights of Persons with Disabilities that Canada has signed.

2. Include “children with disabilities” as a distinct category in the inclusivity sections of the agreements and in progress reports. While this group is no more important than other vulnerable groups, it is the only one that shows up in all ethnic, linguistic, income, and geographical groups.

3. Include provision for children with disabilities in all action plans. Planned actions must include an increase in the number of children with disabilities included; in the types and levels of severity of disabilities included; in the number of ELCC centres that are inclusive (including at least 10% of children with disabilities), and in the quality of inclusion provided.

4. Additional or expanded funding to support inclusion through specific programs or funding agreements should be identified separately in agreements, Action Plan and progress reports.

5. Include leadership training as part of the quality component of the ESDC’S ELCC Innovation Program Framework, 2017. Of course, leadership is always important, but it is especially important in an emerging area such as inclusive ELCC. Our research has shown that centre directors’ leadership has an extremely strong effect on staff attitudes, acceptance, and effectiveness when including children with disabilities. Training related to inclusion that focuses on directors as inclusion leaders as well as on front-line staff should be an important measure of the quality component of the provincial Action Plans.

6. Federal, provincial and territorial governments (and municipal service managers in Ontario) must develop comprehensive policies and initiatives to promote, monitor, and support both overall program quality and inclusion quality and to eliminate the gap between overall quality and inclusion quality that exists in most child care centres. These policies and supports should be developed collaboratively with child care professionals, appropriately resourced, and evaluated on a regular basis to ensure continued improvement. Our research shows that there are valid and reliable instruments for measuring inclusion quality. Children with disabilities deserve to participate in community-based programs that are developmentally appropriate for them as individual children, support their parents, and are part of an integrated system of supports for young children.

7. Valid and reliable methods should be used to collect and analyze national and provincial/territorial data on children with disabilities (by age) on a regular basis. Statistics Canada should ensure that this is part of its ongoing survey research, including data on whether children and families are able to access child care and other services and supports.

8. In addition, comparable administrative data should be collected and made publicly available by the provinces and territories on the number of young children with disabilities and their participation in ELCC programs, including the number of children with varied types and severity levels of their disabilities, and the number of centres including children with disabilities. We recommend regular monitoring of inclusion quality in centres – including unmet needs and challenges centres are facing as critical information for policy planning and quality improvement.

FOR THE PROVINCES AND TERRITORIES

Most provinces and territories provide some funding and supports for centres to include children with disabilities. Our research suggests a number of important directions and efficiencies that may assist them in providing higher quality inclusion.

A Focus on Policy

Provincial/territorial policies must support effective inclusion practice. Funding must be provided to ensure that centres and their staff have access to the resources (both financial and human) needed to continue to be effective and to expand their capabilities and ensure that early childhood educators are compensated for the valuable work they do. Among policy concerns to be addressed are:

9. Child care centres that enroll children with disabilities must have timely access to child assessments, both to determine eligibility and to assist child care staff in their planning efforts.

10. Child care centres must have additional funds to enhance ratios (or employ an in-house resource teacher) when four or more children with disabilities are enrolled, or when any children have severe disabilities. Funding should be stable and adequate to recruit and retain trained and experienced ECEs for this work.

11. Inclusion consultants also must be available to child care centres that enroll fewer than four children with disabilities and, ideally, should support all child care programs as needed.

12. Child care centres must have appropriate levels of support from therapists and other related specialists in the community when they enroll children with disabilities.

13. Child care centres must have additional inclusion assistants when they enroll children with more challenging needs.

14. Since accessibility and physical structure are so closely related to both inclusion quality and global quality, all new centres must be purpose-built to meet current standards, and older centres must be eligible for capital grants to increase accessibility.

A Focus on Research

15. Governments must fund thorough evaluations of the effectiveness of different models of inclusion support and initiatives undertaken to increase inclusion capacity and inclusion quality. These evaluations should be used for continuous improvements in policies and service provision.

16. Governments must fund the monitoring of progress toward "inclusiveness" in child care programs. Tools for monitoring inclusion quality — for example the *SpeciaLink Inclusion Scale* — are available and are familiar to the field.

A Focus on Leadership

Our research confirms the critical role of the child care centre director as an inclusion leader. Some of the centres in this study and in our earlier research lacked resource teachers; some lacked regularized funding for the extra costs of resource supports; some lacked strong boards — but none of the successful programs lacked strong, committed directors. Activities and programs that enhance that role are critical. Fully inclusive child care centres are still rare, and their sustainability is in question as founding directors retire or move on and as child care programs cope with unstable enrollments and increased costs related to COVID-19. Despite the urgent need for new qualified front-line early childhood educators, we must also invest in our leaders and our potential leaders as an important component of national and provincial/territorial workforce strategies.

There is a tremendous reserve of "practice wisdom" that should be widely shared and utilized to enhance inclusive practice and to encourage the next generation of directors and child care professionals.

We strongly recommend that:

17. Governments identify successful, inclusive directors as key change agents, and fund projects that enhance their impact on the broader child care community. This can be achieved through projects that:

- Bring key people from successful inclusive child care sites together to share learnings and best practices, and to strategize with policy makers, professional organizations, post-secondary ECE programs and local child care groups about practical initiatives that can enhance inclusion quality;
- Sponsor inclusion leadership training institutes for directors, and for potential directors with demonstrated commitment to inclusion;
- Support networking opportunities for directors/supervisors of inclusive centres, including the development of local communities of practice;
- Create national and provincial/regional mentorship programs for inclusion, with successful directors/supervisors of inclusive centres as mentors, nominating in-province leaders who are "ready to include";
- Build and sustain capacity through child care resource centres, provincial organizations, the Canadian Child Care Federation and SpeciaLink, including programs that utilize new technologies and web-based portals to expand access to information, opportunities to share experiences, and obtain peer support and mentoring that involves directors/supervisors — credible practitioners — as key figures;
- Promote a career ladder and encourage existing successful inclusion practitioners to become trainers.

18. Governments must fund a variety of opportunities (using in-person presentations, print materials, videos, web-based resources, and on-line coaching) to share with others the knowledge acquired by leaders in inclusive child care.

A Focus on Training and Support

19. Provincial and territorial governments must ensure that there is a variety of courses, conferences and workshops on inclusion that are accessible, affordable, and available to staff and directors on an ongoing basis, addressing the range of topics and issues that are important for successful inclusion.

20. College and university programs in ECE must incorporate more materials about inclusive practice in their curricula and in post-diploma and graduate courses.

21. Practica and placement courses in ECE and related programs must be strategically developed to ensure that students have the opportunity to learn about inclusion by participating in successful inclusive centres.

22. Colleges and universities must re-conceptualize (in consultation with the field) post-diploma/certificate and graduate programs for resource teachers and special needs workers in early childhood education. These should reflect the multiple roles of direct service, collaborative practice, consulting, family support, and adult education. Training programs should also be developed to address the needs of short-term contract workers (inclusion assistants) who work in inclusive child care settings, often without training.

23. Successful intensive inclusion quality enhancement programs, such as *Keeping the Door Open* in New Brunswick (Van Raalte, D.L., 2001); *Measuring and Improving Kids' Environments* (MIKE) in Prince Edward Island; and *Partnerships for Inclusion* in Nova Scotia, typically offered as pilot projects or limited time research projects, should be offered to centres in all provinces and territories with ongoing support, monitoring and evaluation. These initiatives provide on-site assessment, collaborative planning with centre directors and early childhood educators, and support to improve both overall program quality and inclusion quality.

A Focus on Planning for Transitions

Provincial/territorial policy must support a collaborative, inter-disciplinary approach among early years professionals, including school personnel to ensure effective transition planning and continuity of support.

24. Early years personnel must develop protocols and strategies for effective planning and coordination of efforts to assist with child care transitions (from home or early intervention/infant development to child care, and child care to school).

A Focus on the Profession

Considerable variation exists in the roles, training, caseload size, duration and frequency of visits, focus of service, etc. of inclusion consultants in child care as well as access to specialized resources. An integrated community-wide approach to service delivery must be developed and supported to meet the needs of all young children with disabilities across Canada.

25. As an emerging profession, leaders in the field of early childhood intervention and resource teachers/specialists must define their own code of ethics, mandates, appropriate caseloads, and standards of training and practice. Funding must be allocated for research and development projects oriented toward this goal.

Toward a System of High Quality, Affordable, Accessible, Inclusive Child Care Programs Across Canada

26. Federal/provincial/territorial governments must strengthen the funding component of the Multilateral Framework on Early Learning and Child Care to build a national Canadian child care system that includes career ladders with graduated salaries and assures a continuing infrastructure to support high quality, inclusive programs.

Coup d'oel

Cette étude est un volet d'un projet de recherche plus vaste visant à améliorer la qualité de l'inclusion dans les services éducatifs et de garde à l'enfance au Canada. Les objectifs précis de l'étude étaient les suivants :

- Évaluer la qualité globale des services de garde et la qualité des pratiques d'inclusion dans un échantillon de garderies inclusives;
- Examiner s'il existe un écart dans la qualité des services de garde offerts aux enfants qui ont des incapacités en comparant les résultats obtenus à l'échelle de l'échantillon et dans les garderies individuelles au chapitre de la qualité globale des services de garde et de la qualité de l'inclusion;
- Examiner la relation entre la qualité des services de garde et la qualité des pratiques d'inclusion - plus précisément vérifier s'il est essentiel pour assurer la qualité de l'inclusion d'offrir des services de garde de qualité élevée et s'il existe un seuil de qualité de services de garde nécessaire pour que les pratiques d'inclusion soient de grande qualité;
- Déterminer les facteurs qui influencent la qualité des milieux d'apprentissage et de soins qui accueillent des enfants ayant des incapacités en faisant le profil des garderies dont les pratiques d'inclusion sont de qualité élevée ou de faible qualité;
- Examiner ce que le personnel de direction des garderies définit comme étant des forces, des défis particuliers et des mesures à prendre pour améliorer la qualité de l'inclusion; et éclairer les politiques, la recherche et les pratiques afin d'améliorer la qualité des services de garde et des pratiques d'inclusion pour tous les enfants.

Notre recherche s'appuie sur un échantillon choisi à dessein de soixante-sept (67) garderies inclusives situées dans cinq provinces. Nous soulignons que presque toutes les garderies, qui participaient volontairement à l'étude, avaient une longue feuille de route en matière d'inclusion et qu'un grand nombre d'entre elles bénéficiaient d'un éventail de services et de ressources professionnelles pour soutenir l'inclusion. Cela étant, en tant que groupe, il est probable que la qualité de leurs services de garde et de leurs pratiques d'inclusion ait été plus élevée que celle qu'aurait présentée un échantillon aléatoire de garderies au Canada. Les données sur les garderies et l'information sur leur feuille de route et leurs pratiques d'inclusion ont été fournies par les directions, qui ont rempli un questionnaire. La qualité des services de garde et des pratiques d'inclusion a été mesurée par des observatrices et observateurs formés qui ont utilisé l'Échelle d'évaluation de l'environnement préscolaire - révisée (ÉÉEP-R) et l'Échelle d'évaluation de la qualité de l'inclusion en services de garde (ÉÉQISG) de Trait-d'union.

PORTRAIT DE LA QUALITÉ DES SERVICES DE GARDE ET DE LA QUALITÉ DE L'INCLUSION DANS DES GARDERIES INCLUSIVES

Qualité globale des services de garde

• Un peu plus de la moitié des garderies (54 %) ont obtenu un résultat variant de 3,0 à 4,99 sur l'ÉÉEP-R, la plupart se situant dans la fourchette de 4,0 à 4,99 - indiquant des services de garde de faible qualité. Les résultats de 46 % des garderies étaient supérieurs à 5,0, indiquant des services de garde de bonne à excellente qualité. Le résultat moyen obtenu sur l'ÉÉEP-R a été de 4,9.

• En général, les garderies ont obtenu de meilleurs résultats sur les dimensions sociales et structurelles de la qualité, à savoir les interactions enfants-personnel, la structure du programme, les dispositions pour le personnel et les relations parents-personnel. Dans de nombreuses garderies, les résultats indiquent qu'il y a possibilité d'améliorer la qualité des activités éducatives - autant structurées que non structurées - et les soins personnels.

• Les résultats moyens au chapitre de la qualité globale des services de garde variaient considérablement d'une région à l'autre. Un pourcentage plus élevé de garderies en Ontario et en Colombie-Britannique ont obtenu des résultats témoignant de services de garde de bonne à excellente qualité.

Qualité de l'inclusion

• Les résultats obtenus sur l'échelle d'évaluation de la qualité de l'inclusion en services de garde (ÉÉQISG) couvraient l'ensemble de la fourchette, la qualité de l'inclusion variant d'inadéquate à excellente. Plus d'une garderie sur cinq (22 %) a obtenu un résultat inférieur à 3,0, indiquant une faible qualité en matière d'inclusion. Et presque autant de garderies (21 %) ont obtenu des résultats témoignant de pratiques d'inclusion de bonne à excellente qualité. En moyenne, le niveau de qualité sur l'ÉÉQISG était légèrement sous 4,0 et la majorité des garderies était dans la zone de qualité minimale à qualité modérée.

• Les résultats moyens sur la sous-échelle des principes d'inclusion étaient considérablement plus élevés que ceux sur la sous-échelle des pratiques d'inclusion (respectivement 4,3 et 3,8). Quinze garderies ont obtenu des résultats indiquant un niveau inadéquat de qualité sur l'une ou l'autre des sous-échelles. Toutefois, sur la sous-échelle des principes d'inclusion, les résultats de près de 45 % des garderies indiquent qu'elles ont des pratiques d'inclusion de bonne à excellente qualité, ce qui témoigne de leur véritable engagement à l'égard de l'inclusion.

• Il reste énormément de place à l'amélioration des aspects qui ont obtenu les résultats les plus faibles sur la sous-échelle des pratiques d'inclusion, à savoir : appui du conseil d'administration ou du comité consultatif de parents; équipement et matériel; environnement physique; formation du personnel; participation active et leadership de la direction en matière d'inclusion au sein de la garderie et dans la collectivité.

• Une comparaison par province des résultats obtenus sur l'ÉÉQISG a permis de dégager des différences manifestes, même si, en moyenne, le niveau de qualité dans la plupart des garderies était modéré. La Nouvelle-Écosse fait figure d'exception : la qualité de l'inclusion dans les garderies de cette province était nettement inférieure au niveau de la qualité observée dans les autres provinces.

Résultats au chapitre de la qualité globale des services de garde et de la qualité de l'inclusion

• Une comparaison des résultats sur les deux échelles d'évaluation de la qualité indique que moins d'un cinquième des garderies de l'échantillon (18 %) offrait des services de garde et des pratiques d'inclusion se situant dans la fourchette de bonne à excellente qualité.

• Les résultats de la majorité des garderies (60 %) sur les deux échelles se situaient dans la fourchette de qualité inadéquate à qualité minimale.

Y A-T-IL UN ÉCART ENTRE LA QUALITÉ GLOBALE DES SERVICES DE GARDE ET LA QUALITÉ DE L'INCLUSION?

Les enfants qui ont des incapacités méritent de fréquenter des milieux éducatifs qui offrent à tous les enfants des services de qualité et qui sont en mesure de répondre à leurs besoins uniques. L'écart entre la qualité globale des services de garde et la qualité de l'inclusion était évident à l'échelle de l'échantillon et dans les garderies individuelles.

• Les résultats sur l'Échelle d'évaluation de la qualité de l'inclusion en services de garde (ÉÉQISG) de Trait d'union sont en moyenne près d'un point inférieur aux résultats moyens obtenus sur l'Échelle d'évaluation de l'environnement préscolaire - révisée (ÉÉEP-R) qui mesure la qualité globale des services de garde (3,96 à comparer à 4,93). Cette différence est à la fois importante et statistiquement significative.

• Alors qu'aucune garderie n'a obtenu de résultats sur l'ÉÉEP-R indiquant que le niveau de qualité de ses services était inadéquat, quinze garderies (22 %) ont obtenu des résultats inférieurs à 3,0 (qualité d'inclusion inadéquate) sur l'ÉÉQISG.

• De plus, alors que 31 garderies (46 %) offraient des services de garde de bonne ou d'excellente qualité, moins de la moitié de celles-ci (quatorze garderies ou 21 %) avaient des pratiques d'inclusion de bonne à excellente qualité.

• Dans toutes les provinces, la qualité globale des services de garde en moyenne était supérieure à la qualité de l'inclusion. L'écart à cet égard était statistiquement significatif au Nouveau-Brunswick et en Ontario, et plus notablement en Nouvelle-Écosse.

• L'écart entre la qualité globale des services de garde (QSG) et la qualité de l'inclusion (QI) était également manifeste lorsque l'on comparait les garderies entre elles. L'écart moyen QSG et QI était de près d'un point. La moitié des garderies accusaient un écart QSG-QI d'un point ou plus et, dans le cas de quatorze garderies, l'écart était supérieur à deux points.

LA QUALITÉ GLOBALE DES SERVICES DE GARDE EST UNE CONDITION NÉCESSAIRE POUR ASSURER LA QUALITÉ DE L'INCLUSION, MAIS ELLE NE SUFFIT PAS EN SOI

Nous avons trouvé que si la qualité globale des services de garde n'était pas élevée, la qualité de l'inclusion ne l'était pas non plus. Par contre, des services de garde de qualité élevée ne garantissent pas en soi la qualité de l'inclusion. Bref, des services de garde de bonne qualité sont l'assise requise pour que la qualité de l'inclusion soit de bonne à excellente.

• Douze des quatorze garderies dont les résultats étaient supérieurs à 5 sur l'ÉÉQISG ont aussi obtenu des résultats supérieurs à 5 sur l'ÉÉEP-R , qui mesure la qualité globale des services de garde. Dans notre échantillon, il semble qu'un résultat de 4,5 ou plus sur l'ÉÉEP-R était le minimum requis pour assurer la qualité élevée de l'inclusion.

• De bons résultats au chapitre de la qualité globale des services de garde ne suffisent pas en soi à faire en sorte que la qualité de l'inclusion soit élevée. Les résultats de 19 garderies sur l'ÉÉEP-R indiquaient que leurs services de garde étaient en général de bonne qualité, mais leurs résultats sur l'ÉÉQISG indiquaient que la qualité de l'inclusion y était inadéquate, minimale ou faible.

Pour permettre aux garderies d'inclure avec succès des enfants qui ont des incapacités et soutenir leurs capacités à le faire, il faut une combinaison de ressources à l'interne et de ressources et de mesures de soutien externes.

• Sur une échelle de 1 à 10, la plupart des directions ont accordé à leurs pratiques en matière d'inclusion la note de 8, même si les résultats de leurs garderies à cet égard variaient de 4 à 10. L'évaluation des directions reflétait leur point de vue sur les ressources qui leur sont offertes et leur perception des forces et des difficultés de leurs garderies à fournir des services éducatifs et de garde l'enfance de qualité et inclusifs.

• La quantité de ressources offertes aux garderies pour soutenir l'inclusion et les ressources utilisées variaient d'une garderie à l'autre. Les garderies riches en ressources avaient accès à une brochette de spécialistes, d'organismes communautaires et de subventions gouvernementales. Les garderies pauvres en ressources étaient plus limitées et certaines étaient aux prises avec de longues listes d'enfants en attente d'évaluation, de consultation et de soutien.

• Lorsque de tels services existaient, des personnes-ressources fournissaient de l'information, de la documentation, de l'encadrement et du soutien à l'ensemble du personnel. Généralement, ces personnes-ressources intervenaient principalement auprès des éducatrices et éducateurs affectés aux groupes d'enfants d'âge préscolaire. Quelques directions ont souligné l'importance de donner plus de formation et soutien au personnel affecté aux poupons et bambins et aux enfants d'âge scolaire.

• La plupart des directions ont souligné que l'engagement du personnel éducateur envers l'inclusion, les connaissances et la formation, et

la capacité de travailler efficacement en équipe - à la fois à l'intérieur de la garderie et avec le corps professionnel et les parents - étaient des atouts essentiels. Ces facteurs de réussite étaient également véhiculés dans la philosophie et dans la culture positive de la garderie en matière d'inclusion. Les directions, dans un pourcentage moins élevé (19 %), ont mentionné que l'accès à des thérapies et des services, le financement pour l'embauche de personnel additionnel ainsi que les ressources et l'équipement dont elles disposaient faisaient partie des forces qui contribuaient au succès des pratiques d'inclusion de leurs garderies.

• Par ailleurs, le besoin de plus de formation et de soutien pour le personnel et les problèmes plus vastes de recrutement et de rétention de personnel qualifié ont été soulevés en tant que défis majeurs par 79 % des directions. Plus de la moitié des directions (52 %) ont indiqué que le manque de soutien financier pour l'inclusion était un problème de taille et 21 % ont dit que le manque d'accès à des spécialistes et des thérapeutes et les longues listes d'attente pour obtenir du soutien, des services et des évaluations étaient des obstacles considérables à l'inclusion.

Les résultats de cette étude et de nos recherches antérieures confirment que l'offre de services de garde inclusifs et de qualité élevée repose sur des politiques éclairées, du financement, une collaboration avec les thérapeutes et les programmes d'intervention précoce et de soutien à l'inclusion, des programmes de formation continue, le mentorat et du soutien aux directions et au personnel de première ligne.

Nos recommandations portent sur chacun de ces aspects. Nous soulignons qu'il existe dans presque toutes les provinces d'excellents exemples de garderies offrant des services de garde inclusifs et de qualité élevée. Par contre, les décideurs doivent absolument se pencher tout à la fois sur les problèmes plus généraux qui touchent l'accessibilité et la qualité des services de garde et sur les aspects propres à l'inclusion (la formation et le soutien, l'accès au financement et aux ressources) afin que tous les enfants puissent profiter des bienfaits de services éducatifs et de garde à l'enfance qui soutiennent leur développement et leur bien-être et participer activement à la vie au sein de leur collectivité et dans la société canadienne.

RECOMMANDATIONS :

ÉTUDE SUR LA QUALITÉ DE L'INCLUSION DANS LES SERVICES ÉDUCATIFS ET DE GARDE À L'ENFANCE AU CANADA

Depuis quelques décennies, nous observons au Canada une forte convergence dans l'évolution des politiques publiques et des lois, et de la pratique et du soutien du public à l'égard de l'inclusion des enfants qui ont des incapacités en services de garde – des facteurs qui nous rendent modérément optimistes. Par contre, il reste beaucoup de chemin à faire avant que les enfants ayant des incapacités puissent comme d'autres enfants fréquenter un service de garde de qualité adapté pour répondre à leurs besoins uniques.

Le gouvernement fédéral s'est engagé dans le passé à créer, à l'échelle du Canada, un système de services de garde de bonne qualité, abordables, accessibles et inclusifs. La pandémie actuelle a illustré à quel point les services de garde sont essentiels pour soutenir les familles, les enfants, les collectivités et l'économie. Le plus récent discours du Trône a réitéré une fois de plus l'importance de soutenir et de développer ce programme essentiel que sont les services de garde. Porter attention aux besoins des enfants qui ont des incapacités ne devrait pas être une réflexion après-coup pour celles et ceux qui élaborent les politiques, les stratégies de main-d'œuvre et les programmes de financement dans ce domaine.

À compter du début des années 1970, en vertu du Régime d'assistance publique du Canada, dans la plupart des provinces, il y avait des garderies communautaires qui accueillaient des enfants ayant des incapacités. Dans les années 1980 et 1990, suivant de fortes pressions exercées par des associations de parents et de personnes ayant des incapacités, les gouvernements provinciaux ont commencé à encourager l'intégration et un grand nombre de centres spécialisés ont soit fermé leurs portes ou se sont transformés en garderies intégrées. À la fin des années 1990, les enfants ayant des incapacités étaient beaucoup plus nombreux à fréquenter des garderies ordinaires. Mais fréquenter un service de garde n'était pas un droit, il s'agissait plutôt d'un privilège. Si un parent était convaincant, un enfant particulièrement adorable et une direction fortement dédiée à l'inclusion, il arrivait que des enfants ayant des incapacités soient acceptés dans la garderie. Mais dans beaucoup de garderies, les enfants devaient mériter le droit d'être admis et d'y rester.

Jusqu'en 2005, au moment de l'introduction de l'initiative fédérale Fondations : un programme national d'apprentissage et de garde des jeunes enfants, aucun des principes dans les ententes fédérales, provinciales et territoriales ne portait sur « l'inclusion d'enfants ayant des incapacités ». L'initiative Fondations, sous la gouvernance du ministre Ken Dryden, stipulait que : « Les services d'apprentissage et de garde des jeunes enfants devraient assurer l'inclusion des enfants ayant des capacités différentes, des enfants autochtones (c'est-à-dire Indiens, Inuits [...] et Métis) et des enfants de culture ou de situation linguistique différentes, et répondre à leurs besoins

particuliers ». L'inclusion est devenue un des quatre principes de base : qualité - universalité - accessibilité - développement. Malheureusement, l'entente n'a duré que deux ans, jusqu'au moment de l'élection du gouvernement Harper qui a mis fin aux ententes.

De 2005 à 2017, malgré le manque de financement ou de leadership du gouvernement fédéral, on a constaté dans les provinces un accroissement de l'inclusion des enfants ayant des incapacités en services de garde et les programmes d'éducation à la petite enfance de niveau postsecondaire ont ajouté des cours et des spécialités portant sur l'inclusion. L'inclusion est devenue une thématique systématiquement abordée dans les congrès sur les services de garde. De plus, grâce à la représentation médiatique populaire d'enfants ayant des incapacités visibles qui fréquentaient des services de garde ordinaires, l'acceptation du concept d'inclusion avait fait son chemin dans le public.

Malgré cette évolution positive, il restait à voir si les gouvernements au Canada allaient élaborer et appuyer (et la population en général) des politiques et des programmes pour faire en sorte que des services de garde de qualité élevée, abordables, inclusifs et accessibles à tous les enfants deviennent une réalité viable. La présence de familles d'enfants ayant des incapacités demeurait marginale dans les garderies communautaires.

Par conséquent, la mise en place du Cadre multilatéral de l'apprentissage et de la garde de jeunes enfants par le gouvernement fédéral en 2017 et les engagements financiers qui l'accompagnent ont été un pas en avant positif. En vertu des ententes F/P/T conclues pour trois ans et renouvelées par la suite pour sept ans, les « enfants ayant des capacités différentes » sont expressément inclus à titre de groupes vulnérables dont les plans d'action et les rapports d'étape provinciaux et territoriaux doivent rendre compte. Quelques rapports d'étape font état de progrès au cours de la première année quant au nombre d'enfants ayant des incapacités inclus en garderie et l'amélioration de la qualité des pratiques d'inclusion.

Maintenant qu'ils ont commencé à travailler sur la période de 2022 à 2025 et au-delà, dans leurs négociations bilatérales, les gouvernements peuvent élaborer et consolider des politiques, des programmes et des initiatives pour améliorer le sort des enfants qui ont des incapacités. Les autrices du présent rapport appuient fermement la démarche mise de l'avant par Un enfant Une place (anciennement l'Association canadienne pour la promotion des services de garde l'enfance) en matière de services de garde à l'enfance, une démarche qui vise à contrer les lacunes importantes des politiques et du modèle de prestation actuels, lesquels ont une incidence sur la plupart des familles qui ont besoin de services de garde de qualité et abordables dans leurs collectivités. En outre, les gouvernements fédéral, provinciaux et territoriaux doivent accorder plus d'attention à d'autres aspects (indiqués ci-après) qui sont nécessaires pour assurer des services de garde de qualité et inclusifs.

En nous appuyant sur les résultats de la présente étude et sur trois décennies de recherche, de plaidoirie et d'appui aux services de garde, nous formulons les recommandations suivantes :

À L'ATTENTION D'EMPLOI ET DÉVELOPPEMENT SOCIAL CANADA

Nous recommandons les changements et les ajouts suivants au Cadre multilatéral de l'apprentissage et de la garde des jeunes enfants, à de futures politiques en matière d'apprentissage et de garde des jeunes enfants, et aux ententes bilatérales conclues entre le gouvernement fédéral et les gouvernements provinciaux et territoriaux.

1. Remplacer les expressions « enfants ayant des capacités ou des aptitudes différentes » par « enfants ayant des incapacités ». Dans la communauté des personnes ayant des incapacités, les personnes se définissent et définissent leurs enfants et leurs clients comme des « personnes ayant des incapacités ». (Ce qui se démarque de la terminologie utilisée dans le texte de la Convention des Nations Unies relative aux droits des personnes handicapées.)

2. Inclure les « enfants ayant des incapacités » comme une catégorie distincte dans les parties des ententes bilatérales et des rapports d'étape consacrées à l'inclusion. Bien que ce groupe ne soit pas plus important que d'autres groupes vulnérables, il est le seul à figurer dans tous les autres groupes ethniques, linguistiques, économiques et géographiques.

3. Inclure dans tous les plans d'action des dispositions pour les enfants ayant des incapacités. Les plans d'action doivent prévoir l'augmentation (i) du nombre d'enfants ayant des incapacités en services de garde (ii) du type et du degré de sévérité des incapacités des enfants inclus (iii) du nombre de garderies et de services de garde inclusifs (accueillant au moins 10% d'enfants ayant des incapacités) et (iv) l'amélioration de la qualité de l'inclusion.

4. Indiquer dans les ententes, les plans d'action et les rapports d'étape l'ajout ou l'augmentation des fonds destinés à soutenir l'inclusion par l'entremise de programmes ou d'accords de financement particuliers.

5. Inclure la formation au leadership dans la composante qualité du Cadre multilatéral de l'apprentissage et de la garde des jeunes enfants. Bien sûr le leadership est toujours important, mais il l'est spécialement dans un domaine émergent comme celui des services éducatifs et de garde inclusifs. Notre recherche démontre que le leadership du personnel de direction d'une garderie influence considérablement l'attitude, l'ouverture et l'efficacité de l'ensemble du personnel face à l'inclusion d'enfants ayant des incapacités. La formation visant le rôle du personnel de direction en tant que champion de l'inclusion et la formation visant le personnel de première ligne devraient servir toutes deux d'indicateur important de la qualité dans les plans d'action provinciaux.

6. Les gouvernements fédéral, provinciaux et territoriaux (et les gestionnaires de services municipaux en Ontario) doivent élaborer des politiques et des initiatives qui visent (i) à promouvoir, contrôler et soutenir la qualité globale des services de garde et la qualité de l'inclusion et (ii) à éliminer l'écart entre la qualité globale et la qualité de l'inclusion observé dans la plupart des garderies. Ces politiques et ces mesures de soutien devraient être élaborées de concert avec le secteur des services de garde et elles devraient être suffisamment soutenues et évaluées régulièrement afin d'en

assurer l'amélioration continue. Notre recherche démontre qu'il existe des instruments valides et fiables pour mesurer la qualité de l'inclusion. Les enfants qui ont des incapacités devraient pouvoir fréquenter des garderies et des services de garde communautaires adaptés à leur développement particulier et qui appuient leurs parents et font partie d'un réseau intégré de mesures de soutien pour les jeunes enfants.

7. Utiliser systématiquement des méthodes valides et fiables de collecte et d'analyse de données sur les enfants ayant des incapacités à l'échelle nationale, provinciale et territoriale. Statistique Canada devrait veiller à inscrire la collecte et l'analyse de ces données dans ses enquêtes, y compris des données sur la possibilité des enfants ayant des incapacités et de leurs familles de fréquenter des services de garde et d'accéder à d'autres services et mesures de soutien.

8. De plus, des données administratives comparables devraient être recueillies et publiées par les provinces et les territoires sur (i) le nombre de jeunes enfants ayant des incapacités (ii) leur fréquentation des services de garde (iii) le nombre d'enfants ayant différents types et degrés d'incapacité et (iv) le nombre de garderies accueillant des enfants ayant des incapacités. Nous recommandons de surveiller systématiquement à titre d'éléments d'information critiques pour élaborer des politiques et améliorer la qualité la qualité de l'inclusion en garderies, les besoins auxquels on ne répond pas et les défis auxquels font face les garderies.

À L'ATTENTION DES PROVINCES ET DES TERRITOIRES

La plupart des provinces et des territoires accordent du financement et du soutien aux garderies qui accueillent des enfants ayant des incapacités. Notre recherche suggère des orientations et des gains en efficience importants qui pourraient les aider à améliorer la qualité de l'inclusion.

Axé sur les politiques

Les politiques provinciales et territoriales doivent soutenir des pratiques d'inclusion efficaces. Il faut s'assurer que les garderies ont accès aux ressources (financières et humaines) requises pour maintenir leur efficacité, renforcer leurs capacités et rémunérer équitablement leur personnel éducateur pour le travail important accompli. Les enjeux stratégiques suivants doivent être pris en compte :

9. Les garderies qui accueillent des enfants ayant des incapacités doivent avoir accès au moment opportun à l'évaluation de ces enfants afin de déterminer s'ils ont droit aux subventions et afin de soutenir le personnel dans ses efforts de planification.

10. Les garderies doivent obtenir du financement additionnel afin de resserrer les ratios (ou d'embaucher des aides-ressources à l'interne) lorsque quatre enfants qui ont des incapacités ou plus fréquentent la garderie ou lorsqu'un enfant a des incapacités graves. Le financement devrait être stable et suffisamment élevé pour permettre de recruter et de conserver du personnel éducateur d'expérience et formé pour faire ce travail.

11. Les garderies qui accueillent moins de quatre enfants ayant des incapacités devraient avoir accès à des personnes-ressources en matière d'inclusion pour appuyer leurs interventions, ainsi que toutes les garderies au besoin.

12. Les garderies qui accueillent des enfants ayant des incapacités doivent obtenir le niveau de soutien requis de la part de thérapeutes et d'autres spécialistes de domaines connexes au sein de leur collectivité.

13. Les garderies qui accueillent des enfants dont les besoins sont plus exigeants devraient compter un plus grand nombre d'aides à l'inclusion.

14. L'accessibilité et la structure physique étant très étroitement liées à la qualité de l'inclusion ainsi qu'à la qualité globale des services, les nouvelles garderies devraient toutes être construites conformément aux normes en vigueur et les garderies plus anciennes devraient être admissibles à des subventions d'immobilisations afin d'en améliorer l'accessibilité.

Axé sur la recherche

15. Les gouvernements doivent subventionner l'évaluation rigoureuse de l'efficacité de divers modèles de soutien à l'inclusion et des initiatives mises en œuvre pour accroître la capacité d'inclusion des services de garde et la qualité de leurs pratiques d'inclusion. Ces évaluations devraient être utilisées aux fins d'améliorer les politiques et la prestation des services.

16. Les gouvernements doivent subventionner le suivi des progrès réalisés pour « réaliser l'inclusion » au sein des services éducatifs et de garde à l'enfance. Des instruments pour contrôler la qualité de l'inclusion, comme l'Échelle d'évaluation de la qualité de l'inclusion en services de garde de Trait-d'union, existent et sont bien connus dans le domaine.

Axé sur le leadership

Notre recherche confirme le rôle crucial du personnel de direction des garderies en tant que champions de l'inclusion. Certaines garderies qui ont participé à la présente étude et à nos recherches antérieures n'avaient pas de personnel spécialisé. Certaines ne recevaient pas de financement pour couvrir les coûts additionnels des mesures de soutien requises. Certaines n'avaient pas un conseil d'administration solide. Mais toutes les garderies efficaces en matière d'inclusion avaient du personnel de direction solide et fermement engagé à l'égard de l'inclusion. Les activités et les programmes qui renforcent ce rôle de leadership sont essentiels. Les garderies totalement inclusives demeurent rares et leur viabilité est fragilisée lorsque les personnes qui les ont mises sur pied prennent leur retraite ou quittent leur poste de direction notamment dans un contexte où la fréquentation des services de garde est instable et où les coûts augmentent en raison de la COVID-19. Malgré un besoin urgent de personnel éducateur qualifié, nous devons également investir dans les leaders et les leaders futurs et en faire une composante importante des stratégies de main-d'œuvre nationales, provinciales et territoriales.

Il existe un bassin phénoménal « d'expérience pratique et de sagesse » à partag-

er et à utiliser pour améliorer les pratiques d'inclusion et encourager la prochaine génération de directrices, de directeurs et de professionnelles en services de garde.

Nous recommandons vivement que :

17. Les gouvernements reconnaissent à titre d'agents de changement importants le personnel de direction qui réussit à faire de la garderie un milieu inclusif et subventionnent des initiatives qui accroissent l'influence de ses personnes sur la communauté élargie des services de garde à l'enfance. Ce pourrait être accompli à l'aide des initiatives suivantes :

Réunir des personnes clés œuvrant dans des services de garde inclusifs pour qu'elles partagent les leçons apprises et leurs pratiques exemplaires et conçoivent, de concert avec des décideurs, des associations professionnelles, des programmes d'études postsecondaires en éducation à la petite enfance et des organismes locaux de services de garde, des stratégies et des initiatives pratiques pour améliorer la qualité de l'inclusion;

Parrainer des instituts de formation en leadership et en inclusion pour le personnel de direction actuel et futur des services de garde qui fait preuve d'engagement envers l'inclusion;

Appuyer des occasions de réseautage pour le personnel de direction et de supervision des services de garde inclusifs, notamment la création de communautés de pratique locales;

Créer des programmes de mentorat nationaux, provinciaux et territoriaux en matière d'inclusion, dont les mentors sont le personnel de direction et de supervision des services de garde inclusifs, et nommant des leaders provinciaux « disposés et prêts à inclure ».

Développer et soutenir la capacité d'inclusion par l'entremise de centres de ressources pour la garde d'enfants, d'organismes provinciaux, de Trait-d'union et de la Fédération canadienne des services de garde à l'enfance, y compris de garderies qui utilisent de nouvelles technologies et des portails sur Internet pour (i) étendre l'accès à l'information (ii) multiplier les occasions de partager des expériences et (iii) favoriser le soutien entre pairs et le mentorat faisant appel en tant que figures centrales au personnel de direction et de supervision - des praticiennes et praticiens crédibles.

Promouvoir l'avancement professionnel et encourager les personnes qui pratiquent avec succès l'inclusion à devenir des formatrices.

18. Les gouvernements doivent subventionner une gamme diversifiée d'activités (présentations en présentiel, documents imprimés, vidéos, ressources numériques et encadrement en ligne) afin de diffuser le savoir acquis des leaders et des personnes phares en garderies inclusives.

Axé sur la formation et le soutien

19. Les gouvernements provinciaux et territoriaux doivent veiller à ce que divers cours, colloques et ateliers portant sur de nombreux sujets et enjeux importants pour réussir l'inclusion soient accessibles, abordables

et offerts au personnel éducateur et au personnel de direction des garderies.

20. Les programmes d'études collégiales et universitaires en éducation de la petite enfance doivent intégrer à leur curriculum et aux cours de deuxième et de troisième cycle plus de contenu portant sur les pratiques inclusives.

21. Les placements et les stages en éducation à la petite enfance et dans des domaines connexes doivent être organisés stratégiquement pour que les stagiaires s'initient à l'inclusion dans des garderies qui réussissent l'inclusion.

22. Les collèges et les universités doivent repenser (en consultation avec les professionnelles et professionnels du domaine) leurs programmes d'études supérieures en éducation spécialisée et intervention en services de garde auprès d'enfants ayant des incapacités. Ces programmes devraient aborder les multiples rôles associés au service direct, à la pratique collaborative, à la consultation, au soutien des familles et à l'éducation des adultes. Les programmes de formation devraient également répondre aux besoins du personnel contractuel à court terme (aides à l'inclusion) qui travaille souvent sans formation en garderies inclusives.

23. Des programmes intensifs et efficaces pour améliorer la qualité des pratiques d'inclusion, comme Garder la porte ouverte au Nouveau-Brunswick; Measuring and Improving Kids' Environments (MIKE) à l'Île-du-Prince-Édouard; et Partnerships for Inclusion en Nouvelle-Écosse, qui sont habituellement offerts sous forme de projets pilotes ou de projets de recherche limités dans le temps, devraient être offerts aux garderies dans toutes les provinces et tous les territoires. Ils devraient être assortis d'un encadrement soutenu, de suivi et d'évaluation. Ces initiatives fournissent des services d'évaluation sur place et de planification en collaboration avec la direction et le personnel éducateur des garderies, et elles offrent du soutien pour améliorer à la fois la qualité globale des services de garde et la qualité de l'inclusion.

Axé sur la planification des transitions

Les politiques provinciales et territoriales doivent soutenir une approche collaborative et interdisciplinaire entre les professionnelles et professionnels du secteur de la petite enfance, y compris le personnel scolaire, pour faciliter la planification efficace de la transition d'un milieu à l'autre et la continuité des mesures de soutien.

24. Le personnel de la petite enfance doit élaborer des protocoles et des stratégies pour planifier et coordonner efficacement les interventions visant à soutenir les transitions (de la maison ou du centre d'intervention précoce à la garderie, et de la garderie à l'école).

Axé sur la profession

Il existe énormément de différences dans le rôle, la formation, la charge de travail, la durée et la fréquence des visites sur place, la nature des

services offerts, etc., des personnes-ressources en inclusion et au chapitre de l'accès aux ressources spécialisées. Il faut mettre au point et soutenir une approche communautaire intégrée en matière de prestation de services pour répondre aux besoins de tous les enfants ayant des incapacités au Canada.

25. Leur profession étant émergente, les leaders dans le domaine de l'intervention auprès des jeunes enfants, le personnel ressource et les spécialistes doivent établir leur propre code de déontologie et définir leurs mandats, charges de travail appropriées, normes de pratique et exigences de formation. Des fonds doivent être alloués à la recherche et à des projets de développement dans ce domaine.

Vers la création d'un système de services éducatifs et de garde à l'enfance de qualité, abordables, accessibles et inclusifs au Canada.

26. Les gouvernements fédéral, provinciaux et territoriaux doivent renforcer le volet financement du Cadre multilatéral de l'apprentissage et de la garde des jeunes enfants afin de bâtir au Canada un système de services de garde qui comporte des échelles de carrière assorties de salaires correspondants et une infrastructure stable en mesure de soutenir des services de garde à l'enfance de bonne qualité et inclusifs.

1. Introduction

This book is an urgent report about where Canada is today in implementing the inclusion of children with disabilities into early learning and child care (ELCC) programs. While the current federal *Multilateral Framework on Early Learning and Child Care* (2017) addresses many factors essential to the development of a strong national system of early learning and child care, it does not focus sufficiently on inclusion quality for children with disabilities. Without this focus, these children, and their families, will get left behind.

For many years, families and advocates for young children with disabilities fought to have children with disabilities included in ELCC and other community-based programs. Not to be included meant that their children with disabilities were denied the cognitive and social benefits of ELCC, that their mothers often could not be in the workforce, and that typical children, staff and families were denied opportunities to learn and play with children with disabilities. Unlike public education under the *Charter of Rights and Freedoms* (1982), there was no legislation requiring that children with disabilities be included in ELCC. Inclusion was seen as a privilege granted by a child care director, not as a right, and it was the rare parent who would demand anything more than just simple physical inclusion.

Certainly, having your child with disabilities physically included was a relief for many parents. They could then seek gainful employment and know that their children would be around typical children and other children with disabilities in a safe environment.

However, many of these parents began to be concerned about the quality of service that their children with disabilities were receiving. Were significant accommodations and adaptations being made so that their children would be able to participate fully? Granlund & Lillvist (2015) have conceptualized *participation* as having two dimensions: "being there" and "being involved/engaged while being there." "Support provided to children with disabilities should facilitate their participation in the same activities as other children. 'Being there' is not enough for inclusion. It needs to involve practices that ensure their participation and engagement in learning."

Recent conversations with several provincial directors of ELCC have confirmed that the number of enrolled children with disabilities has

increased over the past decade. With more children with disabilities now being included in ELCC, the authors of this report decided to study what might be a quality gap. Is the quality of ELCC services lower for children with disabilities than that for typically developing children?

We investigated the possibility of a quality gap by observing "global quality" (also referred to as "program quality") for typically developing children and "inclusion quality" for quality that meets the needs of children with disabilities. We used *The Early Childhood Environment Rating Scale-Revised* (*ECERS-R*) (Harms, Clifford & Cryer, 1998) to assess global quality and the *SpeciaLink Early Childhood Inclusion Quality Scale* (*SpeciaLink Scale*) (Irwin, 2013) to assess inclusion quality — in the same classrooms at roughly the same time.

The *ECERS-R* is widely used to evaluate global or program quality in ELCC centres in research and in quality improvement initiatives. Since the *ECERS-R* does not address inclusion questions significantly, we used the *SpeciaLink Scale* which was developed to assess the extent to which centres have embraced and used explicit, written principles as part of the centre's philosophy of practice, and utilize resources, interactions and supports effectively to meet the needs of each child with disabilities. Both the *ECERS-R* and the *SpeciaLink Scale* are reliable and valid instruments. They use a similar rating template for scoring indicators based on data about the centre as a whole and observation based on individual classrooms. By using the two scales at roughly the same time, we developed a picture of the relationship between global centre quality and inclusion quality in ELCC programs.

OBJECTIVES

The purpose of this project is to promote the inclusion of children with disabilities in ELCC across Canada in environments that address their individual needs and support their social integration. The objectives are:

- To assess levels of program quality and inclusion quality in a sample of inclusive programs;
- To examine whether there are gaps in the quality of programs available for children with disabilities by comparing scores on program quality and inclusion quality across the sample and within individual centres;
- To examine the relationship between program quality and inclusion quality — specifically whether high program quality is a necessary and/or sufficient condition for inclusion quality and whether there is a program quality threshold that is required for high inclusion quality;
- To learn what factors affect the quality of children's learning and caring environments for children with disabilities by profiling those centres that evidence high and low inclusion quality;
- To consider what centre directors identify as strengths, specific challenges, and actions that can be taken to improve inclusion quality; and

- To inform policy, research, and practice to improve and sustain high program quality and high inclusion quality for all children.

HYPOTHESIS

On average, the inclusion quality experience for children with disabilities will be significantly lower than the overall program quality experience for typical children. (In other words, as measured by the *SpeciaLink Scale*, we anticipate that many ELCC classrooms and centres do far better at meeting the needs of typically developing children as assessed by the *ECERS-R* than they do with respect to children with disabilities.)

ORGANIZATION OF THIS REPORT

This report is written in eight chapters. Following this introduction, Chapter Two presents a literature review on inclusion of children with disabilities in early learning and child care. Chapter Three presents the methodology we used to analyze data collected in 67 child care centres, consisting of 12 centres each from British Columbia, Manitoba, New Brunswick, and Nova Scotia, and 19 centres from Ontario. Ten of these centres (4 each in New Brunswick and Ontario and 2 in Manitoba) were francophone. All of the selected classrooms enrolled at least two children with disabilities. Observational assessments of each classroom, approximately three hours each were made by two trained observers at the same time, one using the *ECERS-R* instrument and the other using the *SpeciaLink Scale*.

Chapter Four provides a general profile of the 67 centres that participated in this study. Chapter Five focuses on the inclusion history of the centres. Chapter Six analyzes both the program quality of the centres (using the *ECERS-R*) and the inclusion quality (using the *SpeciaLink Scale*), individually and comparatively. We also present a profile of centres in this sample that evidence high inclusion quality. Chapter Seven explores the relationship between program quality and inclusion quality, addressing the key questions that led us to this study: 1) Is there a gap between inclusion quality and program quality? 2) What is the relationship between inclusion quality and program quality? And 3) Is there evidence of a threshold of program quality that is needed to support inclusion quality? In Chapter Eight, we provide evidence-based recommendations that may help reduce the discrepancy between inclusion quality for children with disabilities and program quality for typically developing children. A bibliography and related appendices are found at the end of this report.

2. Inclusion — A Literature Review

INTRODUCTION

The goals of quality early childhood education are fourfold: parental employment, community cohesion, social inclusion, and most important of all, positive outcomes for *all* children in cognitive, behavioural, physical and social development (Buysse & Hollingsworth, 2009; Lero & Irwin, 2010; Philpott, Young, Maich, Penney & Butler, 2019; Van Rhijn, Maich, Lero & Irwin, 2019). High overall quality programming in child care centres is beneficial for both typical children and vulnerable children, including those with disabilities (Bartolo, Bjorck-Akesson, Climent & Kyriazopoulou, 2016; Loeb, Fuller, Kagan & Carrol, 2004; Wiart, Kehler, Remple, & Tough, 2014). In addition, children with disabilities have been found to have better social and cognitive outcomes when they attend high quality programs alongside their peers in comparison to those who attend self-contained classrooms (Odom, Buysse, & Soukakou, 2011).

If children with disabilities are to be included in community-based early learning and child care settings (ELCC) as a matter of right (*Canadian Multilateral Framework Agreement on Early Learning and Child Care*, 2017; *United Nations Convention on the Rights of the Child,* 1989; *United Nations Convention on the Rights of Persons with Disabilities,* 2006; *United States Public Law* 94-142, 1972 and *World Health Organization,* 2012), these centres must provide high overall program quality defined by standards that are traditionally based on typically developing children, but must *also* provide high inclusion quality for children with disabilities (Bartolo et al., 2016; Buysse & Hollingsworth, 2009).

A SHORT HISTORY OF INCLUSIVE CHILD CARE

Until the 1960s, there were virtually no preschool services for children with disabilities. Parents were often advised that their children could never learn, and that they would be better off in a residential institution. Usually, parents ignored this advice and kept their child at home where they could provide loving care, if not intellectual or social stimulation. However, under the influence of both the behaviourists who believed that all children could learn and the ameliorative influences of antibiotics on children who otherwise might have died or spent their short lives in hospitals, children with disabilities began to participate in some type of preschool in the 1960s.

Some children with physical disabilities were included in hospital-based preschools that also served the children of hospital staff (as a staff recruitment and retention tool). The hospital-based specialized programs were often seen as adjuncts to the therapies provided in the hospitals. They had highly specialized staff and equipment that was frequently used by therapists in the hospitals to support children with major physical disabilities. Often the children with physical disabilities and the typical children of staff were kept in separate areas, which at that time seemed reasonable to both staff and parents (Irwin, 2005).

Other children, categorized as having intellectual disabilities, did not fit into the hospital-based programs. Advocates for these children with disabilities and their families instituted segregated playgroups and preschools for them. Mainly run by parent volunteers, these developmental preschools were generally part-day, free to eligible children and based on huge amounts of parental volunteer labour for fund-raising, transportation and assistance in the classrooms.

In the 1970s, with the advent of federal programs such as the *Canada Assistance Plan* (CAP, 1966), the *Community Action Plan for Children* (CAPC, 1972), the *Local Initiatives Program* (LIP, 1971), and *Canada Works* (1977), as well as increasing maternal employment, licensed child care expanded rapidly. Mothers of children with disabilities needed full-time child care, too, often impossible in the informal spaces they were using for developmental preschools — such as Sunday School rooms during the week, without kitchens, nap rooms and playgrounds.

Under *CAP*, some provinces built preschools for the handicapped, as they were called. Often, they occupied the basements of residential institutions for older children with disabilities. Nova Scotia, for example, built four of these buildings, including programs that only preschool children with severe disabilities could attend (B. Greig, child care worker for children with disabilities, personal communication, 2020). Other organizations involved with children with disabilities bought and renovated existing buildings for their programs (B. Towler, Executive Director of "Wee Care" in Halifax, personal communication, 2020). Many parents were pleased with these programs and the skills and positive attitudes that staff brought to them.

However some parents, especially those with other children who played with their developmentally disabled siblings, thought that their children could learn better in programs with typical children. The Canadian Association for Retarded Children (CARC) began to express the same thought: "Members of the Association began to ask what kinds of services, what kinds of community, what kinds of society should we be building. The Association shifted its thinking about intellectual disability and began to see the core issues affecting people with an intellectual disability as basic equality, respect, dignity and human rights.

"When the Association changed its name to the Canadian Association for Community Living in 1985, the change reflected this shift in thinking and values. The issue was not to 'fix' people with an intellectual disability but to create communities where all people are welcomed and belong."

Childcare and education were to be included in those communities. (Inclusion Canada, 2020). "About Us," website www.inclusioncanada.ca.

Despite the fact that there was no legal requirement or policy regulation mandating regular child care centres to include children with disabilities, some did in the early 1970s. The concept of integration entered the early childhood repertoire, characterized by attempts to mimic the processes current in special education — namely "pull-out" sessions for skill development and, hopefully, generalization of those new skills into the regular classroom setting.

In 1982, The Canadian Charter of Rights and Freedoms gave impetus to the concept that all children, including those with disabilities, had a right to attend public school. Until that time, children with some disabilities, children who were not toilet trained, children with significant health issues, and children with very low IQs could be denied the right to public schooling. School boards had the right to refuse admissions to children they felt they could not accommodate. Child care was not considered under the Charter — but advocacy by parents and pressure from health professionals increased the number of children with disabilities included there.

Federal funding, continuing under CAP, CAPC, Canada Works, and summer student funding, in addition to some provincial funding, gave the always struggling child care centres financial assistance to cover some of the additional costs of including children with disabilities. Moreover, the closure of many segregated programs provided experienced "special needs workers" who brought their skills of behavioural techniques, and mastery learning and reinforcement for success, along with their commitment to children with disabilities, into the regular centres. "Mainstreaming" replaced "integration" as the descriptive word for this type of program.

From 1990 onwards, "inclusion" began to be used to replace the terms "mainstreaming" and "integration."

Following emerging practices in the public schools and pressure from parents, advocates and educational professionals, child care began to be more holistic for children with disabilities, bringing the previous "pull-out" strategies into the regular classroom and trying to make the classroom fit the child, rather than the other way around. Most provincial governments developed regulations about including children with disabilities, and began to fund some of the necessary extra staffing and equipment that would make inclusion work in child care. Workers on grants, students on practicum placements, and volunteers often filled in as additional staffing.

Although there was no reliable data about the number of children with disabilities attending child care in Canada, the severity of their disabilities, the types of disabilities represented (physical, intellectual, behavioural, autistic, etc.), or the number of centres that were inclusive, it seemed that more children with disabilities were attending, that a deeper and broader range of children with disabilities was being represented,

and that more centres were inclusive (Irwin, Lero & Brophy, 2004).

However, while many ELCC settings attempted to make inclusion a "best practice," many families still experienced access issues due to lack of policies that promote and require the inclusion of children with disabilities (Halfon and Friendly, 2013). According to Philpott, Young, Maich, Penney and Butler (2019), "Poor and inconsistent data collection processes, and an absence of policy to mandate it, sabotages the sector and leads to uninformed public policy (p. 3). Halfon and Friendly (2013) note that, while all jurisdictions in Canada report having policies supporting inclusive ELCC programs, the absence of data creates an illusion of inclusion during the early years.

THE CANADIAN POLICY CONTEXT

The Federal Role

Historically, there is little that stands out in federal Canadian social policy pertaining specifically to (young) children with disabilities until 2017. Where these children are mentioned, it has been within the parameters of "welfare policy" or "child care policy," most often within a broader category of "vulnerable children" with no specific mention of disabilities.

Even within the area of "disability policy," the focus has been almost entirely on adults or school-aged children, with little attention directed to needs and rights of preschool children with disabilities.

The United States, usually a laggard in children's policy, was a world leader in policy that required the inclusion of children with disabilities. The Office of Economic Opportunity's Community Action Program (1965) led by Sargent Shriver, the late president John F. Kennedy's brother-in-law, launched *Project Head Start* as an eight-week summer program in 1965. *Head Start* was led by Dr. Robert Cooke, a pediatrician at Johns Hopkins University, and Dr. Edward Zigler, a developmental psychologist and director of the Yale Child Study Center. Dr. Zigler mandated that all *Head Start* classrooms include at least 10% children with disabilities. Dr. Zigler, when asked, "Suppose no children with disabilities have been enrolled?" pointed to his requirement that 10% of children in *Head Start* classes be children with disabilities and said "Recruit them!" (Zigler and Styfo, 2010). Although *Head Start* was limited to children from very impoverished homes, it had influence far beyond that mandate.

When the *Education for All Handicapped Children Act* of 1975 (*EHA*) was passed, it provided free and appropriate education for children with disabilities from 3 to 21 years of age. The preschool classes remained strictly segregated until the 1980s when educators began to mix groups of children with disabilities with groups of children from poverty backgrounds, when both programs were housed in the same building (usually a public school). Not until much later (*Individuals with Disabilities Education Act* of 1990 and the *Individuals with Disabilities Education Improvement Act* of 2004) did the *Act* require that children

with disabilities attend programs in the "least restrictive" (later changed to the "most enabling") environment, but the stage was set to see inclusive preschool education and child care as a right. In theory, children in the United States with disabilities cannot be denied placement in community programs that receive any federal funding (even surplus food!), but the law does provide an "undue hardship clause" that permits centres to turn away children with disabilities (Grisham-Brown, Cox, Gravil & Missall, 2010).

Canada's first foray into policy related to child care came during the Second World War, when Canada financed child care centres so that women could work at jobs previously filled by men to support the war effort. Within that context, when the men came home, many of these centres closed. Children with disabilities are not mentioned in most historical accounts (Friendly, 2003).

In 1966, when Canadian welfare legislation (the *Canada Assistance Plan* or *CAP*) was proclaimed, it covered a range of social assistance and welfare services, one of which was child care. The purpose of the 50/50 cost-shared program between the federal government and the provinces was to "promote the healthy development of young children from birth to age 6, who face challenges that put their health at risk, such as: poverty, teen pregnancy, social and geographic isolation, substance use and family violence." Its goals were to "improve healthy child development by…providing child-focused activities, such as preschool programs and play groups" (Government of Canada, 1966).

The federal government's conditions stipulated that their funds could pay only for services for needy (or potentially needy) families and to be eligible for funding as a welfare service, child care had to be regulated and public or not-for-profit. The design of *CAP* is important because it meant that federal funds were used almost exclusively for fee subsidies for families who were income-or means-tested to determine eligibility. It also illustrates the role that the federal government played at that time in shaping social programs by tying financing to conditions (Friendly, 2006).

There was no mention of "children with disabilities," "children with special needs," or other phrases to describe these children in the *Canada Assistance Plan*; however, the "such as" phrase was later seen to include "children with disabilities." Little changed in federal social transfer payments regarding young children with disabilities during the next 24 years, nor was there much evidence of policy planning to ensure the inclusion of children with disabilities in the 1986 federal *Task Force Report on Child Care* or in the 1987 Special Committee report, *Sharing the Responsibility* (Friendly, 2006).

In 1991 the Mulroney government imposed a limit on the funds it would pay out for social programs to more affluent provinces and this led to the situation where the federal government was paying only approximately one-third of the actual costs to *these provinces*. In 1996 *CAP* was replaced by the *Canada Health and Social Transfer Program* (*CHST*), which combined federal funding for health, post-secondary

education and welfare (including child care), and transferred a designated block fund to each province rather than transferring a percentage of actual *costs*. Social policy experts expressed fears that without federal leadership through setting conditions and earmarking funding, provincial spending would become less accountable both to the federal government and the public, especially as federal funds were substantially reduced and there was considerable pressure to make budget cuts (Friendly, 2006).

By 2000, there was almost no federal involvement in child care beyond the now capped cost-sharing initiatives for children in poverty, teen pregnancy, social and geographic isolation, substance use and family violence, provided their parents were employed or in training, or if the children were seen by a child welfare agency as being at *high risk*. The absence of national standards and lack of a comprehensive approach to child care policy also meant that there still was no intentional support from the federal government for children with disabilities to attend child care programs, although some social workers stretched the meaning of *high risk* to include these children.

In essence, these changes to cost-sharing provisions resulted in child care becoming much more dependent on provincial/territorial policies and funding, with political ideologies and funding resulting in a greater patchwork of services, which continues to this day. While the Quebec government invested in the development of a province-wide public system with parents paying a nominal daily fee, other provinces have maintained a mixed market approach. Policymaking and funding programs to support inclusion specifically also are provincial and have not been the subject of direct study or evaluation.

In 2005, under the leadership of the Honourable Ken Dryden, Minister of Social Development, a five-year, five-billion-dollar child care plan was negotiated in the form of bilateral agreements between the provinces, the territories and the federal government. It was designed around the QUAD principles: quality, universally inclusive, accessibility and developmental. This *Multilateral Child Care Agreement* (Canada, 2003) includes the first direct mention of children with disabilities in any federal agreement. The 2006 election of a Conservative government under Stephen Harper spelled the end of the *Multilateral Child Care Agreement* and the funding lapsed the following year, replaced by neoliberal policies that favoured "parental choice" through a child care benefit program.

It was not until 2017 under the Trudeau government that a new *Multilateral Early Learning and Child Care Framework* was developed and signed by all provinces and territories, allocating $1.2 billion for the next three years (from 2017 to 2020), with an additional $7.5 billion to be invested over the next decade (Employment and Social Development Canada's [ESDC] Early Learning and Child Care [ELCC] Innovation Program, 2019). The guiding principles were changed slightly from the 2003 QUAD (quality, universally inclusive, accessible and developmental) to quality, accessibility, affordability, flexibility, and inclusivity in early learning and child care. Each bilateral agreement includes an action plan de-

tailing how that jurisdiction will support the specific early learning and child care needs in that province or territory (ESDC'S ELCC Innovation Program, 2017).

The Framework encompasses: "Inclusive early learning systems that respect and value diversity, such as *children with varying abilities*. It also means supporting families and children who are vulnerable, such as families that are lower income, Indigenous, located in underserved communities or families supported by a lone parent or those working non-standard hours" (Government of Canada, 2020, p. 6).

Fifty years after advocates, researchers, parents, social workers, and ELCC staff started fighting to have children with disabilities included as a right, not as a privilege, in child care — as specified in the international documents signed by Canada (*UN Convention on the Rights of the Child, 1989; UN Convention on the Rights of Persons with Disabilities, 2008*) as well as the *Charter of Rights and Freedoms* (1982) — this Agreement provides a glimmer of light. But in order to measure progress toward increasing inclusion of children with disabilities, federal leadership is required, as well as ongoing monitoring and evaluation to assess how many children with disabilities are included and excluded, considering both the severity and types of disabilities that are represented. The provincial and territorial action plans and reports provide an initial focus for meeting this objective (ESDC'S ELCC Innovation Program, 2019).

The Provincial and Territorial Roles

Compared to the U.S. introduction of Project Head Start with federal funding and federal disability legislation that led to the inclusion of children in community-based early childhood programs and in schools, the Canadian experience has been different and uneven across the country. Historical accounts document how much parents were involved in setting up programs — first for their school-age children who had been denied entry into local schools, and later for younger children National Institute on Mental Retardation Canada (NIMRC, 1981).

In Canada, the federal government has had a more indirect role in promoting inclusive care and education for children with disabilities. Nonetheless, every province in Canada began planning reforms and new services for young children over the past decades. In addition to the exciting research in brain development in the 1960s and recognition of the importance of early experience, the Canadian Association for the Mentally Retarded adopted in principle, in the early seventies, the "Normalization principle." This principle, incorporated into Danish Law in 1959, was popularized in Canada by Wolf Wolfensberger (1969) and inspired many professionals and advocates who worked with developmentally disabled children and adults. "Normalization" ensured persons with intellectual disability the right to as normal a life as possible. Institutional life was drawing to a close. Community life needed to open opportunities for involvement. Supports developed by parent groups were group programs, preschools for preschool age children and

home visiting programs for infants. The *Canada Assistance Plan*, which was developed to allow cost-sharing between the Federal and Provincial governments for social service programs, *LIP* grants to communities, and other funding sources emerged and enabled many preschool programs and other learning initiatives to start (Brynelson, 2020).

All the provinces and territories were greatly influenced by the financial incentives provided under the *Canada Assistance Plan*, and quickly developed child care initiatives that addressed some needs of young children with disabilities. A study by Irwin et al. (2004) provides examples of how four provinces — Ontario, British Columbia, Nova Scotia and Prince Edward Island — took up this initiative.

Ontario

Ontario appears to have created some of the earliest policy regarding children with special needs in child care. During the late 1960s, the Day Nurseries Branch (Irwin et al., 2004) formulated a set of specific objectives and aims. One of these objectives was "to provide opportunities in day nurseries for children with physical, developmental and/or social handicaps to achieve their physical, developmental and social potential." In 1971, an amendment to the *Day Nurseries Act* (Ontario, 1971) affirmed the Ministry of Community and Social Services' commitment to this objective and to funding for children with physical and developmental disabilities at 87% of cost. In 1978 the *Policy Manual for Children with Special Needs* (Ontario, 1978) was produced, detailing required procedures and practices. In 1981, the Ministry established, as a specific long-term priority, the expansion of services for handicapped children in integrated centres. As late as 1983, 79% of children with physical and developmental handicaps (*sic*) still received services in segregated day nursery programs (1988, *Integrating Children Experiencing Special Needs in Day Nurseries: A Background Review*). It was clear that the Ministry had accepted integration as the preferred option for most children with physical and developmental disabilities, and was considering how to increase the percentage of children with disabilities served in integrated programs.

In the early 1980s, after public consultations, the Ministry released new Day Nursery standards entitled *Standards for Handicapped Children in Designated Funded Programs* (Ontario, 1980). According to the *Act* and the *Standards*, "funded" children in integrated centres would need to have a written Individual Program Plan (IPP) and a written treatment/training plan. From 1996 through 2017, Ontario continued to develop its regulations, training and staffing requirements regarding children with disabilities in inclusive child care settings, without federal input.

British Columbia

In 1952, twelve parents in Vancouver, BC, formed the Vancouver Association for the Advancement of Retarded Children (VARCO). Their first objective was to start a school for school-aged children, which opened

that year. In BC at that time, there was a law preventing children with disabilities from attending regular school. In 1959, as a result of parents' efforts, a preschool was started for children aged 3 to 6 with volunteer staff. By 1966, thirty-two children were attending the preschool daily from September to June. It operated now with paid preschool teachers as well as volunteers, with funding from a variety of charities and some government funding from the Ministry of Social Services. The BC Lions Society provided bus transportation, and parents did not pay fees.

In 1967 an agreement was reached between VARCO and the University of British Columbia, Special Education Department, for the preschool program to become part of the newly developed Research Unit for Exceptional Children at UBC. Practicum students from Education, Rehab Medicine, and Psychology became part of the program. This preschool program for children with intellectual disabilities was now on campus close to two other classroom complexes, one for preschool children with severe neuromuscular disability and one for typical kindergarten age children. However, efforts to integrate the classes were not realized. The first integration of the VARCO class started as a separate summer program in 1972, called Serendipity, and ran for many years as the only opportunity for integration possible at that time.

The 1967 agreement between VARCO and UBC was sparked in part by the earlier Federal/Provincial Conference, chaired by Judy LaMarsh, Minister of Health and Welfare, held in 1964 with published conference proceedings in 1965. On the heels of the American President's Committee on Mental Retardation, our Canadian efforts proposed a range of "practical steps to improve services for mentally handicapped persons." Throughout the conference participants reiterated the need for early education, preschool programs, and early child care, including home visiting programs staffed by trained persons to establish adaptive programs of home care early in the child's life. At that conference, it was also recommended that each province develop a special project to commemorate the 1967 Centennial Year of Confederation. Federal funding for special projects was announced. For BC, the 1964 conference heightened interest in intellectual disability and led to the creation of the BC Mental Retardation Institute (BCMRI), with a mandate to integrate knowledge of intellectual disability into course work and the training of health, education and social service professionals at UBC. The Institute was funded by UBC. Federal funds, as well as charity funding from the Variety Club, were used to build the Bob Berwick Centre at UBC which opened in 1975. It was built to accommodate offices for the BCMRI, five classrooms for preschool children with intellectual disabilities, a large gym and pool. The BCMRI was disbanded in 1981 and the offices were then used by the Provincial Office of Infant Development Program, Public Health and other community services (Brynelson, 2020).

Under its *Special Needs Day Care Program* in the late 1960s, with shared funding from the *Canada Assistance Plan* and the provincial government, British Columbia began to serve children with disabilities in child care. At first, it provided contract funding so that preschool chil-

dren with special needs could attend specialized, segregated preschools. Gradually it also provided funding to selected non-specialized settings such as community-based child care centres, including preschools, to cover the extra costs of including children with special needs. Some of the specialized centres began to open their programs to typical children as well (reverse integration). In addition, British Columbia funded the placement of individual children with special needs in other non-specialized preschools and child care centres on the basis of one child at a time (called "authorizations").

By the mid-1980s "integrated" child care in British Columbia was characterized by a system of large contracts to specialized settings, small contracts to community settings and "individual authorizations" of children with special needs in many centres. Many community-based centres with contracts developed either a resource teacher position in addition to their mandated child-to-staff ratios or developed a ratio-reduction strategy where a group of sixteen children would share three staff, as opposed to the regularly funded two staff.

Under "authorizations," other centres developed a similar pattern, even though they were not guaranteed regularized funding. However, their reputations usually were high enough so that when one child with a disability left for school, another child on their waiting list was admitted. By 1991, a review of this system was undertaken (B.C., 1993) for two reasons: 1) to give parents of children with extra support needs the same choices other parents have; and 2) to serve more children in more locations with the same amount of money (Irwin, Lero & Brophy, 2004). From 1996 until 2017, British Columbia continued to develop its provincial child care system without any conditions from the federal government.

Nova Scotia

In 1954, Dr. Fred R. McKinnon, considered by many to have been the outstanding public servant of his generation in Nova Scotia (Halifax Association for Community Living, 2020), organized a meeting for parents of children challenged by mental handicaps to share concerns about needs and services for their children. This meeting resulted in what is now called the Nova Scotia Association for Community Living (NSACL) — a group of interested people determined to make life better for their children.

A group of these parents organized a preschool for children with intellectual challenges, which continues to this day as an integrated (or "inclusive") centre with 40% children with disabilities and 60% typical children — the Halifax Preschool. On the second floor of a school building, they had not been able to include children with major mobility issues or major health issues.

In the 1960s, a group of parents of children with cerebral palsy organized a playgroup at Veith House, a large building that had originally housed a children's orphanage. More parents of children with physical and medical disabilities continued to enroll in the playgroup, and in the late 1960s, the *HMCS Iroquios* adopted the program, and enticed

electricians, carpenters and other skilled workmen from the North End of Halifax to renovate the building to be accessible to children in wheelchairs and bring it up to fire code. The Halifax Children's Foundation also helped support the renovations. In 1967, they received a Centennial Year grant from the federal government to finish the project. By 1972, Wee Care's license was formalized and the centre began to receive funding under *CAP*. In the early 1980s, they were able to hire a full-time physiotherapist, and then an occupational therapist in 1993 and a music therapist in 2009. Parents were pleased with the in-house therapists, no longer having to take their children to the Children's Hospital for therapies and seeing that their children were getting almost daily visits with therapists.

In Nova Scotia children with special needs are mentioned in the *Day Nurseries Act* (1967), and under its provisions, segregated child care centres and preschools were set up in various regions of the province during the early 1970s. The funding "differential" was budget-based on costs significantly above those of regular child care programs. Nevertheless, by the mid-1970s, a number of community-based child care centres were including children with special needs through funding from a variety of other sources, such as the *Local Initiatives Program* (*LIP*), *Canada Works*, service clubs, summer student employment programs, and the like (p. 48). Wee Care was including some typical children, mainly siblings of its children with disabilities and often their neighbours and friends.

Following recommendations from the 1979 *Task Force on Day Care Financing* (*Nova Scotia, 1979*), the existing *de facto* spaces for children with special needs in regular child care were formalized and funded at the same differential rate as the spaces in the segregated centres. The onus was on each integrated centre to develop an *Individual Program Plan* (*IPP*) for each funded child with special needs, calling upon community and specialized consultants (such as itinerant teachers from the School for the Blind and the School for the Deaf for expertise and support.

From the early 1990s, provincial policy encouraged integration, the closure of segregated programs or their conversion into integrated ones, and the enrolment of their children into the community-based programs. Each time more subsidized spaces were budgeted for child care centres, 10% were allocated for children with special needs. Staff from the segregated programs often moved into the integrated ones, bringing their skills and commitment with them. Wee Care, with its focus on physical challenges, continued that emphasis, but began to include 60% typical children. Like the other provinces, Nova Scotia continued to develop its integrated child care without leadership from the federal government.

Prince Edward Island

Until 1981, there was no legislation, policy, regulations or guidelines that mandated the inclusion of children with special needs in Prince Edward Island child care centres. In practice, they were included (Irwin

et al., 2004). The final decision as to whether to include a particular child was left up to the individual centre. However, according to a very knowledgeable official, there was only one case where it was collectively decided that a child care centre was not an appropriate placement for a child due to the nature of his disability. (In that case, a home program was set up.) Despite the lack of formal policies, young children with varying disabilities were participating in licensed child care programs by the mid-1970s, and the province was already providing some funding support to cover additional costs.

In 1981, under a more pro-active approach, the Department of Health and Social Services introduced a "Special Needs Policy" which was intended to encourage early childhood centres to provide developmentally appropriate and integrated programs for children with special needs, and to provide additional funding to licensed centres in recognition of the extra costs involved.

The 1988 *Special Needs* (*Grant*) *Program* formalized the additional funding. A further review in 1993 addressed a number of issues with respect to the administration of the program (*Special Needs Pilot Project*). Starting in 2001, under the *Early Childhood Development Agreement*, the province began to fund *Measuring and Improving Kids' Environments* (*MIKE*). Two inclusion facilitators worked with a group of licensed child care centres through an on-site consultation program to help them increase both their global quality (as measured by the *Early Childhood Environmental Rating Scale — Revised*) and their inclusion quality (as measure by the *Specialink Inclusion Scale*). As of 2004, all licensed child care centres had participated, and the province was preparing to use the methodology to address quality in its kindergartens (which were publicly funded but privately owned).

From 1996 until 2017, the province developed its child care program without any conditions from the federal government. During Fiscal Year 2017/2018, with funding from the Bilateral Agreement on ELCC, a total of 133 children with special needs were supported with additional funding for program support in Early Years Centres on Prince Edward Island, 24 children in private centres, and 39 children in school age centres (K. Flanagan, 2018).

Other Provinces and Territories

The other provinces and the territories also began to include children with disabilities in their community-based child care centres, often moving from segregated programs to integrated ones, but sometimes, like Prince Edward Island, bypassing the segregated programs altogether.

Until 2004, when the framework for the short-lived *Multilateral Early Childhood Program* was introduced, there were no federal directions or guidelines for including children with disabilities in child care. That Agreement was quickly dissolved by the Harper government in February 2007, so it wasn't until 2017 that we see a statement regarding vulner-

able children imposed by the federal government in its new *Multilateral Early Learning and Child Care Framework*.

Current Status of Provincial and Territorial Policies

The most recent and relevant information about where the provinces stood with respect to children with disabilities as they entered into the *Multilateral Framework on Early Learning and Child Care* bilateral agreements (2017) is the invaluable *Early Childhood Education and Care in Canada, 2019*, published by the Childcare Resource and Research Unit (CRRU, 2020), headed by Martha Friendly. Data have been obtained and analyzed from all provincial and territorial government offices, succinctly summarizing the situation of inclusion of children with special needs and inclusion supports such as funding for consultation, training, and ratios available to the centres and to family child care providers after a regional inclusion consultant has confirmed the needs. CRRU has also collected data on the number of children with special needs in regulated child care and/or the number who receive inclusion support in each jurisdiction, when available. Elements of inclusive care — such as the training required for inclusion support assistants, and whether any specialized centres exist — are also noted.

The bilateral agreements, each negotiated between the federal government and a single province or territory, are based on the overall Framework that is part of all the agreements. Each bilateral agreement includes an Action Plan, based on the Framework, but is individualized to address elements that each province affirms is important to them. For example, some provinces focus on Indigenous children, others on immigrant children, and some on children referred to as "having varying abilities."

In 2020, the federal government published its *National Progress Report on Early Learning and Child Care* (*2017 to 2018*). This report describes the background of the planned decade long project, in the form of "a shared vision that took shape in June 2017 when the federal, provincial and territorial ministers most responsible for early learning and child care signed the *Multilateral Early Learning and Child Care Framework*" (p. 5). It refers to "Inclusive early learning and child care systems (that) respect and value diversity, such as children with varying abilities. It also means supporting families and children who are vulnerable, such as families that are lower-income, indigenous, located in underserved communities, or families supported by a lone parent or those working non-standard hours" (p. 6). It notes that, "The provinces and territories have provided summaries of their results from the first year of the bilateral agreements (2017 to 2018) and some are still in the process of implementing new programs and services" (p. 10).

An examination of the Action Plans in the individual bilateral agreements indicates that the provincial/territorial action plans all include some children from some vulnerable groups, but it is often difficult to unpack the actions and the amount of funding to be spent on children

with "varying abilities" (which are not defined in the Report but which include words or phrases used by the provinces such as "extra support needs" (BC, p. 13); "diverse needs" (AB, p. 14); "disabilities" and "particularly challenging needs" (SK, p. 16); "diverse needs (MB, p. 17); "significant needs" (QC, 21); "disabilities" and "diverse needs" (NB, p. 21); "diverse needs" and "unique needs" (PEI, p. 23); "inclusion" (NS, p. 25); and "special needs" (Yukon). In fact, some provinces do not specify actions related to children with "varying abilities" at all, but emphasize children from some of the other vulnerable groups.

Growing Recognition of Inclusive Child Care

Reflecting growing consensus in child care organizations and disability organizations about the benefits of inclusion, the U.S. Division of Early Childhood (DEC) of the Council for Exceptional Children adopted and published its *Position on Inclusion* in 1993. In 2009, the National Association for the Education of Young Children (NAEYC), the largest early childhood organization in the United States, finally endorsed the earlier *DEC* statement and revised its own definition of program quality to include a greater emphasis on cultural diversity, family concerns, and individual children's needs (Catlett, 2009). These changes promoted attention to inclusion and diversity as critical components of pre-service training and of practice for all early childhood educators and programs.

Definition of Early Childhood Inclusion

Here is the 2009 joint position statement of the Division of Early Childhood of the Council for Exceptional Children (DEC) and the National Association for the Education of Young Children (NAEYC): "Early childhood inclusion embodies the values, policies, and practices that support" the right of every infant and young child and his or her family, regardless of ability, to participate in a broad range of activities and contexts as full members of families, communities, and society. The desired results of inclusive experiences for children with and without disabilities and their families include a sense of belonging and membership, positive social relationships and friendships, and development and learning to reach their full potential. The defining features of inclusion that can be used to identify high quality early childhood programs and services are access, participation, and supports.

UNESCO, also in 2009, produced a Policy Brief entitled *Inclusion of Children with Disabilities: The Early Childhood Imperative*. It states that, "Positive transition from home to preschool is encouraged when the early childhood programme allows for child-centred pedagogy and necessary individualized support to effectively address the diverse learning needs and abilities of children with disabilities. Indeed, early childhood programs that are responsive to individual needs and respectful of diversity benefit all children and contribute to building the foundations of an inclusive society". In short, the inclusion of children with disabilities benefits those children and typical children as well.

Booth and Kelly (2001, p. 196) in Essa, Bennett, Burnham, Martin, Bingham and Allred (2008) note that, "the paucity of research on the effects of child care on this population (children with disabilities) is striking" and that "research needs to provide insight into other aspects of inclusive child care, beyond the incidence of inclusion. This requires the combination of two discrete, though related, areas of research: early childhood education and early special education. . . . It is in the combination of the two, however, that more research is needed."

Research instruments, too, have been lacking. The *Brigance Diagnostic Inventory of Early Development* (*IED II, Brigance*, 2004) and the *Preschool Desired Results Developmental Profile-Access* (*DRDP*) were among many tools used to assess individual children's progress, but tools for investigating the quantity and quality of the inclusion experience were not available.

The original *Early Childhood Environmental Rating Scale* (*ECERS*) (Harms & Clifford, 1980) — the most widely used preschool classroom rating scale — contained only one item that referred to children with disabilities (and that was only as a point of clarification, not as an indicator). "Practice" preceded policy and research through the next two decades, as advocates and desperate parents who needed child care in order to be employed pushed the existing centres to include their children with disabilities.

A marker of changing attitudes toward the inclusion of children with disabilities appears in the introduction to the 1998 *ECERS-R* (Harms, Clifford and Cryer). The authors wrote, "During this time (since 1980) when the original *ECERS* was published, inclusion of children with disabilities and sensitivity to cultural diversity had become important issues in the assessment of program quality." The changes in *ECERS* between 1980 and 1998 represent a major change in the instrument and evidence of the acceptance of the idea that program quality in child care should encompass provisions that support and enhance inclusion and diversity. However, to many people involved with these issues, the *ECERS-R* still did not adequately reflect the measures needed to assure that children with special needs are truly welcomed into child care settings (Irwin, Lero and Brophy, 2000; Soukakou, 2012). Surprisingly a score on *ECERS-R* of a "7" — the highest possible score — could be achieved even if no children with disabilities were enrolled.

Other researchers were attempting to define and measure quality inclusion in regular child care. For example, in 1993 the *Early Childhood Special Education Program Design and Development Guide* (*EC-SPEED*) was produced (Johnson, Johnson, MacMillan & Rogers, 1993). Along with a set of eleven videos and a comprehensive bibliography related to early childhood special needs, the *EC-SPEED* team developed an assessment instrument for use in early childhood settings. The instrument, unlike *ECERS-R,* unapologetically assessed "regular" group child care settings on the basis of their capacity to include children with a full range of types and levels of disabilities.

"Embedding" or "infusing" inclusion (then called "mainstreaming") into

every element of the instrument, a very high score on the *EC-SPEED* (designed much like the *ECERS-R)* required substantial attention to special needs issues. In a fully inclusive centre, obvious accommodations will have been made for children with small muscle difficulties or blind children — even down to the way coat hooks are designed and positioned. When one of the authors was asked, in 1998, which indicators he thought were the most important, he said: "You could call it 'ideological coherence.' But I like to think about it as centres where everybody — from the board of directors to the cleaning staff — have bought into inclusion. We always visit the cook as well as the child care staff. At one of the very best centres, the cook proudly told us how he ground up food so that a child with a swallowing problem could eat with everybody else" (Johnson et al. 1993). Unfortunately for most researchers, program consultants, trainers and early childhood educators, scoring *EC-SPEED* takes three full days with three highly trained observers — too rich a tool to be practical (Irwin et al. 2000).

It had become obvious that an affordable, reliable, validated measurement tool was needed if inclusion quality in regular child care centres was to be measured and understood. *ECERS-R* was insufficiently geared to inclusion quality; *EC-SPEED* was too labour intensive to be affordable. And although the largest disability-focused early childhood organization in the United States (*DEC*) and the largest more general US early childhood organization (*NAEYC*) had finally developed a shared position on early childhood inclusion, no one had created a tool that measured inclusion.

Similar to the lack of legal mandates, research and research tools that focus on inclusion practices, resources and outcomes in regular child care programs have been sparse in Canada until recently. From 1992 to 1998, SpeciaLink: The National Centre for Early Childhood Inclusion was funded by the *Canadian Child Care Initiatives Fund* to investigate inclusion quality in child care (called "mainstreaming" then). Their task was to locate a child care centre in each province that a government person, a child care person, and a disability advocate all ranked as very high in mainstreaming quality. SpeciaLink planned to have Dr. Sharon Hope Irwin visit each centre for a full day, collecting observations and field notes to try to discern the qualities that made them good (Irwin, 1993).

"We take what works from where we find it," said Irwin (1993). Along with the plan of observations and field notes, enroute to Winnipeg Irwin happened to see a *Cosmopolitan* magazine article that included a 10-item checklist on *How to Find Your Perfect Mate*. She used this checklist as her template for the *SpeciaLink Mainstream Profile* (Irwin, 1993), a two-page, 10-item checklist for quickly observing mainstreaming. The checklist was very popular, especially in ECE training programs and by agencies evaluating their own centres. People found it easy to use and also found that it corresponded to their own opinions about the centres.

During this period, SpeciaLink hosted the first national symposium on child care inclusion and then produced several books, including *The SpeciaLink Book: On the Road to Mainstream Child Care* (1993); *A Matter of Urgency: Including Children with Special Needs in Child Care in*

Canada (2000); *Inclusion: The Next Generation in Child Care in Canada* (2004); and *Inclusion Voices* (*2005*).

In 1996, Dixie Van Raalte of the New Brunswick Association for Community Living, on behalf of a number of researchers, approached SpeciaLink, asking whether it might expand the 1993 *SpeciaLink Mainstream Profile* and construct a research tool to measure inclusion quality. SpeciaLink took up the challenge. After years of research and field testing with hundreds of early childhood consultants and staff, followed by a full analysis for reliability and validity (Lero, 2009), and the *SpeciaLink Early Childhood Inclusion Quality Scale* was published (Breton Books, 2009). Now widely used for both training and evaluative purposes, the current project is using the *SpeciaLink Scale* in conjunction with the *ECERS-R* to investigate relationships between global program quality and inclusion quality in Canadian child care centres.

Components of Inclusion Quality

It is generally agreed that many components contribute to the overall quality of a child care centre. Quality in early childhood education is often measured through two constructs: 1) *structural features* such as adult to child ratios, group size, and teacher education; and 2) *process quality* with features such as teacher-child interactions and learning opportunities (Goelman et al., 2000). A third dimension of quality refers to *contextual features* (funding, policies, etc.) that affect the sustainability and quality of programs and the quality of the child care workforce.

High quality programming in child care centres is beneficial for both children with and without disabilities (UNESCO, 2009; Wiart et al., 2014). Additionally, children with disabilities have been found to have better outcomes when they attend high quality programs alongside their peers, in comparison to those who attend self-contained classrooms (Odom et al. 2011).

It is also widely accepted that high quality, effective inclusion involves not simply placing children with disabilities in the same room as their peers, but rather that children must be able to fully participate in their respective child care settings with a sense of belonging (Granlund, 2013, 2015; Halfon & Friendly, 2013; Odom et al., 2011; Soukakou, 2012; Underwood, 2013; Warren, Martinez and Sortino, 2016).

Granlund and Lillvist (2013) write about attendance being the most commonly used measure of participation of children with disabilities. Two facets of attendance are critical: 1) that children with diagnosed disabilities (and/or presumptive disabilities, according to the region or state) are enrolled in community programs; and 2) that they actually attend the programs on a regular basis. Such barriers as structurally inaccessible centres and outdoor playgrounds, more illnesses than typical children, parents not being employed and thus being less likely to bring the children regularly, and the difficulties of transporting children with limited mobility, particularly in Canadian winters, are obvious. Some of these barriers to attendance and, thus, to effective experiences, can and should be ameliorated.

While *attendance* is a necessary condition of being there, Granlund (2013) in Bartolo et al. (2016) has conceptualized *participation* as having two dimensions: "being there" and "being involved/engaged while being there." "Support provided to children at risk and children with disabilities should facilitate their participation in the same activities as other children. "Being there" is not enough for inclusion. It needs to involve practices that ensure their participation and engagement in learning" (Granlund & Lillvist, 2015).

"Being involved/engaged while being there" is related to adaptation to each child's needs, and promoting each child's learning, participation and engagement. Granlund addresses what child care staff often imply when they refer to a child with severe disabilities as "participating by observing." He suggests ways of involving even these children, sometimes with assistive technology. "Observing" is not good enough.[1]

To the widely accepted constructs of structural features and process quality, researchers have added features that are less direct, but which are critical to the continuation of high inclusion quality and/or necessary for suggesting policy or program changes. Underwood (2013) adds that "*monitoring and assessment* must be considered when determining inclusion quality. Ongoing monitoring and assessments include child care staff responding to developmental changes in children and their lives, and programs being flexible, responsive, and up to date in order to plan and make decisions that promote inclusion. Planning for these children is individualized, the goal of participation is explicit, and early intervention goals for children are accommodated and embedded within the program."

Lero (2010) states that "in order to be considered an inclusive program, the program must have policies that promote inclusion, leadership that supports inclusion, and staff who believe in inclusion. High inclusion quality gives all children, including those with disabilities access to "a wide range of learning opportunities, activities, settings and environments." When designing and implementing an inclusive program, the program must be designed to meet the needs of all children and families. Additionally, programming must be created to promote belonging, participation and engagement. Lastly, agreeing with Underwood, Lero states that "inclusive programs must commit to ongoing monitoring and assessment of their program to ensure it is fully inclusive."

To summarize, there are components and characteristics of inclusion quality that are not generally noted in descriptions of overall program quality. Consequently, the traditional methods of assessing overall program quality, such as the ECERS-R, are not capable of capturing and measuring the characteristics described above to determine if a program is engaging in high inclusion quality. Further understanding of the relationship and similarities between overall program quality and inclusion quality can help to promote practices that enhance both forms of quality.

1 (See DVD clip about Shawn, a child with severe cerebral palsy, for an example of "being involved/engaged while being there" on the SpeciaLink website www.specialinkcanada.org.)

FACTORS AFFECTING QUALITY INCLUSION

Many factors have been found to affect inclusion quality in child care — both positive factors which act as enablers and facilitators of inclusion, and negative factors which create barriers and impediments. Resources have been found to be the strongest predictors of inclusion (Warren et al., 2016). Centres that have more inclusion-specific resources have been found to have higher inclusion quality than those that do not have such resources. These resources can be characterized in two broad categories: resources within centres and resources provided to centres (Irwin, Lero & Brophy, 2004).

Resources Within Centres

These resources include an accessible environment and inclusion-specific material resources, the director's leadership and support of inclusion, centre staff who are trained and experienced in inclusion, and centre policy resources. These resources should be seen as being in addition to overall program quality in the centres.

Accessible Environment:

This includes the physical structure of the early childhood setting that enables children with disabilities to participate in all activities. Very few early childhood classrooms are designed with children with disabilities in mind; even fewer embody universal design principles (Capp, M. J., 2017) that define optimal space for children with disabilities, as well as for typical children. Accessible physical structure is as obvious as wide paths between play areas and room for wheelchairs in the bathrooms. A threshold at the entry door to the centre that does not require lifting a wheelchair up is seldom present, but is certainly welcome. Accessibility is as obvious as materials being reachable by all children. Spaces that promote inclusion quality have well-planned layouts (Irwin et al., 2004; Underwood, 2013).

However, accessibility or inaccessibility does not guarantee inclusion or exclusion, respectively. In one case in our earlier research, a centre that scored low on well-planned layout did not result in the exclusion of a child with blindness since the centre staff were committed to overcoming its deficiencies (Irwin et al., 2004). Staff and children became diligent at putting chairs and materials away constantly, so that the child with blindness wouldn't stumble over them. Children were taught *What If You Couldn't* games, such as "Pin the Tail on the Donkey" to help them understand what the lack of sight would mean.[2] Prior to this experience, even the older four-year-olds thought that being blind meant having no eyes — a good example of benefits of inclusion to typical children!

In many cases, though, poor physical structure results in children being unable to participate fully in programming or even in the ability to attend

2 (See DVD clip about James, a child who is blind for an example of "being involved/engaged while being there" on the *SpeciaLink* website at www.specialinkcanada.org.)

child care at all. Killoran, Tymon and Frempong (2007) reported that 51% of the child care centres they surveyed in Toronto could not accommodate a child in a wheelchair due to stairs and/or lack of an elevator. Physical changes to buildings that would make them fully accessible, such as the removal of stairs and addition of elevators and/or lifts often cannot be completed without substantial funding (Lero & Irwin, 2008).

Accessible washrooms for children who use wheelchairs are another major problem. Very few child care centres were designed or renovated to accommodate these children, so that they can use a toilet and sink independently. But one centre we visited had a set of grab bars that allowed a child using a wheelchair to reach the toilet, and an arrangement for her to use the sink. The director told us that they had consulted with a physiotherapist who had adaptive equipment made for her children by a local carpenter; she and he designed the washroom apparatus, which worked well. Another centre had an adaptive toilet seat that accommodated a child with severe cerebral palsy. Although he was a wheelchair user and could not get out of the chair and onto a toilet by himself, the adapted toilet seat provided the support he needed. It was constructed from plywood, which made it heavy for staff, but a catalog prototype cost about $750 (Irwin, 1993).

Inclusion-Specific Material Resources:

Specialized equipment means purchased, adapted and/or modified equipment that enables children with disabilities to participate. The availability of specialized equipment and adaptive materials, from the least expensive to highly priced items (e.g., from masking tape holders around pencils and picture exchange systems to adaptive computer technology) were often found to be closely linked to a particular child or children who had attended a centre (Irwin et al., 2004).

Having children with particular disabilities enrolled in a centre may result in staff gaining access to specialized materials or training that allows them to be more confident in their abilities to support children with the same or similar disabilities at a later time (Irwin et al., 2004). Again, funding remains an issue for accessing specialized equipment. Access to these items is often linked to centres' relationships with community therapists/specialists and directors' abilities to advocate for funding to purchase these resources. In some cases, expensive specialized equipment is housed in a central location to which several centres have access. This is more likely to occur within agencies that support a number of centres (Irwin, 2019, site visits).

Human Resources: Directors Who Are Leaders and Centre Staff Who Are Trained and Experienced with Inclusion

Although the field has not yet settled on titles for the various positions in inclusive centres, the authors are suggesting the following: director, Early Childhood Educators (ECEs), resource teachers, and inclusion assistants. (See glossary for definitions.) The authors remind us that

it took the child care field several decades to settle on Early Childhood Educators (ECE) for the title of primary frontline staff. It is not surprising that the field has not yet come to consistent terms for other staff — internal and external — who support inclusion.

Attitudes and skills that contribute to inclusion quality include: the director's leadership related to inclusion (Irwin et al., 2004); the director's and staff's knowledge, attitudes, and commitment to inclusion and capacity to function effectively as part of a supportive team; and opportunities for on-going training to develop skills and promote inclusion (Irwin et al., 2004). Centres that have the ability to sustain high inclusion quality have been found to have the following characteristics:

- "having at least one person continuously involved in the program whose primary role involves facilitating successful inclusion in the centre," and
- "the development of a centre culture that embraces being inclusive as something the centre prides itself on, and communicates to others" (Irwin et al., 2004).

Centres that have established strong ethics and a commitment to inclusion showed higher levels of inclusion quality (Irwin et al., 2004). Specifically, the director's attitude towards inclusion has been found to have a strong impact on staff's attitudes and experiences. Directors who hold positive attitudes about inclusion are more likely to have staff (or develop staff) who also hold positive attitudes towards inclusive child care.

Based on their research findings about the centre director's leadership role, the importance of directors' and staffs' attitudes towards inclusion, and how previous experiences with inclusion tend to impact the quality and quantity of inclusion that occurred within a centre, Irwin, Lero & Brophy (2000; 2004) developed a model of a virtuous cycle of inclusion. The authors note that, building on aspects of program quality and staff's knowledge and training, a dynamic process occurs whereby early childhood educators who have positive experiences with inclusion, in turn, develop more positive attitudes toward inclusion, which thus increases inclusion quality within their centres. This concept is referred to by the researchers as a "virtuous cycle of inclusion." See Figure 1, page 26.

The idea of positive experiences with inclusion creating positive attitudes towards inclusion is also supported by Cross et al. (2004) and Underwood (2013). These positive experiences are often associated with working in a supportive team that includes both the staff within the program as well as community professionals and parents. Centre staff who believed in inclusion indicated that having like-minded co-workers and directors made achieving inclusion quality more attainable (Irwin et al., 2004). Inclusion quality is profoundly affected by the vast range of attitudes, beliefs and previous experiences that those employed in early childhood education centres may hold/have had. This range of attitudes, beliefs and experiences results in children with disabilities and their families having very different experiences with inclusion quality.

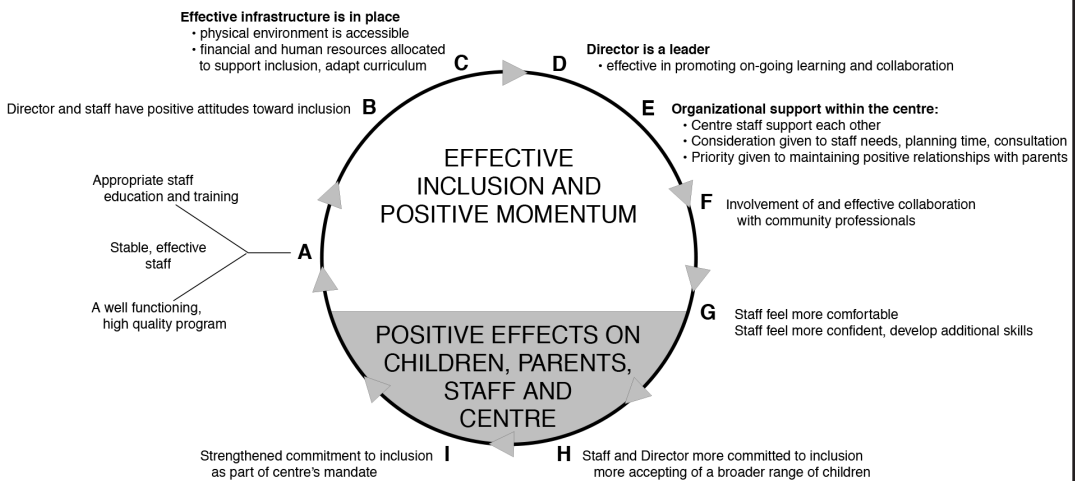
Additionally, a centre with a director who promotes inclusion quality

is more likely to have staff with enhanced training and experience related to inclusion. Lack of staff training has been found in several research studies to be the most prominent barrier to accessing child care for children with disabilities (Brennan, Caplan, & Gamel, 2001; Essa et al., 2008; Irwin et al., 2004; Mulvihill, Shearer & VanHorn, 2002; Palsha & Wesley, 1998).

The common belief that children with disabilities are so exceptional that they require special curricula in order to meet their needs remains widespread (Purdue, 2009). Purdue found that children with disabilities are often assumed to require different or special forms of education that do not align with mainstream educational policies and practices, often resulting in these children being excluded. Therefore, when a centre director or staff holds this attitude towards children with disabilities, the quality and likelihood of inclusion is lowered. Engagement in continuous professional development that increases knowledge and comfort with working with children with disabilities is seen as a key indicator of inclusion quality (Warren et al., 2016). A study completed by Essa et al. (2008), which was interested in determining what factors predict inclusion quality, found that directors and staff who had completed coursework related to children with disabilities was the strongest predictor of an inclusive child care centre.

In the Canadian context, early childhood education training programs are generally designed with the assumption that early childhood educators will interact with children with disabilities once they enter the workforce (Friendly & Halfon, 2003), but many college and university programs may still lack mandatory coursework and placement experiences in inclusive programs that prepare graduates for their work.

Figure 1: A Virtuous Cycle That Supports Effective Inclusion



Educators who feel prepared and are trained to provide interventions for children with disabilities often have more positive beliefs about inclusion and, therefore, are able to offer higher inclusion quality in the child care settings where they work (Forlin, 2009).

Most provinces provide funding for "staff in addition to ratio" in order to include children with disabilities and thus, often, with extra needs. While directors agree that this is essential, they say that it is often not possible to recruit "support staff" with a background in either child care or disability. These inclusion assistants are usually paid at minimum wage with no benefits and often do not receive in-service training. It is not unusual for these staff to be sent home if the child with a disability is absent. In some provinces, the inclusion assistants work fewer hours than full-time staff, thus being paid even less. Such practices do not sustain an ongoing team approach.

In summary, adequate human resources to sustain inclusion are critical for inclusion quality and cannot be taken for granted. Current funding models, training opportunities, staff experiences and attitudinal barriers towards inclusion can act as serious impediments to achieving and sustaining inclusion quality. Broader contextual issues that affect the viability of child care programs and the supply of a qualified child care workforce must be considered as well as those more specific to inclusion resources. Further understanding of key indicators of inclusion quality is needed to support centres in obtaining appropriate human resources to provide sustained inclusion experiences.

Centre Policies and Practices:

While written or verbal inclusion policies in centres can help to increase inclusion quality in Canada, these policies alone cannot ensure the effective inclusion of all children, and the evaluation and monitoring of these policies that will be required.

Currently, New Brunswick is involved in a project to increase inclusion in its child care centres. They use the *SpeciaLink Early Childhood Inclusion Scale* as a progress record and report that they have seen 80% of their centres develop a written inclusion policy. (The scale presumes that a required principle of inclusion quality is having a written inclusion policy).

On the other hand, despite the fact that New Zealand has existing legislation that requires that children with disabilities have the "same rights, to enroll and fully participate in mainstream early childhood settings as does any other child," there are still implementation issues such as financial constraints, training, inadequate physical settings, inadequate access to support services, and specific practices in individual centres. It appears that even though centres have written policies on inclusion, they often demonstrate an unwillingness to be inclusive. Purdue (2009) described centre practices that contradicted documents or verbal statements on inclusion that restricted children with disabilities' access to child care. Such practices included:

- parents being told the centre was “not ready” to “accommodate” children with disabilities,
- parents being allocated time slots for how long their children could attend the centre,
- parents being required to pay for addtional supports for their child to attend the centre,
- management informing parents about the lack of “ability of the centre” to meet the child’s needs, and
- management restricting the number of children with disabilities who could attend a centre.

These experiences are echoed in Canada. *Statistics Canada* (2008) reported that 31.7% of children with a severe disability were refused child care services. Killoran, Tymon and Frempong (2007) reported that, in their study of Toronto preschools, the majority of directors advised that they would exclude a child with disabilities from their program for various reasons. A recent study completed in Alberta (Wiart et al., 2014) surveyed 316 child care centres and 25 home day care agencies; of those, 36% of centres and 29% of home day care agencies were unable to accommodate a child with special needs in the past two years. The child care providers described the following reasons for denying child care: the centre was at full capacity for all children, the child required more attention than could be provided with staffing levels at that time, staff were not adequately trained, the physical environment was unsuitable, and there was inadequate access to support services.

Centres that have clear policy statements regarding the expectations of inclusion and that have educators who can put those policies into practice, often have higher inclusion quality than those that do not have clear guidelines and expectations (Bakkaloglu, Sucuoglu & Yilmaz, 2019; Irwin, 2013; Purdue, 2009; Underwood, 2013). A revision of current centre policies or the creation of new policies that focus on the rights of all children to access and participate in early childhood programs would seem to promote higher inclusion. But on their own, centre policies do not necessarily promote full inclusion. Resources must be available to ensure centre policies and practices are supported and sustained.

External Human Resources Provided to Centres

Partnerships with Inclusion Consultants, Therapists and Specialists:

Inclusion quality is impacted not only by the directors and staff who work within child care centres, but also by individuals from the community such as inclusion consultants, therapists and specialists. Inclusion consultants, therapists and specialists contribute to inclusion quality by providing staff with knowledge about best practices when working with children with disabilities, by modelling individualized activities, and by helping staff to plan next steps (Irwin et al., 2004). These individuals

may also supply or assist the centre to obtain adaptive equipment and specialized materials. This knowledge and these materials give staff a greater understanding of children's needs and abilities and allow for staff to create programming and physical spaces that allow children with disabilities to fully participate. Additionally, this knowledge may increase staff's and director's confidence in working with children with disabilities.

The relationship between staff and inclusion consultants, therapists and/or specialists is found to be more effective for inclusion quality when the director is supportive and staff are involved in planning and progress reviews (Irwin et al., 2004). It is important to note that the quality of support provided by inclusion consultants, therapists, and specialists — including the frequency of visits, the depth of relationship, and the type of support provided — varies greatly, depending on the province and locale in which a centre is located and the needs of the centre (Irwin et al., 2004). "Best practice" in therapies for children in ELCCs is generally seen to involve the external staff working with the child within the regular classroom, rather than in a pull-out situation (Irwin, 2009; Weglarz-Ward et al., 2020). This allows staff to observe her/his methodology and, possibly, to imitate it. In addition, professionals' beliefs and attitudes about a centre's practices can impact their willingness to work with a centre. Irwin at al. (2004) found that when a specialist viewed a centre as providing low inclusion quality care and the staff/director as not especially enthusiastic about improving it, they were less likely to invest their time and energy in that centre. On the other hand, when specialists felt that staff really valued their work, they were eager to visit that centre (Weglarz-Ward et al., 2020). Again, funding can have a large impact on whether these resources are available to a program and is often directly linked to a specific child with a specific diagnosis or disability.

While it is easy to say that current policies must eliminate practices that give centres "negotiable or optional enrollment of children with disabilities based on available resources," it is unreasonable to expect centres to be able to include every child with a disability whose parents want him to attend, and still have a high quality program for all children. Often it is not unwillingness on the part of centres, or the lack of training or resources or funding that keep some children with disabilities out.

Sometimes, staff feel that they cannot include another child with extra needs and still maintain a program that even the most gifted child will find stimulating. In our experience (Irwin, 2013), it is not merely "numbers"; it is often the composition of the classroom. Experienced and dedicated staff told us that they can accommodate one child who is a runner and also self-injurious, with several other children who have intellectual disabilities or physical ones.

Either explicitly (Irwin, 2013) or implicitly, many researchers, parents, and child care staff endorse a classroom composition that reflects the "natural proportions" (approximately 15%) of children with disabilities

in the classroom. They see "inclusion" as giving children with disabilities the opportunities to learn and play with typically developing children, to hear age-appropriate speech, to engage in activities and interactions that are scaffolded to help develop more complex skills.

If many of the children in the classroom have disabilities, some of these opportunities are lost, and we are partially back to the outdated concepts of segregated classrooms. Until universal child care is available, accessible, affordable and of high quality for all children in Canada, this problem will continue to exist.

Partnerships with parents

Parents have been found to play a critical role in inclusion quality. When relationships with parents are positive, respectful, and mutually supportive, these relationships have been found to contribute positively to inclusion quality (Irwin, 2009; Irwin et al., 2004; Underwood, 2013). In our previous research, we found that no centres that scored high on inclusion quality on the *SpeciaLink Early Childhood Inclusion Quality Scale* had low parent support, strongly suggesting that parents are important partners in promoting inclusion quality within a centre (Irwin et al., 2004).

Government funding

In their study of 283 inclusive centres, Irwin et al., 2004 found that no centres reported a high level of funding support for inclusion. Centres that reported having more funding to support inclusion had higher inclusion quality than centres with less funding. Halfon & Friendly (2013) report that, in general, many centres express issues with funding that gravely impact inclusion quality. Funding to pay for resources (both within centres and provided to centres) is often a patchwork of provincial/territorial funding, grants, and private donations. Simply put, financial constraints affect both inclusion quality and inclusion capacity. Many more centres could, and most likely would, provide inclusive quality child care if they had the appropriate resources to do so. Children with disabilities often require additional supports, primarily in the form of extra staff and specialized equipment and adaptive materials that allow them to access learning opportunities and experiences the same way their typically developing peers do. These additional resources require funding since they are not automatically given to a centre based on need.

Inclusion quality is significantly impacted by centre director's and staff's knowledge of available supports and their understanding of how to obtain them (Halfon & Friendly, 2013). Even with adequate knowledge of available supports, waitlists for this funding and for the assessments that are often required for funds to be allocated often hinder programs' abilities to make the required physical/material modifications for children with disabilities or hire additional staff to offer program support (Doherty, Friendly, & Flanagan, 2003).

Having these additional resources in centres positively impacts inclusion quality. For example, Irwin et al., 2004 found that having a full-time resource teacher on site "helped build a sustainable inclusive program, contributed to educators' confidence and positive attitudes towards inclusion, created an ethos of inclusion within the centre and allowed centres to meet new challenges, address the needs and concerns of children and parents, and build on an important set of shared experiences."

Lack of resources, whether they be resources within a centre or resources provided to a centre, is the most common reason given by directors for not accepting children into care (Purdue, 2009). While this section provides only a brief overview of the most prominent barriers and enablers of inclusion quality, it is important to review our current practices and reflect on their implications for improving and promoting inclusion quality, moving forward.

Relationship Between Overall Program Quality in Early Childhood Education Settings and Inclusion Quality/Effectiveness

Despite the differences between overall program quality and inclusion quality, there is a clear relationship between them. According to Lero (Irwin, et al., 2004), overall program quality seems to be a necessary, but not sufficient, condition for inclusion quality. High quality overall programming, by design, allows for the opportunity to include children with varying abilities, including those with disabilities, but does not ensure inclusion quality (Halfon & Friendly, 2013). Programs that have high inclusion quality have been found to be not only beneficial for children with disabilities, but also beneficial for their typically developing peers (Buysse, Grant & Skinner, 2001; Camilli, Vargas, Ryan & Barnett, 2010; Halfon & Friendly, 2013; Pianta, Barnett, Burchinal, & Thornburg, 2009). Centres that were observed to have high inclusion quality were also found to have higher overall quality than those that were deemed non-inclusive (Grisham-Brown et al., 2010; Irwin, Lero & Brophy, 2004; Knoche, Edwards & Jeon, 2006).

Inclusion quality is less well understood than overall program quality, since it arose as a newer issue in the field of early childhood education and care, and fewer tools have been established to measure it (Bakkaloglu et al. 2019; Odom et al., 2011; Soukakou, 2012). In the *SpeciaLink Early Childhood Inclusion Quality Scale* manual, Irwin (2009) addresses critics of the *Inclusion Scale* who protest that their *ECERS-R* scores are higher than their *Inclusion Scale* scores with: "You are likely to have a lower *SpeciaLink Early Childhood Inclusion Quality Scale* score than your *ECERS-R* score. This is completely reasonable since the items in the *ECERS-R* have been part of the early childhood training and practice repertoire for over 30 years, while many of the *Inclusion Scale* items are new to the field."

Further understanding of the relationship between overall program quality and inclusion quality is required in order to determine if there

is a certain threshold of overall quality that is required before inclusion quality can occur (Lero, 2010). Most current indicators and measures of overall program quality have been designed with typically developing children in mind; therefore, assessing overall program quality will not be sufficient to measure inclusion quality and vice versa (Bussye & Hollingsworth, 2009; Harms, 2008; Soukakou, 2012).

Determining and defining the key factors that contribute most to inclusion quality is necessary in order to be able to regulate, evaluate, and improve inclusion practices (Bussye & Hollingworth, 2009).

In summary, Canada as a whole has made great strides in including children with disabilities in child care and the recent *Multilateral Framework Agreement* has identified the promotion of inclusive early learning and child care programs as a critical policy goal. However, more information is needed about the quality of inclusive practice, and what contributes to it, in order to continue eliminating the barriers that families, children, and child care centres experience. Current practices that have been found to promote and support inclusion quality should be identified and supported to increase the overall quality of inclusion throughout Canada, and new practices should be put into place that provide centres with the ability to enhance their inclusion practices.

METHODS 3.

SAMPLE SELECTION AND RECRUITMENT

A total of 67 child care centres participated in this study consisting of 12 centres each from British Columbia, Manitoba, New Brunswick, and Nova Scotia, and 19 centres from Ontario. Centres were clustered in and around Vancouver, Winnipeg, St. John (8) and Nord-Ouest (4), Halifax, Ottawa (7), and Milton (12), a region close to Toronto. A purposive sampling approach was used that involved initial identification of potential centres by regional coordinators who were hired to identify and recruit child care centres that met the sampling criteria. Regional coordinators either worked in a local agency that provides inclusion support to centres in their area, or had prior experience working as an inclusion consultant/facilitator on one or more initiatives in their province. One coordinator was a university professor with strong ties to the child care community and another, Dixie (Van Raalte) Mitchell, was the project's national coordinator and *ECERS-R* trainer for SpeciaLink.

Two criteria were particularly important in sample selection. The first eligibility criterion was that a minimum of two children with identified special needs was enrolled in a preschool classroom in the centre. The reason for this criterion was that it was important that observations take place on a day when at least one child with a disability would be present in order to observe interactions with staff and other children. The fact that observational assessments were to be done in the winter months in Canada when child absences (likely to be more prevalent among children with special needs) might compromise observation schedules made it prudent to select classrooms with at least two children with special needs.

The other criterion was one of centre diversity. Regional coordinators were asked to assist in recruiting centres that varied on several criteria: urban/suburban location; whether the centre served a mixed economic range of children and families or provided service primarily to a low-income population; and centres that represented a range with respect to overall program quality. The latter was based on the coordinator's knowledge of the centres.

In addition, 12 Francophone centres participated — four from Manitoba, four from Nord-Ouest, New Brunswick, and two each from Milton and Ottawa. All data from these centres were collected using French

versions of the director questionnaire and the two observational scales by French speaking observers.

Eighty-three child care centres were originally identified by the regional coordinators and were invited to participate in the study. Of that total, 67 (81%) agreed to participate and 16 centres either did not meet the eligibility criterion of having at least two children with identified special needs in a preschool classroom (5 centres) or declined to participate for other reasons.

POTENTIAL SAMPLE BIASES

It is important for readers to recognize that the participating centres in this study are neither a representative sample of child care centres across Canada nor are they a representative sample of inclusive programs. Centres were chosen from six specific regions in order to allow some comparisons between centres in different provinces while maximizing efficiencies when conducting observations and assessments. Centres' access to resources to support inclusion (provincial funding and the availability of therapists, resource consultants, and other specialized services) reflects both provincial policies and the unique history and location of each centre.

Two factors suggest that the centres included in this sample are more likely to manifest higher program quality and inclusion quality than a random sample of centres. The first is the requirement that the centre have two children with identified special needs in a single preschool classroom. Centres with no or very few children with disabilities in a single classroom were not eligible to participate.[1] Secondly, participation in the study was voluntary.

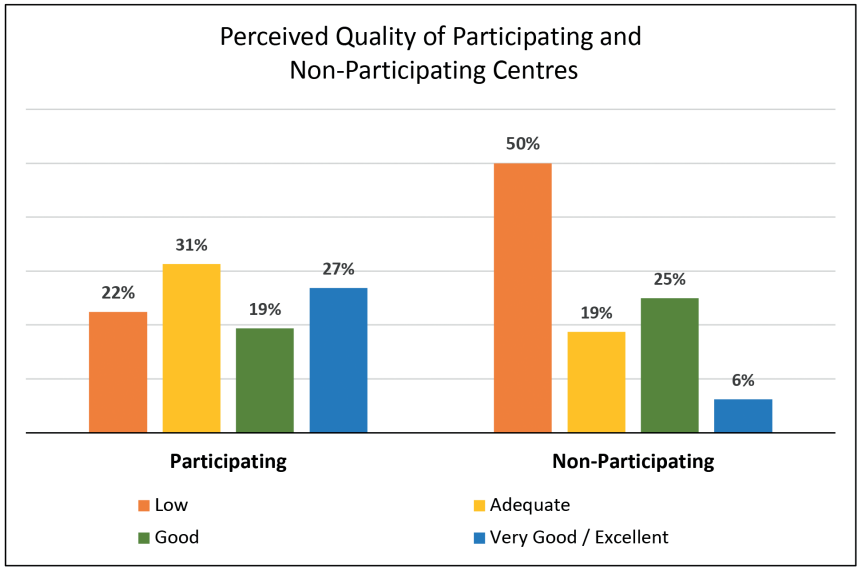
Even though regional coordinators were asked to recommend centres that covered a range of program quality, we can expect directors who felt less confident about their centre's program quality and inclusion practices to be less likely to agree to participate in a study of this kind. In fact, a comparison of the coordinators' ratings of the presumed quality of centres that participated compared to ratings of the centres that were ineligible or where directors declined supports this hypothesis. Fully half of the 18 non-participating centres were rated by regional coordinators to be of low or poor quality, and only one of the non-participating centres was considered to be of very high or excellent quality. In comparison, 22% of the participating centres were perceived to be of low or poor overall quality by regional coordinators, while 27% were perceived to be of very good or excellent quality (see Figure 2).

PROCEDURES

A regional coordinator was hired in each location who sometimes also functioned as an observer, sometimes only in the coordinating role.

1 In fact, many of the participating centres had included children for many years, another factor that should be considered when interpreting their scores on our inclusion quality measure. (See Chapter 4.)

Figure 2: Site Coordinators' Ratings of the Quality of Centres That Did and Did Not Participate in the Study



Based on regional coordinators' perceptions of 67 centres that participated in the study and 18 centres that were ineligible or declined to participate

Regional coordinators recruited centres, explained procedures to centre directors, and were responsible for sending all completed data forms (centre questionnaires and completed score sheets for the *ECERS-R* and *SpeciaLink Early Childhood Inclusion Scale*) to SpeciaLink in a timely fashion.

Observers were recruited and trained locally to administer both the *SpeciaLink Early Childhood Inclusion Scale* and the *ECERS-R* measure of program quality. In most locations, trained observers administered one of the two scales in three or four centres. An exception was Nova Scotia, where the regional coordinator and the director of a successful, inclusive centre who was seconded to do observations worked collaboratively with one observer conducting all the *ECERS-R* assessments and the other responsible for administering the *Specialink Inclusion Scale*.

Observer training was provided by Sharon Irwin and Dixie Mitchell at each site over two days. On Day 1, training on each scale was classroom-based, with DVD segments of "How to Measure Inclusion" or the *ECERS-R* training video shown so that observers could get used to observing and scoring the items. On the second day, observers went to child care centres that included at least one child with a disability. Two observers independently observed a classroom, using either the *ECERS-R* or the *SpeciaLink Inclusion Quality Scale* and interviewed the director and an ECE for the full morning. They then returned to meet with the trainers to debrief and learned how to complete the scoring and then how to compare scores to see whether they achieved inter-rater reliability (at least 85% agreement). Almost always some observers spoke about how Day 2 gave them confidence and enabled them to better understand the work and to observe and score reliably. Both the senior researcher and national coordinator were available for

consultation by telephone or email throughout the project as questions or concerns arose. In some locations, other agency staff and/or government officials who asked to do so also participated in the training. In all, 34 observers were trained and involved in the project including several who were assigned to Francophone centres.

DATA COLLECTION

Once centre directors were recruited, the regional coordinators distributed the centre questionnaire and arranged dates for observers to administer the two scales. Observational assessments were conducted on the same day, at the same time, in the same classroom. This procedure minimized interruption to classroom staff and routines and gave the two observers the opportunity to participate in questions and answers with classroom staff and with the director together.

Data collection occurred between February and March 2019 in all but a few centres. Challenging winter weather sometimes required rescheduling and heroic efforts by observers to keep appointments.

All centres received a complimentary copy of the *SpeciaLink Early Childhood Inclusion Scale* and a centre-specific report that provided detailed information about their centre, identified strengths, and suggested some specific areas for improvement

RESEARCH INSTRUMENTS

Centre directors completed a written questionnaire about their centre. In addition, directors and lead teachers in the observed preschool classrooms responded to brief interviews and provided documents where appropriate to inform observers' ratings on two measures: the *Early Childhood Environment Rating Scale — Revised* (*ECERS-R*) measure of global program quality and the *SpeciaLink Early Childhood Inclusion Quality Scale*. A more detailed description of each measure follows.

1. Centre Questionnaire

Directors completed a brief questionnaire that focused on three main areas:

- Centre characteristics;
- Information about the centre's history of including children with disabilities, as well as information about circumstances the director felt precluded enrolling children with special needs and/or resulted in children with an identified disability being turned down in the last three years;
- The director's rating of how well the centre was doing in providing inclusive child care in their community, the centre's strengths and challenges in providing care and education for children with disabilities, the resources available to the centre to support inclusion, and additional supports/resources/training that would be helpful.

Questions were drawn from our previous research studies on inclusion (Irwin, Lero & Brophy, 2004; Lero & Irwin, 2008). Coding of directors' responses was done by a research assistant based on a codebook developed for this project and all codes were reviewed by one of the senior researchers. The Centre Questionnaire is included in Appendix B.

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

An observational measure of program quality was used to assess this feature. The *ECERS-R* is the most widely used measure of global or program quality in child care centres and preschool programs in North America and in international research on early childhood education and care. The original measure, developed in 1980, was substantially revised in 1998 to reflect changes in the early childhood field, research findings and experiences in quality improvement studies, and an appreciation of the importance of incorporating the inclusion of children with disabilities and sensitivity to cultural diversity in assessments of program quality (Harms, Clifford & Cryer, 1998).[2] The *ECERS-R* yields an overall score and seven subscale scores based on 43 items, each of which is scored from 1 to 7 based on yes/no answers to specific observable indicators, sometimes supplemented by respectful questioning of the centre director or classroom supervisor. The seven subscales are: Space and Furnishings, Personal Care Routines, Language-Reasoning, Activities, Interaction, Program Structure, and Parents and Staff.

Although the *ECERS-R* is based on observations within a specific classroom (and scores can vary across rooms in a child care centre), it is common to refer to *ECERS-R* scores from a single room as reflecting the overall quality of the centre. We note here that while there are many issues one can raise about the *ECERS-R*, it provides a useful snapshot of a number of dimensions of program quality[3] and the measure is well known, easily interpreted, and serves as a useful tool for quality improvement initiatives. Care must be taken to ensure that observers are well trained, and that inter-observer reliability is established and maintained during the course of a research project.

2 A third edition, the *ECERS-3*, was published in 2015 (Harms, Clifford & Cryer, 2015). The new edition includes changes in both the content and administration of the scale, with a stronger focus on literacy and math activities. It relies almost completely on observable indicators, with no or little supplementary information obtained from a director or lead classroom teacher. We decided to use the *ECERS-R* rather than the *ECERS-3* for two main reasons. The first is that the *ECERS-3* is only now beginning to be used in Canada. Given that fact, there are very few individuals who have been trained in its use; as well, we would not be able to compare data from the current study to other research samples in Canada. Secondly, the *ECERS-3* no longer includes a specific item and other indicators that are focused on provisions for children with special needs, substituting in its place a more general item on promoting acceptance of diversity. We wanted to include the *ECERS-R* item on inclusion to further our understanding of inclusion quality.

3 The *ECERS-R* does not assess structural (regulatable) aspects of program quality such as adult-child ratios, group size, or the qualifications of the director and early childhood educators, nor other factors such as auspice, funding, or staff turnover rates that can affect program quality.

3. The SpeciaLink Early Childhood Inclusion Quality Scale

Research, policy development, and initiatives to improve inclusion quality in child care centres requires a reliable, valid instrument to assess inclusion quality. *The SpeciaLink Early Childhood Inclusion Quality Scale* (*Specialink Scale*) (Irwin, 2009) is a unique tool developed for these purposes.[4] It was designed specifically to assess the extent to which centres have embraced and use explicit, written principles on inclusion as part of the centre's philosophy of practice and utilize resources, interactions and supports to meet the need the needs of each child with disabilities effectively. The 2013 *Specialink Scale* builds on earlier versions of the SpeciaLink Inclusion Practices Profile and the SpeciaLink Inclusion Principles Scale, which were developed in 1991

Table 1: Description of Items Comprising the *SpeciaLink Early Childhood Inclusion Quality Scale — Principles Subscale*

Item #	Name of item	Description of item
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 natural proportions	The centre enrolls roughly 10-15% of children with special needs, in "natural proportion" to their occurrence within the community.
3	Same hours/days of attendance available to all children	Children with special needs are not limited in attendance options (e.g., part time or fewer days per week) compared to typically developing children.
4	Full participation	The centre is committed to enabling the full participation of children with special needs within regular group activities and routines through accommodations, modifications and extra support where necessary. Pull-out time is limited or avoided when interventions can be done in the room and can involve other children.
5	Maximum feasible parent participation at the parent's comfort level	The centre makes concrete efforts to encourage parents' participation at Individual Program Planning (IPP) meetings, committee meetings, training sessions and parent networking events. 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.
6	Leadership, pro-active strategies and advocacy for high quality, inclusive child care.	The director, staff and board actively promote inclusion both in the centre and through public activities designed to effect policy change and ensure adequate support for high quality, inclusive programs.

4 The *Specialink Scale* is available from www.specialinkcanada.org along with a video, training manual and scoring sheets.

and revised in 2001 and 2005. The Inclusion Principles and Inclusion Practices scales were reintroduced as two subscales of the *Specialink Scale* in 2009 following revisions. Over the last two decades, more than 3,000 early childhood professionals have received training in the use of the SpeciaLink scales and they have been used in research, in inclusion quality initiatives, and as a tool used by resource consultants and provincial advisors (Irwin, Lero & Brophy, 2004; Lero & Irwin, 2008; Lero, 2010).

The *SpeciaLink Early Childhood Inclusion Quality Scale* yields two subscale scores, Inclusion Principles and Inclusion Practices, as well as a Total Inclusion Quality score. The total score is the average of all 17 items — the six items that assess Inclusion Principles and the 11 items that assess Inclusion Practices. Observations by trained observers focus on specific indicators, each of which is checked as yes or no. Item scores range from 1 (inadequate) to 7 (excellent) using a scoring approach similar to the *ECERS-R*. Observations are informed by respectful questioning of the director and/or supervisor and document review as appropriate.

Inclusion Principles

The Inclusion Principles subscale assesses the extent to which a centre has adopted principles to guide decisions about enrolling children with disabilities and to ensure that their needs are met, as far as possible, within a typical setting. Scores reflect child care centres' experience with inclusion, the extent to which they have developed formal policies that promote equity of access and participation for all children with disabilities, and the extent to which directors provide leadership and advocate for high quality, inclusive care. The scale consists of six items and 92 indicators that pertain to the centre as a whole. Each item is rated from one to seven; the overall Inclusion Principles subscale score is the average of the six items. Scoring is based on observations and respectful questioning of the centre's director and other centre stakeholders such as lead early childhood educators (ECEs), parents, and support staff, as well as document review.

The six items that make up the Inclusion Principles subscale are described in Table 1. A score of 5 or higher on the Inclusion Principles items requires that aspects of inclusion are covered appropriately and explicitly in a written document that reflects the centre's policies and commitment to full inclusion. All of the items contributed meaningfully and significantly to the overall score. Item-total correlations were analyzed, and the Cronbach Alpha reliability coefficient was .89.

Inclusion Practices

Scores on the Inclusion Practices subscale reflect a variety of observable practices including the degree to which adaptations are made and special equipment is used to meet children's needs, the ways staff use resources to plan for and implement activities that enable children with different abilities to participate fully in program activities, and the

director's and staff's involvement with parents and other professionals. Inclusion Practices items reflect the centre's overall approach, but more specifically describe the practices and environment that can be observed in a particular classroom. The Inclusion Practices subscale consists of 11 items and 158 specific indicators. Each item is rated from one to seven and the subscale score is the average of all items. Item-total correlations confirmed that each item contributes meaningfully to the total Inclusion Practices subscale score. The Cronbach Alpha reliability coefficient was .78.

The eleven items that make up the Inclusion Practices subscale are described in Table 2 on page 41.

Reliability and Validity of the *SpeciaLink Early Childhood Inclusion Quality Scale*

A recent article provides an extensive analysis of the reliability and validity of the *Specialink Scale* (van Rhijn, Maich, Lero & Irwin, 2019) using procedures to assess the inter-item consistency and reliability of the subscales, along with exploratory and confirmatory factor analyses. Van Rhijn et al. provided solid evidence of the measure's inter-item consistency and reliability based on data collected from 588 classrooms in 457 ECE programs across Canada. Many of those assessments were completed between 2005 through 2008 from centres that were participating in initiatives to improve both overall program quality and centres' effectiveness in including children with disabilities and extra support needs.

In that study, the Cronbach alpha reliability coefficient for the Principles subscale was .91 for the full sample of classrooms, indicative of high inter-item reliability. The computed Cronbach alpha for the Inclusion Practices subscale was .83, indicating that the internal reliability of this subscale is good. The moderate inter-item correlations suggested that the items in this subscale make distinct contributions to the Practices subscale. Principles and Practices subscale scores were highly correlated, and both were significantly and positively related to directors' ratings of the effectiveness of their centre in including children with special needs

Factor analysis confirmed the utility of using both the Inclusion Principles and Inclusion Practices subscale scores in further assessments of inclusion quality and for educating the field about the contributors to inclusion effectiveness. Future research might also use factor scores based on three factors that emerged from structural analyses: Policies and the Environment, Individualized Supports, and Administrative Commitment to Inclusion (see van Rhijn et al., 2019).

Table 2: Description of Items Comprising the *SpeciaLink Early Childhood Inclusion Quality Scale - Practices Subscale*

Item #	Name of item	Description of item
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	Staff support	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 staffs' 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 (IPPs)	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	Preparing for 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

4. CENTRE CHARACTERISTICS

In this section we provide a general profile of the 67 centres that participated in the study. Later sections describe the centres' inclusion histories and current practices, overall program quality, inclusion quality, and directors' opinions about their centre's strengths and challenges in providing early learning and care to children with disabilities.

PROVINCE

The final sample included 12 centres each from British Columbia, Manitoba, New Brunswick, and Nova Scotia and 19 centres from Ontario (12 from the Milton area in Southwestern Ontario and 7 from Ottawa). Twelve Francophone centres participated — 4 from Manitoba, 4 from Nord-Ouest, New Brunswick, and 2 each from Milton and Ottawa.

PROGRAM TYPE, AUSPICE, COMMUNITY SERVED

Table 3 provides a summary of major characteristics of the sample. The majority of centres (55 or 82%) offered full-day care, including 19 centres that provided a combination of full-day programming along with a half-day or school-age program. The remaining centres operated as half-day preschool programs, including one that offered both preschool and after-school care.

Slightly more than three quarters of the centres (52 or 78%) operated on a non-profit basis while 15 centres (22%) were private/commercial centres. The privately operated centres in this sample were clustered primarily in Ontario and New Brunswick. No centres in this sample were directly operated by a municipal government.

The majority of participating centres (72%) were located in urban areas, 21% were in suburban communities, and five centres (8%) were in more rural areas. According to regional coordinators, 31 centres (46%) primarily served a low-income population.

LENGTH OF OPERATION AND CENTRE AFFILIATION

Many of the centres were well established, with a median age of 20 years. Only 5 centres were relatively new, operating for less than 5

Table 3: Centre Characteristics

Centre Characteristics	Number of Centres	Percent
Auspice		
Non-profit	52	77.6
Private / commercial	15	22.4
Affiliation *		
Stand-alone (No affiliation)	31	46.3
Child care organization with several centres	15	22.4
Family resource program / agency/ Head Start	12	17.9
A school	8	11.9
YM/YWCA or Boys & Girls Club	6	9.0
College / University	5	7.5
Other	6	9.4
Type of program		
Full day	36	53.7
Full and part-day /school-age	19	28.4
Part day preschool / nursery school	12	17.9
Number of children centre is licensed for		
12 – 40	17	25.4
41 – 60	18	26.9
61 – 80	15	22.4
> 80	17	25.4

* Six centres identified more than one affiliation

years. Slightly more than one third of the centres had provided child care in their community for 35 years or more.

In this sample, 31 centres (46%) were described by directors as "stand-alone" centres with no formal affiliation to any other organization. Among those that had some identified affiliation, the most common was a child care organization that operates several centres or a community organization, family resource program, or Head Start program. Eight centres were affiliated with a school, 6 were affiliated with a YM/YWCA or Boys and Girls Club, and five were affiliated with a college or university.

The remainder included 3 centres affiliated with a church or other religious organization, 2 that were associated with a workplace, and 1 centre that was affiliated with a military base. (Six centres mentioned more than one affiliation.)

CENTRE SIZE AND AGES OF CHILDREN SERVED

The number of children that centres were licensed for ranged from as few as 12 to as many as 180 children, with a mean of 67 and a median

of 60. Approximately one third of the centres were licensed for fewer than 50 children, one third were licensed for 50-70 children, and one third were licensed for more than 70 children, including 10 centres that were quite large, licensed to accommodate more than 100 children.

Preschools were licensed to care for fewer children at a time but could be in contact with many more children and families if different groups of children attended on different days or in separate morning and afternoon groups.

The programs offered care to children of many ages. Infants from as young as 1 month old to school-aged children up to and including 13-year-olds were included. The majority of programs (82%) provided care to children under 2 years of age, including 26 centres (39%) that offered care to infants under one year old. About half of the centres (55%) offered care only to children 5 years of age and younger, while 45% accommodated school-aged children 6 years and older as well.

5. Centres' Inclusion History and Current Experiences

CENTRES' INCLUSION HISTORY

In this sample, many centres had a long history of including children with disabilities. In fact, 43% of directors reported that they first began including children with special needs more than 20 years ago. Only 9 centres (13%) began to include children with disabilities in the last five years; another quarter have 6-10 years' experience including children with special needs.

Three quarters of centre directors said their centre began including children with disabilities from the time their centre first started, while one quarter began sometime later. Almost all centre directors said they now include children with special needs on a regular basis.

Directors were asked to describe what influenced them/their centre to begin including children with disabilities on a regular basis. The two most common reasons directors gave were that doing so reflects their centre's values and mission, and their belief that all children have a right to participate in programs that support their development. Additional reasons were to meet community/families' needs, or because the director herself was strongly committed to inclusion as a value. A smaller number said that additional resources enabled them to become more inclusive on a regular basis. (See Table 4.)

Table 4: Reasons Directors Gave for Becoming Inclusive on a Regular Basis

Reason for Becoming Inclusive on a Regular Basis	Number of Centres	Percent
All children have a right to be included	20	30%
Centre philosophy, values, promoting inclusion to benefit all children and families	19	28%
History – just naturally happened / evolved from initially serving only children with special needs	10	15%
Director's personal commitment to inclusion and experience /training	10	15%
Community / families' needs	8	12%
Additional resources enabled inclusion; inclusion facilitator helped	8	12%

* Directors could provide more than one reason.

Directors in their own words:

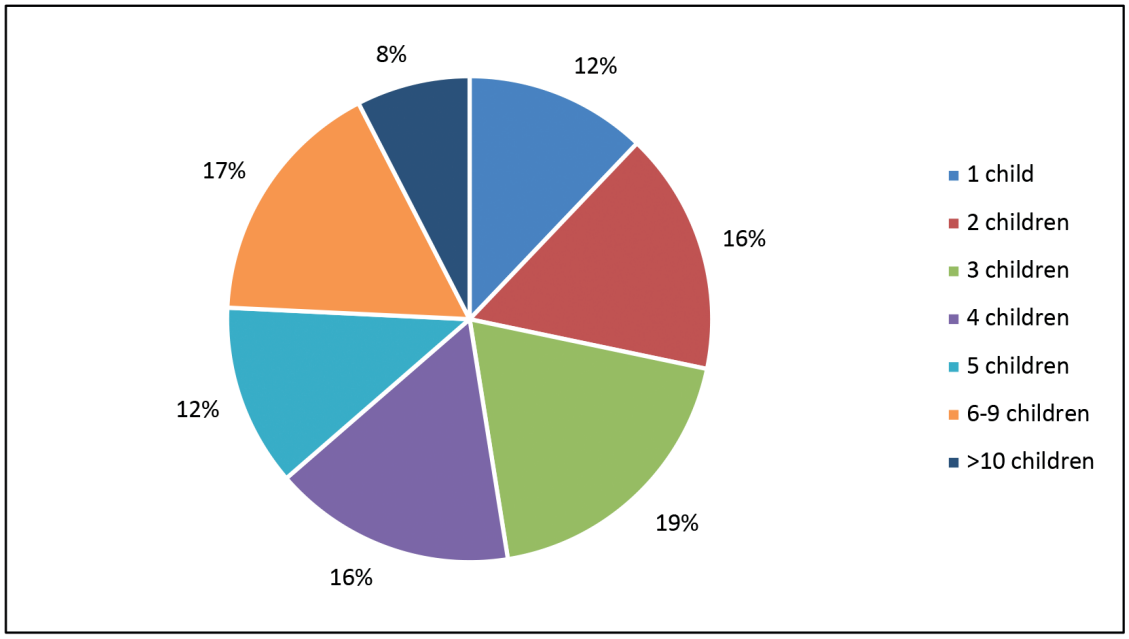
- *"From the beginning of our program we always included children with disabilities on a regular basis. It is in keeping with our mission and core values and beliefs in the development of healthy and competent children. We're committed to treating all children with dignity and respect, helping them grow and develop to their full potential in a supportive environment."*
- *"It is part of a quality program… to support all children and families."*
- *"Through my experience… my belief in giving every individual the opportunity and right to be included and supported to develop as any other child."*

CURRENT EXPERIENCES WITH INCLUSION

Number of children with special needs

At the time directors completed their centre questionnaire, they reported the number of children with identified special needs who were currently enrolled in their centre.[1] All of the centres enrolled at least one child with identified special needs; the median number was 4 children with a range of 1 to 21. Most commonly, centre directors reported having 2, 3, or 4 children with special needs in attendance. In this sample, just under one third of centres enrolled 5 or more children with identified special needs (see Figure 3).

Figure 3: Number of Children with Special Needs Enrolled in Centres



1 Readers should know that often there are children with presumptive disabilities attending child care programs who have not yet been formally assessed and would not be counted in this number nor usually qualify for additional funding.

Table 5: Characteristics of Children with Special Needs

Nature of Children's Special Needs Enrolled In Centres	Number of Centres	Percent
Social–emotional problem	47	72%
Cognitive / language	45	69%
Physical / sensory / mobility	29	45%
Autism spectrum disorder	18	28%
Other	11	17%

* Based on responses from 65 out of 67 directors

Characteristics of children with special needs

Information available from 65 centre directors revealed that the children with disabilities included in this sample of centres had a variety of conditions and types of special educational needs. Most centres included children with social-emotional problems and cognitive or language delays. Almost half the centres had at least one child who had a vision or hearing impairment or limited mobility. Eighteen directors (28%) reported that one or more children attending their centre had been assessed as being on the Autism Spectrum.

Children not included

It is useful to consider how often child care centres exclude children with disabilities and why — as a matter of equity, but also because such circumstances demonstrate what directors and staff see as their limits based on their attitudes and experiences, their skills, and the resources available to them. Directors were asked two questions that shed light on this issue.

Exclusions

Directors were asked, "Are there children whose condition or particular needs are such that you are unlikely to accept them in your program?" Twenty-one directors (31%) said yes. When asked to elaborate,

- 11 directors (16%) said their centre or the external playground area is not accessible and that they could not accommodate a child in a wheelchair or with other significant mobility issues,
- 6 directors said they could not accept a child without adequate funding/supports or staffing in place,
- 1 director said that staff must have training and feel comfortable, and
- 1 director said that their centre could not accept children with complex medical conditions.

Table 6: Reasons Directors Gave for Turning Down Children with Special Needs

Reasons Children with Special Needs Were Turned Down from Centres	Number of Centres	Percent
Maximum number of special needs children	16	24%
Centre was full, no spaces	13	19%
Child too aggressive	8	12%
No funding	8	12%
Child required 1:1	6	9%
Inadequate support; no support services	4	6%
Staff not willing, staff not trained	2	3%
Other	4	6%

Children with special needs turned away in the last three years

More than one third of the centre directors in this sample (36%) said they had turned down one or more children with special needs from their centre in the last three years. Most turned away one or two children, but eight directors reported having turned down three or more children with disabilities in that period. Summed over all centres, an estimated 307 children with special needs who could have benefitted from attending an early learning/child care program were turned away from these 67 centres over the last three years.

The most common reason directors gave for turning away children with disabilities was that they were already at the maximum number of children with special needs their centre could handle. (This is most often an implicit number — no province or municipality specifies a maximum number or proportion of children with special needs.) The second most common reason was that the centre was full — indicative of the broader issue of the limited availability of early learning and care programs in many communities. Other than two directors who cited physical accessibility as a reason, most other responses could be categorized as situations in which the director felt that there was insufficient funding or other supportive resources available to enable the centre to meet children's needs, including when children are aggressive or require 1-to-1 supervision.

PARTICIPATION IN INITIATIVES TO IMPROVE PROGRAM QUALITY OR INCLUSION EFFECTIVENESS

Initiatives to improve program quality or inclusion effectiveness may be offered by child care resource centres, universities and colleges, professional associations, or municipal or provincial governments. In some cases, they are offered on a centre-wide basis; in other cases, individual centre staff may be involved, usually on a voluntary basis as a form of professional development. More than half of the directors in this sample (58%) reported that their program had participated in some initiative to improve program quality or inclusion effectiveness in

the last three years. Specific activities covered a wide range with many involving staff in training on a variety of topics. No single topic or systematic approach to meeting centre/staff's needs was evident, however.

RESOURCES AND SUPPORTS FOR INCLUSION

Our own research (Irwin, Lero & Brophy, 2004) and other studies (Frankel, 2006; Frankel, Gold & Ajodhia-Andrews, 2010; Underwood, Valeo & Wood, 2012) confirm that centres' access to a variety of community resources, including early intervention programs, speech and language therapists, agencies and organizations that provide assessment, therapy and parent support, and government or community-organized services that support inclusion in child care programs is important in many ways.

Such individuals and organizations can provide ECE programs and staff with important information, specialized resources, and guidance and emotional support. Ideally, they collaborate with early childhood educators as partners in promoting children's development, supporting individual children while contributing to staff's skills and confidence. These more specialized community-based resources, when available, complement the additional financial resources provided by provincial governments, when available, to hire an inclusion coordinator or additional early childhood educator to reduce child: adult ratios.

We asked centre directors to tell us, "What supports or resources in your community are helping you to provide inclusive care?" The responses revealed two things: (1) centres differ in terms of their access to resources, and (2) the range of resources identified by centre directors is quite varied. Before presenting directors' responses, we remind readers of several factors:

Figure 4: Number of Community Resources and Supports Available to Support Inclusion as Reported by Centre Directors

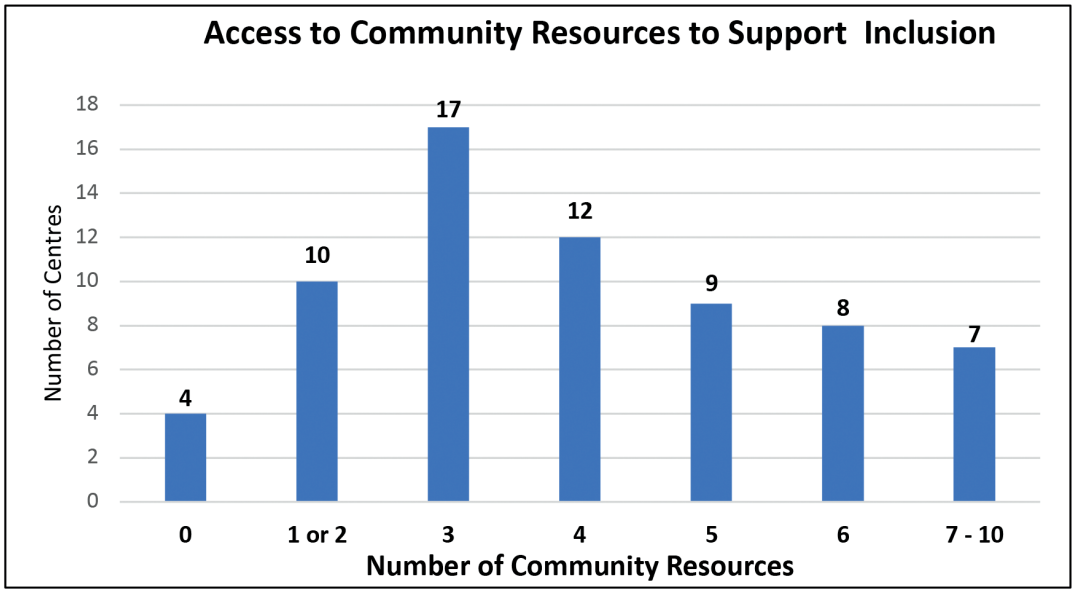


Table 7: Most Common Sources of Community Support to Child Care Centres

Community Resources that Support Child Care Centres' Inclusion Efforts	Number of Centres	Percent
Inclusion Support Services, Resource Consultant	45	67%
Speech and Language Therapists	33	49%
Physiotherapist / Occupational Therapist	21	31%
Autism Support	21	31%
Behavioural Consultant	20	30%
Public Health / Hospital	14	21%
Early Intervention	13	19%
College or University / ECE Training	7	10%
School Board	6	9%
Other (a wide variety of specific workshops or unique sources of support)	41	61%

* Directors frequently named more than one source.

- Directors' responses reflect their current access. Typically, centres that include fewer children with special needs and children whose needs are fairly easy to meet are less likely to have direct contact with specialists or organizations that provide service or support to children with more specialized or challenging conditions;

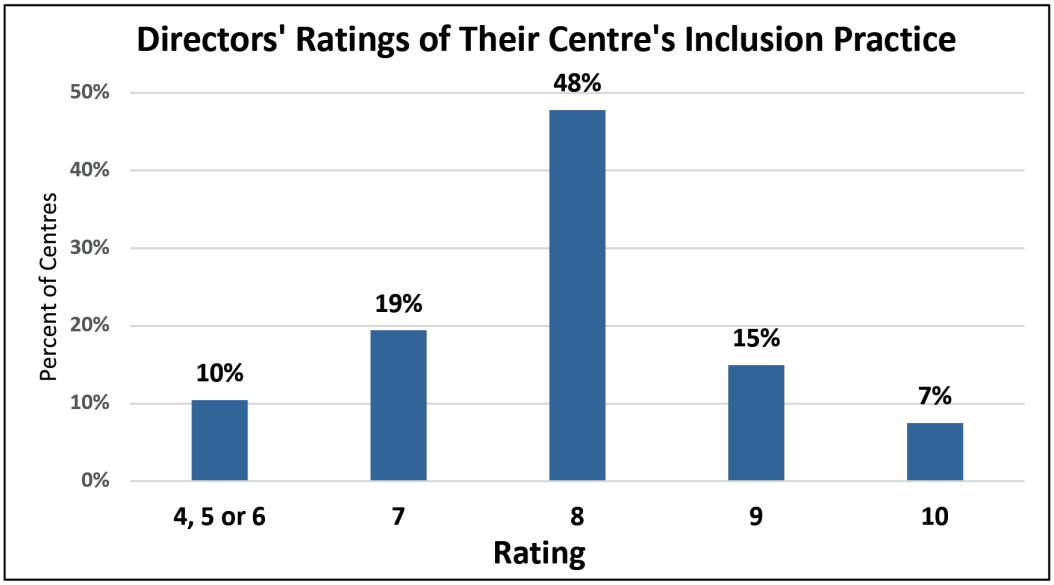
- The geographic location in which centres are located should be considered. Centres in large urban areas can be expected to have a wider range of resources potentially available to them.

- Readers should be reminded that centres in three of the six regions from which centres were drawn were recruited with the assistance of agencies that provide inclusion supports to child care programs. Given that fact, we recognize sample biases that tend toward having centres in our sample that are likely to have ongoing access to inclusion supports.

Resource-rich and resource-poor centres

Directors' responses ranged from 0 to 10 specific resources that were available to support inclusion in their programs, with an average of 3.9 and a median of 4. More than one in five directors (21%) identified two or fewer resources, including four directors (6%) who said they had no access to community resources or supports. The most common response was 3 resources (25%) with another 30% of directors identifying 4 or 5 agencies, specialists or organizations that provided support. Slightly more than one quarter of the centres in this sample could be described as relatively resource-rich with access to more than 5 community resources (see Figure 4, page 49).

Figure 5: Directors' Ratings of Their Centre's Inclusion Practice



Most common sources of community support to child care centres

Directors identified a wide variety of specific sources of support for inclusion within their communities. Some named specific agencies or types of therapists; others listed specific workshops that had been provided by an agency or organization for ECE staff. The most common responses are shown in Table 7.

It is instructive to note the importance of inclusion support services and resource consultants as sources of support for centres in this sample. To some extent this reflects the sampling strategy that was employed in this study.

DIRECTORS' PERCEPTIONS OF INCLUSION QUALITY

While scores on the *SpeciaLink Early Childhood Inclusion Quality Scale* provide an objective measure of inclusion quality, it is also important to understand how directors perceive their centre's practices and what they see as their centre's strengths and challenges. For that purpose, we asked directors to describe how well they feel their centre and staff are currently doing in providing inclusive child care in their community. Directors were asked to use a scale from 1 to 10, where " 1 would indicate that you are not doing at all well, and 10 suggests ideal, or close to your ideal, of inclusive practice."

Directors' ratings ranged from 4 to 10, with almost half rating themselves an "8". The average rating of the centre's inclusion practice by directors was 7.8 with a standard deviation of 1.181. There was no statistical difference between ratings provided by directors from the five provinces. Average ratings across the provinces ranged from 7.5 to 8.4.

- 7 directors (10%) rated themselves as 4, 5 or 6,

- 13 (19%) rated themselves as 7, including two who gave themselves a rating of 7.5,
- 32 (48%) rated themselves as 8, (including one who rated her centre as 8.5), and
- 15 directors (22%) rated themselves as doing very well at 9 or 10 out of 10.

Directors' Perceptions of Strengths and Challenges

Directors were asked to describe what they feel are the strengths of their program in providing care and education for children with special needs and what they perceive to be challenges or difficulties they are currently experiencing or aspects they would like to change. Both were open-ended questions and many directors identified more than one strength or challenge.

Perceived strengths

Directors were able to provide up to four answers to this question. Almost half of the directors provided two or fewer responses, includ-

Table 8: Centre Strengths That Contribute to Inclusive Practice as Described by Directors

Inclusion Strengths	Number of Centres	Percent
ECEs' Characteristics and Competencies *	**55**	**61%**
Staff committed to inclusion, open, seeking new ways to be effective	28	42%
Staff knowledgeable, staff training; Staff includes an inclusion coordinator, someone with special training	24	36%
Staff work well with agencies, professionals	18	27%
Staff work well together, effective team, do strategic planning	15	22%
Staff experienced, long-term staff, experienced with inclusion	8	12%
Staff supportive of parents	3	5%
Director involved, mentoring staff to support inclusion	2	3%
The Centre's Philosophy, Inclusive Culture	**26**	**39%**
Resources Provided to Support Inclusion *	**13**	**19%**
Access to therapies, services	7	10%
Extra staff, enhanced ratio, funding for extra staff	5	8%
Resources and materials, equipment	5	8%
Supportive Parents, Effective Partnership and Communication	**11**	**16%**

* Number and percentage of centres where directors identified one or more of the strengths below. Based on 160 responses provided by 64 centre directors.

ing three directors who could not identify any strengths at this time. Just over half of directors were able to identify three or four specific factors that were contributing to their success. What is most striking is that the vast majority of responses focused on two major categories that reflect resources within the centre: ECEs' attitudes, knowledge, experience, and commitment to inclusion (61% of all responses) and the centre's philosophy and inclusion culture (21%). A smaller number of responses referred to resources provided to centres in the form of access to therapies and services, extra funding for additional staff, and access to specialized materials and equipment (11%). The number and percentage of centre directors who identified each strength or provided one or more responses that fit a major category are presented in Table 8.

Directors stated:

- *Staff are always willing to learn new things and try new strategies suggested by professionals; good communication between parents/staff/management.*

- *Inclusion coordinator is extremely knowledgeable — does research, supports both teacher and children; good mentor for less experienced staff.*

- *Being warm and welcoming; Recognizing our strengths, knowledge, and having an open-minded staff.*

- *Staff are willing to help and have access to supports and services in the community; Centre wants all families and children to have a positive experience; Educators are open-minded and feel every child deserves to get the help they need.*

- *Professional development offered to support staff/team. HR supports monthly meetings and as needed with staff, supports and parents — open communication; funding available to support development.*

- *Good family relationships and positive exchanges. Consistent collaboration with families and specialists to develop goals together and provide resources.*

Perceived challenges and difficulties

Sixty-four centre directors provided 123 responses when asked what challenges or difficulties they are currently experiencing or what aspects they would like to change. While 22 directors identified only one difficulty and three directors said they were not experiencing any challenges currently, the majority of directors (63%) described two or three specific challenges they were experiencing. Three main categories of challenges emerged, and, as was the case when discussing centre strengths, the most prevalent concerns identified by directors related to ECE staff capabilities (44% of responses). Directors expressed concerns about educators' knowledge and training as well as broader staffing issues such as finding qualified staff, a shortage of relief staff, and staff turnover. A second major category of responses related to

Table 9: Challenges / Difficulties That Affect Inclusive Practice as Described by Directors

Inclusion Challenges	Number of Centres	Percent
Staff Capabilities	**53**	**79%**
Need for more training for staff; supports for ongoing professional development	23	34%
Staffing issues – finding qualified staff, shortage of relief staff, staff turnover	17	25%
More time needed for staff to plan, work as a team, collaborate with parents and professionals	9	13%
Staff need emotional support; challenging work	5	7%
Lack of Funding to Support Inclusion	**35**	**52%**
Funding needed for more staff to meet children's needs, enhance ratio, Provide 1:1 support if needed; Funding to allow children to attend full time	26	39%
Lack of funding and support leading to children being turned away; Lack of inclusion capacity to accommodate all children; lack of other centres accepting children with special needs	5	7%

insufficient funding to support inclusion (29% of responses), followed by a lack of specialists and resources (12%), including long wait lists for support, services and assessment. Two additional categories that emerged related to difficulties communicating with parents or lack of support for parents (8% of responses) and limited or inaccessible space in the centre or its playground (7% of responses).

Directors described these difficulties as follows:

- *Funding, finding qualified staff / enough staff*
- *Finding trained staff who are motivated to work — or at the very least, a child care assistant who is willing to perfect herself and get further training. It is difficult for untrained staff to put into place or practice everything therapists recommend as they are lacking global ECE knowledge.*
- *New staff, on-boarding. School-age staff need more training to meet children's needs and have a stronger understanding of child development.*
- *Incredibly long wait times for assessments and resources. Lack of funding for resources — both human and others. Lack of completely accessible playground. Not enough staff with training specific to special needs and inclusion.*
- *Lack of available supports. Educators struggled to meet the needs of all children.*
- *Hours provided and funding needs to be covered for whole of attendance; children not fully supported throughout the day. Inclusion Support Grant is at a low wage rate. Staff need more training in areas of children's needs so all staff can work together. More resources needed for centre and staff.*

- *Funding for children to attend 5 days/week with support; limited funding for staffing support; staff turnover due to lack of funding.*

- *Insufficient amount and lack of consistency in Autism Integration Services; difficulties coordinating, planning and sharing roles and expertise.*

Table 9 illustrates the prevalence with which directors named specific challenges to inclusion success.

We found the directors' comments in this section spoke volumes about the factors that support effective inclusion, as well as those that present challenges and difficulties. Many of the comments bundle together aspects related to staff, teamwork, funding, collaboration with professionals, and relationships with parents. Interestingly, while some centres were doing well with few difficulties and some were struggling, most centre directors described both centre strengths and challenges they were dealing with.

We also note that individual centres function in a wider context defined by provincial policies and local resources. Some centres clearly benefit from being in communities that have well-developed systems for supporting inclusion in child care programs and sufficient resources to support timely assessments and ongoing collaboration with early childhood educators. Other centres have fewer resources to draw on and are even more reliant on having knowledgeable, experienced early childhood educators on staff who are committed to inclusion, and/or additional funding to hire an inclusion coordinator or extra staff to enhance staff: child ratios.

An additional important contextual factor relates to changes in child care policies and services that add to the challenges centres may experience finding and maintaining qualified ECEs. Centre directors in British Columbia were experiencing planned growth in the number of centres at the time of our study and/or were participating in the province's pilot project. Directors and others we consulted in Nova Scotia, which was in the process of opening full-day, free pre-primary classes in the schools were coping with the loss of 4 and 5-year old children from their centres as well as the difficulty of attracting/retaining staff as new, better-paying opportunities in the ELCC field with more attractive hours and benefits became available.

6. Program Quality and Inclusion Quality Profiles

PROGRAM QUALITY

Average Program Quality Scores

The average *ECERS-R* quality score for this sample of centres was 4.93. Scores ranged from 3.2 to 6.7 out of 7. According to Harms, Clifford, & Cryer (1998), quality scores below 3.0 indicate inadequate or poor quality, scores of 3.0 to 4.99 indicate overall quality that is minimal to mediocre, and scores above 5.0 indicate good quality, with scores closer to 7 reflecting excellent quality. Based on those criteria, none of the centres in this sample had global quality scores that indicate poor program quality; the majority - 36 centres (54%) had scores in the minimal to mediocre range, and 31 centres (46%) had scores in the good to excellent range, including eight centres (12%) with an average *ECERS-R* score above 6.0. (See Figure 6).

Figure 6: Distribution of Centres in Quality Categories Based on Average *ECERS-R* Scores

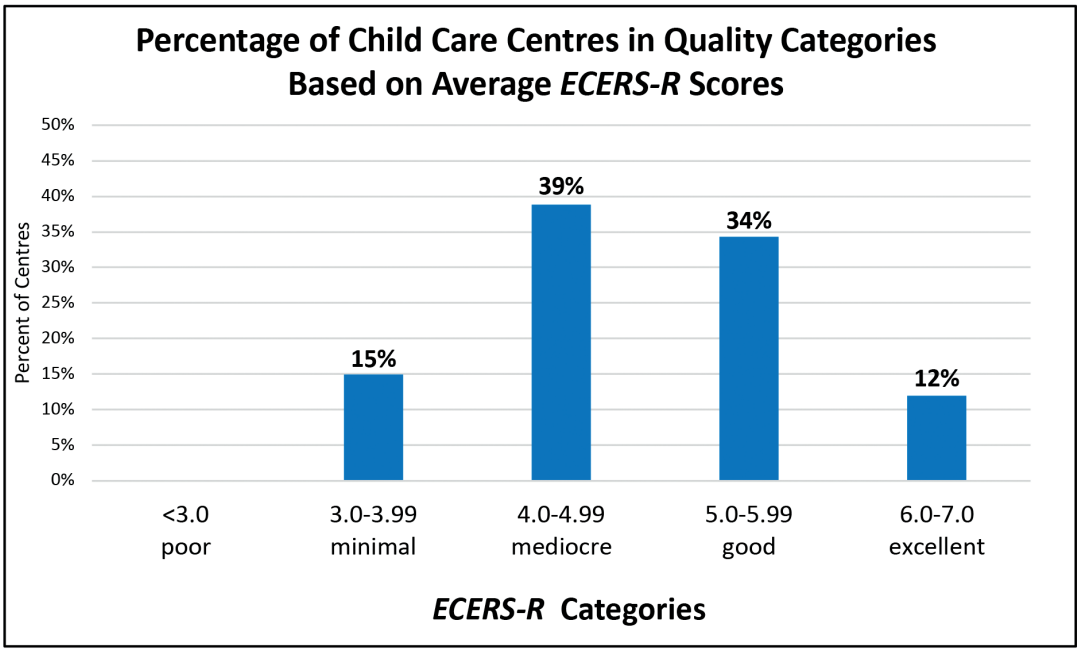


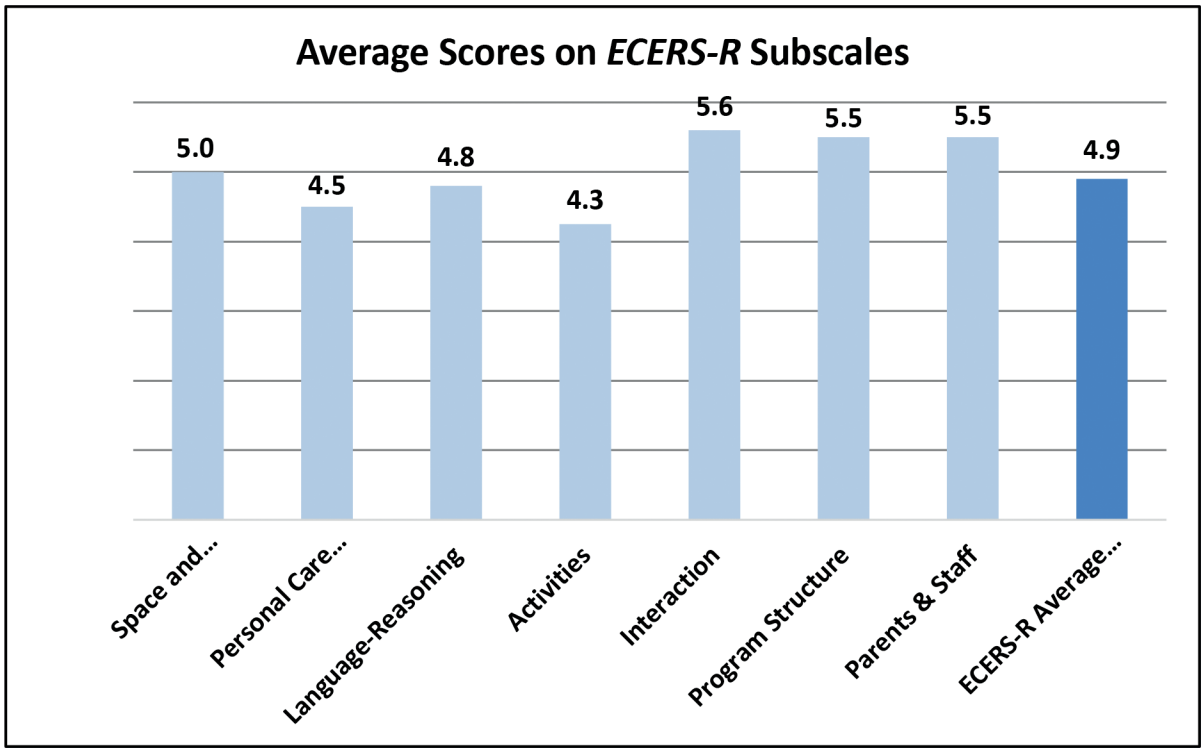
Table 10: Scores on *ECERS-R* Subscales

Subscale	Average	Median	St dev.	Range
Space and Furnishings	5.04	5.00	0.937	2.2 – 6.9
Personal Care Routines	4.51	4.67	1.459	1.7 – 7.0
Language-Reasoning	4.77	4.75	1.345	1.5 – 7.0
Learning Activities	4.25	4.33	1.218	1.3 – 6.8
Staff-Child Interaction	5.57	5.80	1.246	2.6 – 7.0
Program Structure	5.49	5.50	1.117	3.0 – 7.0
Parents & Staff	5.46	5.50	0.778	3.3 – 7.0
***ECERS-R* Average Score**	4.93	4.93	0.857	3.2 – 6.7

Subscale Scores

Average scores on the seven subscales that comprise the full *ECERS-R* are shown in Table 10 and Figure 7 and ranged from a low of 4.3 on Learning Activities to 5.6 on the Staff-Child Interaction subscale. This pattern is consistent with other studies that have collected *ECERS-R* data in the Canadian context (Goelman, Doherty, Lero, LaGrange & Tougas, 2000; Irwin, Lero & Brophy, 2004; Lero & Irwin, 2008), and suggests that while many centres have staff who engage in sensitive and caring

Figure 7: Average Scores on *ECERS-R* Subscales



teacher-child interactions, observers note a limited range of activities and curriculum materials in some centres with missed opportunities to extend learning through both unstructured play and planned activities. Of concern is the number of preschool classrooms in which one or more subscale scores is below 3.0, indicating observations of poor quality on these dimensions. Scores below 3.0 were given to one centre for Space and Furnishings, 13 centres for Personal Care Routines, 5 centres for Language-Reasoning, 10 centres for Learning Activities, and one centre for Staff-Child Interactions. Scores on Staff-Child Interactions, Program Structure, and the Parents & Staff subscales were noticeably higher, with average scores in the good to excellent range obtained for two thirds or more of the centre classrooms observed in this study.

PROVINCIAL DIFFERENCES

A comparison of average *ECERS-R* scores across the five provinces revealed statistically significant differences. Average quality scores ranged from 4.55 in Manitoba to 5.38 in Ontario (see Table 11). More telling is a comparison of how centre scores were distributed across the major quality categories. Figure 8 on page 60 illustrates that the proportion of centres with scores of 5.0 or above (good to excellent) was considerably higher in BC and Ontario, and that the distribution of centres in quality categories was quite different among the provinces.

A PROFILE OF INCLUSION QUALITY

The *SpeciaLink Early Childhood Inclusion Quality Scale* (*Specialink Scale*, Irwin 2013) is a valuable tool for assessing inclusion quality in early childhood centres. It was developed to provide a picture of each centre's current effectiveness in providing a welcoming environment that addresses children's individual needs and recognizes the right of all children to participate equally in high quality programs that promote equity as well as children's development. Scores on two subscales and an overall score can be used to benchmark inclusion quality in individual centres, in communities, and across Canada. Information provided to centres and to policy makers provide an opportunity to identify areas for improvement.

Table 11: Average *ECERS-R* Scores by Province

Province	Average	Median	St. dev.	Minimum	Maximum
BC	5.25	5.33	5.25	3.71	6.43
MB	4.55	4.58	4.55	3.76	5.21
NB	4.65	4.76	4.65	3.16	5.95
NS	4.56	4.42	4.56	3.76	5.67
ON	5.38	5.48	5.38	3.83	6.67

Figure 8: Distribution of Centres in Quality Categories Based on Average *ECERS-R* Scores, by Province

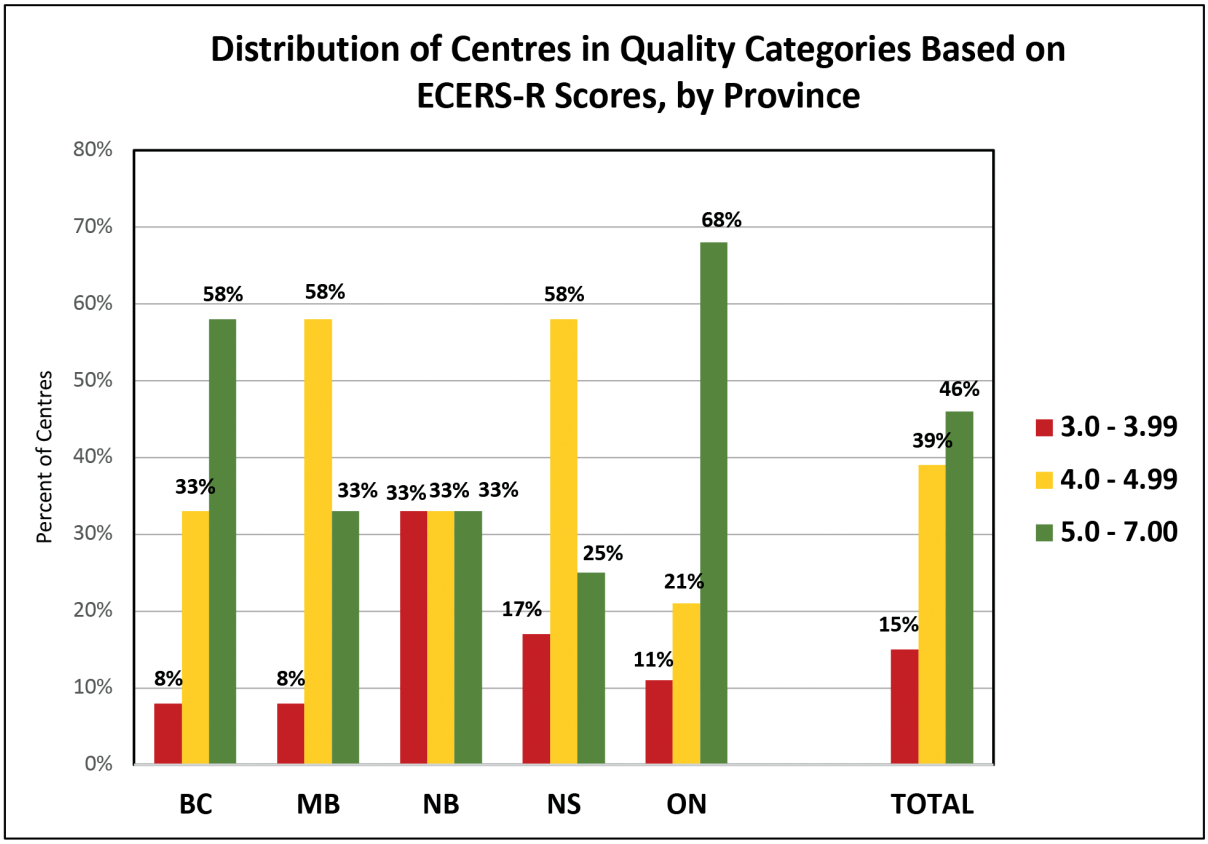
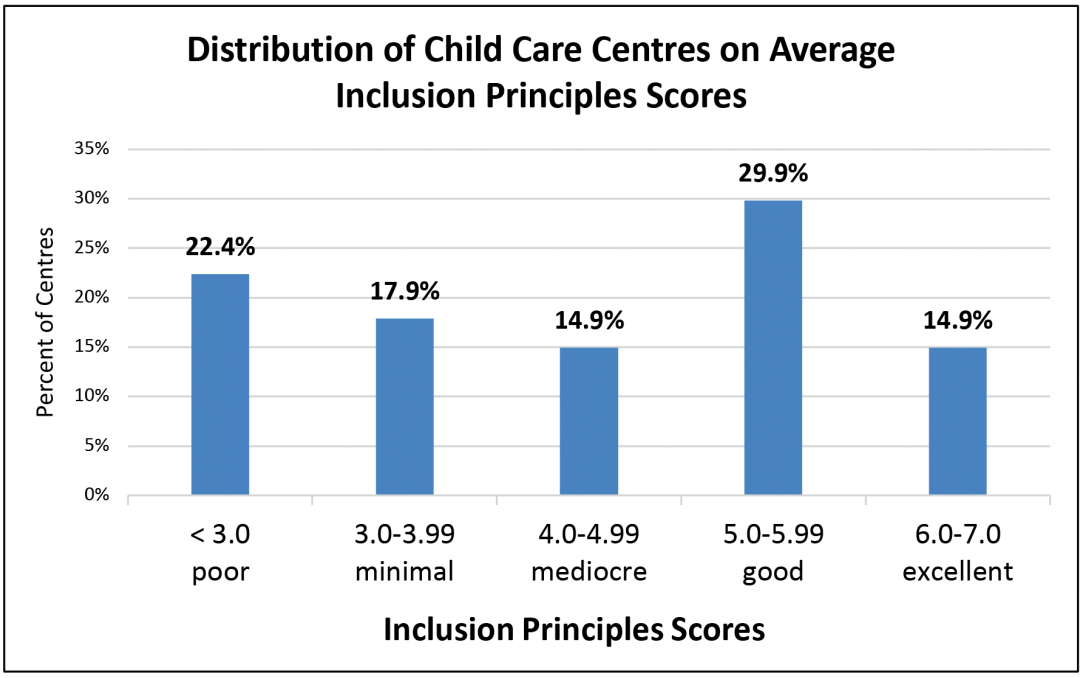


Figure 9: Distribution of Centres on Average Inclusion Principles Scores



In this section, we first provide information about scores obtained on the Inclusion Principles subscale, then Inclusion Practices, and finally overall Inclusion Quality scores.

1. Inclusion Principles

In this sample, the average Inclusion Principles score was 4.26 with centre scores that ranged from 1.2 to 6.8. The median score was 4.7. The distribution of centres into major categories based on average Inclusion Principles scores is shown in Figure 9. Of the 67 centres, 15 (22%) had average Inclusion Principles scores below 3.0, indicating limited experience, ad hoc processes that can restrict children's access and degree of participation in the program, and limited proactive leadership on the part of the director. On a more positive note, 30 centres (45%) had average scores of 5.0 or higher, including six centres with average Inclusion Principles scores of 6.0 or above, indicative of excellence on this aspect of inclusion quality.

Inclusion Principles Item Scores

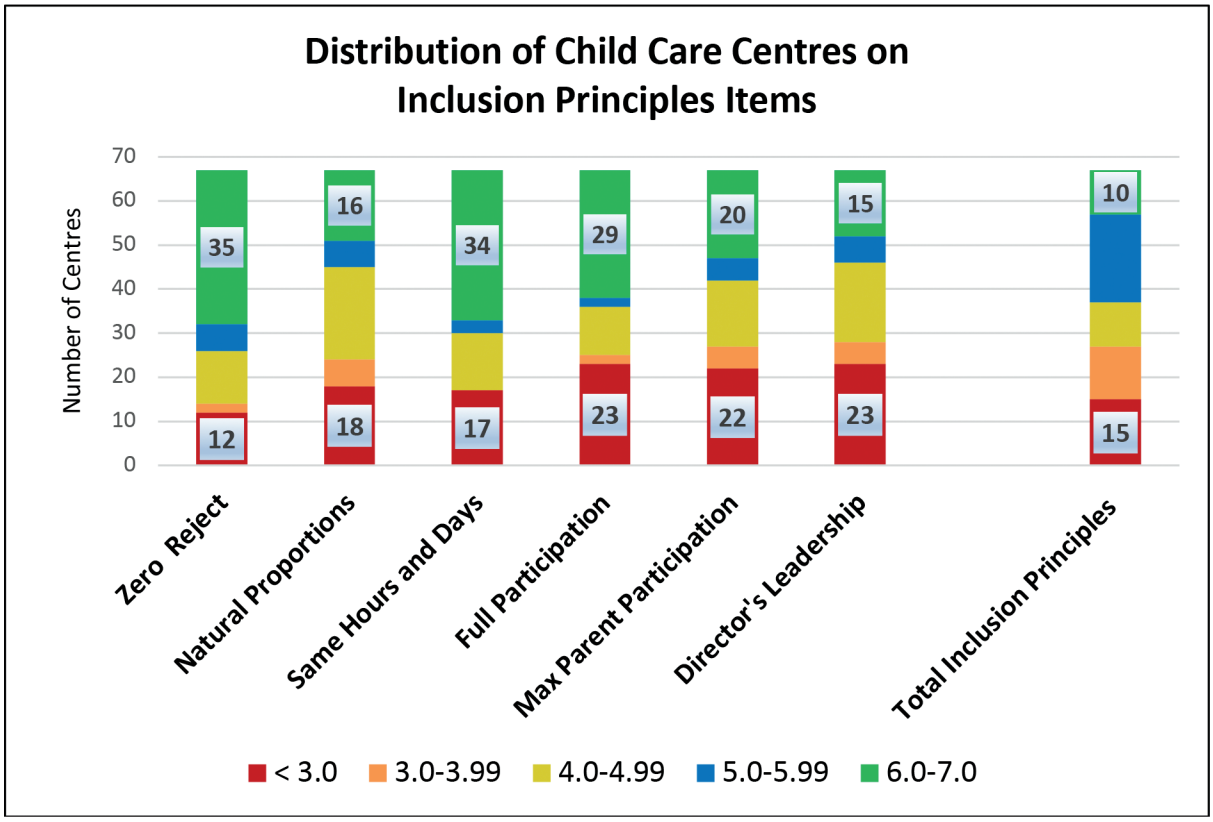
Table 12 provides the average scores obtained for each of the six Principles items. Scores ranged from 3.6 for the Director's Role as an Inclusion Leader to 5.1 for the Principle of Zero Reject — no a priori exclusion of children with certain levels or types of disabilities. Scores on each item covered the full range from 1 inadequate to 7 excellent.

Of concern is the number of centres with item scores below 3.0, indicating a lack of commitment to these inclusion principles and/or a failure on the part of the centre to have a written or verbal policy on inclusion that confirms these values for parents, staff, and the community. Scores below 3.0 were given to a substantial number of centres for the principles of Full Participation, Maximum Parent Participation, and Director's Leadership and Advocacy (see Figure 10, page 62). A low score on Director's Leadership and Advocacy is particularly concerning,

Table 12: Scores on Inclusion Principles Items

Inclusion Principles Items	Average	Median	St dev.	Range
Zero Reject	5.1	6.0	1.95	1 – 7
Natural Proportions	4.0	4.0	1.76	1 – 7
Same Hours and Days	4.8	6.0	2.05	1 – 7
Full Participation	4.3	4.0	2.34	1 – 7
Maximum Parent Participation	3.8	4.0	2.01	1 – 7
Director's Leadership, Advocacy	3.6	4.0	1.90	1 – 7
Average Principles Score	**4.26**	**4.67**	**1.61**	**1.2 – 6.8**

Figure 10: Distribution of Centres on Individual Inclusion Principles Items



since our previous research has shown that a director's commitment to inclusion and her leadership as an inclusion advocate is critical for creating and maintaining the commitment and effective functioning of centre staff and for marshalling community resources to support inclusion (Irwin, Lero & Brophy, 2000; Irwin, Lero & Brophy, 2004). Figure 10 also shows, however, that there are substantial numbers of centres in our sample that had scores of 6.0 or higher on each item, indicating excellence and a strong commitment to full inclusion.

Provincial Differences in Inclusion Principles Scores

Average Inclusion Principles scores were similar across most provinces, ranging from 4.2 to 5.1. An exception is Nova Scotia where the average

Table 13: Average Inclusion Principles Scores by Province

Province	Average	Median	St. dev.	Minimum	Maximum
BC	4.81	4.83	1.07	3.33	6.83
MB	4.67	5.17	1.47	2.00	6.33
NB	5.11	5.50	0.89	3.67	6.33
NS	2.50	1.75	1.55	1.17	6.00
ON	4.22	4.00	1.61	1.67	6.83

Inclusion Principles score was 2.5 and 75% of the centres had average scores below 3.0, a finding that provokes concern and the need to understand what is impeding progress in the province.

2. Inclusion Practices

The average Inclusion Practices score was 3.79. Scores ranged from a low of 1.1 to 6.3, with a median score of 4.0. The distribution of Inclusion Practices scores in major categories is shown in Figure 11.

Similar to Principles scores, Practices scores clustered most often in the moderate/mediocre range of 4.0-4.99. More than one fifth of centre classrooms (22%) had an average Inclusion Practices score below 3.0, indicating that there were few resources and practices used to support the development and inclusion of the children with special needs who were present. Only 12% of the centres (one in eight) displayed good to excellent Inclusion Practices scores.

Practices Item Scores

Average scores on each of the 11 items comprising the Inclusion Practices subscale are shown in Table 14 on page 64. Two items had average scores across the whole sample of less than 3.0. Practice 10 — Board of Directors had an average score of 2.7. Many centres either do not have a board or parent advisory committee that can promote inclusion policy and support the director and staff or have a committee that has failed to act toward this goal. Practice 2 — Equipment and Materials had an average score just below 3.0, a score that indicates no or very limited specialized or adapted special equipment available for children with special needs.

Figure 11: Distribution of Inclusion Practices Scores

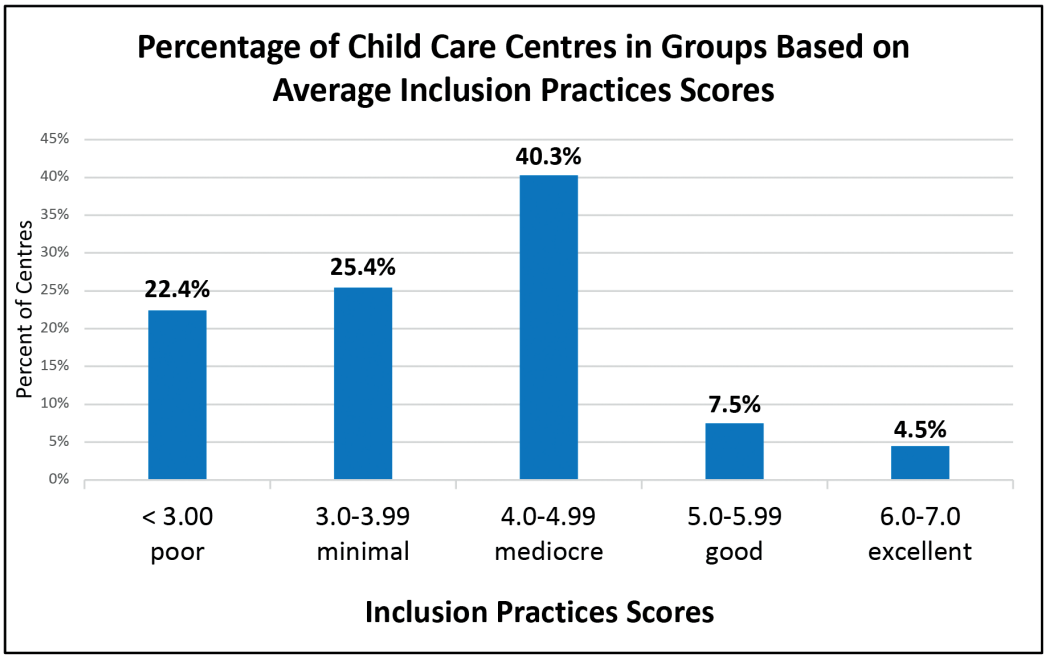


Table 14: Average Scores on Items from the *Specialink Early Childhood Inclusion Practices Subscale*

Practices Items	Average	Median	St dev.	Range
1. Physical Environment	3.3	4.0	1.97	1 – 7
2. Equipment & Materials	3.0	3.0	1.63	1 – 7
3. Director and Inclusion	3.5	4.0	1.84	1 – 7
4. Staff Support	4.1	4.0	2.04	1 – 7
5. Staff Training	3.4	3.0	2.04	1 – 7
6. Therapies	4.9	6.0	2.22	1 – 7
7. Individual Program Plans	4.4	5.0	2.05	1 – 7
8. Parents of Children with Special Needs	3.6	4.0	2.28	1 – 7
9. Involvement of Typical Children	4.3	4.0	2.20	1 – 7
10. Board of Directors and Other Similar Units	2.7	3.0	1.77	1 – 7
11. Preparing for the Transition to School	4.4	5.0	2.29	1 – 7
Average Practices Score	**3.79**	**4.0**	**1.14**	**1.1 – 6.3**

Average scores on four other Inclusion Practices items ranged from 3.3 to 3.6, signifying substantial room for improvement. Among them was the item on Staff Training. An average score of 3.4 on this item indicates that, in these inclusive centres, either early childhood educators or directors or both have limited training and/or involvement in professional development activities specific to inclusion. Similarly, an average score of 3.5 on Practices item 3 — Director and Inclusion reflects circumstances where directors provide some support to staff, board members or parents, but are not active, strong advocates for inclusion in their program or their community. The remaining five Inclusion Practices items had average scores that ranged from 4.1 to 4.9.

It is notable that none of the Inclusion Practices items had an average score of 5.0 or above, indicative of good inclusion practice.

Table 15: Average Inclusion Practices Scores by Province

Province	Average	Median	St. dev.	Minimum	Maximum
BC	4.72	4.43	0.77	4.00	6.27
MB	4.12	4.45	0.87	2.45	4.91
NB	3.67	3.59	0.66	2.91	5.18
NS	2.49	2.05	1.25	1.09	5.00
ON	3.89	3.82	0.98	2.45	6.18

Provincial Differences in Inclusion Practices Scores

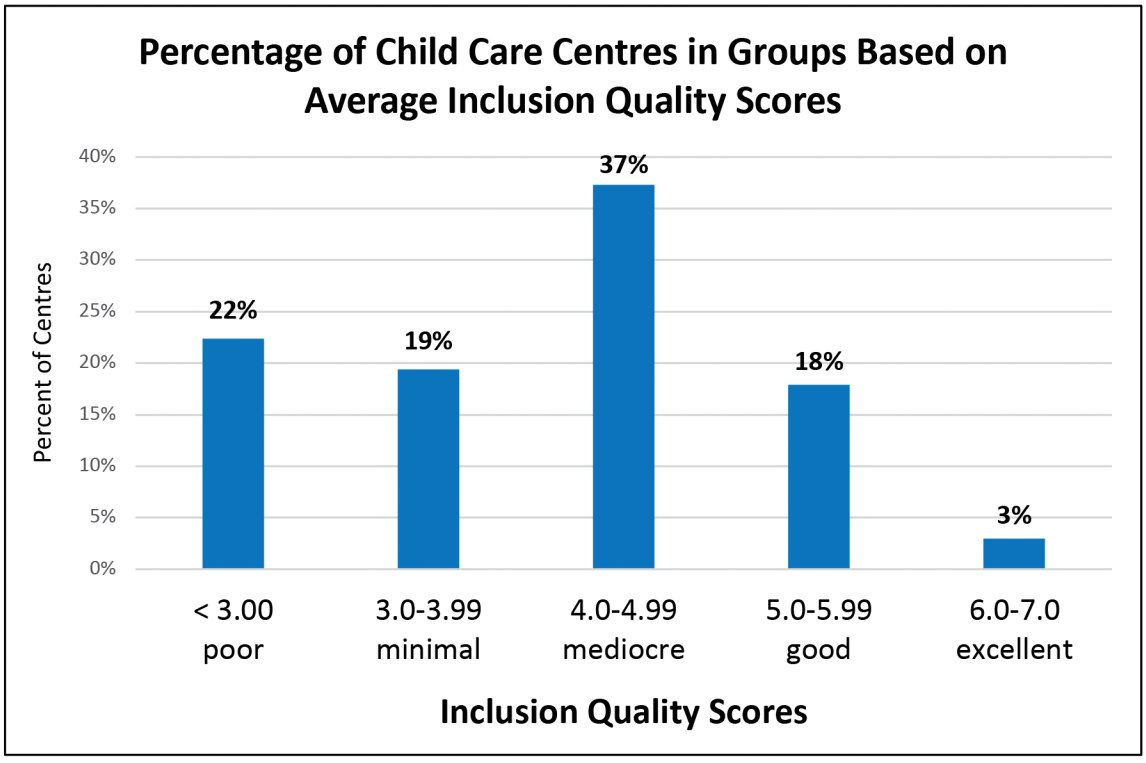
Average Inclusion Practices scores ranged from a low of 2.5 for centres in Nova Scotia to 4.7 for centres in British Columbia (see Table 15). The difference between provincial average scores was statistically significant with the biggest difference between Nova Scotia and the other provinces, as was the case for scores on the Inclusion Principles Subscale.

3. Inclusion Quality Scores

Total scores on the *SpeciaLink Early Childhood Inclusion Quality Scale* are based on all 17 items that comprise the Principles and Practices subscales. The total score weights each item the same, hence the distribution of average Inclusion Quality scores more closely resembles the distribution of scores obtained on the Inclusion Practices subscale.

For this sample the average score on the *SpeciaLink Inclusion Scale* was 3.96 with a median of 4.1 and a standard deviation of 1.24. Total scores ranged from 1.24 to 6.47, covering the full range. The distribution of Inclusion Quality scores is shown in Figure 12. Fifteen centres (22%) had average Inclusion Quality scores below 3.0, indicative of poor quality in inclusion principles and practices. Fourteen centres (21%) had scores above 5.0, indicating good to excellent inclusion quality. The majority (38 centres or 57%) had inclusion quality scores in the minimal to mediocre range of 3.0-4.99.

Figure 12: Distribution of Centres on Total *SpeciaLink Inclusion Quality Scale* Scores



Comparisons across provinces were similar to those noted previously for the Inclusion Principles and Practices subscales. Average *SpeciaLink Inclusion Quality Scale* scores ranged from 2.50 to 4.75. The average score was significantly lower for Nova Scotia centres than for centres in the other provinces. Table 16 provides information on average scores on the Inclusion Quality Scale for each province and Figure 13 illustrates the distribution across categories of Inclusion Quality for the provinces and the total sample.

A COMMENT ABOUT NOVA SCOTIA INCLUSION QUALITY SCORES

The unusually low scores on the *SpeciaLink Inclusion Quality Scale* among many of the Nova Scotia child care centres that participated in this study is both troubling and puzzling. Our previous involvement in training early childhood educators and in inclusion initiatives in the province (such as Partnerships for Inclusion, 2008) and the fact that almost all of the centres in Nova Scotia had a long history of including children with special needs notwithstanding, the findings beg for an explanation. We know that there were no differences among the provinces in the amount of training and experience observers had administering the Inclusion Quality scale and that all observers achieved high levels of inter-rater reliability. There was also nothing unique about the sampling and recruitment procedures used in Nova Scotia compared to other provinces and, in fact, scores on the *ECERS* measure of program quality in Nova Scotia centres were comparable to the scores obtained in the other provinces.

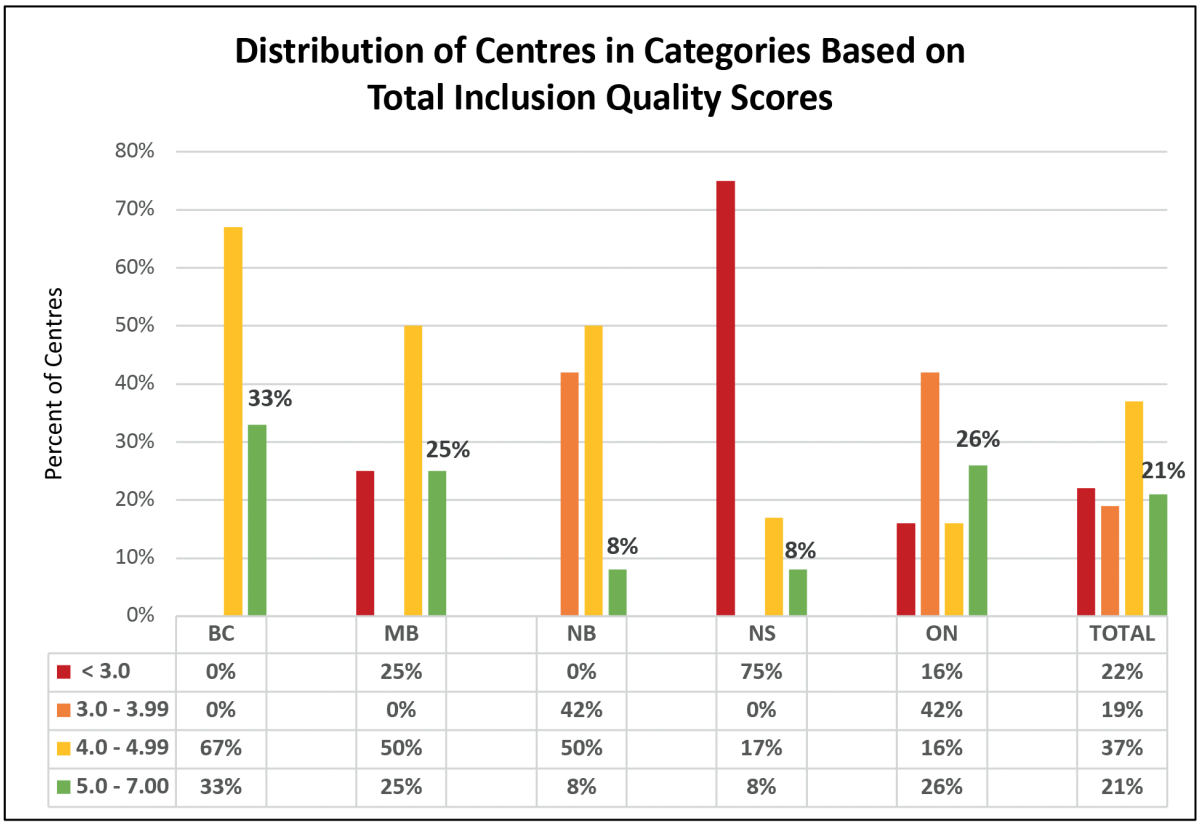
To provide further insight into what might account for such low scores on the Inclusion measure we discussed these results with three Nova Scotia consultants familiar with the *SpeciaLink Inclusion Quality Scale* and with inclusion in general (one in government, one a private consultant, one a regional coordinator for the pre-primary program who had been an inclusion consultant). We also interviewed two additional current child care consultants to get their perspectives.

Based on their input, we suggest one important factor that may partially account for the findings is the fact that, at the time data were collected, Nova Scotia was still in the midst of a profound system change in child care as a result of the province-wide rollout of universal pre-primary education.

Table 16: Average *SpeciaLink Inclusion Quality* Scores, by Province

Province	Average	Median	St. dev.	Minimum	Maximum
BC	4.75	4.35	0.82	4.00	6.47
MB	4.31	4.71	1.05	2.41	5.35
NB	4.18	4.12	0.61	3.29	5.47
NS	2.50	1.88	1.29	1.24	5.35
ON	4.01	3.88	1.16	2.18	6.41

Figure 13: Distribution of Centres in Quality Categories based on Average Inclusion Quality Scores, by Province



	BC	MB	NB	NS	ON	TOTAL
< 3.0	0%	25%	0%	75%	16%	22%
3.0 - 3.99	0%	0%	42%	0%	42%	19%
4.0 - 4.99	67%	50%	50%	17%	16%	37%
5.0 - 7.00	33%	25%	8%	8%	26%	21%

Begun in 2017, this initiative has enabled most 4-year olds in Nova Scotia to participate in free pre-primary education in their local school with qualified early childhood educators recruited for that purpose. As beneficial as this initiative may be, we know that this kind of transformative change has profound, destabilizing impacts on the child care sector. The effects on child care programs typically include reduced revenues, challenges in orienting to a younger age range of children, and difficulty retaining trained, experienced ECEs who are drawn to work in the schools where salaries, benefits, and working conditions are often more attractive. News reports of staff shortages in the child care sector and difficulties replacing qualified ECEs attest to this reality, often resulting in centres having to replace experienced ECEs with staff who have less education and experience.

Given the importance of knowledgeable, experienced ECEs working together as a team for effective inclusion, disruptions to such teams can take a heavy toll on centres' capacities to include children with special needs effectively. In addition, there is likely to be greater competition with the schools for the involvement of early interventionists and other professionals whose services are required to support inclusion in both settings.

While further research is needed to confirm our hypothesis, it is worth noting that Nova Scotia directors, like those in other provinces, com-

mented on the importance of having ECEs who are trained specifically on inclusion issues, as well as on the importance of funding and timely access to professional resources to support inclusion.

Two comments from directors in Nova Scotia who described the challenges they were experiencing are illustrative.

- *Lack of educators, understaffed, dealing with more aggressive behaviors… We are stretched too thin.*

- *Funding, staffing, and staff training…We are overwhelmed by all the initiatives by government.*

WHAT DISTINGUISHES CENTRES WITH HIGH INCLUSION QUALITY SCORES?

One of the objectives of this study was to profile those centres with High Inclusion Quality scores to determine what might distinguish those centres/classrooms from others. To do so, we identified those centres with scores on the *SpeciaLink Inclusion Quality Scale* of 5.0 or higher — a subgroup of 14 centres in this sample. Comparisons were made between this top (High Inclusion Quality) group and those with Low Inclusion Quality scores (15 centres with scores below 3.0).

To be precise, it should be noted that because all of the High Inclusion Quality centres also had relatively high scores on the *ECERS-R*, our comparison of centres in the top and bottom inclusion quality groups actually compares a group of centres demonstrating both high program quality and high inclusion quality (an ideal) to a group that had low scores on inclusion quality and was quite variable with respect to program quality.

While there were some differences between the groups in centre characteristics, the most significant and meaningful factors that were associated with high inclusion quality were the number of children with special needs they enrolled and the resources available to support inclusion — both in-centre resources (director and staff training and in-house supports) and the number and variety of community resources available to support inclusion.

The differences in inclusion resources were further corroborated by differences between the two groups in how directors rated their centre's inclusion efforts and what directors described as strengths and challenges in providing the quality of inclusive care they aspire to on a daily basis.

DIFFERENCES IN INCLUSION QUALITY AND PROGRAM QUALITY

Table 17 illustrates the differences in inclusion quality and program quality between the top and bottom inclusion quality groups. T-test comparisons confirmed that the differences between the groups on overall inclusion quality and program quality scores and on the *SpeciaLink Inclusion* Principles and Inclusion Practices subscales were all highly statistically significant.

Table 17: Differences in Inclusion Quality and Program Quality Between High and Low Inclusion Quality Groups

	High Inclusion Quality Centres Scores ≥ 5.0 (N = 14)	**Low Inclusion Quality Centres** Scores < 3.0 (N = 15)
SECIQS Average Score	5.52	2.13
SECIQS Range	5.1 – 6.5	1.2 – 2.9
SECIQS Average Principles Score	6.10	1.91
SECIQS Average Practices Score	5.20	2.25
ECERS-R Average Score	5.66	4.55
ECERS-R Range	4.5 – 6.7	3.8 – 6.0
Percent with *ECERS-R* ≥ 5.0	86%	27%

DIFFERENCES IN PROVINCIAL DISTRIBUTION AND CENTRE CHARACTERISTICS

The High Inclusion Quality group of 14 centres included at least one centre from each province represented in this sample; however, centres

Table 18: Differences in Centre Characteristics and Inclusion Experiences Between High and Low Inclusion Quality Groups

	High Inclusion Quality Centres Scores ≥ 5.0 (N = 14)	**Low Inclusion Quality Centres** Scores < 3.0 (N = 15)
Province		
British Columbia	4 (29%)	--
Manitoba	3 (21%)	3 (20%)
New Brunswick	1 (7%)	--
Nova Scotia	1 (7%)	3 (20%)
Ontario	5 (36%)	9 (60%)
Centre Size (Licensed capacity)	X =66	X = 80
≤ 40	5 (36%)	1 (7%)
41 – 60	2 (14%)	3 (20%)
61 - 80	2 (14%)	7 (47%)
> 80	4 (29%)	4 (27%)
N of Children with Special Needs Enrolled	X = 7	X = 3
1 – 3	4 (29%)	8 (53%)
4 – 5	2 (14%)	7 (47%)
6 – 9	5 (36%)	--
≥ 10	3 (21%)	--
Exclude Some Children with Disabilities - Yes	3 (21%)	7 (47%)

in British Columbia and Ontario were overrepresented in this top group, while centres in New Brunswick and Nova Scotia were under-represented (see Table 18). In stark contrast, no British Columbia or New Brunswick centres were in the Low Inclusion Quality group, which was comprised mostly of centres from Nova Scotia.

Several other factors characterized the High Inclusion Quality group, particularly in contrast to centres with Low Inclusion Quality scores. Four centres in the High Inclusion Quality group were half-day preschool programs; all centres in the Low Inclusion Quality group offered full-day care. A larger proportion of the High Inclusion Quality centres were licensed for fewer than 60 children compared to the Low Inclusion Quality group (50% compared to 26.7%). There were no differences between the High Inclusion Quality and Low Inclusion Quality groups in the proportions that were non-profit vs private/commercial, standalone vs affiliated with another organization or agency, or the extent to which they served primarily low-income communities.

DIFFERENCES IN INCLUSION

There were several notable differences in inclusion experiences observed when high and low inclusion quality groups were compared. Despite the fact that the High Inclusion Quality group contained more small centres, these centres enrolled more children with special needs. Ten of the 14 High Inclusion Quality centres (71%) enrolled more than five children with special needs, while no centre in the bottom group did so. More than half of the Low Inclusion Quality centres (53%) included three or fewer children with special needs. It was also noted that a larger proportion of centres in the Low Inclusion Quality group reported excluding children with special needs (47% compared to 21% in the High Inclusion Quality group), most commonly because their centre is not accessible.

Differences in Director and Staff Characteristics

While limited direct information was obtained about director and staff qualifications or experience, a combination of directors' responses to the centre questionnaire and scores on specific items in the *SpeciaLink Inclusion Scale* provided important insights. These items assess the director's role as an inclusion leader in her centre, staff training with respect to inclusion, and the extent to which the centre benefits from additional staff and consultative assistance. All contributed to a profile of High Inclusion Quality centres with more in-centre resources to support inclusion effectiveness and a picture of Low Inclusion Quality centres lacking the resources needed to provide quality inclusion.(See Figure 14.)

Directors' Experience

First, directors in the High Inclusion Quality group tended to have more experience. On average, centre directors in the High Inclusion Quality group had 12 years of experience in their position; fully half had 10 or more years experience as a centre director. In contrast, the average

centre director in the Low Inclusion Quality group had 6.6 years of experience in their role. More than half had less than five years experience, including five directors who had three years experience or less.

Directors who have more experience with inclusion have had more opportunities to learn how to support staff and parents and to support children with a broad range of disabilities/special needs. They also have had more time and opportunities to establish effective relationships with community agencies, professionals, and other centre directors who can provide advice and support.

Directors' Inclusion Leadership in the Centre

One of the items on the *Specialink Inclusion Quality Practices* subscale focuses specifically on the director's active role in promoting inclusion within the centre. Practices Item 3: Director and Inclusion — consists of indicators that reflect the director's active role in supporting staff's participation in training and professional development related to inclusion, educating board members and parents on inclusion issues and policies, and collaborating with other agencies and community groups. Directors in the High Inclusion Quality centres averaged 4.6 out of 7 on this item; five of the 14 directors in this group (35%) had scores of 5 or above and only one director had a score below 3. In contrast, the average score on this item for directors in the Low Inclusion Quality group was 2.2 and 80% of the directors had a score below 3. A score of 1 or 2 on this item reflects an inadequate level of involvement in enabling staff

Figure 14: Comparison of Director and Staff Resources in High and Low Inclusion Quality Groups

to seek additional training, engaging a board or parent advisory group to support and sustain effective inclusion efforts, and limited contact with relevant agencies.

Staff Training

Inclusion Practices Item 5 pertains to Staff Training. Item scores reflect the number of staff who have specialized training in inclusion ranging from periodic workshops to a completed certificate, the director's own participation in training/workshops, and the extent to which she/he provides opportunities and support for staff to participate in a variety of workshops, courses and conferences specific to inclusion. The contrast between centres in the two Inclusion Quality groups was striking. Ten of the 14 centres in the High Inclusion Quality group had scores of 6 or 7 (very good to excellent) on Staff Training. In contrast, 11 of the 15 centres in the Low Inclusion Quality group had a score of 1 or 2 (inadequate), indicating that few, if any, staff had any training specific to inclusion and that the director was not participating in training or encouraging staff to do so. The difference in average scores (5.2 vs 2.1 for the High and Low Inclusion Quality groups, respectively) was highly significant.

Staff Support

Inclusion Practices Item 4 focuses on the amount and nature of additional staff and consultative assistance available to centres that include children with special needs. Centres with higher scores on this item have additional staff to support inclusion, resulting in a reduced ratio of children to staff. The additional staff member in centres with high scores on this item (an in-house resource teacher or inclusion facilitator) has specialized training in inclusion and is in the centre on a full-time basis. One to one staffing may also be provided as needed and consultative assistance to staff is also available and responsive to the centre's needs. Centres with low scores on this item have little or no in-centre staff with inclusion training in addition to ratio, or perhaps have a part-time support person with some training in ECE or special needs; consultative assistance is limited and planning may not be done collaboratively with staff. The differences between High and Low Inclusion Quality centres on this item were similar to those related to staff training. Ten of the 14 centres in the High Inclusion Quality group had scores of 6 or 7; none had a score below 3. By contrast, only two centres in the Low Inclusion Quality group had scores of 5 or higher, indicating a good or very good level of staff support; more than half of the centres in the Low Inclusion Quality group (8 or 53%) had scores of 1 or 2, indicating inadequate levels of staff support. Average scores were 5.6 and 2.9, and the difference was highly significant.

Taken together, these findings underscore serious shortcomings in the in-centre human resources available to support effective inclusion in the Low Inclusion Quality group. Our research over 25 years suggests that having directors who are inclusion leaders in their centres, well-qualified staff with at least some who have specific training in

inclusion, additional staff to reduce ratios when needed, and effective collaborative assistance are essential to sustain inclusion quality.

Differences in Access to Community Resources

Community resources, including early intervention programs, speech and language therapists, and agencies and organizations that provide assessment, therapy and parent support are critical sources of support to child care programs. In addition to directly assisting ECEs in their work with individual children, these specialists and agencies provide centres and their staff with important information, specialized resources, and guidance and emotional support. When they collaborate with early childhood educators as partners in promoting children's development, they help staff develop the knowledge, skills, and confidence that sustain a centre's capacity to continue to be inclusive and even include a broader range of children.

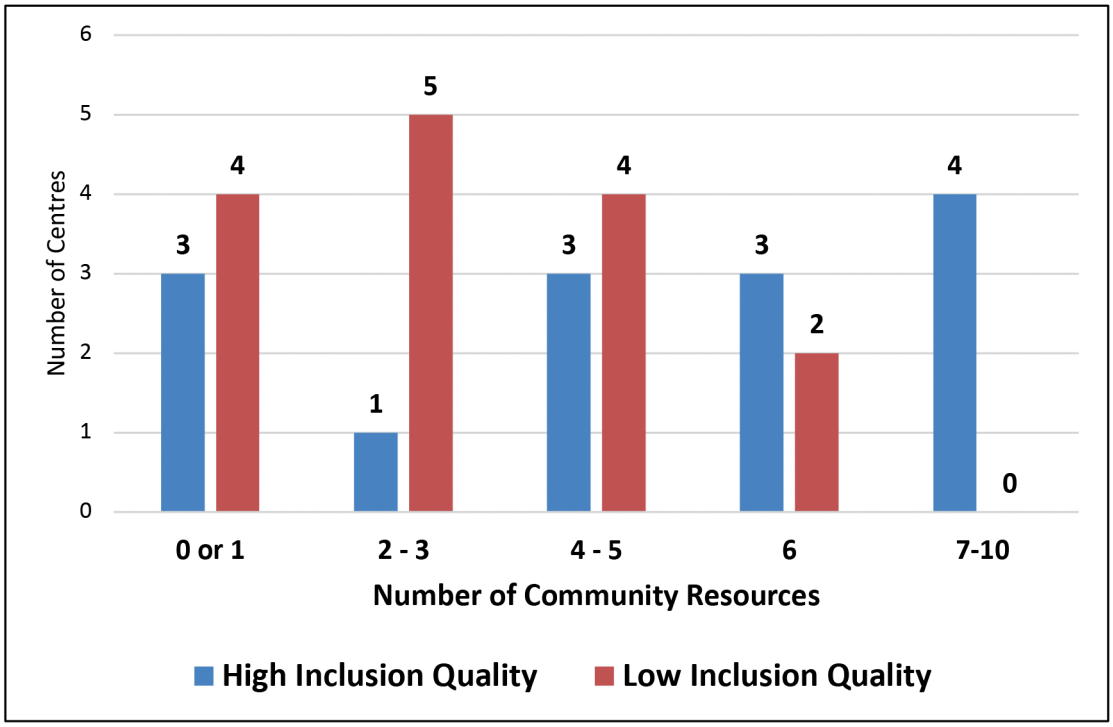
We would therefore expect to see that centres that are observed to demonstrate High Inclusion Quality (and who include a larger number of children with special needs) have access now, and have benefitted in the past, from positive relationships with a range of specialists and community resources that support their efforts. Likewise, we might expect to see that centres with Low Inclusion Quality scores (with few children with special needs enrolled) have limited access to community resources, leaving centre staff to do the best they can, but without the kind of resources that can provide guidance, specialized assistance, access to equipment and materials, and positive feedback to sustain their efforts.

Indeed, the data clearly show how different High Inclusion Quality and Low Inclusion Quality centres are in both the number and variety of resources available to them. The average number of resources identified by directors of the High Inclusion Quality centres was 4.9. While three of the 14 centres had only one resource assisting them at the time data were collected, almost two thirds of the directors in this group named five or more sources of community support they were working with and could be considered "resource rich". By contrast, the average number of community resources identified by directors in the Low Inclusion Quality centres was 2.9, with a median of 3. Almost half of these centres were relying on just one or two community resources and two of the 15 centres said they had no access to community resources to support inclusion. These centres would be considered "resource poor". Figure 15 on page 74 illustrates the differences between the High and Low Inclusion Quality groups.

DIRECTORS' PERCEPTIONS OF INCLUSION EFFECTIVENESS

As expected, there was a substantial and statistically significant difference in how directors of centres in the two groups rated how well they felt their centre and staff are doing in providing inclusive child care. On a scale from 1 to 10, the average rating by directors in the High Inclusion Quality group was 8.4 compared to 7.2 among directors of centres in the

Figure 15: Access to Community Resources by Centres in High and Low Inclusion Quality Groups



Low Inclusion Quality group. More specifically, almost all directors in the top group rated their centre as 8 or above, including five directors (36%) who rated their centre a 9 or 10. Eight of the 15 directors in the bottom group (53%) rated their centre's effectiveness as less than 8, including three directors who rated their current effectiveness as 4, 5 or 6 (the lowest ratings in the sample). Interestingly, two of the directors in the Low Inclusion Quality group rated their centre as a 9 or 10, a rating that did not match their scores on the externally administered *SpeciaLink Early Childhood Inclusion Quality Scale*.

Perceived Strengths

Centre directors in both groups identified strengths that contribute to their centre's success with inclusion as well as ongoing difficulties and challenges. Centre directors in the High Inclusion Quality group were more positive. Eleven of the 14 directors in this group identified three or more strengths (averaging 3.1 responses). Less than half of the centre directors in the Low Inclusion Quality group listed 3 or more strengths; 8 of the 15 provided two or fewer responses including one director who did not identify any strengths at this time and was clearly struggling.

The overwhelming majority of positive comments by directors in both groups highlighted early childhood educators' characteristics and competencies, include their commitment to inclusion, as shown in Table 19. Fewer directors identified external resources or supportive relationships with parents as primary strengths.

Table 19: Centre Strengths That Contribute to Inclusive Practice as Described by Directors in High and Low Inclusion Quality Centres

Inclusion Strengths	High Inclusion Quality Centres	Low Inclusion Quality Centres
ECEs' Characteristics and Competencies *	**93%**	**73%**
Staff committed to inclusion, open, seeking new ways to be effective	64%	40%
Staff knowledgeable, staff training; Staff includes an inclusion coordinator, someone with special training	36%	47%
Staff work well with agencies, professionals	29%	27%
Staff work well together, effective team, do strategic planning	29%	13%
Staff experienced, long-term staff, experienced with inclusion	31%	7%
Staff supportive of parents	7%	0%
The Centre's Philosophy, Inclusive Culture	**36%**	**33%**
Resources Provided to Support Inclusion *	**36%**	**13%**
Access to therapies, services	7%	13%
Extra staff, enhanced ratio, funding for extra staff	24%	7%
Resources and materials, equipment	14%	0%
Supportive Parents, Effective Partnership and Communication	**29%**	**13%**

* Percentage of centres in each group where directors identified one or more of the strengths below.

Based on responses provided by 14 directors of centres in the High Inclusion Quality group and 15 directors in the Low Inclusion Quality group.

ONGOING CHALLENGES / DIFFICULTIES

Directors in both Inclusion Quality groups identified an average of two sources of ongoing difficulties that affect inclusive practices. Their responses were fairly similar with a few notable exceptions (see Table 20 on page 76). Fully 100 percent of centre directors in the Low Inclusion Quality group identified some aspect of staff capabilities that were an ongoing challenge and were more likely than directors in the High Inclusion Quality group to identify weaknesses in staff training and lack of time and support to work together effectively as a team. Both groups (50% of the High Inclusion Quality and 60% of the Low Inclusion Quality directors) identified the lack of funding to support staff as an ongoing challenge. A higher percentage of directors of centres in the High Inclusion Quality group indicated that lack of support for parents of children with special needs is an ongoing concern.

Table 20: Challenges / Difficulties That Affect Inclusive Practice as Described by Directors of Centres in High and Low Inclusion Quality Groups

Inclusion Challenges	High Inclusion Quality Centres	Low Inclusion Quality Centres
Staff Capabilities	**64%**	**100%**
Need for more training for staff; supports for ongoing professional development	21%	40%
Staffing issues – finding qualified staff, shortage of relief staff, staff turnover	21%	20%
More time needed for staff to plan, work as a team, collaborate with parents and professionals	0%	27%
Staff need emotional support; challenging work	0%	13%
Lack of Funding to Support Inclusion	**50%**	**60%**
Funding needed for more staff to meet children's needs, enhance ratio, provide 1:1 support if needed; Funding to allow children to attend full time	57%	40%
Lack of funding and support leading to children being turned away; Lack of inclusion capacity to accommodate all children; lack of other centres accepting children with special needs	7%	13%
Lack of funds to purchase / replace equipment	0%	7%
Lack of Access to Specialists/Therapists; Long Wait List for Support, Services, Assessment	**29%**	**27%**
Difficulties Communicating with Parents; Lack of Support for Parents	**21%**	**7%**
Limited Space in Centre, Some Areas not Accessible	**14%**	**13%**

* Percentage of centres in each group where directors identified one or more of the strengths below.

Based on responses provided by 14 directors of centres in the High Inclusion Quality group and 15 directors in the Low Inclusion Quality group.

SUMMARY

This chapter provided a profile of the sample of 67 centres that participated in our study with respect to overall program quality as assessed by the *ECERS-R*, and inclusion quality, based on scores obtained on the *SpeciaLink Inclusion Quality Scale*. We also identify the characteristics of centres that had scores indicative of high and low inclusion quality. Key findings are as follows:

Overall Program Quality

- Somewhat more than half of the centres (54%) had scores indicating minimal or moderate levels of overall program quality, while 46% had scores in the good to excellent range. No centres in this sample were assessed as demonstrating poor overall program quality. The average score on the *ECERS-R* was 4.9.

- In general, centres have higher scores on the social and structural aspects of program quality with higher scores on staff-child interactions, program structure, and provisions for staff and parent-staff relationships. In many centres, scores indicate room for improvement in the provision of stimulating learning activities — both structured and unstructured — and in personal care routines.

- Although there was variation in observed program quality among the centres within each province, there were significant differences across sites. A higher proportion of centres had scores indicative of good to excellent program quality in Ontario and BC.

Inclusion Quality

- Scores on the *SpeciaLink Inclusion Quality Scale* covered the full range from inadequate to excellent. More than one in five centres (22%) had an average score below 3.0, indicating poor inclusion quality, while almost as many (21%) had scores indicating good or excellent inclusion quality. The average score on the *SpeciaLink Inclusion Scale* was just under 4.0 and the majority of centres clustered in the minimal to moderate range.

- Average scores on the Inclusion Principles subscale were significantly higher than on the Inclusion Practices subscale (average scores were 4.3 and 3.8, respectively). Scores on the Principles measure were more variable. Fifteen centres had scores in the inadequate range on one or the other measure, however almost 45% of centres had scores in the good to excellent range for Inclusion Principles, indicating a strong commitment to full inclusion.

- Items with the lowest average scores on the Inclusion Practices subscale indicate substantial room for improvement. These include: Support from a Board of Directors or Parent Advisory Board, Equipment and Materials, the Physical Environment, Staff Training, and Director's Active Involvement as an Inclusion Leader in the Centre and in the Community.

- Differences in Inclusion Quality scores were evident when the provinces were compared, although most had average scores in the moderate range. A notable outlier is Nova Scotia, which had much lower inclusion quality scores than the other provinces.

Scores on Both Program Quality and Inclusion Quality

- When centres' scores on the two quality measures are considered together, we find that the majority of centres (60%) had scores on one or both measures in the minimal to mediocre range.

- Less than one fifth of the sampled centres (18%) had scores in the good to excellent range on both quality measures.

What Distinguishes Centres with High Inclusion Quality?

Centres that had high scores on the *SpeciaLink Inclusion Quality Scale* had a number of distinguishing characteristics. They had higher scores on the *ECERS-R* measure of program quality and tended to enroll more children with special needs than other centres. Most critically, they had access to a wide range of community resources to support their efforts. Directors in these centres, who took on the role of being inclusion leaders, relied on staff who were knowledgeable, experienced, and worked well together as a team. While not without challenges, including having sufficient funding to support hiring additional trained staff, the combination of resources within the centre and resources available to the centre clearly distinguished these centres from others.

The next chapter provides an in-depth examination of the relationship between observed program quality and inclusion quality for the sample as a whole and in individual centres.

7. THE RELATIONSHIP BETWEEN INCLUSION QUALITY AND PROGRAM QUALITY

There are a number of ways to envision the relationship between inclusion quality and overall program quality. In this chapter we present analyses that address the key questions that led to this study.

1. Is there a gap between inclusion quality and program quality?

2. What is the relationship between inclusion quality and program quality? Is there evidence of a threshold of program quality that is needed to support inclusion quality?

IS THERE A GAP BETWEEN INCLUSION QUALITY AND PROGRAM QUALITY?

It is important to determine whether specific efforts are needed to address deficiencies in child care programs to effectively support the inclusion of children with a range of disabilities. The level and nature of program quality in a centre affects all the children present, including children with different abilities. However, in order for children with disabilities to be successfully included, rather than merely present, both overall program quality and those aspects that are critical to ensuring that children with special needs are welcomed and supported appropriately must be addressed.

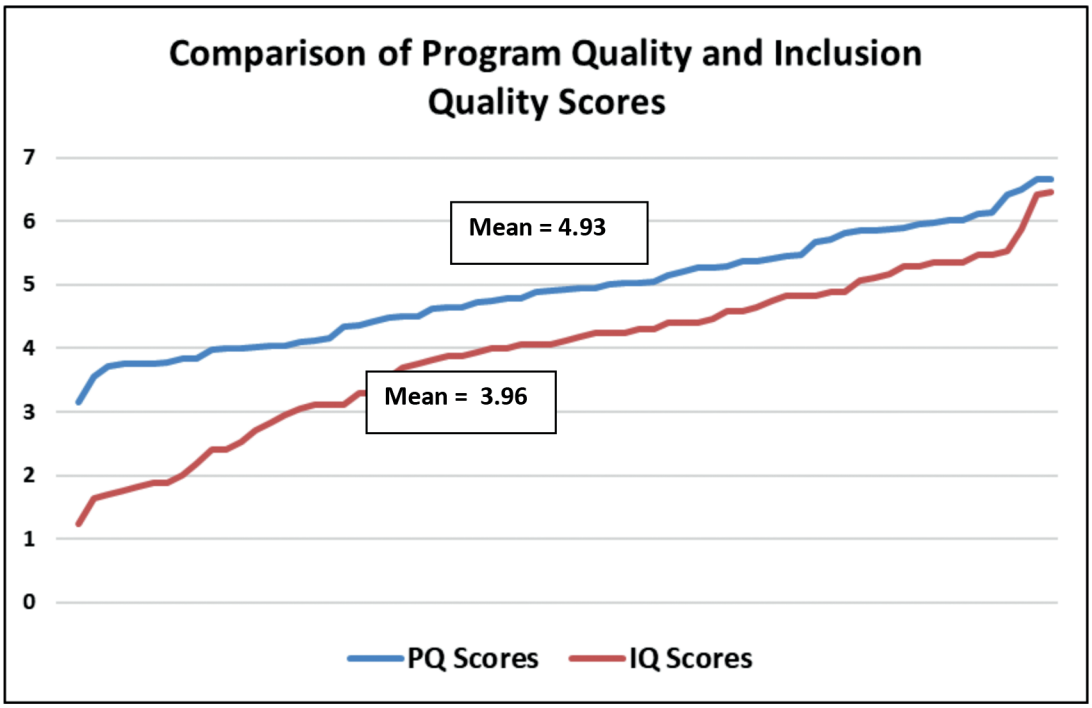
In this section we consider the question of whether there are significant Inclusion Quality —Program Quality gaps (IQ-PQ gaps) in the sample as a whole and in individual centres.

The IQ-PQ Gap: Overall Findings

In the previous chapter we provided descriptive information for the sample as a whole on scores obtained on the *ECERS-R* measure of program quality and on the *SpeciaLink* measure of inclusion quality. An examination of average scores on the two measures, as well as the distribution of centre scores in quality categories, clearly demonstrate a significant gap between observed inclusion quality and program quality.

• The average score on *SpeciaLink Inclusion Quality Scale* was almost a full point lower than the average score obtained on the *ECERS-R* measure of overall program quality for the full sample of centres (3.96 compared to 4.93). This difference is both meaningful and statistically significant (t= 6.822, df=66, p=.000).

Figure 16: The Gap Between Inclusion Quality and Program Quality Scores



Based on *ECERS-R* and *SECIQS* scores, n=67

Figure 17: The Gap Between Inclusion Quality and Program Quality — Distribution of Average *ECERS-R* and *SpeciaLink Inclusion Scale* Scores in Quality

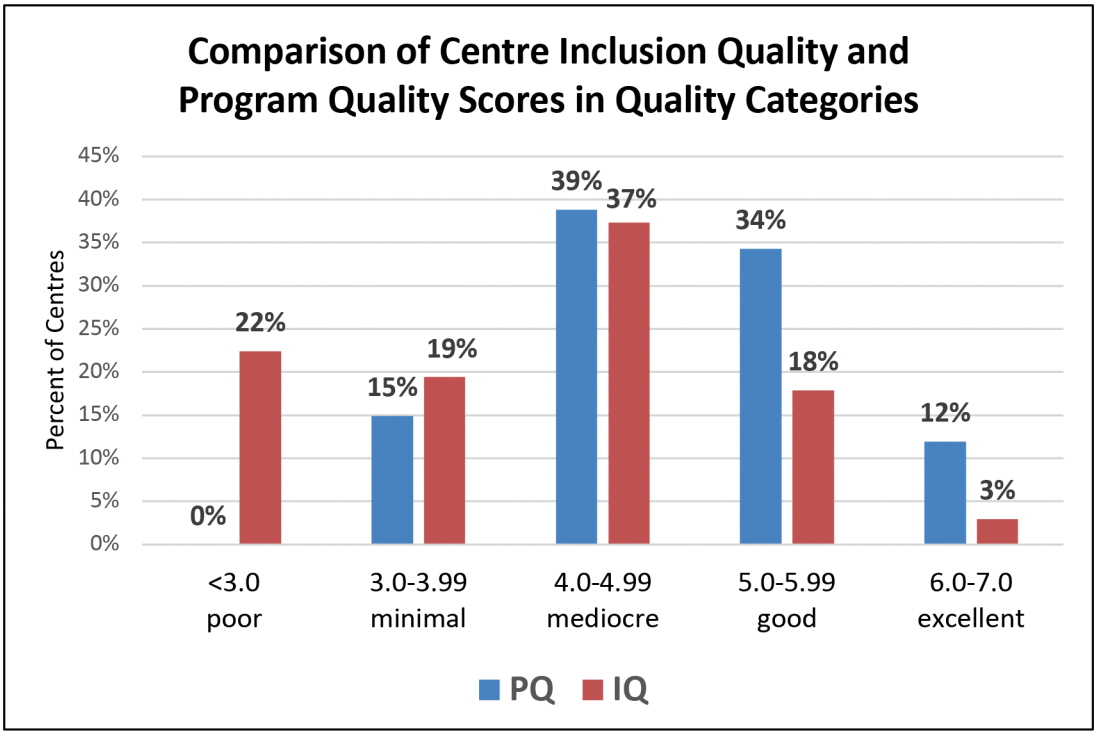
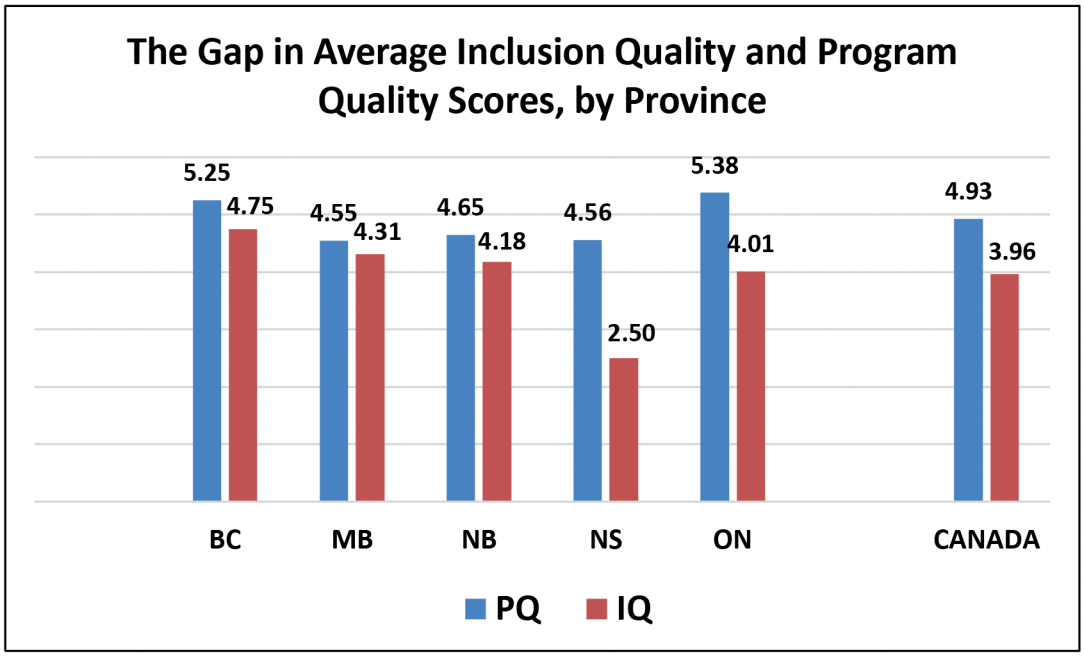


Figure 18: The Gap Between Average Inclusion Quality Scores and Program Quality Scores, by Province



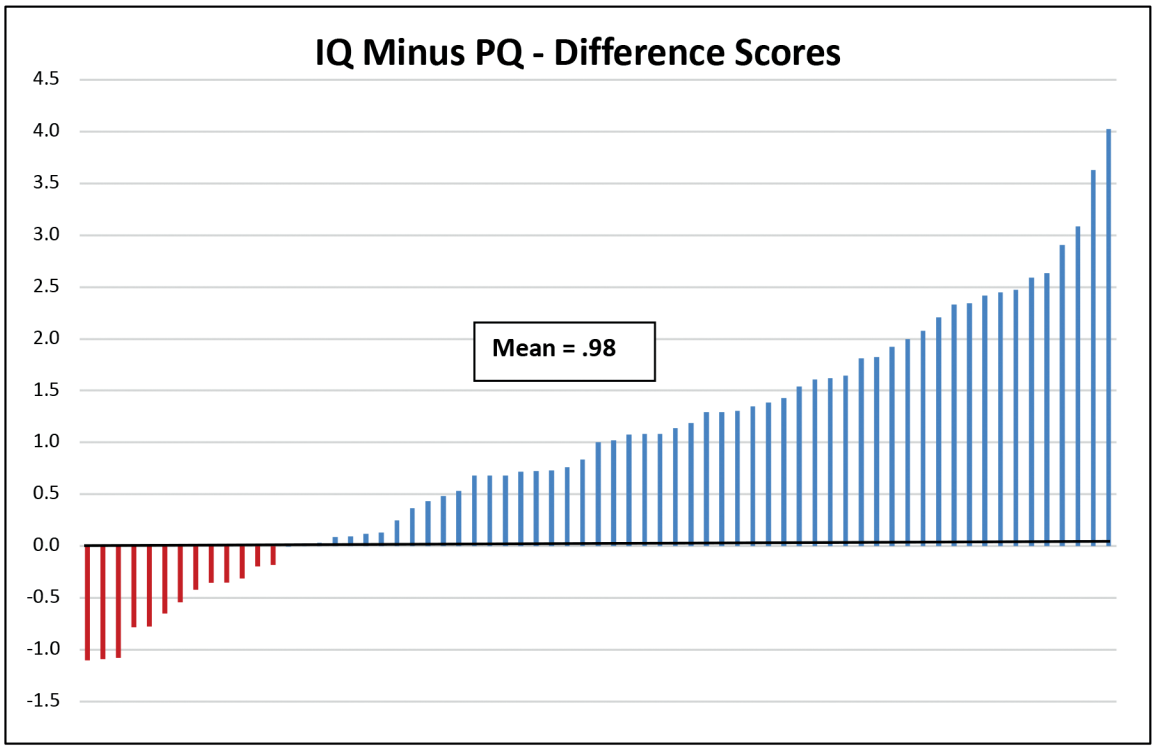
• In addition to the difference in average scores, the distribution of scores on the two measures was very different. No centre had an *ECERS-R* score indicative of inadequate program quality, while 15 centres (22%) had a score below 3.0 on the SpeciaLink scale. In addition, while 31 centres (46%) had scores indicative of good or excellent program quality, less than half that number (14 centres — 21%) attained scores in the good-excellent range for inclusion quality (see Figure 17).

• Average program quality scores were higher than average inclusion quality scores in every province. The difference was statistically significant in New Brunswick, Ontario, and, most dramatically, among centres in Nova Scotia. (See Figure 18 and Table 21.)

Table 21: Inclusion Quality — Program Quality Gaps Based on Average *ECERS-R* and *SpeciaLink Inclusion Scale* Scores, by Province

Province	IQ – PQ Gap	Average *SpeciaLink* Score	Average *ECERS-R* Score	Statistical Significance of Difference
BC	- 0.50	4.75	5.25	NS
MB	- 0.24	4.31	4.55	NS
NB	- 0.47	4.18	4.65	NS
NS	- 2.06	2.50	4.56	***
ON	- 1.82	4.01	5.83	***
TOTAL	**- 1.01**	**4.93**	**3.96**	***

Figure 19: The IQ-PQ Gap at the Centre Level



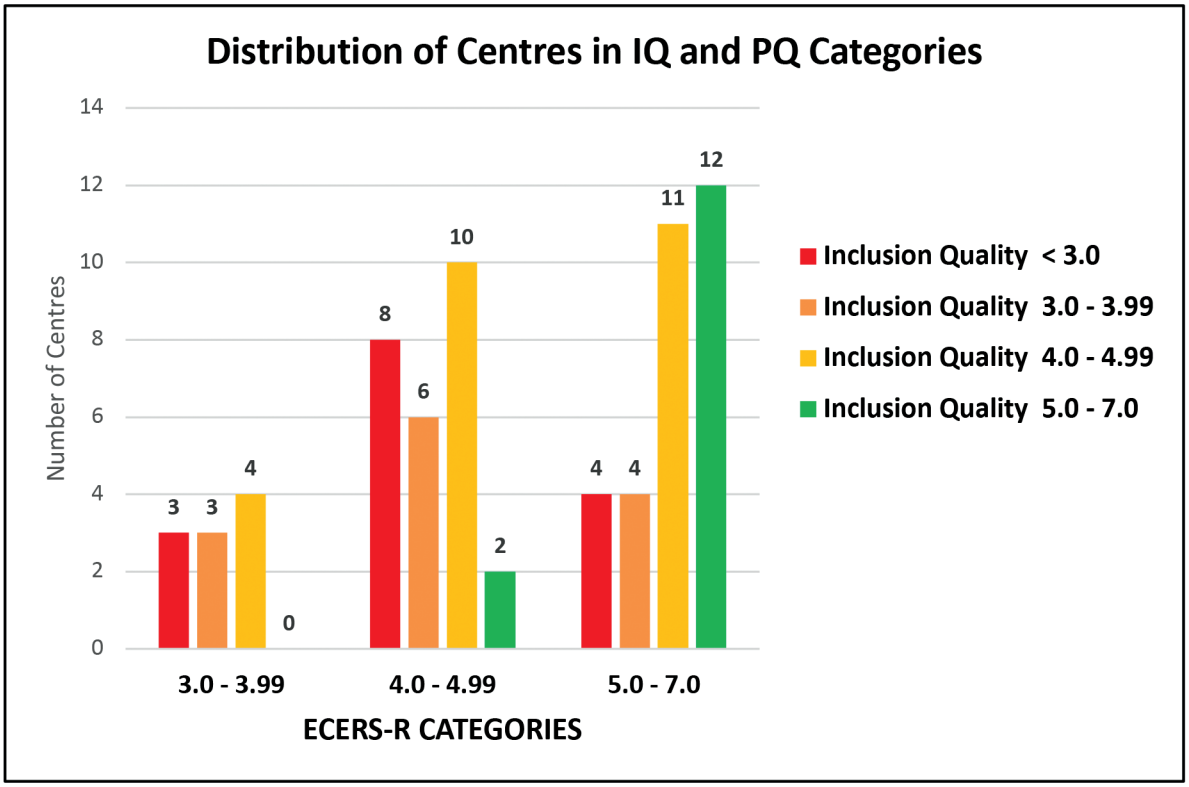
The IQ-PQ Gap in Individual Centres

We calculated the difference between *SpeciaLink* and *ECERS-R* scores obtained in each centre by simple subtraction. Difference scores ranged from — 1.1 to +4.0 with higher scores representing a larger gap between the centre's program quality score and observed inclusion quality.

Red bars in Figure 19 represent centres where the *SpeciaLink Inclusion Quality* score is higher than the centre's score on the *ECERS-R*. Blue bars signify centres where the *ECERS-R* score exceeds the SpeciaLink score. Thirteen centres had higher scores on the Inclusion measure, while the majority of centres had higher *ECERS-R* scores. We consider those centres with an IQ-PQ difference of 1.0 or more to be demonstrating a meaningful gap between program quality and inclusion quality. Using that criterion, fully half the centres in this sample (34 centres) evidenced a meaningful gap with higher scores for overall program quality than inclusion quality. Indeed, in 14 centres the IQ-PQ gap exceeded two full points.

The conclusion that is easily drawn from data from both the sample as a whole and at the individual centre level is that in many centres the quality of the environment for children with disabilities falls short of the quality afforded to typically developing children. We remind readers that this sample of centres likely has more resources and a longer history of including children with special needs than most centres across Canada. For that reason, we infer that the gap in scores we see here may be "a best-case scenario" compared to what we would find in average centres across Canada. It is imperative that inclusive centres

Figure 20: Distribution of Centres on Both Inclusion Quality and Program Quality



have the resources they require to meet the needs of all children and families in the community.

WHAT IS THE RELATIONSHIP BETWEEN PROGRAM QUALITY AND INCLUSION QUALITY?

A Positive Correlation

As a first step, we note as expected that there is a significant positive correlation between *ECERS-R* and *SpeciaLink Inclusion Quality* scores. The Pearson correlation coefficient is .43, significant at the .01 level. Higher scores on the *ECERS-R* measure are associated with higher scores on the Inclusion Quality scale and lower program quality is associated with lower inclusion quality.

Program Quality — A Necessary, but not Sufficient Condition for High Inclusion Quality

If high program quality were sufficient, on its own, to ensure high inclusion quality, we would see a perfect correlation. All centres with scores of 5.0 or higher on the *ECERS-R* would have high inclusion quality scores. An examination of Figure 20 shows that this is not the case. Thirty-one centres had a score of 5.0 or higher on the *ECERS-R*, however only 12 of those centres also demonstrated high inclusion quality.

If high program quality is necessary to ensure high inclusion quality,

then all centres with high inclusion quality (which we consider those with a score of 5.0 or higher on the *SpeciaLink Inclusion Quality Scale*) should have high *ECERS-R* scores. Likewise, centres with low or modest scores on program quality would be unable to have the capacity to demonstrate high inclusion quality. The data mostly confirm the hypothesis of a necessary relationship, which makes conceptual sense. Of the 14 centres with high scores on inclusion quality, 12 also have high scores on the *ECERS-R*. Moreover, only two of the 36 centres that had *ECERS-R* scores below 5.0 had high inclusion quality scores.

Is There Evidence of a Threshold of Program Quality Needed to Support Inclusion Quality?

In this sample, the two centres that had high inclusion quality scores but had scores below 5.0 on the *ECERS-R* had scores of 4.51 and 4.78 on that measure. No centre with an *ECERS-R* score below 4.50 had a *SpeciaLink Inclusion Quality score* in the good to excellent range. Further research may confirm whether a threshold of 4.5 or higher or 5.0 or higher on the *ECERS-R* or a similar instrument is necessary (but not sufficient) to ensure high inclusion quality. That being said, the goal of ECEC policy makers and professionals should be to ensure high program quality and high inclusion quality in all programs that serve young children and their families. In this particular study, 12 centres (18%) — less than one fifth of the sampled centres - scored in the good to excellent range on both quality measures. The majority of centres (60%) had scores on one or both measures in the minimal to mediocre range (3.0-4.99).

SUMMARY

What does our analysis tell us about the relationship between overall program quality and inclusion quality? The data support our hypothesis that good overall program quality is a platform that is required for good to excellent inclusion quality. All 14 centres that had high *SpeciaLink Inclusion Quality scores* had *ECERS-R* scores of at least 4.5 or higher and 12 of the 14 had *ECERS-R* scores of 5.0 or above, suggesting that a threshold of at least 4.5, but more conservatively, at least 5.0 or above, is important to assure high inclusion quality.

The data also confirm that high program quality is a necessary, but not sufficient condition for assuring high inclusion quality in child care programs. Specifically, 19 centres had *ECERS-R* scores that indicated good overall program quality, but they had *SpeciaLink Inclusion Quality scores* reflecting inadequate, minimal or mediocre inclusion quality. Clearly, while high overall program quality, as measured by the *ECERS-R*, is an important and necessary resource to support inclusion quality, there are other factors that are important contributors to inclusion quality that must be addressed by policy makers and professionals in early childhood programs if high quality inclusive care is to be a reality across Canada. Those other factors, which we identified as character-

istic of centres that demonstrate high inclusion quality, include the director's role as an inclusion leader; early childhood educators who are committed to, and knowledgeable about inclusion, experienced, and effective in working together as a team to support individual children's development and full participation in the centre; and parents who both support the centre's inclusion efforts and, in turn, receive appropriate support themselves. In addition, early learning and child care programs require timely, appropriate and collaborative support from a range of professionals and organizations in their community; and government funding to ensure that programs are accessible, and that additional staff are provided to reduce ratios and sustain positive, inclusive child care programs. Addressing these factors that are critical for inclusion quality is essential to close the gap between program quality and inclusion quality — thus ensuring that all children can benefit from community-based early learning and child care programs across Canada.

8. Lessons Learned and Recommendations

CONTEXT

Research and policy analyses have consistently confirmed that Canada needs a national, comprehensive approach to early learning and child care if it is to achieve important economic and social policy goals. Renewed federal leadership and funding, as evidenced in the *2017 Multilateral Early Learning and Child Care Framework Agreement* and the bilateral agreements with provinces and territories that have followed, highlight the importance of high quality programs that are accessible, affordable, flexible and inclusive in order to ensure that "all children can experience the enriching environment of quality early learning and child care so they can reach their full potential" (ESDC'S ELCC Innovation Program, 2019).

Following unprecedented experiences with the COVID-19 pandemic that have affected every aspect of life for families — including parents' employment and access to child care, the September, 2020 Throne Speech pledged greater involvement by Canada's federal government in rebuilding and transforming Canada's child care system as an essential pillar of Canada's economic restart and recovery. Doing so requires a national vision, shared by the federal and provincial/territorial governments, substantial funding, and policies and programs that are evidence-based.

Ensuring that children with disabilities have access to high quality, community based ELCC programs with appropriate supports to meet their needs cannot be an afterthought in policy development, funding, programs, or the development of strategies to strengthen and sustain the child care workforce. Our research findings, based on a voluntary sample of inclusive child care centres across Canada, provide clear evidence that most child care programs, while making a valiant effort to do so, are not able to provide disabled children and their parents with access to programs that can be considered to exemplify high inclusion quality. We also identify the critical need for resources — both within centres and provided to centres — that are essential to support and sustain inclusion quality.

This research study is one component in a larger project designed to improve inclusion quality in early learning and child care programs across Canada. The specific objectives of the study were:

- To assess levels of program quality and inclusion quality in a sample of inclusive programs;
- To examine whether there are gaps in the quality of programs available for children with disabilities by comparing the scores on program quality and inclusion quality across the sample and within individual centres;
- To examine the relationship between program quality and inclusion quality — specifically whether high program quality is a necessary and/or sufficient condition for inclusion quality and whether there is a program quality threshold that is required for high inclusion quality;
- To learn what factors affect the quality of children's learning and caring environments for children with disabilities by profiling those centres that evidence high and low inclusion quality;
- To consider what centre directors identify as strengths, specific challenges, and actions that can be taken to improve inclusion quality; and
- To inform policy, research, and practice to improve and sustain high program quality and high inclusion quality for all children.

KEY FINDINGS

1. PROGRAM QUALITY AND INCLUSION QUALITY PROFILES

Overall Program Quality

- Somewhat more than half of the centres (54%) had *ECERS-R* scores that ranged from 3.0-4.99, indicative of mediocre program quality; 46% of centres had scores above 5.0, in the good to excellent range. No centres in this sample had scores reflecting poor overall program quality. The average score on the *ECERS-R* was 4.9.
- There were significant differences in average program quality scores across regions. A higher proportion of centres had scores indicative of good to excellent program quality in Ontario and BC.

Inclusion Quality

- Scores on the *SpeciaLink Early Childhood Inclusion Quality Scale* covered the full range from inadequate to excellent. More than one in five centres (22%) had an average score below 3.0, indicating poor inclusion quality, while almost as many (21%) had scores indicating good or excellent inclusion quality. The average score on the *SpeciaLink Inclusion Quality Scale* was just under 4.0 and the majority of centres clustered in the minimal to moderate range.
- Average scores on the Inclusion Principles subscale were significantly higher than on the Inclusion Practices subscale (average

scores were 4.3 and 3.8, respectively). Almost 45% of centres had scores in the good to excellent range for Inclusion Principles, indicating a strong commitment to full inclusion.

- Items with the lowest average scores on the Inclusion Practices subscale indicate substantial room for improvement. These include: Support from a Board of Directors or Parent Advisory Board, Equipment and Materials, the Physical Environment, Staff Training, and Director's Active Involvement as an Inclusion Leader in the Centre and in the Community.
- Differences in *Specialink Inclusion Quality Scale* scores were evident when the provinces were compared. A notable outlier was Nova Scotia, which had much lower inclusion quality scores than the other provinces.

Scores on Both Inclusion Quality and Program Quality

- When centres' scores on the two quality measures are considered together, we found that the majority of centres (60%) had scores on one or both measures in the minimal to mediocre range.
- Less than one fifth of the sampled centres (18%) had scores in the good to excellent range on both quality measures.

2. THERE IS A GAP BETWEEN INCLUSION QUALITY AND PROGRAM QUALITY

One of the major questions motivating this study was to determine whether there is an observable gap between the quality of programs that affect all children who attend ELCC programs and inclusion quality — the extent to which programs welcome and support children with special needs and demonstrate the capacity to be adaptive and responsive to their individual circumstances. We estimated the gap between program quality and inclusion quality across the sample and within individual centres and found clear evidence of a significant gap between observed inclusion quality and program quality.

- The average score on the *SpeciaLink Inclusion Quality Scale* was almost a full point lower than the average score obtained on the *ECERS-R* measure of overall program quality for the full sample of centres (3.96 compared to 4.93). This difference is both meaningful and statistically significant.
- In addition to the difference in average scores, the distribution of scores on the two measures was very different. No centre had a score indicative of inadequate program quality, while 15 centres (22%) had a score below 3.0 on the *SpeciaLink Inclusion Quality Scale*. In addition, while 31 centres (46%) had scores indicative of good or excellent program quality, less than half that number (14 centres — 21%) attained scores in the good-excellent range for inclusion quality.
- Average program quality scores were higher than average inclu-

sion quality scores in every province. The difference was statistically significant in New Brunswick, Ontario, and in Nova Scotia.

- Fully half the centres in this sample evidenced a meaningful gap of at least one full point out of seven with higher scores for overall program quality than inclusion quality. Indeed, the IQ-PQ gap exceeded two full points in one fifth of this sample.

3. GOOD PROGRAM QUALITY IS A PLATFORM FOR INCLUSION QUALITY. HOWEVER, WHILE IT IS NECESSARY, HIGH PROGRAM QUALITY IS NOT SUFFICIENT ON ITS OWN TO ENSURE HIGH INCLUSION QUALITY.

- Our analyses confirmed that good program quality is required as a support for good inclusion quality. No centre that was observed to have a score of 5.0 or higher on the *SpeciaLink Inclusion Quality Scale* had a score lower than 4.5 on the *ECERS-R* measure of program quality.
- However, good program quality, on its own, does not ensure high inclusion quality. Specifically, 19 centres (28%) had scores that indicated good overall program quality, but had *SpeciaLink Inclusion Quality scores* reflecting inadequate, minimal or mediocre inclusion quality.
- In this particular sample of inclusive centres, 18% — less than one fifth of the sampled centres — scored in the good to excellent range on both quality measures. The majority of centres (60%) had scores on one or both measures in the minimal to mediocre range.

4. CENTRES THAT EVIDENCE BOTH HIGH PROGRAM QUALITY AND HIGH INCLUSION QUALITY ARE MORE LIKELY TO HAVE A MIX OF IN-CENTRE RESOURCES AND RESOURCES PROVIDED TO CENTRES THAT ARE IMPORTANT FOR INCLUSION QUALITY.

Centres that had high scores on the *SpeciaLink Inclusion Quality Scale* had a number of distinguishing characteristics, in addition to having higher scores on the *ECERS-R* measure of program quality. They tended to enroll more children with special needs than other centres and were less likely to exclude children with disabilities for reasons related to physical accessibility or staff confidence. A combination of directors' perceptions of their strengths and difficulties in providing inclusive care and education and comparisons of scores obtained on individual items on the Practices subscale of the *SpeciaLink Inclusion Quality Scale* demonstrated that these "best practices" centres had:

- Directors with more experience who are inclusion leaders both in their centres and in their communities;
- Staff whom they described as committed to inclusion, knowledgeable, experienced, and effective in working well together as a team and supported parents;

- Access to a wide range of community resources to support their efforts; and
- Fewer challenges in obtaining sufficient funding and additional staff in addition to ratio. A number of these centres had access to inclusion coordinators/resource consultants who provided information, access to resources, role modeling and support for all staff.

These findings have both policy and practice implications that are reflected in the recommendations that follow. Here, we underscore the fact that it is imperative that early learning and child care programs have the resources they require to meet the needs of all children and families in the community. This cannot be left to chance if governments are serious about their stated goals, nor ignored as plans are made for the transformative changes in child care policies and programs that are required across Canada.

RECOMMENDATIONS

Over the past several decades there has been a strong convergence of developments in public policy and legislation, practice, and public support that makes us cautiously optimistic about the future of inclusive child care for children with disabilities in Canada. However, there is a long way to go before children with disabilities have the same opportunities to attend quality child care as do other children, with accommodations and adaptations that meet their unique needs.

Federal commitments to develop a system of high quality, affordable, accessible, inclusive child care programs across Canada have been made before. The current pandemic has made visible how critical child care programs are as an essential support to families, children, communities and the economy (Employment and Social Development Canada's [ESDC] Early Learning and Child Care [ELCC] Innovation Program, 2019). The most recent Speech from the Throne (Trudeau, J., 2000) again identified child care as an essential program that must be supported and expanded. Attention to the needs of children with disabilities must not be an afterthought in policy planning, workforce strategies and funding.

From the early 1970s, under the *Canada Assistance Plan* (*CAP*), most provinces saw some children with disabilities included in community-based child care centres. In the 1980s and 1990s, under strong parental and disability organizational advocacy, provinces began to encourage integration or mainstreaming, and many specialized centres either closed or developed into integrated centres. By the end of the 1990s, more children with disabilities attended mainstream child care. But attendance was not a right; it was a privilege. With a persuasive parent, a particularly adorable child, perhaps a centre director who was committed to inclusion — some children with disabilities were included. But children had to earn their right to enroll and stay in many centres.

Until 2005, when Foundations: A National Early Learning and Child Care Program of the federal government was introduced, no F/T/P agreement had specified "inclusion of children with disabilities" in any

of its principles. The Foundations Program, under Minister Ken Dryden, stated that "Early learning and child care should be inclusive of, and responsive to, the needs of children with differing abilities; Aboriginal (i.e., Indian, Inuit and Métis) children; and children in various cultural and linguistic circumstances…." Inclusion became one of the QUAD principles, the others being Quality, Accessibility, and Developmentally Appropriate. Unfortunately, this agreement only lasted two years until the Harper government was elected and closed those doors.

From 2005 to 2017, despite the lack of federal funding or leadership, provinces reported increasing inclusion of children with disabilities; post-secondary ECE training programs reported the addition of courses and specializations regarding children with disabilities; and inclusion became a regular topic at child care conferences. Moreover, popular media presentations of children with visible disabilities in typical settings had increased public acceptance of the concept of inclusion.

While these developments were positive, it remained to be seen whether Canadian governments (and the public in general) would develop and support effective policies and program approaches to ensure that high quality, affordable, accessible, inclusive child care for all children would become a sustainable reality. Families with children with disabilities were often still marginalized from community-based child care.

Thus, the Liberal government's Multilateral Early Learning and Child Care Framework (ESDC'S ELCC Innovation Program Framework, 2017) and its accompanying funding commitments was a positive step forward. In the F/T/P agreements that were signed for a 3-year period, to be followed by renewal for the next seven years, "children with differing abilities" were specifically included as a vulnerable group, to be addressed in the provincial Action Plans and progress reports. Several of the first year Progress Reports specifically describe progress in their plans for increasing the number of children with disabilities included and increasing centres' inclusion quality.

Now that work is being done for the 2022-2025 period and beyond, governments have the opportunity, when negotiating the bi-lateral agreements, to develop and strengthen policies, programs, and initiatives to improve the situation of children with disabilities.

The authors of this report are strongly supportive of the child care agenda proposed by Child Care Now (formerly the Child Care Advocacy Association of Canada) which addresses the significant deficiencies in current policies and provision that affect most families who need affordable, high quality child care in their communities. In addition, there are other elements that are necessary to ensure high quality, inclusive child care that require additional attention from the federal/provincial/territorial governments as listed below.

Based on our research findings in this report and three decades of research, advocacy, and support for child care programs, we make the following recommendations:

FOR EMPLOYMENT AND SOCIAL DEVELOPMENT CANADA

We recommend the following changes and expansions to the *Multilateral Early Learning and Child Care Framework* and to further policy development related to early learning and child care, as well as to the bilateral agreements developed with provincial and territorial governments pursuant to the Framework:

1. Change the phrases "differing abilities" and "varying abilities" to "children with disabilities." People in the disability community usually refer to themselves, their children and their clients as "persons with disabilities" as does the UN Convention on the Rights of Persons with Disabilities that Canada has signed.

2. Include "children with disabilities" as a distinct category in the inclusivity sections of the agreements and in progress reports. While this group is no more important than other vulnerable groups, it is the only one that shows up in all ethnic, linguistic, income, and geographical groups.

3. Include provision for children with disabilities in all action plans. Planned actions must include an increase in the number of children with disabilities included; in the types and levels of severity of disabilities included; in the number of ELCC centres that are inclusive (including at least 10% of children with disabilities), and in the quality of inclusion provided.

4. Additional or expanded funding to support inclusion through specific programs or funding agreements should be identified separately in agreements, Action Plans and progress reports.

5. Include leadership training as part of the quality component of the ESDC'S ELCC Innovation Program Framework, 2017. Of course, leadership is always important, but it is especially important in an emerging area such as inclusive ELCC. Our research has shown that centre directors' leadership has an extremely strong effect on staff attitudes, acceptance, and effectiveness when including children with disabilities. Training related to inclusion that focuses on directors as inclusion leaders as well as on front-line staff should be an important measure of the quality component of the provincial Action Plans.

6. Federal, provincial and territorial governments (and municipal service managers in Ontario) must develop comprehensive policies and initiatives to promote, monitor, and support both overall program quality and inclusion quality and to eliminate the gap between overall quality and inclusion quality that exists in most child care centres. These policies and supports should be developed collaboratively with child care professionals, appropriately resourced, and evaluated on a regular basis to ensure continued improvement. Our research shows that there are valid and reliable instruments for measuring inclusion quality. Children with disabilities deserve to participate in community-based programs that are developmentally appropriate for them as individual children, support their parents, and are part of an integrated system of supports for young children.

7. Valid and reliable methods should be used to collect and analyze national and provincial/territorial data on children with disabilities (by age) on a regular basis. Statistics Canada should ensure that this is part of its ongoing survey research, including data on whether children and families are able to access child care and other services and supports.

8. In addition, comparable administrative data should be collected and made publicly available by the provinces and territories on the number of young children with disabilities and their participation in ELCC programs, including the number of children with varied types and severity levels of their disabilities, and the number of centres including children with disabilities. We recommend regular monitoring of inclusion quality in centres – including unmet needs and challenges centres are facing as critical information for policy planning and quality improvement.

FOR THE PROVINCES AND TERRITORIES

Most provinces and territories provide some funding and supports for centres to include children with disabilities. Our research suggests a number of important directions and efficiencies that may assist them in providing higher quality inclusion.

A Focus on Policy

Provincial/territorial policies must support effective inclusion practice. Funding must be provided to ensure that centres and their staff have access to the resources (both financial and human) needed to continue to be effective and to expand their capabilities and ensure that early childhood educators are compensated for the valuable work they do. Among policy concerns to be addressed are:

9. Child care centres that enroll children with disabilities must have timely access to child assessments, both to determine eligibility and to assist child care staff in their planning efforts.

10. Child care centres must have additional funds to enhance ratios (or employ an in-house resource teacher) when four or more children with disabilities are enrolled, or when any children have severe disabilities. Funding should be stable and adequate to recruit and retain trained and experienced ECEs for this work.

11. Inclusion consultants also must be available to child care centres that enroll fewer than four children with disabilities and, ideally, should support all child care programs as needed.

12. Child care centres must have appropriate levels of support from therapists and other related specialists in the community when they enroll children with disabilities.

13. Child care centres must have additional inclusion assistants when they enroll children with more challenging needs.

14. Since accessibility and physical structure are so closely related

to both inclusion quality and global quality, all new centres must be purpose-built to meet current standards, and older centres must be eligible for capital grants to increase accessibility.

A Focus on Research

15. Governments must fund thorough evaluations of the effectiveness of different models of inclusion support and initiatives undertaken to increase inclusion capacity and inclusion quality. These evaluations should be used for continuous improvements in policies and service provision.

16. Governments must fund the monitoring of progress toward "inclusiveness" in child care programs. Tools for monitoring inclusion quality — for example the *SpeciaLink Inclusion Scale* — are available and are familiar to the field.

A Focus on Leadership

Our research confirms the critical role of the child care centre director as an inclusion leader. Some of the centres in this study and in our earlier research lacked resource teachers; some lacked regularized funding for the extra costs of resource supports; some lacked strong boards — but none of the successful programs lacked strong, committed directors. Activities and programs that enhance that role are critical. Fully inclusive child care centres are still rare, and their sustainability is in question as founding directors retire or move on and as child care programs cope with unstable enrollments and increased costs related to COVID-19. Despite the urgent need for new qualified front-line early childhood educators, we must also invest in our leaders and our potential leaders as an important component of national and provincial/territorial workforce strategies.

There is a tremendous reserve of "practice wisdom" that should be widely shared and utilized to enhance inclusive practice and to encourage the next generation of directors and child care professionals.

We strongly recommend that:

17. Governments identify successful, inclusive directors as key change agents, and fund projects that enhance their impact on the broader child care community. This can be achieved through projects that:

- Bring key people from successful inclusive child care sites together to share learnings and best practices, and to strategize with policy makers, professional organizations, post-secondary ECE programs and local child care groups about practical initiatives that can enhance inclusion quality;
- Sponsor inclusion leadership training institutes for directors, and for potential directors with demonstrated commitment to inclusion;
- Support networking opportunities for directors/supervisors of inclusive centres, including the development of local communities of practice;

• Create national and provincial/regional mentorship programs for inclusion, with successful directors/supervisors of inclusive centres as mentors, nominating in-province leaders who are "ready to include";

• Build and sustain capacity through child care resource centres, provincial organizations, the Canadian Child Care Federation and SpeciaLink, including programs that utilize new technologies and web-based portals to expand access to information, opportunities to share experiences, and obtain peer support and mentoring that involves directors/supervisors — credible practitioners — as key figures;

• Promote a career ladder and encourage existing successful inclusion practitioners to become trainers.

18. Governments must fund a variety of opportunities (using in-person presentations, print materials, videos, web-based resources, and on-line coaching) to share with others the knowledge acquired by leaders in inclusive child care.

A Focus on Training and Support

19. Provincial and territorial governments must ensure that there is a variety of courses, conferences and workshops on inclusion that are accessible, affordable, and available to staff and directors on an ongoing basis, addressing the range of topics and issues that are important for successful inclusion.

20. College and university programs in ECE must incorporate more materials about inclusive practice in their curricula and in post-diploma and graduate courses.

21. Practica and placement courses in ECE and related programs must be strategically developed to ensure that students have the opportunity to learn about inclusion by participating in successful inclusive centres.

22. Colleges and universities must re-conceptualize (in consultation with the field) post-diploma/certificate and graduate programs for resource teachers and special needs workers in early childhood education. These should reflect the multiple roles of direct service, collaborative practice, consulting, family support, and adult education. Training programs should also be developed to address the needs of short-term contract workers (inclusion assistants) who work in inclusive child care settings, often without training.

23. Successful intensive inclusion quality enhancement programs, such as *Keeping the Door Open* in New Brunswick (Van Raalte, D.L., 2001); *Measuring and Improving Kids' Environments* (MIKE) in Prince Edward Island; and *Partnerships for Inclusion* in Nova Scotia, typically offered as pilot projects or limited time research projects, should be offered to centres in all provinces and territories with ongoing support, monitoring and evaluation. These initiatives provide on-site assessment, collaborative planning with centre directors and early childhood educators, and support to improve both overall program quality and inclusion quality.

A Focus on Planning for Transitions

Provincial/territorial policy must support a collaborative, inter-disciplinary approach among early years professionals, including school personnel to ensure effective transition planning and continuity of support.

24. Early years personnel must develop protocols and strategies for effective planning and coordination of efforts to assist with child care transitions (from home or early intervention/infant development to child care, and from child care to school).

A Focus on the Profession

Considerable variation exists in the roles, training, caseload size, duration and frequency of visits, focus of service, etc. of inclusion consultants in child care as well as access to specialized resources. An integrated community-wide approach to service delivery must be developed and supported to meet the needs of all young children with disabilities across Canada.

25. As an emerging profession, leaders in the field of early childhood intervention and resource teachers/specialists must define their own code of ethics, mandates, appropriate caseloads, and standards of training and practice. Funding must be allocated for research and development projects oriented toward this goal.

Toward a System of High Quality, Affordable, Accessible, Inclusive Child Care Programs Across Canada

26. Federal/provincial/territorial governments must strengthen the funding component of the Multilateral Framework on Early Learning and Child Care to build a national Canadian child care system that includes career ladders with graduated salaries and assures a continuing infrastructure to support high quality, inclusive programs.

SPECIALINK CENTRE QUESTIONNAIRE

(to be completed by centre director/supervisor)

I. CENTRE DEMOGRAPHICS

Please describe your centre:

1. Is your child care program a: (Check all that apply)
   - ❒ Nursery school or preschool program (half-day program)
   - ❒ Full-day child care centre
   - ❒ Program for school-age children

2. The number of children your centre is licensed for: __

3. The number of children who attend on a full-time basis: _____

4. The number of children who attend on a part-time basis: _____

5. The children who attend your centre range in age from:_____
   to _____

6. Is your centre affiliated with any organization or agency?
   (Please indicate below)
   - ❒ no affiliation—a stand-alone centre
   - ❒ a YMCA or YWCA
   - ❒ a child care organization that operates several centres
   - ❒ a child care organization that operates centres and home child care
   - ❒ a municipal government
   - ❒ a workplace
   - ❒ a military base
   - ❒ a college or university
   - ❒ a school
   - ❒ a church or other religious organization
   - ❒ a family resource program or other community agency
   - ❒ other (Please specify) _____

7. How long has your centre been operating? (since)

8. Is your centre considered:
   - ❒ a non-profit centre
   - ❒ a private/commercial centre
   - ❒ a municipal centre

9. Would you describe yourself as:
   - ❒ a director/supervisor with administrative responsibilities only
   - ❒ a director/supervisor with teaching responsibilities
   - ❒ other (Please specify) _____

10. How long have you worked in the child care field? years.

11. How long have you worked in this centre? _____ years.
    How long have you worked as director/supervisor?_ years.

II. HISTORY OF INCLUSION

12. When did this centre first begin including children with special needs?_____

13. a) Is there a point when this centre began to include children with special
needs on a regular or continuing basis? Or has it been more irregular?
❒ Not including children on a planned, regular basis (skip to Question 14)
❒ On a regular basis since: _____
b) What influenced you/your centre to begin including children with special needs on a regular basis?
_____
_____
_____

14. How many children with identified special needs are currently attending your centre?_____

15. Is this number ❒ more than usual? ❒ fairly typical? ❒ less than usual?

16. Are there children whose condition or particular needs are such that you are unlikely to accept them in your program?
❒ No ❒ Yes

17. If you answered "Yes" to Question 16, please elaborate. In what situations would you be unlikely to accept a child and why?
_____
_____
_____

18. Have you had to turn down any children with an identified disability or special need in the last 3 years?
❒ Yes How many children? _____
❒ No (If no, please skip to Question 20)

19. What were the main reasons that caused you to turn down a child (or children) from your program? (Please check all that apply)
❒ Physical access to program/rooms
❒ Child too aggressive
❒ No funding available
❒ Complex health concerns could not be addressed (e.g. tube feeding, catheterization)
❒ Loss of centre-based resource teacher/support worker
❒ Unable to access external support services (e.g. early inter ventionists, physiotherapist, etc.)
❒ Centre was fully enrolled—no spaces
❒ Child required 1:1 attention
❒ Child not toilet trained
❒ Staff not trained
❒ Staff not willing

- ❒ Difficult to meet parents' expectations
- ❒ Inadequate support from local resource consultants
- ❒ Could not find or hire aide
- ❒ Already had maximum number of children with special needs
- ❒ Other_____

_____

III. CURRENT INCLUSION PRACTICE

20. Please rate how well you feel your centre and staff are currently doing in providing inclusive child care in your community. Use a scale of 1 to 10, where 1 would indicate that you are not doing at all well, and 10 suggests ideal, or close to your ideal, of inclusive practice.

1 2 3 4 5 6 7 8 9 10

21. Please describe what you feel are the strengths of your program in providing care and education for children with special needs.

_____

_____

_____

22. Please describe what you feel are challenges or difficulties you currently are experiencing or aspects you would like to change.

_____

_____

_____

23. What supports or resources in your community are helping you to provide inclusive care? (Please be specific: who helps; what do they provide for you?)

_____

_____

_____

24. What additional supports/resources/training would assist you your staff to provide high quality inclusive care?

_____

_____

_____

25. Have you or your program participated in any special initiative in the last years to improve program quality or inclusion effectiveness?

❒ No ❒ Yes (Please describe)_____

THANK YOU SO MUCH FOR YOUR TIME IN RESPONDING TO THIS QUESTIONNAIRE! IF YOU WOULD LIKE TO ADD ANY COMMENTS, PLEASE DO SO ON THE BACK.

Would you like to receive a summary of our findings from this survey?
If so, please make sure we have your full mailing address and/or e-mail address:

_____

_____

GLOSSARY

The child care field has not yet settled on common terms for occupations and concepts related to inclusion. In some ways, the field is now where it was twenty years ago with the terms "child care worker," "daycare worker," "ECE," and "Early Childhood Educator" — when the terms were often used interchangeably or differently in different provinces. In most situations, the term Early Childhood Educator (or ECE) is now commonly used. We realize that some terms (e.g., "child with special needs") are evolving, and that some of the terms we have chosen may soon go out of use.

"Authorized" spaces: This term has been used in British Columbia to denote case-by-case funding to child care centres that include a child with special needs. The funding is for a specified period, and ceases when the child leaves the centre. (See also "contracted" spaces.)

Child with disabilities/child with special needs: In this report we use these two terms interchangeably. International conventions, such as the *UN Convention on the Rights of Persons with Disabilities* (2008) use the term "children with disabilities." However, usage of the term "child with special needs" is still used frequently in the child care field. In some provinces, the term "child with extra support needs" seems to be favoured.

In some Canadian government documents, the phrases "children with varying abilities" or "children with differing abilities" are used to discuss these children. The structure "child with…" has been adopted by many organizations, replacing the phrase "disabled child" used earlier in the *UN Convention of the Rights of the Child* (1989). The usage has been developed so that "the child is a child first" and then comes the disability.

"Children with special needs" (or disabilities) refers to children whose disabilities/disorders/health conditions meet your province's eligibility criteria for additional support or funding in child care settings. In areas with no additional support or funding, this term refers to children with an identified physical or intellectual disability that would be classified as moderate to severe. This definition does not include children usually described as being at high risk, who have not actually been identified as having a significant disability or delay — even though such children may require curriculum modifications and/or additional attention. Depending on your province/region, a child with significant emotional and/or behavioural problems may be classified either as a child with special needs or as a child at risk."

"Contracted" spaces: This term has been used in British Columbia to denote a child care centre or a specialized facility that had a contract with the Ministry to provide services to children with special needs. Funding for the contract was built into the budget of the facility on a yearly, and generally renewable, basis. (See also "authorized" spaces.)

Inclusion assistant/special needs worker/contract staff: In contrast to a resource teacher (RT), an inclusion assistant, special needs worker/contract staff is often hired on a limited term contract to work at the centre while a particular child/ren with special needs attends. There is no long-term com-

mitment from the centre that lasts beyond the contract. Hours of work may be reviewed at intervals, decreasing as the child needs less support.

Because these are short-term jobs, they are often filled by new ECE graduates or by community members without either special needs training or ECE training. These staff are usually paid only on days when the designated child is in attendance.

"Inclusive" child care centres: This term is used to refer to child care centres that enroll at least one child with special needs who meets the criterion of "special needs," as defined by that province. We use the term "fully inclusive child care centres" to refer to centres that have an inclusion policy that embodies the principles of "zero reject," "natural proportions, "same hours of attendance as other children," "full participation," "advocacy and maximum feasible parent participation," and that provide evidence of a wide range of children with disabilities in their enrollment and evidence of high inclusion quality. The term "inclusive" supersedes both "mainstream" and "integrated" in popular usage.

"Integrated" centres: The term was common throughout Ontario during the late 1980s and 1990s, where it meant a child care centre with an integrated license — one which included at least four children with designated disabilities or special needs and was funded for a half day resource teacher. In other provinces the term did not have an explicit meaning, but was usually used to describe centres that included children with special needs on a regular basis. (See "inclusive" centres.)

"Purpose-built" centres: A term used to describe buildings designed and built for child care. Universal Design or UD takes purpose-built a big step forward, incorperating design elements that make attendance possible for all children and all adults.

Related service professionals (related health professionals): This term includes all the therapists/specialists such as speech and language therapists, occupational therapists, physical therapists, behavioural therapists, etc. who work with children with special needs who attend child care centres.

Resource consultants (RCs) or Inclusion consultants (ICs): These external staff usually serve a group of child care centres, preschools, family day homes and other facilities that enroll children with disabilities. Caseload sizes vary greatly across Canada, from 2-4 children to a more customary 20, but even to 30 or more. Most RCs have diplomas in Early Childhood Education and an additional certificate or training in special needs/inclusion, as well as experience in early childhood programs. They often see their roles as facilitative, not direct service, although they frequently model the strategies or routines they are recommending.

Resource teacher (or RT): This term refers to a staff member, in addition to ratio, who facilitates inclusion through consultation, role-modeling, role release, resources, meeting with related service professionals, and who may provide regular or periodic direct (hands-on) support to a child or children with special needs. As we define this term and differentiate it from "special needs workers/contract staff," the resource teacher has an ongoing position in the centre that does not end when a particular child leaves the centre.

Many, but not all, resource teachers have formal training in special needs or inclusion beyond their basic ECE diploma, and have worked as ECEs before becoming in-house RTs.

Specialized or segregated centres: These centres either serve only children with disabilities or serve a large percentage of children with disabilities. They are used less frequently than in the past, but are still seen for children with severe disabilities.

Therapists/specialists: This term is used to refer to physical therapists, occupational therapists, speech and language pathologists, behavioural consultants, and other therapists and specialists who work with children with special needs who attend child care centres. Occasionally, the term is also used to include physicians, nurses, licensed practical nurses, who work with children with disabilities who attend child care centres.

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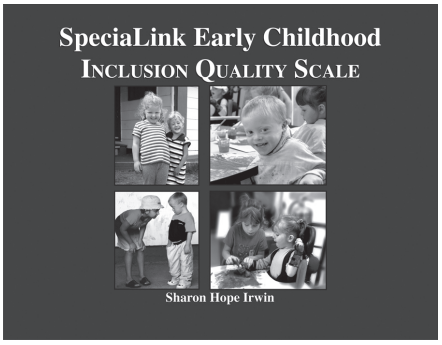

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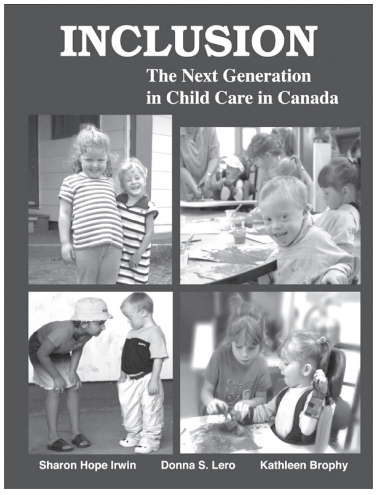

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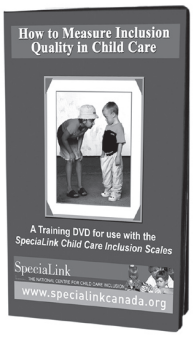

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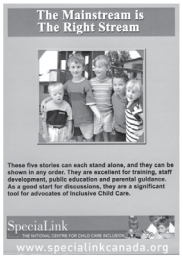

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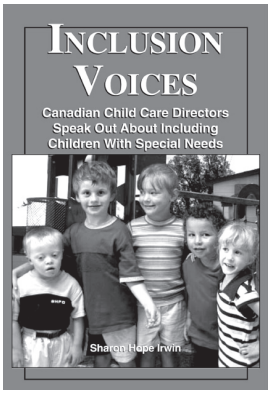

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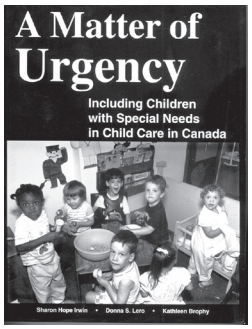

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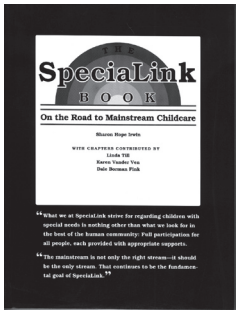

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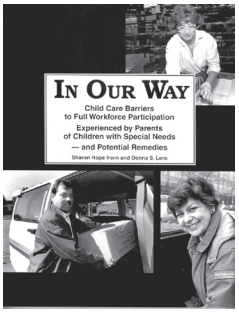

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